MOUNTAIN REGIONAL SERVICES, INC.

Employee Benefit Plan

Effective:	February 1, 1992
Restated:	February 1, 2011
Group No.:	02166

P.O. BOX 27267
MINNEAPOLIS, MN 55427-0267

MOUNTAIN REGIONAL SERVICES, INC.

EMPLOYEE BENEFIT PLAN

This Plan is written, adopted and operative under the provisions of the Employee Retirement Income Security Act of 1974, as may be amended, and for the sole and exclusive purpose of providing to the Eligible Employees and their Eligible Dependents employee welfare benefits as described herein.

The Plan agrees to provide the Benefits set forth in the Schedule of Benefits to all Covered Persons in accordance with the provisions and conditions of the Plan.

The Plan is subject to all the conditions and provisions set forth in this document and subsequent amendments that are made a part of this Plan.

It is understood by the Employer that once claim processing has begun, any claims needing to be reprocessed as a result of changes or corrections to this document may result in a reprocessing fee.

Mountain Regional Services, Inc. has caused this RESTATED Plan to take effect as of 12:01 a.m., local time on February 1, 2011 at Evanston, Wyoming.

_____ _____

Authorized Signature Date Title

_____ _____

Witness Date Title

TABLE OF CONTENTS

GENERAL PLAN INFORMATION 1
SCHEDULE OF BENEFITS 3
PRESCRIPTION DRUG CARD BENEFITS 6
ELIGIBILITY, ENROLLMENT & EFFECTIVE DATE OF COVERAGE 7
ELIGIBLE EXPENSES 10
SUPPLEMENTAL ACCIDENT BENEFIT 17
ALTERNATIVE BENEFITS 17
PRE-EXISTING CONDITION LIMITATION 18
MEDICAL MANAGEMENT 19
EXCLUSIONS AND LIMITATIONS 23
DEFINITIONS 27
TERMINATION OF BENEFITS 34
CONTINUATION OF BENEFITS (COBRA) 36
COORDINATION OF BENEFITS 40
EFFECT OF MEDICARE 42
SUBROGATION 43
REIMBURSEMENT RIGHTS 44
RIGHTS OF RECOVERY 44
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION 44
RIGHTS OF COVERED EMPLOYEES (ERISA) 45
GENERAL PROVISIONS 47
INSTRUCTIONS FOR SUBMISSION OF CLAIMS 51
USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 53

GENERAL PLAN INFORMATION

The Mountain Regional Services, Inc. Employee Benefit Plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime dollar limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (307) 789-3710. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Name of Plan:	Mountain Regional Services, Inc. Employee Benefit Plan
Type of Plan:	Self-funded welfare plan providing medical and prescription drug coverage.
Plan Number:	501
Plan Administrator:	Mountain Regional Services, Inc. 50 Allegiance Circle Evanston, WY 82930 (307) 789-3710
Group Number:	02166
Employer Tax ID Number:	83-0275464
Plan Effective Date: Plan Restated Date:	February 1, 1992 February 1, 2011
Plan Renewal Date:	February 1
Plan Year Ends:	January 31
Agent for Legal Service: (Process may be serviced upon the Plan Administrator)	Mountain Regional Services, Inc. 50 Allegiance Circle Evanston, WY 82930 (307) 789-3710
Contract Administrator:	Meritain Health[sm] P.O. Box 27267 Minneapolis, MN 55427-0267 (952) 546-0062 (800) 925-2272
Named Fiduciary:	Mountain Regional Services, Inc. 50 Allegiance Circle Evanston, WY 82930 (307) 789-3710

Contributions:	The cost of coverage provided by the Employer will be funded in part by Employer contributions and in part by employee contributions. The Employer will determine and periodically communicate the employee's share of the cost of coverage, and it may change that determination at any time.
Funding:	Coverage for employees and their eligible dependents are paid in part by the Employer out of its general assets and in part by employee contributions.
Effective Date of Coverage:	See **Eligibility, Enrollment & Effective Date of Coverage** section.
Termination Date of Coverage:	See **Termination of Benefits** section.

IMPORTANT: Meritain Health[sm] Medical Management must precertify all Inpatient stays (including acute Inpatient rehabilitation, Long-Term Acute Care Facility/Hospital, residential treatment, and subacute care provided in a facility that has nursing staff on-site 24x7, and a Physician on call 24x7). See **Medical Management** section of the Plan for details on Precertification. **If the Inpatient stay is not precertified at least forty-eight (48) hours in advance of the hospitalization, or within forty-eight (48) hours after the emergency admission, or is precertified outside the time frames specified, eligible expenses will be reduced by 20%, to a maximum reduction of $1,000 per confinement, per individual.**

SCHEDULE OF BENEFITS		
	PPO PROVIDERS	**NON-PPO PROVIDERS** (Subject to Usual & Customary Charges)
OVERALL LIFETIME MAXIMUM BENEFIT	Unlimited	
CALENDAR YEAR DEDUCTIBLE Individual Family	 $300 $400	
CALENDAR YEAR COINSURANCE LIMIT First $10,000 of Eligible Expenses per Covered Person (2 per Family) per Calendar Year Over $10,000 of Eligible Expenses per Covered Person (2 per Family) per Calendar Year	 70% 100%	 60% 100%
The Deductibles, Coinsurance Limits, and all maximum amounts (Calendar Year or Lifetime) are combined for both PPO Providers and Non-PPO Providers. Expenses incurred for the following cannot be applied toward the Coinsurance Limit or increase to 100%: (1) Copays; (2) Deductibles; (3) any penalty amounts; and (4) any charges as defined in the **Exclusions and Limitations** section. The Plan does have a Pre-Existing Condition Limitation. Please refer to the **Pre-Existing Condition Limitation** section for further details regarding coverage limitations and provisions for Creditable Coverage.		
MEDICAL BENEFITS		
Supplemental Accident Benefit (within 90 days of Accident)	100% of the first $300 (Deductible waived), then same as any other Illness	100% of the first $300 (Deductible waived), then same as any other Illness
Ambulance Services	70% after Deductible	60% after Deductible
Chiropractic Care/Spinal Manipulation	70% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	15 visits	
Durable Medical Equipment	70% after Deductible	60% after Deductible
NOTE: The Plan will cover certain Durable Medical Equipment at 100% with no Deductible for a Covered Person suffering from Asthma, Coronary Arterial Disease (CAD), Congestive Heart Failure (CHF), Hypertension or Diabetes that chooses to participate in the Disease Management component of the Healthy Merits Program. For a list of Durable Medical Equipment covered at 100%, please refer to the Healthy Merits Program section under **Medical Management**.		
Emergency Room Services	70% after Deductible	60% after Deductible
Home Health Care	70% after Deductible	60% after Deductible
Calendar Year Maximum Benefit	180 visits	
Hospice Care <u>Inpatient and Outpatient</u> <u>Bereavement Counseling</u> (within 6 months of patient's death)	 70% after Deductible 50% after Deductible not to exceed 15 visits per family	 60% after Deductible 50% after Deductible not to exceed 15 visits per family

	PPO PROVIDERS	NON-PPO PROVIDERS (Subject to Usual & Customary Charges)
Evanston Regional Hospital, Memorial Hospital of Laramie County and Cheyenne Regional Medical Center (facility charges) Inpatient Room & Board Allowance Intensive Care Unit Miscellaneous Services & Supplies Outpatient	 50% after Deductible Semi-private room rate* 50% of actual charge after Deductible 50% after Deductible 50% after Deductible	 50% after Deductible Semi-private room rate* 50% of actual charge after Deductible 50% after Deductible 50% after Deductible
NOTE: Emergency services received at Evanston Regional Hospital, Memorial Hospital of Laramie County or Cheyenne Regional Medical Center will be paid under the regular plan of benefits for All Other Hospitals.		
All Other Hospitals or Long-Term Acute Care Facilities/Hospitals (facility charges) Inpatient Room & Board Allowance Intensive Care Unit Miscellaneous Services & Supplies Outpatient	 70% after Deductible Semi-private room rate* 70% of actual charge after Deductible 70% after Deductible 70% after Deductible	 60% after Deductible Semi-private room rate* 60% of actual charge after Deductible 60% after Deductible 60% after Deductible
***** A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.		
Mental Disorders Inpatient Outpatient Emergency Care (ambulance and emergency room)	 70% after Deductible 70% after Deductible 70% after Deductible	 60% after Deductible 60% after Deductible 70% after Deductible
Outpatient Lab Card Services	100%; Deductible waived	N/A
The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of Lab Card, the Plan will pay 100% of the eligible charges a Covered Person incurs for outpatient laboratory services, and will waive any of this Plan's Copays, Deductibles and/or Coinsurance requirements. If a Covered Person and/or a Physician elect to use another lab – including the lab in the Physician's office, normal Plan benefits will apply. See the Diagnostic Testing, X-ray and Laboratory Services benefit under **Eligible Expenses** for further details of this program.		
Outpatient Pre-Admission Testing	100% after Deductible	100% after Deductible
Outpatient Therapies (i.e. physical, speech, occupational)	70% after Deductible	60% after Deductible
Physician's Services Inpatient/Outpatient Services	 70% after Deductible	 60% after Deductible
Rehabilitation Facility	70% after Deductible	60% after Deductible
Maximum Benefit per Confinement	120 days	
Routine Care (age 2 and over) Routine eye exams are limited to one per Calendar Year.	100%; Deductible waived	100%; Deductible waived
Scalp Hair Prosthesis	70% after Deductible	60% after Deductible
Maximum Benefit	1 wig every 96 month period	
Voluntary Second Surgical Opinion	100%; Deductible waived	100%; Deductible waived

	PPO PROVIDERS	NON-PPO PROVIDERS (Subject to Usual & Customary Charges)
Skilled Nursing Facility	70% after Deductible	60% after Deductible
Maximum Benefit per Confinement	120 days	
Substance Use Disorders		
Inpatient	70% after Deductible	60% after Deductible
Outpatient	70% after Deductible	60% after Deductible
Emergency Care (ambulance and emergency room)	70% after Deductible	70% after Deductible
Non-Surgical Treatment of TMJ	70% after Deductible	60% after Deductible
Urgent Care Facility	70% after Deductible	60% after Deductible
Well Child Care (up to age 2)	70% after Deductible	60% after Deductible
All Other Eligible Expenses	70% after Deductible	60% after Deductible

BENEFIT PROVISIONS

A separate listing may be obtained from the Plan Administrator showing the providers available within the Preferred Provider Network at no cost to the Covered Person.

PPO Providers are not subject to Usual and Customary Charges. Non-PPO Physician's services are subject to Usual and Customary Charges and any charges in excess of Usual and Customary will not be considered eligible for payment.

Eligible expenses incurred by individuals who reside outside the PPO Network area will be paid at the PPO Provider level of benefits.

Expenses that are incurred due to a Medical Emergency by a Non-PPO Provider will be paid at the PPO Provider level of benefits.

Professional services that are not available within the PPO Network will be paid at the PPO Provider level of benefits.

Medical supplies and Durable Medical Equipment for which there is no network provider available will be paid at the PPO Provider level of benefits.

Individuals who are referred outside the PPO Network by a PPO Physician will have benefits paid at the Non-PPO Provider level of benefits.

If a PPO Physician or PPO facility refers x-ray and laboratory services to a Non-PPO Provider, those services will be paid at the Non-PPO Provider level of benefits.

Professional services that are provided by a Non-PPO Provider but rendered at a PPO facility will be paid at the Non-PPO Provider level of benefits.

Expenses for obtaining medical records will be paid at 100% with no Deductible up to a maximum benefit of $100 per provider.

SCHEDULE OF PRESCRIPTION DRUG CARD BENEFITS	
Retail:	
Generic Drugs	$10 Copay + 10% of the cost of the drug
Brand Name Drugs	$20 Copay + 20% of the cost of the drug
Mail Order:	
Generic Drugs	$20 Copay + 10% of the cost of the drug
Brand Name Drugs	$40 Copay + 20% of the cost of the drug

PRESCRIPTION DRUG CARD PROGRAM

Eligible drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, up to a thirty (30) day supply or one hundred (100) unit dose, whichever is greater, (90 day supply for mail order) which are deemed necessary for treatment of an Illness or Injury, including, but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician; and oral contraceptives (regardless of intended use).

Expenses for eligible injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Non-PPO Deductibles and Coinsurance.

NOTE: Coverage, limitations, and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Employer and will not be subject to any limitations and exclusions under the major medical plan. The Prescription Drug Card Program is a separate benefit from the major medical plan.

BRAND NAME DRUG: Means a trade name medication.

GENERIC DRUG: A Prescription Drug, which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

PRESCRIPTION DRUG: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, "Caution: federal law prohibits dispensing without prescription"; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

ELIGIBILITY, ENROLLMENT & EFFECTIVE DATE OF COVERAGE

A - ELIGIBLE EMPLOYEES

A full-time employee of the Employer who regularly works **forty (40)** or more hours per week will be eligible to enroll for coverage under this Plan, provided such employee chooses this benefit versus employment at a higher non-benefited rate of pay. Employees who work at least twenty (20) hours per week and are attending school in order to continue in the field/position in the company will be eligible for coverage under this Plan. Other employees such as higher-rate, part-time, temporary, or seasonal will not be eligible to enroll for coverage under this Plan.

