PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

The Humboldt Del Norte Foundation for Medical Care
2662 Harris St.
Eureka, CA 95503

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Benefit Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator: North Coast Cooperative, Inc.

Kelli N Costa 10/14/14

Signed (authorized representative of Plan Sponsor) Date

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YOU SHOULD ALSO BE AWARE OF THE FOLLOWING REQUIREMENTS THAT MAY APPLY TO YOUR PLAN...

- It is important that the Summary Plan Description be reviewed and signed in a timely manner to assure that booklets can be prepared, printed and distributed to employees to assure compliance with ERISA requirements.

  Within 30 days of a request, the administrator of any employee benefit plan must furnish to the Secretary of the Dept. of Labor, any documents relating to the Plan, including but not limited to, the latest Summary Plan Description (the booklet) and any summaries of Plan changes not contained in the Summary Plan Description, the bargaining agreement, trust agreement, contract or other instrument(s) under which the Plan is established or operated.

- In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries must be furnished a summary of the change not later than 60 days after the adoption of the change. This does not apply if you provide summaries of modifications or changes at regular intervals of not more than 90 days. "Material modifications" are those that would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

- Except for fully insured or unfunded plans covering fewer than 100 participants at the beginning of a plan year, employee welfare benefit plans must file annual reports with the IRS on IRS/DOL/PBGC Form 5500.

  The 5500 form must be filed by the last day of the seventh month following the end of the Plan Year. An extension of up to 2.5 months may be granted for the filing of such forms.

  NOTE: The Secretary of Labor may assess a civil penalty against a Plan Administrator for failure or refusal to file an annual report.

  If required, a Summary Annual Report (generally prepared in conjunction with the 5500 filing) must be given to Plan participants within two months after the deadline (including extensions granted by the IRS) for filing the Form 5500.

  If you have any questions or concerns about these accounting requirements, talk to your broker/consultant, claims (contract) administrator, or accounting professional.

THIS DOCUMENT WAS NOT PREPARED OR REVIEWED BY AN ATTORNEY AND IS NOT INTENDED AS LEGAL ADVICE.

NORTH COAST COOPERATIVE, INC.

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION

OF THE

MEDICAL, DENTAL, VISION & RX BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE
"NORTH COAST COOPERATIVE, INC. HEALTH AND DENTAL PLAN" – PLAN # 501

EFFECTIVE: JULY 1, 2011
RESTATED: JANUARY 1, 2014

Contract Administrator:

Humboldt Del Norte Foundation for Medical Care
2662 Harris St. Eureka, CA 95503
(707)443-4563 or (866) 443-4563

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IMPORTANT NOTICES

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

While the Employer self -insured medical, dental and vision plans are in effect, the Employer will maintain the existing core benefits, including the benefits described below, as provided for in the current "Northcoast Cooperative Group Health Benefit Plans," (the "Plan Booklet"). This obligation includes but is not limited to the types of benefits identified in the Plan Booklet, benefit or coverage maximums or limitations; covered expenses; exclusions from coverage; deductibles; co -payments and rules respecting coverage, types of "illnesses" and "injuries" which are covered under the plan or for which plan benefits are (or are not) provided; the plan's definition of a covered "mental illness" or a medically necessary" procedure, or "semi-private" accommodations in a hospital, which are (or are not) covered by the plan; the "package" of COBRA benefits available to terminated participants (but not the annual COBRA rate), the duration of the plan's waiting period for eligibility to enroll in the plan, preauthorization requirements or changes on coverage.

In the event the Employer intends to terminate its self-insurance of medical, dental or vision benefits, the Employer will provide the Participants advance notice as the circumstances reasonably permit, and the parties agree to immediately meet and negotiate regarding alternative substantially similar medical, dental and life insurance plans to be purchased from a carrier, or other third party entity.

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant can obtain additional information about coverage of a specific drug, treatment, procedure, preventive service, etc. from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the **Definitions** section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

COBRA NOTICE REQUIREMENTS

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee's or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-hired employees. The procedures are also included herein and are located immediately following the **COBRA Continuation Coverage** section (see the **COBRA Notice Requirements for Plan Participants** section). Please review that section for additional details or contact the Plan Administrator for the most current notice procedures.

NOTE: It is important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become COBRA Qualified Beneficiaries.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

NOTE: An "attending provider" does not include a plan, hospital, managed care organization or other issuer.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Such coverage may be subject to annual deductibles and coinsurance provisions as may be deemed appropriate and are consistent with those established for other benefits under the plan or coverage.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

Under Federal law, group health plans that already provide coverage for mental health conditions and/or substance addictions (referred to in the law as "substance use disorders") must provide coverage for such covered conditions in the same manner as coverage is provided for Sickness. This law applies to group health plans on their Plan Year anniversary beginning on or after October 3, 2009.

NOTE: The Plan is not required to provide coverage for mental health conditions or substance use disorders. Also, the Plan (and not the Act) determines what will be a covered mental health condition and/or a covered substance use disorder. This legislation does not apply to employers with fewer than 51 employees.

CHILDRENS' HEALTH INSURANCE PROGRAM (CHIP)

Effective April 1, 2009, Employees and Dependents who are eligible but not enrolled for the Employer's group health plan, may enroll for coverage thereunder in the following instances:

- Loss of Medicaid or CHIP Eligibility: If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the Employee may request coverage under the Employer's group health plan coverage within sixty (60) days after Medicaid or CHIP coverage terminates.
- Eligibility for State Premium Assistance: Where a State has chosen to offer premium assistance subsidies for qualified employer-sponsored benefits (see NOTES) and if the Employee or Dependent becomes eligible for such subsidy under Medicaid or CHIP, then the Employee may request coverage under the Employer's group health plan within sixty (60) days after eligibility for the subsidy is determined.

Also, if an Employee's child(ren) become eligible for CHIP, Employee has the ability to drop the child(ren) from the group health coverage.

NOTES: CHIPRA allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

A "group health plan" does not include benefits provided under a health FSA or a high deductible health plan.

GENETIC INFORMATION AND NON-DISCRIMINATION ACT

GINA (Genetic Information and Non-discrimination Act) applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan's eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered employees and their families.

The Act defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.
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PRE-TAX CONTRIBUTIONS

Employee contributions for coverage are made on a pre-tax basis. The Internal Revenue Service (IRS) does not permit an Employee to make election changes or terminate participation outside of the Plan's Open Enrollment period unless he experiences an IRC "qualified change" or has a Special Enrollment Right as defined by the Health Insurance Portability and Accountability Act of 1996.

NOTICE OF RIGHT TO RECEIVE A CERTIFICATE OF CREDITABLE COVERAGE

Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a "certificate of creditable coverage" or "certificate of group health plan coverage," from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates, the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

UTILIZATION MANAGEMENT PROGRAM

The medical benefits of the Plan include a **Utilization Management Program** as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

PRE-SERVICE REVIEW

The Plan Sponsor has contracted with an independent organization to provide pre -service review. The name and phone number of the organization is shown on the Employee's coverage identification card.

Compliance Procedures - The procedures outlined below should be followed:

Inpatient Admission - Except as noted, prior to any non-emergency admission to a Hospital or Skilled Nursing Facility, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization. If pre-service review and authorization is needed the rendering provider must request prior authorization.

Emergency admission

Emergency is defined as:
When a delay of care could seriously jeopardize the life or health of the member or the ability of the member to regain maximum function, or, in the opinion of a physician with knowledge of the member's medical condition, would subject the member to severe pain that cannot be adequately managed without care or treatment.
Requests for pain medication or treatment for the terminally ill will be treated as an urgent request.

Urgent/Emergent admissions will follow urgent pre-service timeliness standards.
Urgent Concurrent Requests – Urgent concurrent requests involve both urgent care and the extension of a course of treatment beyond the period of time or number of treatments previously approved and the request is made at least 24 hours prior to the expiration of prescribed period of time or number of treatments.

Upon admission to the facility, the facility UR staff (Utilization Review/Discharge planning/Admissions) notifies the pre-service review organization, usually by faxing the facility "face sheet", which includes the unit in facility where admitted (i.e. ICU, med/surg etc.)

Monitoring and determination of medical necessity will be based on daily UR from the admitting facility. The facility is responsible for providing current, clinical data regarding procedures, interventions/treatments, findings and any unusual occurrences on a daily basis. Without daily review, medical necessity cannot be determined and the inpatient stay may be denied in part or in whole.

Monitoring Lengths of Stay:
When an inpatient stay exceeds the estimated length of stay as reported on the daily UM report, care coordination staff communicate with hospital UR/ Discharge staff to identify possible problems with treatment and discharge plans which might cause unnecessary extension of the inpatient stay; consulting with the pre-service review organizations Medical Director, as needed. The Medical Director may contact the attending physician as s/he feels is appropriate, or consult with relevant specialists on a case-by-case basis, to resolve any problem. Communication related to possible denials of extended inpatient LOS management are documented in the pre-services review organization system. Inpatient length of stay may be less than 24 hours if the patient stay "overnight" in the facility and inpatient medical necessity criteria is met

NOTE: Pre-service review will not be required for an Inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Specified Outpatient Services & Supplies - Prior to receipt of the following services and supplies, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for written approval:

Gleevec
Durable Medical Equipment

In order to obtain authorization for Gleevec, the patient's Physician must provide the Plan with information describing the condition being treated.

Certain Surgical Recommendations - The Plan recommends that the Covered Person, or someone acting on his behalf, contact the Utilization Management Organization prior to undergoing the following surgical procedures:

Abdominoplasty
Blepharoplasty
Breast reduction or enlargement
Dermabrasion
Facial or nasal reconstruction
Gastric bypass
Lipectomy
Penile implant
Scar revision
Sex alteration
Any experimental or research procedure not considered generally accepted medical practice

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes.

Pre-service review and authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Plan benefits will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered hereunder.

CASE MANAGEMENT SERVICES

In situations where extensive or ongoing medical care will be needed, the Utilization Management Organization may, with the patient's and Plan Sponsor's consent, provide case management services. Such services may include contacts with the patient, his family, the primary treating Physician, other caregivers and care consultants, and the hospital staff as necessary.

The Utilization Management Organization will evaluate and summarize the patient's continuing medical needs, assess the quality of current treatments, coordinate alternative care when appropriate and approved by the Physician and Plan Sponsor, review the progress of alternative treatment after implementation, and make appropriate recommendations to the Plan Sponsor.

The Plan Sponsor expressly reserves the right to make modifications to Plan benefits on a case-by-case basis to assure that appropriate and cost-effective care can be obtained in accordance with these services.

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

SECOND SURGICAL OPINIONS

Expenses for a second and, if necessary, a third surgical opinion are eligible medical expenses. Refer to the description of “Second (& 3rd) Surgical Opinion” in the **Medical Benefit Summary** and **Eligible Medical Expenses** sections of this document.

The Plan recommends that a Covered Person obtain a second surgical opinion **prior to** undergoing any of the following procedures:

Adenoidectomy
Bunionectomy
Cataract removal
Coronary bypass
Cholecystectomy (removal of gallbladder)
Dilation and curettage
Hammer toe repair
Hemorrhoidectomy
Herniorrhaphy
Hysterectomy
Laminectomy (removal of spinal disc)
Mastectomy
Meniscectomy (removal of knee cartilage, including arthroscopic approach)
Nasal surgery (repair of deviated nasal septum, bone or cartilage)
Prostatectomy (removal of all or part of prostate)
Release for entrapment of medial nerve (Carpal Tunnel Syndrome)
Tonsillectomy
Varicose veins (tying off and stripping)

When a second opinion is requested, the Plan will pay 100% of Usual and Customary and Reasonable expenses incurred for the opinion along with laboratory, X-ray and other Medically Necessary services ordered by the second Physician. Second opinions for cosmetic surgery, normal obstetrical delivery and surgeries that require only local anesthesia are not covered.

If the second opinion does not concur with the first opinion, the Plan will pay for a third opinion. The second or third opinion must be given within ninety (90) days of the first opinion.

In all cases where a second opinion is requested, the original recommendation for surgery must have been obtained from a Physician licensed in the medical specialty under which the recommended surgery falls. The Physician consulted for the second opinion must be licensed in the same medical specialty and may not be a partner of or in association with the original Physician.

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MEDICAL BENEFIT SUMMARY

CHOICE OF NETWORK OR NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates.

The Plan Sponsor will provide a Plan participant with information about how he can access a directory of Network Providers. This information will be provided without charge. The directory will be available either in hard copy as a separate document, or in electronic format.

CLAIMS AUDIT

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

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

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

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

SCHEDULE OF MEDICAL BENEFITS – SILVER PLAN

The percentages shown in the following schedule reflect the amount the Plan Pays. The percentages apply to Network provider negotiated rates or the Usual and Customary and Reasonable charges of non-Network providers. A "Deductible" or a "Co-Pay" is an amount the Covered Person must pay and is usually paid to the provider at the time of service.

LIFETIME / ANNUAL MAXIMUMS	Unlimited

Lifetime and annual dollar limits are not allowed for "essential health benefits." Essential health benefits are those within the scope of the typical employer group health plan, such as:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

NOTE: Where annual dollar limits may be applied in a schedule entry, the Plan Sponsor has determined that the benefit is not an essential health benefit.

CALENDAR YEAR DEDUCTIBLES	
Individual Deductible	$350
Family Maximum Deductible	$1,000

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

Individual Deductible - The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year. The deductible usually applies before the Plan begins to provide benefits.