An employee's participation in the Plan is subject to a waiting period of sixty (60) days of full-time employment, from the date such full-time employment begins.

An employee's Eligibility Date is the first of the month following completion of the waiting period.

B - ELIGIBLE DEPENDENTS

An Eligible Dependent will be a Covered Employee's legally married spouse and each Dependent Child until the date the child attains age twenty-six (26), provided such child does not have coverage available through another employer-sponsored group health plan (other than one available through his or her parent's employer). The term "married" means only a legal union between one man and one woman as husband and wife, and the term "spouse" refers only to a person of the opposite sex who is a husband or wife.

The term "Dependent Child" shall mean a Covered Employee's natural born son or daughter; stepson or stepdaughter; legally adopted child (from the date of placement with the employee for the purpose of legal adoption); or a child for whom the employee is the legal guardian (coverage will remain in effect until the date the child no longer meets the age and support and maintenance requirements of an Eligible Dependent under the terms of this Plan, regardless of whether or not such child has attained age 18 or any other applicable age of emancipation of minors).

For purposes of this section, the term "legal guardian" 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 an individual that is placed with such person by judgment, decree, or other order of any court of competent jurisdiction.

A child for whom the Covered Employee is required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO) shall also be considered an Eligible Dependent. Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The Plan Administrator shall have the right to require documentation necessary, in its sole discretion, to establish an individual's status as an Eligible Dependent.

No individual may be covered under this Plan as both an employee and a dependent. Also, no individual will be considered an Eligible Dependent of more than one employee.

Mentally or Physically Handicapped Child: If a Dependent Child age twenty-six (26) or older is unable to be self-supporting by reason of mental or physical handicap and is incapacitated, such child will be considered an Eligible Dependent for purposes of this Plan; provided the child suffered such incapacity prior to the date the child attained age twenty-six (26). The child must be unmarried, primarily dependent upon the employee for support and have the same principal residence of the employee.

C - PLAN ENROLLMENT (TIMELY, SPECIAL AND LATE ENROLLMENT)

Timely Enrollment: An Eligible Employee who elects to participate in the Plan must complete, sign, and return the provided "enrollment form" to the Employer within thirty-one (31) days of the Eligibility Date. Failure to enroll within this time limit will be deemed waiver of participation and the employee or dependents will be considered Late Enrollees or Special Enrollees.

An Eligible Dependent is able to participate in the Plan when the Covered Employee completes, signs and returns an enrollment form indicating dependent coverage to the Employer. The employee must enroll the dependent(s) within thirty-one (31) days of whichever of the following occurs first:

1. The employee's Eligibility Date if the employee has any Eligible Dependents at that time; or

2. The date the employee acquires an Eligible Dependent.

The Pre-Existing Condition Limitation and Creditable Coverage provisions will apply to Covered Persons age nineteen (19) and over.

Children covered by Qualified Medical Child Support Orders (QMCSO) may be enrolled in this Plan if the employee would otherwise be eligible for coverage, regardless of whether the employee is currently enrolled. The Plan must enroll the child(ren) and the employee covered by the notice without any enrollment restrictions (i.e. they will not be considered Late Enrollees).

If dependent coverage is already in force, the employee does not have to enroll additional dependent children acquired after dependent coverage is in force.

If dependent coverage is not already in force, newborn children and adopted children will be covered on the date of birth or adoption (or placement for adoption) if enrolled within thirty-one (31) days of the birth, adoption or placement for adoption.

Special Enrollment: If an employee is declining enrollment for single or family coverage because of other health coverage under a Qualified Health Plan, the employee may in the future be able to enroll for single or family coverage, provided the request for enrollment is received within thirty-one (31) days after coverage under the Qualified Health Plan terminates due to one or more of the following:

1. Loss of eligibility, which includes, but is not limited to:

    (a) Legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be considered an Eligible Dependent under the plan), death of an employee, termination of employment, reduction in the number of hours of employment;
    (b) Coverage is offered through an HMO or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual);
    (c) Coverage is offered through an HMO or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
    (d) When a Covered Person incurs a claim that would meet or exceed a lifetime limit on all benefits (this right continues until at least 31 days after the earliest date that a claim is denied due to the operation of the lifetime limit);
    (e) When a plan no longer offers any benefits to a class of similarly situated individuals, i.e. terminated coverage for part-time employees, etc.

2. Termination of employer contributions toward the cost of coverage; or

3. COBRA continuation coverage is exhausted.

If an employee has a new dependent as a result of marriage, birth, adoption, or placement for adoption, the employee may be able to enroll for coverage, provided the employee requests enrollment within thirty-one (31) days after the marriage, birth, adoption or placement for adoption of a new dependent child.

A written waiver of coverage stating the existence of coverage under another Qualified Health Plan must have been completed by the employee in order for the employee to be considered a Special Enrollee at a later date.

The Pre-Existing Condition Limitation and Creditable Coverage provisions will apply to Covered Persons age nineteen (19) and over.

Special enrollment due to coverage under Medicaid or under a State Children's Health Insurance Program (CHIP)

If an employee or eligible dependent did not enroll in the Plan when initially eligible, but was otherwise eligible to enroll, they will be permitted to later enroll in the Plan under one of the following circumstances:

1. The employee or eligible dependent was covered under Medicaid or CHIP at the time of initial enrollment and such coverage subsequently terminates; or

2. The employee or eligible dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP subsequent to the time they were initially eligible.

The employee or dependent must request enrollment in the Plan within sixty (60) days after coverage under Medicaid or CHIP terminates or within sixty (60) days after their eligibility for a premium assistance subsidy under Medicaid or CHIP is determined, whichever is applicable.

Late Enrollment/Open Enrollment: There will be an annual open enrollment period during the month of December, at which time a Late Enrollee may elect single or family coverage under the Plan to be effective on February 1st. The waiting period will be waived; however, the Pre-Existing Condition Limitation and Creditable Coverage provisions will apply to Covered Persons age nineteen (19) and over.

D - RETURN TO WORK – USERRA

Employees who are covered under the Uniformed Services Employment and Reemployment Rights Act (USERRA) will be eligible for coverage on the date they return to work, provided the employee returns to work with the Employer within the specified time period in the Uniformed Services Employment and Reemployment Rights Act (USERRA). Coverage for a reservist will be on the same basis it is for active employees and dependents. Eligibility waiting periods and the Pre-Existing Condition Limitation will be imposed only to the extent they were applicable prior to the period of uniformed services. See the **Termination of Benefits** section for more information regarding USERRA.

E - EFFECTIVE DATE OF COVERAGE

Timely Enrollees:

1. **Employees**: The employee's Eligibility Date if the employee enrolls within thirty-one (31) days thereafter.
2. **Dependents**: The employee's effective date of coverage.

Special Enrollees:

1. The day following the date the employee or dependent's coverage terminated due to loss of eligibility under a Qualified Health Plan, provided enrollment is received within thirty-one (31) days of losing coverage.

2. The day following the date the employee or dependent's coverage terminated due to termination of employer contributions toward the cost of coverage, provided enrollment is received within thirty-one (31) days of losing coverage.

3. The date of marriage, provided the employee enrolls for single or family coverage within thirty-one (31) days of the marriage.

4. The date of birth or adoption (or placement for adoption) of a new dependent, provided the employee enrolls for single or family coverage within thirty-one (31) days of the birth, adoption or placement for adoption.

5. The day following the date in which COBRA coverage is exhausted if the employee or dependent had elected COBRA coverage under a Qualified Health Plan, provided enrollment is received within thirty-one (31) days of exhausting benefits.

Late Enrollees:

1. February 1st following the Open Enrollment period for a Late Enrollee. The Pre-Existing Condition Limitation and Creditable Coverage provisions will apply to Covered Persons age nineteen (19) and over.

ELIGIBLE EXPENSES

Eligible expenses shall be the charges actually made to the Covered Person and, unless otherwise shown, will be considered eligible only if the expenses are:

1. Due to Illness or Injury (except as specified);

2. Ordered or performed by a Physician;

3. Medically Necessary;

4. Usual and Customary Charges; and

5. Not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses incurred at a Preferred Provider will be reimbursed to the provider.

1. **ALLERGY SERVICES:** Allergy testing, treatment, serum and injections.

2. **AMBULANCE SERVICE:** Commercial ground or air ambulance service will be payable as shown in the **Schedule of Benefits** to transport the patient:

   (a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or
   (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the patient; or
   (c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or
   (d) From the Hospital to the individual's home, or to a convalescent facility when there is documentation the patient required ambulance transportation.

3. **AMBULATORY SURGICAL FACILITY:** Services and supplies provided by an Ambulatory Surgical Facility.

4. **ANESTHETICS:** Anesthetics and their professional administration.

5. **BLOOD AND BLOOD DERIVATIVES:** Blood, blood plasma, or blood components not donated or replaced.

6. **CARDIAC REHABILITATION**: Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; and (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility.

   Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

7. **CHIROPRACTIC CARE/SPINAL MANIPULATION:** Skeletal adjustments, manipulation, or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays will be payable as shown in the **Schedule of Benefits**.

8. **CIRCUMCISION:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as part of the mother's expense.

9. **CLINICAL TRIALS:** Healthcare services for the treatment of cancer for an individual enrolled in a Qualified Clinical Trial (see **Definitions**), which is consistent with the usual and customary standard of care for someone with the patient's diagnosis, is consistent with the study protocol for the clinical trial, and would be covered if the patient did not participate in the Qualified Clinical Trial.

Healthcare services do not include any of the following:

(a) An FDA approved drug or device shall be considered eligible only to the extent that the drug or device is not paid for by the manufacturer, the distributor or the provider of the drug or device; or
(b) Non-healthcare services that a patient may be required to receive as a result of being enrolled in the Qualified Clinical Trial; or
(c) Costs associated with managing the research associated with the Qualified Clinical Trial; or
(d) Costs that would not be covered for non-investigational treatments; or
(e) Any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Qualified Clinical Trial; or
(f) The costs of services, which are not provided as part of the Qualified Clinical Trial's stated protocol or other similarly, intended guidelines.

10. **CONTRACEPTIVES**: Contraceptive procedures and medications, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants, Depo Provera and any related office visit. Some contraceptives may be available under the Prescription Drug Card program. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter.

11. **COSMETIC PROCEDURES/RECONSTRUCTIVE SURGERY:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances: (a) for the correction of a Congenital Anomaly for a dependent child; (b) any other Medically Necessary surgery related to an Illness or Injury.

12. **DENTAL CARE:** Dental services and x-rays rendered by Dentist or dental surgeon for:

(a) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
(b) Emergency repair due to Injury to sound natural teeth within one year of the Accident, including the replacement of sound natural teeth;
(c) Surgery needed to correct Accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
(d) Excision of benign bony growths of the jaw and hard palate;
(e) External incision and drainage of cellulitis;
(f) Incision of sensory sinuses, salivary glands or ducts;
(g) Removal of impacted wisdom teeth.

General anesthesia and Hospital expenses for covered dental care that would require the dental service to be done in a Hospital to monitor the patient due to a serious underlying medical condition, such as heart condition, blood disorder, etc., or is necessary due to Accidental Injury to sound natural teeth.

13. **DIABETIC SUPPLIES:** Diabetic supplies for the treatment of gestational, Type I or Type II diabetes.

The following diabetic education and self-management programs: (a) all Physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes; and (b) diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I or Type II diabetes.

14. **DIAGNOSTIC TESTING, X-RAY AND LABORATORY SERVICES:** Diagnostic testing, x-ray, and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under **Dental Care**.

The use of the Lab Card program offered by Quest Diagnostics is strictly voluntary. If a Covered Person uses the services of the Lab Card Program, benefits will be payable as shown in the **Schedule of Benefits**. When a Physician orders laboratory work, the Covered Person should present the Lab Card or medical ID card with the Lab Card logo on it and verbally request to use the Lab Card Program. The Physician will then collect the specimen and send to Quest Diagnostics. Any Physician can collect specimens and call Quest Diagnostics Lab Card Client Services at (800) 646-7788 for courier pick-up and supplies. In the event the Physician does not participate with the Lab Card Program, simply take the test orders to an approved Lab Card collection site for the draw. Collection site locations can be found by calling Lab Card Client Services or by going to the website at www.labcard.com.

The Lab Card Program covers routine outpatient testing. The Lab Card does **NOT** cover: (a) testing ordered during hospitalization; (b) lab work needed on an emergency or (STAT) basis; (c) testing done at another laboratory; or (d) time sensitive esoteric testing such as fertility testing, bone marrow studies and spinal fluid tests.