Family Maximum Deductible - If eligible medical expenses equal to the Family Maximum Deductible are incurred collectively by family members during a Calendar Year and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

OUT-OF-POCKET MAXIMUMS	
Individual Out-of-Pocket Maximum	$6,000
Family Out-of-Pocket Maximum	$10,500

Individual Out -of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $6,000 in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

Family Out -of-Pocket Maximum - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than $ 10,500 in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

ELIGIBLE MEDICAL EXPENSES	**PLAN BENEFITS**
Ambulance	70%
Ambulatory Surgical Center	70%
Birthing Center	70%
Physical Therapy / Chiropractic Care / Acupuncture / Massage Therapy	70%†
Limited to $1,000 in benefits per Calendar Year.	
Diagnostic Lab & X-ray, Outpatient	70%
Durable Medical Equipment	70%
Glaucoma & Cataract Surgery	70%
Home Health Care	70%
Limited to 100 visits per Calendar Year.	
Hospice Care	
Inpatient Care	70%
Outpatient Care	70%
Family Bereavement Counseling	70%
Hospital Services	
Inpatient Care	70%
Emergency Room Use:	
for a Medical Emergency	$100 Co-Pay, then 70%
for a non-emergency	$500 Co-Pay, then 70%
Other Outpatient Services & Supplies	70%

Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see **Definitions**) or the Usual and Customary and Reasonable charge for an Intensive Care Unit. Excess charges for a private room accommodation will be covered only when isolation of the patient is Medically Necessary and is ordered by the attending Physician to protect the health of the patient or others.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

ELIGIBLE MEDICAL EXPENSES	PLAN BENEFITS
Mental Health & Substance Use Disorder Care	Covered same as Sickness (see text below)
"Covered same as Sickness" means that the Plan's treatment limitations and financial requirements that apply to covered mental health conditions or covered substance use disorders (see "Mental Health Care / Substance Use Disorder Care" in the **Eligible Medical Expenses** section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements). See schedule entries titled "Hospital Services" and "Physician Services" for information on how such Eligible Medical Expenses will be handled. Physician visits will be treated as care provided by a primary care Physician or "generalist" rather than a specialist.	
Physician Services	70%
Pre-Admission Testing	(see "Diagnostic Lab & X-Ray, Outpatient")
Prescription Drugs, Outpatient	75% (See the **Addendum for Prescription Drugs**)
Preventive Care	100% (no cost-sharing)
See services described in the **Appendix for Federally-Required Preventive Care Benefits**.	
Second (& 3rd) Surgical Opinion	
Includes Medically Necessary laboratory, X-ray, and other services ordered by the second Physician. NOTE: Benefits are not available for a 2nd or 3rd opinion for cosmetic surgery, normal obstetrical delivery, or procedures that require only local anesthesia.	
Skilled Nursing Facility / Rehabilitation Center	70%
Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 100 days per Calendar Year.	
Substance Use Disorder Care	(see "Mental Health & Substance Use Disorder Care")
Transplant-Related Expenses	70%
All Other Eligible Medical Expenses	70%

† Calendar Year Deductible does not apply.

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMIATIONS** AND **EXCLUSIONS SECTIONS** FOR MORE INFORMATION.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

SCHEDULE OF MEDICAL BENEFITS – BRONZE PLAN

The percentages shown in the following schedule reflect the amount the Plan Pays. The percentages apply to Network provider negotiated rates or the Usual and Customary and Reasonable charges of non-Network providers.

A “Deductible” or a “Co-Pay" is an amount the Covered Person must pay and is usually paid to the provider at the time of service.

LIFETIME / ANNUAL MAXIMUMS	Unlimited

Lifetime and annual dollar limits are not allowed for “essential health benefits.” Essential health benefits are those within the scope of the typical employer group health plan, such as:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

NOTE: Where annual dollar limits may be applied in a schedule entry, the Plan Sponsor has determined that the benefit is not an essential health benefit.

CALENDAR YEAR DEDUCTIBLES	
Individual Deductible	$1,000
Family Maximum Deductible	$3,000

Individual Deductible - The Individual Deductible is an amount of Eligible Expenses that a Covered Person must pay each year. The deductible usually applies before the Plan begins to provide benefits.

Family Maximum Deductible - If eligible medical expenses equal to the Family Maximum Deductible are incurred collectively by family members during a Calendar Year and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

OUT-OF-POCKET MAXIMUMS	
Individual Out-of-Pocket Maximum	$5,300
Family Out-of-Pocket Maximum	$16,050

Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than $6,000 (Silver) or $5,300 (Bronze) in any Calendar Year toward his share of Eligible Expenses that are not paid by the Plan. Once he has paid his out-of-pocket maximum, his Eligible Expenses will be paid at 100% for the balance of the Calendar Year.

Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than $10,500 (Silver) and $16,050 (Bronze) in any Calendar Year toward their Eligible Expense obligations. Once the family has paid their out-of-pocket maximum, their Eligible Expenses will be paid at

ELIGIBLE MEDICAL EXPENSES	**PLAN BENEFITS**
Ambulance	60%
Ambulatory Surgical Center	60%
Birthing Center	60%
Physical Therapy / Chiropractic Care / Acupuncture / Massage Therapy	60%†
Limited to $1,000 in benefits per Calendar Year.	
Diagnostic Lab & X-ray, Outpatient	60%
Durable Medical Equipment	60%
Glaucoma & Cataract Surgery	60%

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

Home Health Care	60%
Limited to 100 visits per Calendar Year.	
Hospice Care	
Inpatient Care	60%
Outpatient Care	60%
Family Bereavement Counseling	60%
Hospital Services	
Inpatient Care	60%
Emergency Room Use:	
for a Medical Emergency	$100 Co-Pay, then 60%
for a non-emergency	$500 Co-Pay, then 60%
Other Outpatient Services & Supplies	60%
Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see **Definitions**) or the Usual, Customary and Reasonable charge for an Intensive Care Unit. Excess charges for a private room accommodation will be covered only when isolation of the patient is Medically Necessary and is ordered by the attending Physician to protect the health of the patient or others.	

ELIGIBLE MEDICAL EXPENSES	**PLAN BENEFITS**
Mental Health & Substance Use Disorder Care	Covered same as Sickness (see text below)
"Covered same as Sickness" means that the Plan's treatment limitations and financial requirements that apply to covered mental health conditions or covered substance use disorders (see "Mental Health Care / Substance Use Disorder Care" in the **Eligible Medical Expenses** section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements). See schedule entries titled "Hospital Services" and "Physician Services" for information on how such Eligible Medical Expenses will be handled. Physician visits will be treated as care provided by a primary care Physician or "generalist" rather than a specialist.	
Physician Services	60%
Pre-Admission Testing	(see "Diagnostic Lab & X-Ray, Outpatient")
Prescription Drugs, Outpatient	Generic: $10 co-pay Brand: $25 co-pay Non-Formulary: $40 co-pay Specialty: 30% (co-insurance to $250 max) (See the **Addendum for Prescription Drugs**)
Preventive Care	100% (no cost-sharing)
See services described in the **Appendix for Federally-Required Preventive Care Benefits**.	
Second (& 3rd) Surgical Opinion	
Includes Medically Necessary laboratory, X-ray, and other services ordered by the second Physician. NOTE: Benefits are not available for a 2nd or 3rd opinion for cosmetic surgery, normal obstetrical delivery, or procedures that require only local anesthesia.	
Skilled Nursing Facility / Rehabilitation Center	60%
Eligible Expenses for room and board are limited to the facility's Semi-Private Room Charge. Coverage is limited to 100 days per Calendar Year.	
Substance Use Disorder Care	(see "Mental Health & Substance Use Disorder Care")
Transplant-Related Expenses	60%

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

All Other Eligible Medical Expenses	60%

† Calendar Year Deductible does not apply.

THIS IS A SUMMARY ONLY. SEE THE **ELIGIBLE MEDICAL EXPENSES** AND **MEDICAL LIMIATIONS** AND **EXCLUSIONS SECTIONS** FOR MORE INFORMATION.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g., application of Deductible and Co-Pay requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual and Customary and Reasonable charges for the items listed below and that are incurred by a Covered Person - subject to the **Definitions**, **Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by and received from a Physician or other appropriate Covered Provider and must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition.

For benefit purposes, medical expenses will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

Abortion - Abortion is covered same as Sickness for Employees and Dependents, whether or not the mother's life would be endangered if the Pregnancy were allowed to continue to term.

Complications arising out of an abortion are covered same as Sickness.

Acupuncture - see **"Chiropractic Care / Acupuncture / Massage Therapy"** below

Alcoholism - see "Mental Health & Substance Use Disorder Care"

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

Ambulance - Transportation by professional ambulance, including approved available train and air transportation (excluding chartered air flights), to a local Hospital or to transfer the patient to the nearest facility having the capability to treat the condition if the transportation is connected with an Inpatient confinement.

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

Anesthesia - Anesthetics and services of a Physician and/or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Birthing Center - Services and supplies provided by a Birthing Center (see **Definitions**) in connection with a covered Pregnancy.

Blood - Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank.

Cancer Clinical Trials - Drugs, Physician visits, lab tests and other routine services received by a Covered Person who is a cancer patient, who is involved in a clinical trial, and whose attending Physician has determined that the trial will have a beneficial effect on the patient. This coverage is provided as an exception to the Plan's exclusion for investigational or experimental services.

Chemical Dependency - see "Mental Health & Substance Use Disorder Care"

Chemotherapy & Radiation Therapy - Services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Radium and radioactive isotope therapy when provided for treatment or control of a Sickness.

Chiropractic Care / Acupuncture / Massage Therapy – Chiropractic Care: Musculoskeletal manipulation and modalities (e.g., hot & cold packs) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain – and including X-rays, acupuncture and massage therapy services. Acupuncture: The stimulation of specific acupoints along the skin of the body involving various methods such as the application of heat, pressure, or laser or penetration of thin needles provided by a licensed acupuncturist. Massage Therapy: The manual manipulation of soft body tissues (muscle, connective tissue, tendons and ligaments) to enhance a person's health and well-being, provide by a licensed massage therapist.

Contraceptives - Contraception-related services, including an initial visit to the prescribing Physician and any follow-up visits or Outpatient services. Benefits will be provided on the same terms as are offered for other Outpatient preventative care services.

NOTE: Contraceptives that can be obtained without a Physician's written prescription (e.g., condoms, foams, jellies) or contraceptives that do not require the services of a Physician are not covered. Also, any contraceptive that can be obtained through the prescription drug program (see the **Addendum for Prescription Drugs** section), must be obtained through that program.

Dental / Oral Care - see "Oral Surgery & Oral Care, Etc." below

Diagnostic Lab & X-ray, Outpatient - Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

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

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost -effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician.

"Durable medical equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen, glucose home monitors for insulin-dependent diabetics, and dialysis equipment that: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Coverage is limited to the least expensive item that is adequate for the patient's needs. Duplicate equipment and excess charges for deluxe equipment or devices are not covered.

Foot Disorders - Surgical treatment of foot disorders, including associated services, performed by a licensed podiatrist.

NOTE: Routine foot care is not covered.

Glaucoma, Cataract Surgery & Lenses - Treatment of glaucoma, cataract surgery and contact lenses or frame-type lenses.

Gleevec - Gleevec when prescribed by a Physician for treatment of any of the following conditions:

CML myeloid blast crisis;

CML accelerated phase; or

CML in chronic phase after failure of interferon treatment.

Hearing Care – Adult and Pediatric hearing exams and pediatric hearing care for children under age 21 when medically necessary. See the **Appendix for Federally-Required Preventive Care Benefits** for hearing tests for a covered newborn.

NOTE: Hearing aids or hearing aid exams for the prescription or fitting of hearing aids are not covered.

Home Health Care - Services and supplies that are furnished to a Covered Person by a Home Health Care Agency including:

Part-time or intermittent services of a registered nurse (RN) or a licensed practical nurse (LPN);

Services of certified home health aides under the direct supervision of a Registered Nurse;

Services of physical, occupational and speech therapists;

Physician calls in the office, home, clinic or Outpatient department of a Hospital, but not including custodial care; and

Rental (or purchase if economically justified) of durable medical equipment.

NOTE: Covered home health care expenses will not include food, food supplements, home -delivered meals, transportation, housekeeping services or other services that are custodial in nature and could be rendered by non-professionals.

Hospice Care - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Expenses for Hospice care are limited to:

Inpatient Hospice room and board;

Ancillary services and supplies furnished by the Hospice while the patient is confined therein, including the rental of durable medical equipment;

Medical, supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;

Physician services and services of a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;

Services of home health aides;

Home care furnished by a Hospital or Home Health Care Agency under the direction of a Hospice, including custodial care if it is provided during a regular visit by an RN, LPN or LVN;

Medical social services by licensed or trained social workers, psychologists or counselors;

Nutrition services provided by a licensed dietitian;

Respite care; and

Bereavement counseling. Bereavement counseling is a supportive service provided by the Hospice to treat Covered Persons in the deceased's family and to assist such family in adjusting to the death. Benefits will be payable if the following requirement are met: (1) on the day immediately before his/her death, the terminally ill person was in a Hospice Care Program and was a Covered Person, and (2) expenses for counseling services are incurred by the surviving Covered Persons within six months of the terminally ill person's death.

The Hospice care program must be renewed in writing by the attending Physician every 30 days. Hospice care ceases if the terminal illness enters remission.

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

Infertility Testing - Testing for infertility or sterility to determine a diagnosis.

NOTE: Treatment of infertility is not covered.

Injectables - Injectables that are not available through the prescription drug program and professional services for their administration if they cannot be self-administered.