15. **DURABLE MEDICAL EQUIPMENT:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs, and other Durable Medical Equipment will be payable as shown in the **Schedule of Benefits**, subject to the following:

    (a) The equipment must be prescribed by a Physician and needed in the treatment of an Illness or Injury; and
    (b) The equipment will be provided on a rental basis, however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and
    (c) Benefits will be limited to standard models, as determined by the Plan; and
    (d) The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless Medically Necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan; and
    (e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and
    (f) Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible.

16. **EMERGENCY ROOM SERVICES**: Treatment in a Hospital emergency room, including professional services will be payable as shown in the **Schedule of Benefits**.

17. **HEMODIALYSIS/PERITONEAL DIALYSIS**: Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility, or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaced Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit.

18. **HOME HEALTH CARE:** Services provided by a Home Health Care Agency to a Covered Person in the home will be payable as shown in the **Schedule of Benefits**. The following are considered eligible home health care services:

    (a) Home nursing care;
    (b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);
    (c) Physical, occupational or speech therapy if provided by the Home Health Care Agency;
    (d) Medical supplies, drugs and medications prescribed by a Physician;
    (e) Laboratory services; and
    (f) Nutritional counseling by a licensed dietician.

    For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each four (4) hours of home health aide services shall be considered as one home health care visit.

    In no event will the services of a Close Relative, social worker, transportation services, housekeeping services, and meals, etc. be considered an eligible expense.

19. **HOSPICE CARE:** Hospice care on either an Inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan will be payable as shown in the **Schedule of Benefits**. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of six (6) months or less.

    Covered services include:

    (a) Room and board charges by the Hospice;
    (b) Other Medically Necessary services and supplies;

(c) Nursing care by or under the supervision of a registered nurse (R.N.);
(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following: (i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and (ii) physical and speech therapy;
(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family;
(f) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within six (6) months after the patient's death.

The term "Patient's Immediate Family" as used herein means the patient's spouse, parents, and/or dependent children who are covered under the Plan.

20. **HOSPITAL SERVICES OR LONG-TERM ACUTE CARE FACILITY/HOSPITAL**:
Inpatient
Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital will be payable as shown in the **Schedule of Benefits**. Charges made by a facility having only single or private rooms will be considered at the least expensive rate for a single or private room.

Care provided in an Intensive Care Unit will be payable as shown in the **Schedule of Benefits**.

Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

Outpatient
Services and supplies furnished while being treated on an outpatient basis will be payable as shown in the **Schedule of Benefits**.

21. **LENSES**: Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

22. **MATERNITY:** Expenses incurred by an employee or a dependent spouse for:

(a) Pregnancy;
(b) Services provided by a Birthing Center;
(c) One amniocentesis test per Pregnancy;
(d) Up to two (2) ultrasounds per Pregnancy (more than 2 only when it is determined to be Medically Necessary);
(e) Elective induced abortions only when carrying the fetus to full term would seriously endanger the life of the mother.

If complications arise after the performance of any abortion, any expenses incurred to treat those complications will be eligible, whether the abortion was eligible or not.

Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. **If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.**

23. **MEDICAL AND SURGICAL SUPPLIES:** Casts, splints, trusses, braces, crutches, orthotics, dressings, and other Medically Necessary supplies ordered by a Physician.

24. **MEDICAL RECORDS**: Charges for obtaining medical records will be payable as shown in the **Schedule of Benefits**.

25. **MENTAL DISORDERS:** Inpatient and outpatient treatment of Mental Disorders will be payable as shown in the **Schedule of Benefits**. This benefit also includes family therapy provided to the patient and the patient's family when the patient is present at the session.

26. **MORBID OBESITY**: Lap-band surgery for treatment of Morbid Obesity (see Definition). All other non-surgical or surgical treatment of Morbid Obesity will not be considered eligible.

27. **NUTRITIONAL SUPPLEMENTS**: Physician prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

    Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

28. **OCCUPATIONAL THERAPY:** Rehabilitative occupational therapy rendered by an occupational therapist under the recommendation of a Physician. Outpatient occupational therapy will be payable as shown in the **Schedule of Benefits**. Expenses for Maintenance Therapy, or therapy primarily for recreational or social interaction will not be considered eligible.

29. **OUTPATIENT PRE-ADMISSION TESTING:** Outpatient pre-admission testing performed within seven (7) days of a scheduled Inpatient hospitalization or Surgery.

30. **PHYSICAL THERAPY:** Physical therapy rendered by a physical therapist under the recommendation of a Physician. Outpatient physical therapy will be payable as shown in the **Schedule of Benefits**. Maintenance Therapy will not be considered eligible.

31. **PHYSICIAN'S SERVICES**: Services of a Physician for medical care or Surgery will be payable as shown in the **Schedule of Benefits**.

    For multiple or bilateral surgeries performed during the same operative session which are not incidental, or not part of some other procedure, and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (a) 100% for the primary procedure; (b) 50% for the secondary procedure, including any bilateral procedure; and (c) 50% for each additional covered procedure. This applies to all surgical procedures, except as determined by the Plan.

    For surgical assistance by an Assistant Surgeon, the charge will be 20% of the Usual and Customary Charge for the corresponding surgery.

32. **PODIATRY:** Treatment for the following foot conditions: (a) weak, unstable or flat feet; (b) bunions, when an open cutting operation is performed; (c) non-routine treatment of corns or calluses; (d) toenails when at least part of the nail root is removed; (e) any Medically Necessary surgical procedure required for a foot condition; or (f) orthotics, including orthopedic shoes when an integral part of a leg brace.

33. **PROSTHETICS:** Artificial limbs, eyes, or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered.

34. **RADIATION THERAPY/CHEMOTHERAPY:** Radium and radioactive isotope therapy, and chemotherapy treatment.

35. **RECONSTRUCTIVE SURGERY/COSMETIC PROCEDURES**: Reconstructive Surgery or Cosmetic procedures will be considered eligible only under the following circumstances: (a) for the correction of a Congenital Anomaly for a dependent child; (b) any other Medically Necessary surgery related to an Illness or Injury.

    Charges for reconstructive breast surgery following a mastectomy will be eligible as follows: (a) reconstruction of the breast on which the mastectomy has been performed; (b) surgery and reconstruction of the other breast to produce symmetrical appearance; and (c) coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

    The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the patient.

36. **REHABILITATION FACILITY:** Inpatient care provided in a Rehabilitation Facility will be payable as shown in the **Schedule of Benefits**, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) begins within fourteen (14) days after discharge from a required Hospital or Skilled Nursing Facility confinement of at least three (3) days in length for which room and board benefits are paid; (c) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (d) is not for Custodial Care.

    See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.

37. **ROUTINE CARE:** Routine care age two (2) and over, including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care (age 2 and over), pap smears, mammograms, colon exams, PSA testing, and routine eye exams will be payable as shown in the **Schedule of Benefits**. If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

38. **ROUTINE NEWBORN CARE:** Routine newborn care, including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense.

    If the newborn is ill, suffers an Injury, or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

39. **SCALP HAIR PROSTHESIS:** Purchase of a scalp hair prosthesis when necessitated by hair loss due to the medical condition known as alopecia areata, or as the result of hair loss due to radiation or chemotherapy for diagnosed cancer will be payable as shown in the **Schedule of Benefits**.

40. **SECOND SURGICAL OPINIONS:** Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person. Benefits will be payable as shown in the **Schedule of Benefits** for expenses associated with obtaining a second opinion before the Surgery is performed.

    Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

41. **SKILLED NURSING FACILITY:** Skilled nursing care provided in a Skilled Nursing Facility will be payable as shown in the **Schedule of Benefits**, provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) begins within fourteen (14) days after discharge from a required Hospital or Rehabilitation Facility confinement of at least three (3) days in length for which room and board benefits are paid; (c) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (d) is not for Custodial Care.

    See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

42. **SPEECH THERAPY:** Restorative or rehabilitative speech therapy necessary because of loss or impairment due to an Illness, Injury or Surgery, or therapy to correct a Congenital Anomaly. Speech therapy for developmental delay or to change voice sound will not be considered eligible. Outpatient speech therapy will be payable as shown in the **Schedule of Benefits**. Maintenance Therapy will not be considered eligible.

43. **STERILIZATION:** Elective sterilization procedures.

44. **SUBSTANCE USE DISORDERS:** Inpatient and outpatient treatment and emergency care of Substance Use Disorders will be payable as shown in the **Schedule of Benefits**.

45. **TEMPOROMANDIBULAR JOINT DYSFUNCTION (TMJ):** Hospital and surgery expenses related to a surgical procedure for the treatment of Temporomandibular Joint Dysfunction (TMJ). Expenses for non-surgical treatment of TMJ will be payable as shown in the **Schedule of Benefits**.

    The treatment of jaw joint disorders (TMJ) includes conditions of structures linking the jawbone and skull and complex muscles, nerves, and other tissues related to the temporomandibular joint. Treatment shall include, but is not limited to: orthodontics; physical therapy; and any appliance that is attached to or rests on the teeth.

46. **TRANSPLANTS:** Services and supplies in connection with Medically Necessary non-Experimental transplant procedures, subject to the following conditions:

(a) A concurring opinion must be obtained prior to undergoing any transplant procedure. This mandatory opinion must concur with the attending Physician's findings regarding the Medical Necessity of such procedure. The Physician rendering this concurring opinion must be qualified to render such a service either through experience, specialist training, education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual Surgery.
(b) If the donor is covered under this Plan, eligible expenses incurred by the donor will be considered eligible. If the donor is not covered under this Plan, reference provision (e).
(c) If the recipient is covered under this Plan, eligible expenses incurred by the recipient will be considered eligible.
(d) If both the donor and the recipient are covered under this Plan, eligible expenses incurred by each person will be treated separately for each person.
(e) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology, and pathology fees for the removal of the organ, and a Hospital's charge for storage or transportation of the organ will be considered eligible.

Exclusions

(a) Non-human and artificial organ transplants;
(b) Lodging expenses, including meals;
(c) Expenses related to the Covered Person's transportation;
(d) The purchase price of any of bone marrow, organ, tissue, or any similar items which are sold rather than donated; and
(e) Transplants which are not medically recognized and are Experimental/Investigational in nature.

47. **URGENT CARE FACILITY**: Services and supplies provided by an Urgent Care Facility will be payable as shown in the **Schedule of Benefits**.

48. **WELL CHILD CARE:** Well child care up to age two (2), including, but not limited to, vaccinations and immunizations, routine office visits, developmental assessments, and related laboratory tests and x-rays will be payable as shown in the **Schedule of Benefits**.

SUPPLEMENTAL ACCIDENT BENEFIT

Benefits are payable for eligible medical expenses incurred as a result of an Accidental Injury. Expenses must be incurred within ninety (90) days of the date of the Accident. Eligible expenses include charges incurred upon the recommendation and approval of a duly qualified Physician and include:

1. Medical or surgical treatment rendered or prescribed by a Physician;

2. Hospital room and board, services, and supplies; and

3. X-ray or laboratory examinations.

Benefits payable under this provision shall not exceed the maximum amount shown in the **Schedule of Benefits**. Any expenses incurred in excess of the maximum amount shall be payable under the benefits otherwise provided by the Plan.

ALTERNATIVE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative care services are Medically Necessary and cost effective. If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.

PRE-EXISTING CONDITION LIMITATION
(Does not apply to Covered Persons under age 19)

Expenses incurred in connection with a Pre-Existing Condition will not be considered eligible. A Pre-Existing Condition is defined as an Illness or Injury (whether physical or mental), regardless of cause, for which medical advice, diagnosis, care, or treatment was recommended or received during the **six (6)** consecutive month period prior to the individual's Enrollment Date of coverage under this Plan. Pre-Existing Conditions will be covered after the end of **twelve (12)** consecutive months (**18** consecutive months for Late Enrollees) after the individual's Enrollment Date. The Pre-Existing Condition Limitation does not apply to:

1. Covered Persons under age nineteen (19).

2. Maternity benefits.

3. A newborn child or newly adopted child if enrolled within thirty-one (31) days of the birth, adoption or placement with the employee for the purpose of adoption.

4. Genetic Information provided there has been no diagnosis of a condition related to the Genetic Information.

5. Prescription drugs purchased through the Prescription Drug Card program.

6. An employee and/or dependent who was covered under a Qualified Health Plan which is replaced by this Plan, unless they have not satisfied the Pre-Existing Condition Limitation of the Qualified Health Plan in effect prior to the effective date of this Plan.

   The length of the Pre-existing Condition Limitation may be reduced or eliminated if a Covered Person has Creditable Coverage from another Qualified Health Plan, provided there was not a break in coverage of sixty-three (63) or more days. A Covered Person may request a Certificate of Creditable Coverage from their prior plan within twenty-four (24) months of losing coverage. Certificates of Creditable Coverage should be submitted to Meritain Health, and appropriate credit for time covered will be applied to the pre-existing condition limitation. A HIPAA Determination letter will then be sent to the Covered Person, advising them of the credit applied to their pre-existing condition limitation.

The Plan must establish a procedure for Covered Persons to request and receive a certificate of Creditable Coverage. Any questions regarding obtaining a Certificate of Creditable Coverage or obtaining credit for additional past periods of coverage, please contact Meritain Health's Service Center at (800) 925-2272, or fax the Certificate(s) of Creditable Coverage from the prior plan(s) to: (952) 593-3779.