Learning Disabilities - see "Mental Health & Substance Use Disorder Care" below

Massage Therapy – see "Chiropractic Care / Acupuncture / Massage Therapy" above

Mastectomy - see "Cosmetic & Reconstructive Surgery, Etc." in the **Medical Limitations and Exclusions** for coverage exceptions with regard to mastectomy.

Medical Supplies - Dressings, casts, splints, trusses, braces and other Medically Necessary supplies including syringes for diabetics and for persons with allergy conditions as well as lancets and chemstrips for diabetics.

Medicines - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit or as part of a home health care or hospice care program.

See the **Addendum for Prescription Drugs** for pharmacy benefit information.

Mental Health & Substance Use Disorder Care - The following services and supplies for the treatment of mental health conditions and substance use disorders:

Individual psychotherapy;

Group psychotherapy;

Psychological testing;

Family counseling; and

Convulsive therapy treatment.

Mental Health Conditions: For Plan purposes, a covered "mental health condition" is any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

A mental health condition or covered mental health care will not include:

Hypnotherapy;

Sex counseling or sex therapy;

Vocational testing or training.

Substance Use Disorders: Covered "substance use disorders" include physical and/or psychological dependence on drugs, narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree. It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

Newborn Care - Hospital, Physician and nursery care for a newborn who is the natural child of an Employee or an Employee's spouse and who is properly enrolled in the Plan.

Eligible Expenses include:

Routine Hospital care for the newborn during the child's birth confinement; and

The following Physician services for well-baby care during the child's birth confinement:

- An initial newborn examination;
- A second examination performed prior to discharge from the Hospital; and
- Circumcision.

NOTE: The Plan will provide coverage for Hospital, Physician and nursery care for an ill newborn in the same manner as for any other medical condition, provided the newborn is properly enrolled hereunder.

Nursing Services - Nursing services by a registered nurse (RN**)** or licensed practical nurse (LPN) when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

Private duty nursing services, Outpatient only.

Occupational Therapy – Services provided by a registered occupational therapist under the direct supervision of a Physician when provided in a home setting, at a facility or institution whose primary purpose is to provide care for a Sickness or Accidental Injury, or at a free-standing Outpatient facility.

Oral Surgery & Oral Care, Etc. - Oral surgery in relation to the bone, including treatment of tumors, cysts and growths not related to the teeth, and extraction of soft tissue-impacted teeth by a Physician or Dentist.

Pediatric oral care for children under age 21 when medically necessary.

Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion and including:

Excision of oral tumors or cysts;

Removal of impacted wisdom teeth;

Repair or prosthetic replacement of sound natural teeth that are damaged in an Accidental Injury if the repair is made within 12 months from the date of the injury (unless otherwise required by applicable law);

Hospital room and board and necessary ancillary Hospital services when Inpatient confinement is necessary for a dental procedure.

Orthoptics / Vision Therapy - Treatment of defective visual habits (e.g., eye muscle imbalance or "strabismus") through reeducation of visual habits, exercise and visual training.

Orthotics - Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition, or an Accidental Injury or Sickness.

NOTE: Expenses incurred for orthopedic shoes (unless they are an integral part of a leg brace and the cost is included in the orthotist's charge) and other supportive devices for the feet are not covered.

Osseous Surgery

Oxygen - see "Durable Medical Equipment"

Pain Management - Services and supplies provided in accordance with an intensive program that is administered on an Inpatient or Outpatient basis by qualified health care professionals and facilities and under the orders of the patient's attending Physician. Such care must be provided to a Covered Person who is suffering with chronic, intractable pain that has failed to respond to medical or surgical treatment.

For these purposes and in addition to appropriate Covered Providers as defined (see **Definitions**), "qualified health care professionals and facilities" with regard to a pain management program will include any of the following when licensed to perform such services and acting within the scope of that license or, in the absence of licensing requirements, certified by the appropriate regulatory agency or professional association:

Acupuncturists (CA)

Pain control centers

Massage therapists

Covered supplies and products include, but are not limited to:

Drugs prescribed or administered by qualified health professionals or facilities as part of the pain management program and that are not otherwise available through the Plan's coverage for prescription drugs;

Electronic nerve and muscle stimulators (TENS devices, micro-current stimulators, galvanic stimulators) and related supplies (e.g., gels);
Heating pads and ice packs; and

Water pillows.

Physical Therapy - Treatment or services rendered by a physical therapist, under the direct supervision of a Physician. Such services may be provided in a home setting or a facility or institution whose primary purpose is to provide care for a Sickness or Accidental Injury, or at a free-standing and duly-licensed Outpatient therapy facility.

Physician Services - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

NOTE: Consultations, charges for failure to keep a scheduled visit, or charges for completion of claim forms are not covered.

Pregnancy Care - Pregnancy-related expenses of a covered Employee or covered Dependent spouse. Eligible Pregnancy-related expenses are covered in the same manner as expenses for a Sickness and include the following, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

Pre-natal visits and routine pre-natal and post-partum care;

Expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy;

Expenses associated with a normal delivery in the home with a midwife;

Genetic testing or counseling when deemed Medically Necessary by a Physician;

Newborn Hospital services provided during the mother's confinement for delivery, but not to exceed the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, (3) expenses of a surrogate mother who is not a Covered Person, or (4) pregnancy-related expenses of a Dependent daughter.

Prescription Drugs - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the **Prescription Benefit Summary** for more information.

Preventive Care - Certain preventive services that are provided in the absence of sickness or injury. See the **Medical Benefit Summary** and the **Addendum for Federally-Required Preventive Care Benefits** for more information.

Immunizations or vaccinations and tetanus or rabies vaccinations administered in connection with an Accidental Injury.

Prosthetics - External prosthetics such as artificial limbs, eyes or other appliances to replace natural body parts, including the fitting and adjustment of such appliances. Orthotic devices, except as noted.

Internally implanted prosthetics such as pacemakers and hip and knee joint replacements.

Post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act.

NOTE: Prosthetics coverage does not include:

Dental prosthetics, except as expressly included under "Dental Care" in the **Medical Limitations and Exclusions** section;

Repair or replacement of a prosthetic device except for replacement that is Medically Necessary due to a change in the Covered Person's physical condition; or

Orthopedic shoes and other supportive devices for the feet.

Radiation Therapy - see “Chemotherapy & Radiation Therapy”

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

Rehabilitation Center - see "Skilled Nursing Facility or Rehabilitation Center"

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

Second (& 3rd) Surgical Opinion - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

The second and, if applicable, third opinion must be rendered within 90 days from the date the first surgeon recommends the procedure.

Skilled Nursing Facility or Convalescent Care Facility - Inpatient care in Skilled Nursing Facility or convalescent care facility, but only when the admission to the facility is Medically Necessary and:

Is preceded by confinement of at least three (3) days in a Hospital, is for the same condition causing the preceding Hospital confinement and occurs within fourteen (14) days of discharge from such prior confinement; or

Occurs within fourteen (14) days of discharge from a prior Skilled Nursing Facility or Rehabilitation Center confinement for the same condition; or

Is ordered by a Physician in lieu of Hospital confinement.

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Substance Use Disorders - see Mental Health & Substance Use Disorder Care" above and in the **Medical Benefit Summary** for information.

Surgery - Any of the following procedures:

Incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;

Manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

The induction of artificial pneumothorax and the injection of sclerosing solutions;

Arthrodesis, paracentesis, arthrocentesis and all injections into the joint or bursa;

Obstetrical delivery and dilatation an curettage; or

Biopsy.

TMJ / Jaw Joint Treatment - Treatment of jaw joint problems, including temporomandibular joint syndrome, cranio-mandibular disorders or other conditions of the joint linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to that joint.

Surgical treatment of diseases, injuries, fractures and dislocations of the jaw.

Transplant-Related Expenses (Human Tissue) - Eligible Expenses for a human organ or tissue transplant, subject to the following conditions:

Transplants of only the following organs or tissue will be covered:

Bone marrow
Cornea
Heart
Lung
Heart & lung
Kidney
Liver
Pancreas

In addition, the Plan will cover any other transplant that is not experimental. Eligible Expenses will be considered the same as any other Sickness for an Employee or Dependent who is the recipient of an organ or tissue transplant.

Eligible transplant-related expenses include those for:

Organ or tissue procurement from a cadaver consisting of removing, preserving and transporting the donated part;

Services and supplies furnished by a covered provider;

Drug therapy treatment to prevent rejection of the transplanted organ or tissue; and

Surgical, storage and transportation costs directly related to the procurement of an organ or tissue used in a transplant as described herein. If an organ or tissue is sold rather than donated, no benefits will be available for the purchase price of such organ or tissue.

You have organ transplant coverage insured by National Union Fire Insurance Company of Pittsburgh, Pa. (National Union). The organ transplant coverage provided by National Union pays benefits for certain organ transplants without regard to any benefits that may or may not be provided by this major medical plan. Please contact the AIG Benefit Solutions Transplant Unit at 888-449-2377 for benefit information, pre-authorization of services, and network provider access.

A fully insured separate policy is provided for organ transplant coverage. This policy is provided by National Union Fire Insurance Company of Pittsburgh, Pa. (National Union). The organ transplant coverage provided by National Union pays benefits for certain organ transplants without regard to any benefits that may or may not be provided by this major medical plan. Please contact the AIG Benefit Solutions Transplant Unit at 888-449-2377 for benefit information, pre-authorization of services, and network provider access.

Urgent Care Facility - Eligible Medical Expenses, as defined herein, that are incurred by a Covered Person at an Urgent Care Facility.

Vision Care - Pediatric vision care for children under age 21. See the **Vision Benefit Summary** for additional coverage information.

Weight Control – Life Skills Program when provided for treatment of morbid obesity. "Morbid obesity" means the Covered Person's body weight exceeds the medically-recommended weight by either 100 pounds or is twice the medically-recommended weight for a person of the same height, age and mobility as the Covered Person. Contact The Humboldt Del Norte Foundation for Medical Care for more information.

NOTE: Other hair restoration services/supplies are <u>not</u> covered. See “Hair Restoration” in the **Medical Limitations and Exclusions** section.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

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

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

Complications of Non-Covered Treatment - Care, services or treatments that are required to treat complications resulting from a treatment or surgery that is not or would not be covered hereunder, unless expressly stated otherwise.

Consultations, Etc. - Consultations, charges for failure to keep a schedule visit, or charges for completion of claim forms.

Cosmetic & Reconstructive Surgery, Etc. - Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except for:

Services necessitated by an Accidental Injury;

Coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

Treatment necessary to correct a congenital abnormality (birth defect) resulting in the malformation or absence of a body part.

Custodial & Maintenance Care - Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

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

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

Environmental change, including Hospital or Physician expenses incurred in connection with prescribing an environmental change.

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

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly included.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Experimental / Investigational Treatment - see **General Exclusions**

Hair Restoration / Hair Pieces - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hearing Exams & Hearing Aids - Hearing exams, hearing aids or the fitting of hearing aids.

NOTE: This exclusion will <u>not</u> apply to pediatric hearing care for children younger than age 21.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

Holistic, Homeopathic or Naturopathic Medicine - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy - Treatment by hypnosis.

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

Infertility Treatment - Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

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

Learning & Behavioral Disorders - Except as noted, testing or treatment for learning or behavioral disorders, mental retardation, or autism.

NOTE: See “Mental Health & Substance Use Disorder Care” in the list of **Eligible Medical Expenses** for coverage information.

Maintenance Care - see “Custodial & Maintenance Care”
Never Events - Serious preventable adverse events. A “Never Event” includes:

Surgery performed on the wrong body part;

Surgery performed on the wrong patient;

Wrong surgical procedure performed on a patient;

Unintentional retention of a foreign object in a patient after a surgery or other procedure;

Inoperative or immediate postoperative death in an ASA Class I patient;

Patient death or serious disability associated with any of the following while being cared for in a healthcare facility:

- The use of contaminated drugs, devices or biologicals provided by the facility
- The use or function of a device in a patient in which the device is used for functions other than as intended
- Intravascular air embolism
- Patient leaving the facility without permission
- Medication error (e.g., error involving the wrong drug, wrong dose, wrong patient, wrong time, wrong rate, wrong preparations, or wrong route of administration)
- A hemolytic reaction due to the administration of ABO-incompatible blood or blood products
- Hypoglycemia, the onset of which occurs while the patient is being cared for in a healthcare facility
- Failure to identify and treat hyperbilirubinemia (condition where there is a high amount of bilirubin in the blood) in newborns
- Spinal manipulative therapy
- An electric shock
- A burn incurred from any source
- Use of restraints or bedrails

Patient death associated with a fall while being cared for in a healthcare facility;

Maternal death or serious disability associated with labor and delivery in a low-risk pregnancy while being cared for in a healthcare facility;

Patient suicide or attempted suicide resulting in a serious disability;

Infant discharge to the wrong person;

Stage 3 or 4 pressure ulcers acquired after admission to a healthcare facility;

Artificial insemination with the wrong donor sperm or wrong egg;

Any incident in which a line designated for oxygen or other gas to be delivered to a patient contains the wrong gas or is contaminated by toxic substances;

Any instance of care ordered by or provided by someone impersonating a Physician, nurse, pharmacist, or other provider;

Abduction of a patient of any age;

Sexual assault on a patient within or on the grounds of a healthcare facility; and

Death or significant injury of a patient or staff member resulting from a physical assault (i.e., battery) that occurs within or on the grounds of a healthcare facility.

Nicotine Addiction - see “Smoking Cessation”

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the Plan’s prescription coverage’s.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed / Not Generally-Accepted - Any services or supplies that are: (1) not Medically Necessary, (2) not recommended on the advice of a Physician - unless expressly included herein, or (3) not in accordance with generally-accepted professional medical standards.