If all necessary information is not received by the Plan for determination of a pre-existing condition, or the Plan requests a Certificate of Creditable Coverage and that information is not received as requested, all additional claims related to that condition will receive an Adverse Benefit Determination and will be denied until the necessary information is received. Please refer to the **General Provisions - Right of Review and Appeal** section for further details.

MEDICAL MANAGEMENT

Meritain Health℠ Medical Management

The patient or family member or the patient's representative must call to receive certification of Inpatient Hospital admissions. This call must be made at least forty-eight (48) hours in advance of hospitalization or within forty-eight (48) hours after emergency admission.

MERITAIN HEALTH℠ MEDICAL MANAGEMENT

Meritain Health℠ Medical Management is a program designed to help ensure that all Covered Persons receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

1. Precertification of the Medical Necessity for hospitalization before medical services are provided. Precertification is required for all Inpatient stays (including acute Inpatient rehabilitation, Long-Term Acute Care Facility/Hospital, residential treatment, and subacute care provided in a facility that has nursing staff on-site 24x7, and a Physician on call 24x7).

2. Concurrent Review for continued length of stay and assistance with discharge planning activities.

3. Retrospective review for Medical Necessity of non-precertified Inpatient confinements.

Medical Management Does Not Guarantee Payment. All benefits/payments are subject to the Covered Person's eligibility under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.

DEFINITIONS

Concurrent Review: All Inpatient admissions or confinements that occur in a facility are subject to review by Meritain Health℠ Medical Management staff. The review is based on clinical information received in the medical management department by the provider or facility.

Emergency Care: Medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

Non-Emergency Care: Any services which are not considered Emergency Care, or services that are scheduled in advance.

Precertification: All Inpatient admissions or confinements that take place in a facility are subject to review by Meritain Health℠ Medical Management staff. The review is based on clinical information received in the medical management department from the provider or facility.

HOW THE PROGRAM WORKS

PRECERTIFICATION

Before a Covered Person is admitted to a medical facility on a non-emergency basis, Meritain Health℠ Medical Management staff will, based on clinical information from the provider or facility, certify the care according to Meritain Health℠ Medical Management's policies and procedures. A non-emergency stay in a medical facility is one that can be scheduled in advance.

The medical management program is set in motion by a telephone call from the Covered Person.

To allow for adequate processing of the request, contact Meritain Health[sm] Medical Management staff **at least forty-eight (48) hours** before the Hospital admission with the following information:

1. Name, identification number and date of birth of the patient;
2. The relationship of the patient to the Covered Employee;
3. Name, identification number, address and telephone number of the Covered Employee;
4. Name of Employer and group number;
5. Name, address, Tax ID #, and telephone number of the admitting Physician;
6. Name, address, Tax ID #, and telephone number of the medical facility with the proposed date of admission and proposed length of stay;
7. Proposed treatment plan; and
8. Admitting diagnosis.

If there is an **emergency** admission to the medical care facility, the patient or the patient's designee, the facility or admitting Physician must contact Meritain Health[sm] Medical Management **within forty-eight (48) hours** after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than forty-eight (48) hours following a vaginal delivery, or ninety-six (96) hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

The Covered Person or provider is NOT REQUIRED to precertify the maternity delivery admission, unless the stay extends past the applicable forty-eight (48) or ninety-six (96) hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. **If a newborn remains hospitalized beyond the time frames specified above, the confinement must be pre-certified with Meritain Health[sm] Medical Management or a penalty will be applied.**

The Meritain Health[sm] Medical Management staff, in coordination with the facility and/or provider, will make a determination on the number of days certified based on Meritain Health[sm] Medical Management's policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call Meritain Health[sm] Medical Management those extra days begin and obtain certification for the additional time. **If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.**

If the Covered Person does not have their Inpatient stay precertified at least forty-eight (48) hours in advance of the hospitalization, or within forty-eight (48) hours after the emergency admission, or is precertified outside the time frames specified, eligible expenses will be reduced by 20%, to a maximum reduction of $1,000 per confinement, per individual.

CONCURRENT REVIEW, DISCHARGE PLANNING

Discharge planning needs is part of the medical management program. The Meritain Health[sm] Medical Management staff will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a Covered Person to stay in the medical care facility for a greater length of time than has been pre-certified, the attending Physician or the medical facility must request the additional service or days.

TO FILE A COMPLAINT OR REQUEST AN APPEAL TO A NON-CERTIFICATION

Verbal appeal requests and information regarding the appeal process should be directed to 1-800-242-1199. From the automated options you must elect the option to speak to an individual to receive information on the appeal process.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient's condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient's home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or skilled nursing care or home health care;
4. Determine alternative care options; and
5. Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan staff, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

NOTE: Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

ORGAN TRANSPLANT PROGRAM

Transplant case management is a process for attaining significant cost savings on transplants while ensuring high quality care is provided. It involves patient education regarding the risks and benefits of transplants, and helping the patient to choose a "Center of Excellence". The Transplant Case Manager coordinates contracting for the transplant, and forwards the patient evaluation to an independent Physician review team for Medical Necessity and Experimental/Investigational determination. The Transplant Case Manager is a patient advocate from diagnosis through the post-operative phase to ensure the best possible care for the patient, while effectively managing the pre- and post-transplant costs. See the **Eligible Expenses** section for further information on eligible transplants.

HEALTHY MERITS PROGRAM

The Healthy Merits Program is a wellness benefit offered by the Employer to reduce the health risks of a Covered Person. The Healthy Merits Program is made up of several different components and is designed to provide a Covered Person with the tools and personal support they need to make positive lifestyle changes. Participation in this program is completely voluntary.

The Employer has chosen to offer the Disease Management component of the Healthy Merits Program to a Covered Person. It is aimed at reducing the health risks of Covered Person. The program consists of a 24x7 Nurse Line and certain Durable Medical Equipment (DME). It is important to note that participation is limited to Covered Persons that also participate in the medical plan of the Employer.

***24x7 Nurse Line*.** A Covered Person may contact the Healthy Merits 24-hour Nurse Line, 7 days a week, at (877) 348-4533, Option 1, to discuss current illnesses, health issues, treatments, lifestyle choices and self-care strategies or to access a health information library to research certain health information.

Durable Medical Equipment (DME). If a Covered Person suffers from Asthma, Coronary Arterial Disease (CAD), Congestive Heart Failure (CHF), Hypertension or Diabetes and chooses to participate in the Disease Management component of the Healthy Merits Program, such person will be provided with the below listed DME (applicable to his or her condition) at no cost while participating in the program.

Condition	Durable Medical Equipment Covered at 100%
Asthma	Peak flow meter Spacer
CAD	Eocene blood pressure cuff Eocene tracker
CHF	Eocene weight scale Eocene tracker
Hypertension	Eocene blood pressure cuff Eocene tracker
Diabetes	Eocene glucose meter Eocene tracker Testing strips, lancets, lancing device, control solution, batteries.

Once participation in the program ends, coverage for the above DME will be provided in accordance with the terms of the Plan. Please refer to the **Schedule of Medical Benefits** section of the Plan.

A Covered Employee will receive program welcome materials in the mail. The program welcome materials are an important part of the Healthy Merits Program; it explains this program in greater detail and contains additional requirements that may need to be satisfied to qualify under this program. If there are any discrepancies between the information contained in this Plan and the information contained in program welcome materials, the terms of the program welcome materials will govern.

EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person, or from future benefits, and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **ABORTIONS:** Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under **Eligible Expenses**.

2. **ACUPUNCTURE:** Expenses for acupuncture will not be considered eligible.

3. **CARDIAC REHABILITATION**: Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made, and exercise therapy that no longer requires the supervision of medical professionals.

4. **CHELATION THERAPY**: Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning. Chelation therapy reduces the plaque deposits in the arteries and other parts of the body.

5. **CLOSE RELATIVE**: Expenses for services, care or supplies provided by a Close Relative will not be considered eligible.

6. **COGNITIVE AND KINETIC THERAPY**: Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning, and memory. Kinetic therapy is defined as therapy related to motion or movement (i.e. the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major Illness.

7. **COMPLICATIONS:** Expenses for care, services or treatment required as a result of complications from a treatment not covered under the Plan will not be considered eligible, except complications from abortions as specified under **Eligible Expenses**.

8. **CONVENIENCE ITEMS**: Expenses for personal hygiene and convenience items will not be considered eligible.

9. **COSMETIC PROCEDURES**: Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under **Eligible Expenses**.

10. **COUNSELING:** Expenses for religious, marital, family or relationship counseling will not be considered eligible, except as specified under **Eligible Expenses**.

11. **COVERAGE UNDER OTHER PLANS**: Expenses for treatment for which the Covered Person is also eligible for benefits under any other group insurance or service plan through any employer (see **Coordination of Benefits** section); or the medical payment or personal Injury sections of automobile, casualty or liability insurance regardless of whether such policy is owned by the Covered Person or some other party (see **Subrogation** section) will not be considered eligible.

12. **CUSTODIAL CARE**: Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

13. **DENTAL CARE**: Expenses incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under **Eligible Expenses**.

14. **DEVELOPMENTAL DELAYS**: Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible.

15. **DURABLE MEDICAL EQUIPMENT**: Expenses for the rental or purchase of any type of air conditioner, air purifier, or any other device or appliance will not be considered eligible, except as specified under **Eligible Expenses**.

16. **EXPERIMENTAL/INVESTIGATIONAL:** Expenses for services or supplies which are not medically recognized or are Experimental/Investigational in nature will not be considered eligible, except as provided under the Clinical Trials benefit shown under **Eligible Expenses**.

17. **FOOT CARE**: Expenses for routine foot care will not be considered eligible.

18. **GAMBLING ADDICTION**: Expenses for services related to gambling addiction will not be considered eligible.

19. **GENETIC TESTING**: Expenses for genetic testing or genetic counseling will not be considered eligible, except amniocentesis testing as specified under **Eligible Expenses**.

20. **GOVERNMENTAL AGENCY**: Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

21. **HAIR LOSS:** Expenses for hair loss, hair transplants, wigs or scalp hair prostheses will not be considered eligible, except as specified under **Eligible Expenses**.

22. **HEARING EXAMS/AIDS**: Expenses for routine hearing examinations and hearing aids, including the fitting thereof, will not be considered eligible.

23. **HOMEOPATHIC TREATMENT**: Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

24. **HUMAN SUBJECT STUDY**: Expenses which are performed subject to the Covered Person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study experiment will not be considered eligible.

25. **HYPNOTHERAPY:** Expenses for hypnotherapy will not be considered eligible.

26. **ILLEGAL OCCUPATION/FELONY**: Expenses for or in connection with an Injury or Illness arising out of the commission of an illegal occupation or felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

27. **INCARCERATION**: Expenses for services or supplies received while incarcerated in a penal institution or in legal custody will not be considered eligible.

28. **INFERTILITY:** Expenses for confinement, treatment, testing or service related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible.

29. **MAINTENANCE THERAPY**: Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

30. **MANDIBLE TREATMENT**: Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia, or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: underbite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is considered dental surgery, performed by dental surgeons. This is not considered a medical procedure.

31. **MASSAGE THERAPY**: Expenses for massage therapy will not be considered eligible, except when part of an overall patient treatment plan and the services are provided by an eligible provider.

32. **MATERNITY**: Expenses for maternity expenses incurred by a dependent other than an employee's spouse will not be considered eligible.

33. **MEDICALLY NECESSARY**: Expenses which are determined not to be Medically Necessary will not be considered eligible.

34. **MISSED APPOINTMENTS**: Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.

35. **NO LEGAL OBLIGATION**: Expenses for services which are furnished under conditions which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses which may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

36. **NOT PERFORMED UNDER THE DIRECTION OF A PHYSICIAN**: Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

37. **NOT RECOMMENDED BY A PHYSICIAN**: Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

38. **NUTRITIONAL SUPPLEMENTS**: Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under **Eligible Expenses**. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

39. **OBESITY:** Expenses for weight loss programs or treatment of obesity will not be considered eligible, except for Morbid Obesity as specified under **Eligible Expenses**.

40. **OCCUPATIONAL THERAPY**: Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

41. **OPERATED BY THE GOVERNMENT**: Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to covered expenses rendered by a Hospital owned or operated by the United States Veteran's Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

42. **OUTSIDE THE UNITED STATES**: Expenses for services or supplies if the Covered Person leaves the United States, the U.S. Territories, or Canada for the express purpose of receiving medical treatment will not be considered eligible.

    Expenses for a patient who becomes sick or injured while out of the United States, the U.S. Territories, or Canada will not be considered eligible after one hundred twenty (120) consecutive days. This time limit will not be applied if the Covered Person is out of the country for business or as a Full-Time Student.

43. **OVER-THE-COUNTER MEDICATION**: Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible.

44. **PRIOR TO EFFECTIVE DATE:** Expenses which are incurred prior to the effective date of coverage, or after the termination date of coverage will not be considered eligible.