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Obesity - see “Weight Control”

Orthognathic Surgery - Surgery to correct discrepancies in the relationship of the jaws.

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones, or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Pregnancy Care - Pregnancy-related expenses of a Dependent child.

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

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

Smoking Cessation - Smoking cessation programs or any other services or supplies intended to assist an individual to quit smoking.

Speech Therapy - Services or supplies related to speech therapy.

Sterilization Reversal -) The reversal of a prior sterilization procedure (e.g., vasectomy or tubal ligation.

Travel - Travel, whether or not recommended by a Physician, except as specifically provided herein.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (e.g., eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment.

Orthoptics, other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy or laser surgery or other plastic surgeries on the cornea in lieu of eyeglasses.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery, (3) aphakic patients and soft lenses or sclera shells intended for use as corneal bandages, and (4) pediatric vision care for children under age 21.

See **Vision Benefits Summary** section for additional vision coverage information.

Vitamins

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

Weight Control - Services or supplies for obesity, weight reduction or dietary control, except when provided for treatment of morbid obesity. "Morbid obesity" means the Covered Person's body weight exceeds the medically-recommended weight by either 100 pounds or is twice the medically-recommended weight for a person of the same height, age and mobility as the Covered Person. See Eligible Medical Expenses, Weight Control. Weight Loss surgical procedures are excluded.

Wigs or Wig Maintenance - see "Hair Restoration"

*- (See also **General Exclusions** section) -*

DENTAL BENEFIT SUMMARY

CALENDAR YEAR MAXIMUM BENEFIT	
Silver Plan	$2,000
Bronze Plan	$1,500

Plan benefits for each Covered Person will not exceed the maximum shown above, except that the Calendar Year Maximum Benefit limit will not apply to pediatric dental care for children under the age of 21. Such care includes coverage of dental services necessary to prevent disease and promote oral health, restore oral structures to health and function (fillings, crowns, etc.), and treat emergency conditions.

NOTE: Because these dental benefits are "stand-alone" or "limited scope" benefits, they are not subject to the "unlimited" Lifetime Maximum that applies to the medical benefits described in this Benefit Document. A "stand - alone" or "limited scope" benefit is one that is not offered as part of a "package" (i.e., a package that includes medical benefits) but that is offered to Employees for a separate cost. Participants must have the right to choose not to receive the benefits.

CALENDAR YEAR DEDUCTIBLE, per person	$50 (waived for **Preventive Services**)

Individual Deductible - The Individual Deductible is an amount that a Covered Person must contribute toward payment of eligible dental expenses. Usually, the deductible applies before the Plan begins to provide benefits.

Deductible Carry-Over - Eligible Expense incurred in the last 3 months of a Calendar Year and applied toward that year's Deductible can be carried forward and applied toward the person's Deductible for the next Calendar Year.

Common Accident Provision - If 2 or more Covered Persons who are members of the same family are injured in the same accident, only 1 Individual Deductible will be taken from the total eligible dental expenses incurred as the result of such accident during the Calendar Year in which the accident occurred. Each member of the family will be credited with an equal, pro-rata share of the Annual Individual Deductible amount toward their Individual Deductible requirement for non-accident-related expenses.

ELIGIBLE DENTAL EXPENSES	**Covered Person Pays**	**Plan Pays**
Preventive Services		
Silver Plan	-0-†	100%†
Bronze Plan	-0-†	100%†

Limits applicable to certain Preventive Services:

- Routine oral examinations and cleanings are limited to 1 exam/cleaning per 6-month period;
- Fluoride treatment is limited to children under age 18 and to 1 application per 12-month period;
- Sealants for children under age 16 are limited to once per 36-month period;
- Space maintainers are limited to children under age 16;
- Routine full-mouth X-rays are limited to once per 36-month period;
- A panoramic X-ray is limited to once per 36-month period;
- Routine bitewing X-rays are limited to once per 6-month period.

Basic Services		
Silver Plan	20%	80%
Bronze Plan	20%	80%
Major Services		
Silver Plan	30%	70%
Bronze Plan	30%	70%

† Calendar Year Deductible does not apply.

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE **ELIGIBLE DENTAL EXPENSES** AND **DENTAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

ELIGIBLE DENTAL EXPENSES

Eligible dental expenses are the Usual and Customary and Reasonable charges for the dental services and supplies that are listed below and that are: (1) incurred while a person is covered hereunder, and (2) received from a licensed dentist, a qualified technician working under a dentist's supervision or any Physician furnishing dental services for which he is licensed.

For benefit purposes, dental expenses will be deemed incurred as follows:

For an appliance or modification of an appliance, on the date the final impression is taken;

For a crown, inlay, onlay or gold restoration, on the date the tooth is prepared;

For root canal therapy, on the date the pulp chamber is opened;

For any other service, on the date the service is rendered.

PREVENTIVE SERVICES

Exams & Cleanings, Routine - Routine oral examinations and routine cleaning and polishing of the teeth.

Fluoride - Topical application of stannous or sodium fluoride for Dependent children under age 18.

Palliatives - Emergency treatment for the relief of dental pain.

Sealants - Application of sealants to the pits and fissures of the teeth for children under age 16, with the intent to seal the teeth and reduce the incidence of decay. Coverage is limited to application on the occlusal (biting) surface of permanent molars that are free of decay or prior restoration.

X-rays - Dental X-rays for diagnostic purposes (periapical X-rays), as well as routine “full mouth” X-rays or a panoramic X-ray, and routine bitewing X-rays. Medically Necessary X-rays.

BASIC SERVICES

Anesthesia - General anesthesia when administered in connection with oral surgery or when deemed necessary by the dental provider for other covered dental services.

NOTES: Separate charges for pre -medication, local anesthesia, analgesia or conscious sedation are not covered. Such services are often included in the cost of the procedure itself.

Local infiltration or block anesthetics that are performed by or under the direct personal supervision of a dentist other than the operating Dentist or his/her assistant are not covered.

Consultation - Consultation by a dental specialist upon referral by the patient's attending dentist.

Endodontia - Endodontic services including but not limited to: root canal therapy (except for final restoration), pulpotomy, apicoectomy and retrograde filling.

Extractions - Simple extractions.

Fillings, Non-Precious - Amalgam, silicate, acrylic, synthetic porcelain and composite filling restorations to restore diseased or accidentally broken teeth.

For teeth posterior to (behind) the second bicuspid, an allowance for amalgam fillings will be made. See “Cosmetic Dentistry” in the list of **Dental Limitations and Exclusions**.

NOTE: Gold foil restorations are not covered.

Injections - Injection of antibiotic drugs.

Pathology - Laboratory services required for dental procedures.

Periodontia – Periodontal exams.

Space Maintainers - Fixed and removable appliances to retain the space left by a prematurely lost primary or "baby" tooth and to prevent abnormal movement of the surrounding teeth.

Study Models

Visits, Non-Routine - Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure. Professional visits after hours.