45. **PRIVATE DUTY NURSING**: Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.

46. **RADIOACTIVE CONTAMINATION**: Expenses incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

47. **RECREATIONAL AND EDUCATIONAL THERAPY:** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies will not be considered eligible. Diabetic education is considered eligible as specified under **Eligible Expenses**.

48. **REFRACTIVE ERRORS**: Expenses for radial keratotomy, lasik surgery or any surgical procedure to correct refractive errors of the eye will not be considered eligible.

49. **REQUIRED BY LAW**: Expenses which would be eligible for payment under any plan or policy required by law, whether the Covered Person chose to be covered under such plan or not will not be considered eligible. Under required No-Fault auto coverage, the minimum required coverage or actual coverage elected, whichever is higher, will be treated as an additional Deductible.

50. **RIOT/REVOLT**: Expenses resulting from a Covered Person's participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

51. **SELF-INFLICTED INJURY**: Expenses for Injury or Illness arising out of attempted suicide or an intentional self-inflicted Injury, will not be considered eligible. This exclusion will not apply if self-inflicted injuries result from a medical condition such as depression and the benefits for such injuries are normally covered under the Plan.

52. **SEX TRANSFORMATION**: Expenses in connection with sex transformation will not be considered eligible.

53. **SEXUAL DYSFUNCTION**: Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.

54. **SMOKING CESSATION**: Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible.

55. **STAND-BY PHYSICIAN**: Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

56. **STERILIZATION**: Expenses for the reversal of elective sterilization will not be considered eligible.

57. **TRAVEL:** Expenses for travel will not be considered eligible, except ambulance services as specified under **Eligible Expenses**.

58. **USUAL AND CUSTOMARY CHARGE**: Expenses in excess of the Usual or Customary Charge will not be considered eligible.

59. **VISION CARE**: Expenses for vision care, including professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices will not be considered eligible, except routine eye exams as specified under **Eligible Expenses**. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary surgical procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages.

60. **WAGE OR PROFIT:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

61. **WAR:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, or while in the armed forces of any country or international organization will not be considered eligible.

62. **WEEKEND ADMISSIONS:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless surgery is scheduled within twenty-four (24) hours.

63. **WORKER'S COMPENSATION**: Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

    Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.

DEFINITIONS

The following defined terms are capitalized and used throughout the document:

ACCIDENT/ACCIDENTAL: An unforeseen or unexplained sudden occurrence by chance without intent or violation.

ADVERSE BENEFIT DETERMINATION: Means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A termination of benefits; or
4. A failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan.

AMBULATORY SURGICAL FACILITY: An ambulatory surgical center, free-standing surgical center, or outpatient surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician's services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

ASSISTANT SURGEON: A Physician who actively assists the Physician in charge of a case in performing a surgical procedure. Depending on the type of surgery to be performed, an operating surgeon may have one or two (2) Assistant Surgeons. The technical aspects of the surgery involved dictate the need for an Assistant Surgeon.

AUTHORIZED REPRESENTATIVE: A Claimant may authorize a representative to act on their behalf in pursuing a benefit claim or appeal of an Adverse Benefit Determination. The Claimant must authorize the representative in writing, and this written authorization must be provided to the Plan. The Plan will recognize this Authorized Representative when the Plan receives the written authorization. In the case of a claim involving urgent care, a Healthcare Professional with knowledge of the Claimant's medical condition is also permitted to act as the Claimant's Authorized Representative.

BIRTHING CENTER: A place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

CALENDAR YEAR: January 1 through December 31 each year.

CLAIM FOR BENEFITS: A request for a plan benefit or benefits made by a claimant in accordance with a Plan's reasonable procedure for filing benefit claims. A claim for benefits includes any Pre-Service and Post-Service Claims. A request for benefits includes a request for coverage determination, for pre-authorization or approval of a plan benefit, or for a utilization review determination in accordance with the terms of the Plan.

CLAIMANT: A person requesting benefits under the Plan. A Claimant may or may not be a Covered Person under the Plan.

CLOSE RELATIVE: A Covered Person's spouse, parent (including step-parents), sibling, child, grandparent, or in-law.

COINSURANCE: The percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the **Schedule of Benefits**.

COPAY: The portion of the medical expense that is the responsibility of the Covered Person as shown in the **Schedule of Benefits**. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible or Coinsurance Limit.

COBRA: Consolidated Omnibus Reconciliation Act of 1985, as amended.

CONCURRENT CARE: Ongoing care or course of treatment.

CONGENITAL ANOMALY: A physical developmental defect that is present at birth.

CONTRACT ADMINISTRATOR: The organization providing services to the Employer in connection with the operation of this Plan and performing such other functions, including processing of claims, as may be delegated to it.

COSMETIC: Any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat Illness or disease.

COVERED EMPLOYEE: An Eligible Employee whose coverage has become effective and has not terminated.

COVERED PERSON: An Eligible Employee or Eligible Dependent whose coverage has become effective and has not terminated.

CREDITABLE COVERAGE: Coverage provided under any Qualified Health Plan.

CUSTODIAL CARE: Care or service which is designed primarily to assist a Covered Person, whether or not 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: The total amount of eligible expenses, as shown in the **Schedule of Benefits**, which must be incurred by a Covered Person during any Calendar Year before covered expenses are payable under the Plan. The Family Deductible maximum, as shown in the **Schedule of Benefits**, is the maximum amount which must be incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to the family Deductible.

C*arry-Over*: If the medical Deductible is satisfied in whole or in part by eligible expenses incurred during October, November, or December, those expenses will apply to the Deductible applicable in the next Calendar Year.

Common Accident: If two (2) or more covered family members suffer Injuries from the same Accident, only one Deductible will be applied to all charges incurred for the treatment of those Injuries during the same Calendar Year.

DENTIST: An individual who is duly licensed to practice dentistry or to perform oral surgery in the state where the service is performed and is operating within the scope of such license. A physician will be considered a Dentist when performing any covered dental services allowed within such license.

DURABLE MEDICAL EQUIPMENT: Equipment prescribed by the attending Physician which meets all of the following requirements: (1) is Medically Necessary; (2) can withstand repeated use; (3) is not disposable; (4) is not useful in the absence of an Illness or Injury; (5) it would have been covered if provided in a Hospital; and (6) is appropriate for use in the home.

ELIGIBILITY DATE: The first date of coverage after the Eligible Employee has satisfied any applicable waiting period. See **Eligibility & Enrollment** section.

EMPLOYER: Mountain Regional Services, Inc., or any successor thereto.

ENROLLMENT DATE: The earlier of: (1) the first date of coverage; or (2) the first day of any applicable waiting period. The Enrollment Date with regards to a Late Enrollee will be the first date of coverage.

ERISA: The Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL AND/OR INVESTIGATIONAL: Services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment.

The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

2. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

3. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials, 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, then it is deemed to be Experimental and/or Investigational; or

4. If 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, then it is deemed to be Experimental and/or Investigational.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental if they are not commercially available for purchase and/or they are not approved by the FDA for general use.

Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

1. The named drug is not specifically excluded under the General Limitations of the Plan; and

2. The named drug has been approved by the FDA; and

3. The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

4. If the drug is used for the treatment of cancer, the American Hospital Formulary Service Drug Information or the NCCN Drugs and Biologics Compendia recognize it as an appropriate treatment for that form of cancer.

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

GENETIC INFORMATION: Information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility), (2) establishing contribution or premium accounts for coverage under the Plan, and (3) applying the Pre-Existing Condition rule under the Plan.

HEALTHCARE PROFESSIONAL: A Physician or other Healthcare Professional licensed, accredited, or certified to perform specified health services consistent with State law.

HOME HEALTH CARE AGENCY: 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, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

HOSPICE: An agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides twenty-four (24) hour-a-day, seven (7) days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with four (4) years of full-time clinical experience, at least two (2) of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded, and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist, or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

HOSPITAL: A facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has twenty-four (24) hour a day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental/Nervous Disorders or Chemical Dependency which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

ILLNESS: A disease, sickness, Pregnancy or a condition involving bodily disorder of any kind, Mental Disorder, or Substance Use Disorder. All disorders which exist simultaneously and are due to the same or related causes shall be considered one Illness.

INJURY: A bodily Injury which results independently of Illness and is caused by Accidental means. All bodily Injuries sustained in any one Accident and all related conditions and recurrent symptoms will be considered one Injury.

INPATIENT: Admission as a bed patient to an eligible institution.

INTENSIVE CARE UNIT: A separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit”, or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least two (2) beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

LATE ENROLLEE: An Eligible Employee or Eligible Dependent who does not elect coverage under this Plan within thirty-one (31) days of their Eligibility Date and who is not otherwise considered a Special Enrollee. An employee not enrolled or not eligible for coverage under the Employer's previous Employer-sponsored plan will be considered a Late Enrollee.

LEGAL GUARDIAN: 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.

LIFETIME MAXIMUM: The maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan provides for a Lifetime Maximum Benefit for specific types of medical treatment, as well as for the total benefits provided by the Plan as shown in the medical and prescription drug **Schedule of Benefits**.

LONG-TERM ACUTE CARE FACILITY/HOSPITAL: Facilities that provide specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a twenty-four (24) hour a day, seven (7) days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; (5) education for the patient and family to manage their present and future healthcare needs.

MAINTENANCE THERAPY: Medical and non-medical health-related services that do not seek to cure, or that which are provided during periods when the medical condition of the patient is not changing, or does not require continued administration by medical personnel.

MEDICAL EMERGENCY: Medical services and supplies provided after the sudden onset of a medical condition (Injury or Illness) manifesting itself by acute symptoms, including intense pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in any of the following: (1) the patient's health would be placed in serious jeopardy; (2) bodily function would be seriously impaired; or (3) there would be serious dysfunction of a bodily organ or part.

MEDICALLY NECESSARY/MEDICAL NECESSITY: Treatment which is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

"Proven" means the care is not considered Experimental/Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

"Effective" means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

"Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

MENTAL DISORDER: Means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases, published by U.S. Health and Human Services.

MORBID OBESITY: A condition of morbid or clinically severe obesity in which the body weight is in excess of the norm for a person of the same age, sex and height by the lesser of one hundred (100) pounds or 50% of the persons ideal weight, provided treatment is under the recommendation and supervision of a Physician. Any treatment for the condition of Morbid Obesity must be determined to be Medically Necessary by the Plan.

PHYSICIAN: A legally licensed Physician who is acting within the scope of their license, and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist, Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

PLAN: The Mountain Regional Services, Inc. Employee Benefit Plan, and any amendments attached thereto.

PLAN ADMINISTRATOR: The Employer, which is sponsoring this Plan for its employees. The Plan Administrator may hire persons or firms to process claims and perform other Plan connected services.

POST-SERVICE CLAIM: Post-Service Claims are all claims that are not Pre-Service Claims.

PRE-SERVICE CLAIM: Pre-Service Claim is any request for approval of a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

PREFERRED PROVIDER NETWORK: All participating providers, health professionals, Hospitals, or other organizations having an agreement with the Preferred Provider Organization (PPO).

PREGNANCY: Childbirth and conditions associated with Pregnancy, including complications of Pregnancy.

QUALIFIED CLINICAL TRIALS: A Qualified Clinical Trial is defined as a clinical trial that meets all the following conditions:

1. The clinical trial is intended to treat cancer in a patient who has been so diagnosed; and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
   (a) One of the United States National Institutes of Health;
   (b) A cooperative group or center of the National Institutes of Health;
   (c) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;
   (d) The United States Food and Drug Administration pursuant to an investigational new drug exemption;
   (e) The United States Departments of Defense or Veterans Affairs;
   (f) Or, with respect to Phase II, III and IV clinical trials only, a qualified institutional review board; and
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise; and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial; and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards; and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial; and
7. The clinical trial does not unjustifiably duplicate existing studies; and
8. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

QUALIFIED HEALTH PLAN: The following will be considered Qualified Health Plans: (1) a group health plan; (2) health insurance coverage; (3) Medicare; (4) Medicaid; (5) TRI-CARE; (6) an Indian Health Service plan or tribal organization plan; (7) a state risk pool coverage; (8) a federal employees health insurance coverage; (9) a public health plan (this includes plans established or maintained by a state, the U.S. government, a foreign country, a state or federal penitentiary, U.S. Veterans Administration, or any political subdivision of a state, the U.S. government, or a foreign country that provides health coverage to individuals who are enrolled in the Plan); (10) a Peace Corps plan; (11) the State Children's Health Insurance Program.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO): A judgment or decree by a court of competent jurisdiction or order issued through an administrative process established under state law that has the force and effect of state law that requires the Plan to provide coverage to the children of an employee pursuant to a state domestic relations law.

RECONSTRUCTIVE SURGERY: Surgery that is incidental to an Injury, Illness, or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such surgery as cosmetic when a physical impairment exists, and the surgery restores or improves function. The fact that a Covered Person may suffer psychological consequences, or socially avoidant behavior as a result of an Injury, Illness, or Congenital Anomaly does not classify surgery done to relieve such consequences or behavior as Reconstructive Surgery.

REHABILITATION FACILITY: The facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute rehabilitation facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) twenty-four (24) hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

SEMI-PRIVATE ROOM: A hospital room shared by two (2) or more patients.

SKILLED NURSING FACILITY: An institution or that part of any institution which operates to provide convalescent or nursing care which: (1) is primarily engaged in providing to Inpatients skilled nursing care and related services for patients who require medical or nursing care; or sub-acute rehabilitation services for the rehabilitation of injured, disabled, or sick persons; (2) has policies which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered nurses (R.N.) to govern the skilled nursing care and related medical or other services it provides; (3) has a Physician, a registered nurse (R.N.), or a medical staff responsible for the execution of such policies; (4) has a requirement that the healthcare of every patient be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency; (5) maintains clinical records on all patients; (6) provides twenty-four (24) hour nursing service which is sufficient to meet nursing needs in accordance with the policies developed above, and has at least one registered nurse (R.N.) employed full-time; (7) provides appropriate methods and procedures for the dispensing and administering of drugs and injections; (8) in the case of an institution in any state in which state or applicable local law provides for the licensing of institutions of this nature, is licensed pursuant to such law, or is approved by the agency of the state or locality responsible for licensing institutions of this nature as meeting the standards established for such licensing; and (9) meets any other conditions relating to the health and safety of individuals who are furnished services in such institutions or relating to the physical facilities thereof.

SPECIAL ENROLLEE: See **Eligibility, Enrollment & Effective Date of Coverage** section.

SUBSTANCE USE DISORDER: Means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases, published by U.S. Health and Human Services.

SUCCESSIVE PERIODS OF CONFINEMENT: With respect to an employee, Successive Periods of Confinement for the same or related causes shall be considered one period of confinement unless the subsequent confinement commences after a return to active work on a full-time basis for a period of two (2) weeks. Successive Periods of Confinement due to entirely unrelated causes shall be considered one period of confinement unless the subsequent confinement commences after a return to active work on a full-time basis for one day.

With respect to a dependent, Successive Periods of Confinement will be considered one period of confinement unless the subsequent confinement commences after three (3) months following the prior confinement.

SURGERY: Any operative or diagnostic procedure performed in the treatment of an Illness or Injury by an instrument or cutting procedure through any natural body opening or incision. The reduction of a fracture or dislocation will also be considered Surgery.

URGENT CARE CLAIM: Any Pre-Service 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 ability of the Claimant 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. A Post-Service Claim is never an Urgent Care Claim.

URGENT CARE FACILITY: A facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse, and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

USUAL AND CUSTOMARY CHARGE: Charges made for medical services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical complications or unusual circumstances which require additional time, skill or experience.

TERMINATION OF BENEFITS

An employee or dependent's coverage shall terminate at the earliest time indicated below:

1. In the event the employee fails to make any required contributions when due, benefits shall automatically terminate at the end of the period for which the contribution was made.

2. Upon termination of employment or retirement, benefits will cease on the day the employee terminated. Cessation of active work by an employee shall be deemed termination of employment, except as follows:

   (a) In the event an employee is absent on account of Illness or Injury, employment shall be deemed to continue for the purpose of benefits hereunder until the earlier of: (i) the date contributions received from the Employer for such employee's benefits are discontinued; or (ii) a period of twelve (12) months; or

   (b) The benefits of an employee who is temporarily laid-off or granted leave of absence may be continued, but not beyond the end of the leave of absence or lay-off. The leave of absence or lay-off may not exceed six (6) months.

3. The date the employee ceases to be eligible for coverage or ceases to be in a class eligible for coverage.

4. The date the dependent ceases to be eligible for coverage or ceases to be in a class eligible for coverage.

5. The date the dependent becomes an Eligible Employee.

6. When the employee or spouse enters military service on a full-time active duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year.

7. The date the employee or dependent (or any person seeking coverage on behalf of the employee or dependent) performs an act, practice, or omission that constitutes fraud.

8. The date the employee or dependent (or any person seeking coverage on behalf of the employee or dependent) makes an intentional misrepresentation of a material fact.

9. The date the Plan is terminated.

RETROACTIVE TERMINATION OF COVERAGE

Except in cases where an employee or other Covered Person fails to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan for any Covered Person unless the Covered Person (or a person seeking coverage on behalf of that person) performs an act, practice, or omission that constitutes fraud with respect to the Plan, or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least thirty days advance written notice to each Participant or Dependent who would be affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

1. An eligible employee that qualifies for FMLA is entitled to a maximum of twelve (12) weeks of unpaid leave in any twelve (12) month period for reasons that qualify under FMLA. The employee must have worked for the Employer for at least twelve (12) months, and have worked at least 1,250 hours during the twelve (12) months preceding the start of the leave.

2. The National Defense Authorization Act (NDAA) expands FMLA to include leaves for military families. A spouse, son, daughter, parent, or next of “kin” will be allowed up to twenty-six (26) weeks during a twelve (12) month period to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness.

3. During the single twelve (12) month period described in number (2) above, an eligible employee shall be entitled to a total of twenty-six (26) weeks of leave under numbers (1) and (2) combined.

An employee may choose not to retain health coverage during the FMLA leave. However, when an employee returns from leave, the employee is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. Coverage will be reinstated without any additional qualification requirements imposed by the Plan. (The Plan's provisions with respect to Pre-Existing Conditions, Deductibles and Coinsurance amounts will apply on the same basis as they did prior to the FMLA leave.)

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If an individual was covered under this Plan immediately prior to being called to active duty by any of the uniformed services of the United States of America, coverage may continue for up to twenty-four (24) months or the period of uniformed service leave, whichever is shortest, if the individual pays any required contributions toward the cost of coverage during the leave. If the leave is less than thirty (30) days, the contribution rate will be the same as for active employees. If the leave is longer than thirty (30) days, the required contribution will not exceed 102% of the cost of coverage.

Whether or not the individual elects continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), coverage will be reinstated on the first day the individual returns to active employment with the Employer if released under honorable conditions and the individual returns to employment: (a) on the first full business day following completion of the military service for a leave of thirty (30) days or less; or (b) within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or (c) within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days (a reasonable amount of travel time or recovery time for an Illness or Injury determined by the VA to be service connected will be allowed).

When coverage under this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived and the Pre-Existing Condition Limitation will be credited as if you had been continuously covered under this Plan from the original effective date, unless the waiting period or Pre-Existing Condition Limitation would have applied to the employee if the employee had remained continuously employed during the period of military leave. (This waiver of limitations does not provide coverage for any Illness or Injury caused or aggravated by the military service, as determined by the VA. For complete information regarding the rights under USERRA contact the Employer.)

CONTINUATION OF BENEFITS (COBRA)

COBRA continuation coverage is temporary continuation of Plan coverage that can become available to individuals who are covered under the Plan when a "Qualifying Event" occurs which results in a loss of coverage under the Plan.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (COBRA).

COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary". A Qualified Beneficiary is an individual who is covered under the Plan the day before a Qualifying Event takes place which results in a loss of coverage under the Plan. A Qualified Beneficiary can be the Covered Employee, the covered spouse of the employee, or the covered dependent child(ren) of the employee. Any child born to or placed for adoption with the covered employee during a period of continuation coverage is also considered a Qualified Beneficiary.

If COBRA continuation coverage is elected, coverage will continue as though the Qualifying Event had not occurred. Any Deductible or Coinsurance amounts satisfied, or amounts credited toward any maximum benefits of this Plan, will be retained. Similarly, no new or additional waiting periods or pre-existing limitation requirements will apply.

If any changes are made to the coverage for employees actively-at-work, the coverage provided to individuals under this continuation provision will be similarly changed.

COBRA may not be denied to an individual who had coverage under another group health plan or Medicare prior to a Qualifying Event.

Specific Qualifying Events and the corresponding time period for which continuation coverage is available are listed below. In some instances, Qualified Beneficiaries may be covered under multiple Qualifying Events (see "Extension of Continuation Coverage" below).

QUALIFYING EVENTS

An **eighteen (18) month** continuation is available to employees and/or dependents in the event of any one or both of the following Qualifying Events:

1. An employee's termination of employment for any reason except gross misconduct;

2. An employee's loss of eligibility to participate due to reduced work hours.

In the event that both Qualifying Events happen, the total length of the continuation will not exceed eighteen (18) months.

A **thirty-six (36) month** continuation shall be available to a covered dependent spouse and/or child of an employee in the event of any one of the following Qualifying Events:

1. An employee's death;

2. Divorce or legal separation from the employee;

3. A child ceasing to meet the eligibility requirements described in the **Eligibility, Enrollment & Effective Date of Coverage** section; or

4. A dependent's loss of eligibility to participate in this Plan due to the employee becoming entitled to Medicare benefits (under Part A, Part B, or both), either as the result of disability or choosing Medicare in the place of this plan at age sixty-five (65).

Notification of some Qualifying Events is required. In the case of divorce or legal separation from the employee, or a child ceasing to meet the eligibility requirements, the employee or Qualified Beneficiary must send written notice of the event to the Plan Administrator within sixty (60) days after the later of: (a) the date of the Qualifying Event; (b) the date on which coverage would have been lost as a result of the Qualifying Event; or (c) the date on which the Qualified Beneficiary is informed, through the furnishing of this summary plan description or the initial general COBRA notice, of the responsibility and procedures for providing such notice to the Plan Administrator. This written notice must include supporting legal documentation when applicable (e.g. divorce decree or legal separation agreement). Failure to notify the Plan Administrator as described will cause any Qualified Beneficiary to lose eligibility for COBRA continuation coverage.

If a Qualified Beneficiary has a new dependent eligible for coverage as the result of a marriage or birth, adoption, or placement for adoption of a child, the Qualified Beneficiary must notify the Plan Administrator as described under the **Eligibility & Enrollment** section.

EXTENSION OF CONTINUATION COVERAGE

In certain circumstances, a Qualified Beneficiary may be able to continue coverage beyond the initial eighteen (18) month continuation period.

Due to Disability: An eleven (11) month extension of the eighteen (18) month continuation period (resulting in a total of 29 months of continuation coverage) may be available to all covered family members in the event a Qualified Beneficiary is determined to be disabled by the Social Security Administration. In order to be eligible for this extension, the following requirements must all be satisfied:

1. The initial Qualifying Event must have been either termination of employment or reduction in hours; and

2. The Qualified Beneficiary must be declared disabled by the Social Security Administration on or before the date of the Qualified Beneficiary's initial Qualifying Event, or during the first sixty (60) days of COBRA continuation coverage; and

3. The Qualified Beneficiary must send written notice of a disability determination to the Plan Administrator before the end of the original eighteen (18) months of COBRA continuation coverage and within sixty (60) days of the later of: (a) the date of the disability determination; (b) the date of the initial Qualifying Event; (c) the date coverage would have been lost as a result of the Qualifying Event; or (d) the date on which the Qualified Beneficiary is informed, through the furnishing of this summary plan description or the initial general COBRA notice, of the responsibility and procedures for providing such notice to the Plan Administrator. A copy of the Social Security Administration's determination letter must be included in this written notice.

Failure to meet any of the above requirements will cause the Qualified Beneficiary to lose eligibility for the eleven (11) month extension.

If the Qualified Beneficiary is later determined by the Social Security Administration to no longer be disabled, the Qualified Beneficiary must notify the Plan Administrator in writing of that fact within thirty (30) days of the Social Security Administration's determination.

Multiple Qualifying Events: An eighteen (18) month extension of the initial eighteen (18) month continuation period (resulting in a total of 36 months of continuation coverage) may be available to a Qualified Beneficiary of a former employee who experiences a second Qualifying Event during the first eighteen (18) months of continuation coverage. This extension is not available to the former employee. A second Qualifying Event must be one of the events listed under the **thirty-six (36) month continuation** section and must occur during the initial eighteen (18) month continuation period.

In order to be eligible for this extension, the following requirements must all be satisfied:

1. The initial Qualifying Event must have been either the former employee's termination of employment or reduction in hours; and

2. The event would have to have caused the Qualified Beneficiary to lose coverage under the Plan had the first Qualifying Event not occurred; and

3. The Qualified Beneficiary must send written notice to the Plan Administrator within sixty (60) days of the later of: (a) the date of the second Qualifying Event; (b) the date coverage would have been lost as a result of the Qualifying Event; or (c) the date the Qualified Beneficiary is informed, through the furnishing of this summary plan description or the initial general COBRA notice, of the responsibility and procedures for providing such notice to the Plan Administrator. This written notice must contain supporting legal documentation when applicable (e.g. death certificate, divorce decree, or legal separation agreement).

Failure to notify the Plan Administrator as described will cause the Qualified Beneficiary to lose eligibility for extended COBRA continuation coverage.

In no event will coverage be continued for more than thirty-six (36) months.

NOTICE OF CONTINUATION

At the time coverage commences under the Plan, or as permitted by applicable law, the Plan Administrator will provide written notice to each Covered Employee and spouse (if any) of the right to continuation coverage.

When a Qualifying Event occurs, COBRA continuation coverage will be offered to each affected Qualified Beneficiary, provided any applicable notification requirements have been met. The cost of the continuation coverage will be included with the election form. A Qualified Beneficiary eligible to elect continuation coverage shall have the right to continue the level of coverage in effect on the day before the Qualifying Event.

The decision to elect COBRA continuation coverage is the responsibility of the Qualified Beneficiary. However, failure to continue group health plan coverage may affect the Qualified Beneficiary's future rights under federal law, including the portability of health coverage and special enrollment rights as provided by the Health Insurance Portability and Accountability Act (HIPAA), and the guaranteed right to purchase an individual health insurance policy. For more information on a Covered Person's rights under ERISA, including COBRA and HIPAA, the Covered Person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

To elect COBRA continuation coverage, the Qualified Beneficiary must complete the election form and return it to the COBRA administrator by mail or fax within sixty (60) days of the date of the notice, or sixty (60) days of the date coverage ends as a result of the Qualifying Event, whichever is later. The names of each Qualified Beneficiary electing COBRA continuation coverage must be listed on the COBRA election form, the coverage being elected must be checked, and the form must be signed by a Qualified Beneficiary. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. A parent may elect to continue coverage on behalf of any dependent children. The employee or employee's spouse can elect continuation coverage on behalf of all the Qualified Beneficiaries.

Failure to fully complete and return the election form by the due date will result in the loss of the right to elect COBRA continuation coverage.

If a Qualified Beneficiary initially waives coverage under COBRA, the Qualified Beneficiary may still later elect coverage, provided the election is made within sixty (60) days of the date of the notice, or sixty (60) days after coverage ends as a result of the Qualifying Event, whichever is later. However, coverage will not begin until the date of the election (the date the election form is postmarked, if mailed, or the date faxed).

PAYING FOR CONTINUATION COVERAGE

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

The first payment for continuation coverage must be made within forty-five (45) days after the date of the election (this is the date the election form is postmarked, if mailed, or the date faxed). If the first payment for continuation coverage is not made in full within that forty-five (45) days, the Qualified Beneficiary will lose all continuation coverage rights under the Plan.

The first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated up to the time the first payment is made. The Qualified Beneficiary is responsible for making sure that the amount of the first payment is correct.

Thereafter, periodic payments can be made on a monthly basis. Each of these periodic payments for continuation coverage is due on the first day of every coverage period, although a grace period of thirty (30) days will be allowed. Continuation coverage will be provided for each coverage period as long as payment for that period is made before the end of the grace period. If a periodic payment is made later than its due date, but during the grace period, coverage under the Plan will be suspended as of the first day of the coverage period and then retroactively reinstated (going back to the first day of the coverage period) when the periodic payment is made. Any claims submitted while coverage is suspended may be denied, and will have to be resubmitted when coverage is reinstated.

If a Qualified Beneficiary fails to make a periodic payment before the end of the grace period for that payment, all rights to continuation coverage under the Plan will be lost. The plan will not send periodic notices of payments due.

TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If an individual has questions about these new tax provisions, the Health Coverage Tax Credit Customer Contact Center may be contacted toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at: www.doleta.gov/tradeact/2002act_index.asp.

TERMINATION OF CONTINUATION COVERAGE

Continuation of coverage under this Plan shall not be provided beyond whichever of the following dates is first to occur:

1. The date the maximum continuation period expires for the corresponding Qualifying Event;

2. The date the individual fails to pay any required contributions in full on time;

3. The date a Qualified Beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the Qualified Beneficiary;

4. The date a Qualified Beneficiary becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage;

5. The date this Plan is terminated, though a Qualified Beneficiary may have the right to continue COBRA under another group health plan provided by the Employer to similarly situated employees;

6. The date the employer ceases to provide any group health plan for its employees; or

7. In the month that begins more than thirty (30) days after a final determination has been made that an individual is no longer disabled.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

KEEP PLAN INFORMED OF ADDRESS CHANGES

In order to protect an individual's rights under COBRA, it is important that the Plan Administrator be informed of any address changes. Individuals should keep a copy of any notices sent to the Plan Administrator for their records.

COORDINATION OF BENEFITS

If a Covered Person is covered under more than one group plan as defined below, including this Plan, benefits will be coordinated. The benefits payable under this Plan for any Claim Determination Period, will be either its regular benefits or reduced benefits which, when added to the benefits of the other plan, may equal 100% of the Allowable Expenses defined below.

DEFINITIONS

Allowable Expenses: Any Medically Necessary, Usual and Customary item of expense incurred by a Covered Person which is covered at least in part under this Plan.

Claim Determination Period: A Calendar or Plan Year or that portion of a Calendar or Plan Year during which the Covered Person for whom claim is made has been covered under this Plan.

Plan: Any plan under which benefits or services are provided by:

1. Group, blanket or franchise insurance coverage;

2. Any group Hospital service prepayment, group medical service prepayment, group practice or other group prepayment coverage;

3. Group coverage under labor-management trusteed plans, union welfare plans, Employer organization plans or employee benefits plans;

4. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;

5. Coverage provided through a school or other educational institution; or

6. Coverage under any Health Maintenance Organization (HMO).

ORDER OF BENEFIT DETERMINATION

When a claim is made, the primary plan pays its benefits without regard to any other plans. The secondary plan adjusts its benefits so that the total benefits paid by both plans will not exceed 100% of the Allowable Expenses. Neither plan pays more than it would without the Coordination of Benefits provision.

A plan without a Coordination of Benefits provision is always the primary plan. The FIRST rule that applies determines primary carrier and supersedes the following rules. If all plans have a Coordination of Benefits provision:

1. The plan covering the person directly, rather than as an employee's dependent, is primary and the other plans are secondary.

2. Dependent children of parents not separated or divorced, or unmarried parents living together: the plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

   However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent, and if, as a result, the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.

3. Dependent children of separated or divorced parents, or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:

   (a) The plan of the parent with custody pays first;
   (b) The plan of the spouse of the parent with custody (the step-parent) pays next;
   (c) The plan of the parent without custody pays next; and
   (d) The plan of the spouse of the non-custodial parent pays last.

However, if specific terms of a court decree state that one of the parents is responsible for the child's healthcare expenses, and the insurer or other entity obliged to pay or provide the benefits of that parent's plan has actual knowledge of those terms, that plan pays first.

4. Active/Laid-Off or Retired Employees: The plan which covers that person as an active employee (or as that employee's dependent) determines its benefits before the Plan which covers that person as a laid-off or retired employee (or as that employee's dependent). If the Plan which covers that person has not adopted this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule (4) will not apply.

5. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (i.e. COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber, or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule (5) is ignored.

6. If none of the above rules determines the order of benefits, the plan covering a person longer pays first. The plan covering that person for the shorter time pays second.

Coordination of Benefits may operate to reduce the total amount of benefits otherwise payable during any Claim Determination Period with respect to a Covered Person under this Plan. When the benefits of this Plan are reduced, each benefit is reduced proportionately. The reduced amount is then charged against any applicable benefit limit of this Plan.

When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered will be considered to be both an Allowable Expense and a benefit paid.

RECOVERY

If the amount of the payment made by this Plan is more than it should have been, the Contract Administrator on behalf of the Plan, has the right to recover the excess from one or more of the following:

1. The person this Plan has paid or for whom it has paid;

2. Providers of care;

3. Insurance companies; or

4. Other organizations.

PAYMENT TO OTHER CARRIERS

Whenever payments, which should have been made under this Plan in accordance with the above provisions, have been made, this Plan will have the right to pay any organization making those payments any amounts it determines to be warranted in order to satisfy the intent of the above provisions. Amounts paid in this manner will be considered to be benefits paid under this Plan and, to the extent of these payments, this Plan will be fully discharged from liability.

EFFECT OF MEDICARE

In accordance with Federal Medicare regulations, the following is a brief explanation of the Medicare guidelines, not to be considered all inclusive.

When an employee or spouse reaches age sixty-five (65), they may become entitled to Medicare based on their age. An employee or dependent may also become entitled to Medicare under age sixty-five (65) due to disability or End Stage Renal Disease (ESRD).

The Plan will pay benefits **before** Medicare for an employee or covered dependent:

1. If the employee or spouse is age sixty-five (65), is actively working, and the employer has twenty (20) or more employees;

2. For the first thirty (30) months the employee or dependent is eligible for Medicare due to End Stage Renal Disease (or 33 months, depending upon whether a transplant or self-dialysis is involved); or

3. For the employee or dependent who is actively working, is eligible for Medicare under sixty-five (65) due to disability, and the employer has one hundred (100) or more employees.

The Plan will pay benefits **after** Medicare for an employee or covered dependent:

1. Who is age sixty-five (65) or older and are not actively working;

2. Who is age sixty-five (65) or older and the employer has fewer than twenty (20) employees;

3. After the first thirty (30) months an employee or spouse is eligible for Medicare due to End Stage Renal Disease (or 33 months, depending upon whether a transplant or self-dialysis is involved); or

4. Who is eligible for Medicare under age sixty-five (65) due to disability, but are not actively working or are actively working for an employer with fewer than one hundred (100) employees.

All Individuals Eligible for Medicare. Covered Persons should be certain to enroll in Medicare Part A & B coverage in a timely manner to assure maximum coverage. Contact the Social Security Administration office to enroll for Medicare. If this Plan is secondary, benefits under this Plan will be coordinated with the dollar amount that Medicare will pay, subject to the rules and regulations specified by federal law.

Medicare and COBRA. For most COBRA beneficiaries, Medicare rules state that Medicare will be primary to COBRA continuation coverage, and this would apply to this Plan's Continuation of Benefits (COBRA) coverage.

SUBROGATION

Benefits are payable only upon the Covered Person's acceptance of the terms of the Plan. As a condition to receiving benefits under this Plan, a Covered Person agrees:

1. To serve as a constructive trustee, and to hold in constructive trust such money or property resulting from any payments or settlement proceeds and agrees that they will not dissipate any such money or property without prior written consent of the Plan, regardless of how such money or property is classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

2. To restore to the Plan any such benefits paid or payable to, or on behalf of, the Covered Person when said benefits are paid or established by any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, other insurance policies for funds; and

3. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds that may be liable for or obligated to the Covered Person for the Injury or condition without obtaining the Plan's written approval; and

4. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Covered Person claims an entitlement to benefits under this Plan, regardless of how classified or characterized.

In the event a Covered Person settles, recovers, receives, or is reimbursed by any first or third party or Coverage, the Covered Person agrees that they are a constructive trustee, and shall hold any such funds received in constructive trust for the benefit of the Plan, and to transfer title to the Plan for all benefits paid or that will be paid as a result of said Injury or condition. The Covered Person acknowledges that the Plan has a property interest in the Covered Person's settlement, recovery, or reimbursement, and that the Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Covered Person as the result of the Illness or Injury, regardless of whether the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.

The Covered Person shall execute and return a Subrogation Agreement to the Plan Administrator and shall supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be payable under the Plan with respect to costs incurred in connection with such Illness or Injury.

If the Covered Person (or guardian or estate) decides to pursue a first or third party or any Coverage available to them as a result of the said Injury or condition, the Covered Person agrees to include the Plan's subrogation claim in that action and if there is failure to do so the Plan will be legally presumed to be included in such action or recovery. In the event the Covered Person decides not to pursue any and all first or third parties or Coverage, the Covered Person authorizes the Plan to pursue, sue, compromise or settle any such claims in their name, to execute any and all documents necessary to pursue said claims in their name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person (or guardian or estate) agrees to take no prejudicial actions against the subrogation rights of the Plan or to in any way impede the action taken by the Plan to recover its subrogation claim. Such cooperation shall include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights and take such action as requested by the Plan to secure the subrogation rights of the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Covered Person pursuing a claim against any Coverage or first or third party. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of the Plan document. The Plan Administrator may amend the Plan in its sole discretion at anytime without notice. This right of subrogation shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

REIMBURSEMENT RIGHTS

The Covered Person, by accepting benefits under this Plan, agrees to hold in constructive trust any money or property resulting from any recovery, insurance payments or settlement proceeds, first or third party payments, settlement proceeds or judgment for the Plan's benefits under this provision. If a Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of their Illness or Injury, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person. This right of reimbursement shall bind the Covered Person's guardian(s), estate, executor, personal representative, and heir(s).

RIGHTS OF RECOVERY

In the event of any overpayment of benefits by this Plan, the Plan will have the right to recover the overpayment. If a Covered Person is paid a benefit greater than allowed in accordance with the provisions of this Plan, the Covered Person will be required to refund the overpayment. If payment is made on behalf of a Covered Person to a Hospital, Physician or other provider of healthcare, and the payment is found to be an overpayment, the Plan will request a refund of the overpayment from the provider. If the refund is not received from the provider, or from the Covered Person, the amount of the overpayment will be deducted from future benefits, if available. If future benefits are not available, the Covered Person will be required to refund the overpayment.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of implementing the terms of this Plan, the Contract Administrator retains the right to request any medical information from any insurance company or provider of service it deems necessary to properly process a claim. The Contract Administrator may, without consent of the Covered Person, release or obtain any information it deems necessary. Any person claiming benefits under this Plan shall furnish to the Contract Administrator such information as may be necessary to implement this provision.

RIGHTS OF COVERED EMPLOYEES (ERISA)

As a participant in this Plan, Covered Persons are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

RECEIVE INFORMATION ABOUT THE PLAN AND BENEFITS

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as work sites, all documents governing the Plan, including insurance contracts and a copy of the latest annual report (Form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and copies of the latest annual report (Form 5500 series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

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

CONTINUE GROUP HEALTH PLAN COVERAGE

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

Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under the Plan, if the Covered Person has Creditable Coverage from another plan. A Covered Person should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when the Covered Person loses coverage under the Plan, when the Covered Person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if the Covered Person requests it up to twenty-four (24) months after losing coverage. Without evidence of Creditable Coverage, a Covered Person may be subject to a Pre-Existing Condition exclusion after the Covered Person's Enrollment Date for coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "Fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all plan participants and beneficiaries. No one, including the Employer, or any other person, may fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising a Covered Person's rights under ERISA.

ENFORCEMENT OF RIGHTS

If a claim for a welfare benefit is denied or ignored, in whole or in part, a Covered Person has 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 a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests a copy of plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, a Covered Person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to $110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If a Covered Person has a claim for benefits that is denied or ignored, in whole or in part, a Covered Person may file suit in a state or federal court, however, a Covered Person must follow the appeal procedures outlined in the Plan before initiating any legal actions. These are the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, a Covered Person may file suit in federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if the Covered Person is discriminated against for asserting their rights, the Covered Person may seek assistance from the U.S. Department of Labor, or the Covered Person may file suit in a federal court. The court will decide who should pay court costs

and legal fees. If the Covered Person is successful, the court may order the person the Covered Person has sued to pay these costs and fees. If a Covered Person loses, the court may order the Covered Person to pay these costs and fees, for example, if it finds the claim is frivolous.

ASSISTANCE WITH QUESTIONS

If a Covered Person has any questions about the Plan, the Covered Person should contact the Plan Administrator. If a Covered Person has any questions about this statement or about the Covered Person's rights under ERISA, or if the Covered Person needs assistance in obtaining documents from the Plan Administrator, the Covered Person should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210, or visit the EBSA website at www.dol.gov/ebsa. (Addressees and phone numbers of regional and District EBSA offices are available through EBSA's website.)

GENERAL PROVISIONS

NOTICE OF CLAIM

Written notice of a claim and all information needed to process the claim must be given to the Contract Administrator as soon as reasonably possible and in no event, later than one year from the date such claim is incurred.

RECORDS

For the purposes of claims administration, each Covered Person authorizes and directs any provider that has attended, examined, or treated them to furnish to the Contract Administrator, at any time upon its request, any and all information, records or copies of records relating to the attendance, examination or treatment rendered to the Covered Person; and the Contract Administrator agrees that such information and records will be considered confidential. Further, any charges imposed relative to the acquisition of such information will be absorbed by the Covered Person, except as specified in the **Schedule of Benefits**.

CLAIM DETERMINATION

Urgent Care Claims: Determination for any pre-service Urgent Care Claims (whether adverse or not) must take place as soon as possible but not longer than seventy-two (72) hours, unless the Claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such failure, the Contract Administrator shall notify the Claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Contract Administrator shall notify the Claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

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

2. The end of the period afforded the Claimant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

Pre-Service Claims: Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following an Adverse Benefit Determination. In the case of a failure by a Claimant or an Authorized Representative of a Claimant to follow the Plan's procedures for filing a Pre-Service Claim, the Claimant or representative shall be notified of the failure and the proper procedures to be followed in filing a Claim for Benefits. This notification shall be provided to the Claimant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Claimant or Authorized Representative.

Post-Service Claims: Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

Filing Extensions: The Plan may extend determination on both Pre-Service and Post-Service Claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Contract Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Claimant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Claimant until the date on which the Claimant responds to the notice. The time periods for making a decision are considered to commence when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

Concurrent Care Decisions: If a Plan has approved an ongoing course of treatment to be provided over a period of time, or number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Contract Administrator shall notify the Claimant of the Adverse Benefit Determination at a time 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.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the medical exigencies, and the Contract Administrator shall notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

Adverse Benefit Determination: The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon request by the Claimant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on Medical Necessity, Experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Claimant's medical circumstances, or an explanation will be provided free of charge to the Claimant upon request.

Where the Plan utilizes a specific internal rule or protocol, it must furnish the protocol to the Claimant or their Authorized Representative upon request.

Authorized Representative: The Plan will recognize an Authorized Representative, including a healthcare provider, acting on behalf of a Claimant. The Plan will recognize a Healthcare Professional with knowledge of a Claimant's medical condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Claimant.

RIGHT OF REVIEW AND APPEAL

A Claimant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Covered Person has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Covered Person in the appeal. All relevant documents will be provided free of charge, upon request by the Claimant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it was considered or generated in the course of making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Claimant or an Authorized Representative appeals an Adverse Benefit Determination, the Contract Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include:

1. Specific reasons for denial with reference to the Plan Document section(s);

2. A description and need for any other material pertinent to the claim; and

3. An explanation of this Plan's review procedure and the names of any medical professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, who is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records and other information submitted by the Claimant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Covered Person, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.

A Covered Person must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. These are the Covered Person's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Claimant is deemed to have exhausted the administrative remedies and is free to pursue legal action on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

No legal action involving this Plan or its administration shall be allowed or brought after the expiration of two (2) years following the date any eligible expense is incurred, or one year following the date of the Adverse Benefit Determination, whichever is the shorter period.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health
Appeals Department
P. O. Box 1380
Amherst, NY 14226-1380

PLAN INTERPRETATION

All decisions concerning the interpretation or the application of this Plan and its terms shall be at the discretion of the Plan Administrator.

PERIODIC REPORT

Within one month following the date of any change in the group of employees and dependents covered, the Employer shall furnish the Contract Administrator the names of all employees who have become covered or cease to be covered since the date of the previous reports.

Failure on the part of the Employer to report the name of any employees or dependents who are eligible for coverage, shall not deprive such persons of their benefits under the Plan; nor shall failure on the part of the Employer to report any termination of any employee or dependent, obligate the Plan to continue such benefits beyond the date of termination.

CHOICE OF PHYSICIAN

The Covered Person shall have the free choice of any legally qualified Physician and the Physician-patient relationship shall be maintained.

AFFILIATED COMPANIES

Any of the Employer's affiliates, subsidiaries or divisions may be deleted or added to the Plan upon written notice by the Employer on or before the date such deletion or addition is effective.

EMPLOYEE CONTRIBUTION

Participation in this Plan is entirely voluntary. The Employer reserves the right to modify the amount of any employee contributions.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as constituting a contract or other arrangement between the employee and the Employer to the effect that the employee will be employed for any specific period of time.

INSPECTION OF PLAN DOCUMENT

Upon request, the Employer shall make this Plan Document available for inspection by any Covered Person at a reasonably accessible place.

AMENDMENT OR TERMINATION OF THE PLAN

The Plan may be amended or terminated at any time without prior notice and, except as otherwise provided, in any manner, by written authorization and signed by one of the following officers of the Employer: Chief Executive Officer, Chief Financial Officer, President, Vice President, or by any other officer to whom the Employer's Board of Directors delegates the authority to amend the Plan.

It is the intent of this Plan to comply with all applicable Federal and State laws. Wherever this Plan is in conflict with either Federal or State law, the Federal or State law will prevail, unless exempt from either law.

INSTRUCTIONS FOR SUBMISSION OF CLAIMS

All claims submitted should include all of the following:

1. Employee's name, identification number and home address.
2. If claim is made for a dependent, the dependent's name, Employer and age.
3. Employer's name and group number.
4. Name and address of the Physician or Hospital.
5. Physician's diagnosis.
6. Itemization of charges.
7. Date the Injury or Illness began.
8. Drug bills (not cash register receipts) showing RX number, name of drug, date prescribed, and name of person for whom drug is prescribed.

Claims Processing Procedures:

Acceptable claims forms, bills and/or documents:

1. HCFA/UB or ADA Dental Claim Forms; or

2. Superbills - any submitted claim form with all of the following information:

   (a) Detail of procedure performed
   (b) Detailed breakdown of charges
   (c) Diagnosis
   (d) Date of service
   (e) Federal Tax Identification Number (TIN) and address of provider

A claim submitted with all of the above information included will be processed, unless additional information is required to complete the claim. Additional information that may be required to process a claim may include, but is not limited to the following:

1. Coordination of Benefits - Other Insurance Coverage
2. COBRA eligibility
3. Parental custody
4. Legal responsibility for dependent child health coverage
5. Divorce decree
6. Medicare eligibility
7. Certificate of Creditable Coverage
8. Medical history information
9. Injury or Accident information.

When the Contract Administrator receives a billing with the required information, the Contract Administrator will process it in accordance with the time frames for Post-Service Claims, Pre-Service Claims and Urgent Care Claims, and in accordance with all other Plan provisions, and in accordance with eligibility and claim information on file. The Contract Administrator will provide a notice of benefit determination or a notice of Adverse Benefit Determination to the Covered Person's designated address.

Please direct all questions regarding claims to:

Meritain Health[sm]
P.O. Box 27267
Minneapolis, MN 55427-0267
(952) 546-0062
(800) 925-2272

Please direct all claims to the address shown on the ID card.

Every attempt will be made to help Covered Persons understand their benefits; however, any statement made by an employee of the Employer or the Contract Administrator will be deemed a representation and not a warranty. Actual benefit payment can only be determined at the time the claim is submitted and all facts are presented in writing.

If a definite answer to a specific question is required, please submit a written request, including all pertinent information, and a statement from the attending Physician (if applicable), and a written reply (which will be kept on file) will be sent.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION 1 - USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

This Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to healthcare treatment, payment for healthcare and healthcare operations.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits that relate to an individual to whom healthcare is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility;
2. Coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
3. Coordination of Benefits;
4. Adjudication of health benefit claims (including appeals and other payment disputes);
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related healthcare data processing;
8. Claims management and related healthcare data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
10. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
11. Utilization review, including pre-authorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security Number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Plan.

Healthcare operations include, but are not limited to, the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing healthcare costs, protocol development, case management and care coordination, disease management, contacting healthcare providers and patients with information about treatment alternatives and related functions;
3. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to healthcare claims (including stop-loss insurance and excess loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to:
   (a) Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
   (b) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
8. Resolution of internal grievances; and
9. Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

SECTION 2 - THE PLAN WILL USE AND DISCLOSE PHI AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFICIARY

With an authorization, the Plan will disclose PHI to the benefit plans or other separate plans of this Employer.

SECTION 3 - FOR PURPOSES OF THIS SECTION, THE EMPLOYER IS THE PLAN SPONSOR

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

SECTION 4 - WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS

The Plan Sponsor agrees to:

1. Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
2. Ensure that any agents, including a subcontractor and the Contract Administrator, 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;
3. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
4. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
5. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
6. Make PHI available to an individual in accordance with HIPAA's access requirements;
7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. Make available the information required to provide an account of disclosures;
9. Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the plan's compliance with HIPAA; and
10. 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

SECTION 5 - ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

1. The Benefits Manager or other authorized representative of the Plan; and/or
2. Staff designated by the Benefits Manager or other authorized representative of the Plan.

SECTION 6 - LIMITATIONS OF PHI ACCESS AND DISCLOSURE

The persons described in Section 5 may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

SECTION 7 - NONCOMPLIANCE ISSUES

If the persons described in Section 5 do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

SECTION 8 – SECURITY OF ELECTRONIC PHI

To the extent required by 45 C.F.R. section 164.314(b), except when the only electronic PHI disclosed to the Plan Sponsor is disclosed pursuant to 45 C.F.R. section 164.504(f)(1)(ii) or (iii), or as authorized under 45 C.F.R. section 164.508, the Plan Sponsor will reasonably and appropriately safeguard electronic PHI created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan.

In accordance with the foregoing, the Plan Sponsor shall:

1. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect confidentiality, integrity, and availability of the electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;
2. Ensure that the adequate separation required by 45 C.F.R. section 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 this information agrees to implement reasonable and appropriate security measures to protect the information; and
4. Report to the Plan any security incident of which it becomes aware.

Section 9 - Health Information Technology for Economic and Clinical Health (HITECH) Act

The Plan will comply with all applicable requirements of final Regulations issued by the Department of Health and Human Services pursuant to Subtitle D of the HITECH Act and any authoritative guidance issued pursuant to that Act, if and as they become applicable to the Plan. If there is any conflict between the requirements of Subtitle D of the HITECH Act, and any provision of this Plan, applicable law will control. Any amendment or revision or authoritative guidance relating to Subtitle D of the HITECH Act is hereby incorporated into the Plan as of the date that the Plan is required to comply with such guidance.

The Plan Administrator will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan's compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.