MAJOR SERVICES

Crowns - Initial placement of a gold, porcelain or composite crown restoration when a tooth cannot be satisfactorily restored with a filling restoration. Coverage for a crown includes a post and core when necessary.

Replacement of a crown, if the existing crown is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on veneer or facing (i.e., "tooth-colored") restorations. Crowns placed for periodontal splinting are not covered.

Dentures / Bridgework - see “Prosthetics” below

Inlays, Onlays & Gold Fillings - Initial placement of an inlay, onlay or gold filling when a tooth cannot be satisfactorily restored with a less costly filling (e.g., amalgam) restoration.

Replacement of an inlay, onlay or gold restoration, if the existing restoration is at least five (5) years old and cannot be made serviceable.

See "Cosmetic Dentistry" in the list of **Dental Limitations and Exclusions** for restrictions on "tooth-colored" restorations.

Oral Surgery - Surgical extraction of bone or tissue-impacted teeth. Other surgical and adjunctive treatment of disease, injury and defects of the oral cavity and associated structures.

Periodontal Scaling

Prosthetics - Initial placement of a full or partial denture or bridge to replace one or more natural teeth. Any allowance made for a prosthetic includes necessary adjustments within six (6) months of placement.

Replacement of or addition of teeth to an existing full or partial denture or bridge, but only if:

The existing denture or bridge cannot be made serviceable and is at least five (5) years old; or

The existing denture is an immediate temporary denture to replace one (1) or more natural teeth and replacement by a permanent denture is required and takes place within twelve (12) months from the date of the initial installation of the immediate temporary denture.

Repairs & Adjustments - Repair or re-cementing of a crown, inlay, bridge or denture or the relining of a denture. Prosthetic adjustments, but only for services provided more than six (6) months after placement.

Stainless Steel Crowns

Veneers (for children under age 16 only)

DENTAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated, no benefits will be payable under this Plan for:

Anesthetics, Local - Local infiltration anesthetic when billed for separately by a Dentist.

Appliances - Items intended for sport or home use, such as athletic mouth guards or habit-breaking appliances.

Congenital Conditions - Treatment of congenital (hereditary) conditions (e.g. congenitally missing teeth), unless expressly included.

Consultations, Missed Visits, Claims Forms - Charges for consultations, charges for failure to keep a scheduled visit, or charges for completion of claim forms.

Cosmetic Dentistry - Treatment rendered for cosmetic purposes, except when necessitated by an Accidental Injury.

Excess charges for a veneer or facing (i.e., a "tooth-colored" exterior) on a crown or pontic or excess charges for a tooth-colored restoration on a tooth posterior to the second bicuspid. The maximum allowance will be the allowance for the least costly restoration that will provide a functional result.

Customized Prosthetics – Excess charges for precision or semi-precision attachments, overdentures, or customized prosthetics.

Discoloration Treatment - Teeth whitening or any other treatment to remove or lessen discoloration, except in connection with endodontia.

Excess Care - Services that exceed those necessary to achieve an acceptable level of dental care. If it is determined that alternative procedures, services, or courses of treatment could be (could have been) performed to correct a dental condition, Plan benefits will be limited to the least costly procedure(s) that would produce a professionally satisfactory result.

Duplicate prosthetic devices or appliances.

Experimental & Non-Standard Procedures – Services or supplies which do not meet the standards accepted by the American Dental Association (ADA) or by the Council of Dental Therapeutics of the American Dental Association.

Grafting - Extra oral grafts (grafting of tissue from outside the mouth to oral tissues).

Hospital Expenses

Implants - Implants (materials implanted into or on bone or soft tissue to support a crown or prosthetic, including services and supplies necessary for their installation), or the removal of implants.

Lost or Stolen Prosthetics or Appliances - Replacement of a prosthetic or any other type of appliance that has been lost, misplaced, or stolen.

Medical Expenses - Any dental-related services to the extent to which coverage is provided under the terms of the medical benefits of this Plan.

Myofunctional Therapy - Muscle training therapy or training to correct or control harmful habits.

Non-Professional Care - Services rendered by someone other than:

A dentist (DDS or DMD);

A dental hygienist, X-ray technician or other qualified technician who is under the supervision of a dentist; or

A Physician furnishing dental services for which he is licensed.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

Occlusal Restoration - Procedures, appliances or restorations that are performed to alter, restore or maintain occlusion (i.e., the way the teeth mesh), including:

Increasing the vertical dimension;

Replacing or stabilizing tooth structure lost by attrition;

Realignment of teeth;

Gnathological recording or bite registration or bite analysis;

Occlusal equilibration.

Oral Hygiene Instruction & Supplies, Etc. - Dietary or nutritional counseling or related supplies, personal oral hygiene instruction or plaque control. Oral hygiene supplies including but not limited to: toothpaste, toothbrushes, waterpiks, and mouthwashes.

Orthodontia, Etc. - Orthodontia procedures, appliances or restorations used to increase vertical dimension or to restore occlusion.

Orthognathic Surgery - Surgery to correct discrepancies in the relationship of the jaws.

Personalization or Characterization of Dentures

Plaque Control Programs

Prescription Drugs - see "Prescription Drugs, Outpatient" in the **Medical Benefit Summary**

Prescription Drugs - see the **Addendum for Prescription Drugs**

Prior to Effective Date / After Termination Date - Courses of treatment that began prior to the person's effective date of coverage, including crowns, bridges or dentures that were ordered prior to the effective date.

Expenses incurred after termination of coverage, except that benefits will be extended for up to two (2) months following termination of coverage for the completion of the following:

An appliance or modification of an appliance when the impression was taken prior to the date of termination;

A crown, inlay, onlay or gold restoration when the tooth was prepared prior to the date of termination;

Root canal therapy when the pulp chamber was opened prior to the date of termination.

Splinting - Appliances or restorations for splinting teeth.

Temporary Restorations & Appliances - Excess charges for temporary restorations and appliances. Expenses for the permanent restoration or appliance will be the maximum Eligible Expense.

TMJ Treatment / Jaw Surgery - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

*- (See also **General Exclusions** section) -*

VISION BENEFIT SUMMARY

The Plan will provide benefits, up to the amounts shown at the far right, for the vision services and supplies that are listed below. Vision services or supplies must be rendered or ordered by a licensed ophthalmologist or optometrist.

Co-Pays are the Covered Person's responsibility.

ELIGIBLE VISION EXPENSES	**Plan Pays**
Vision Examination (after Covered Person pays $10 Co-Pay)	Balance
Limited to 1 complete vision exam every 12 months.	
Lenses for Glasses (after Covered Person pays $25 Co-Pay) Single Vision Bi-focals Trifocals Blended (Verilux) Progressive Multifocal	 $65 $90 $130 $151 $151
Silver Plan: Limited to 1 pair of lenses or frames once every 12 months as needed. **Bronze Plan:** Limited to 1 pair of lenses or frames once every 24 months as needed.	
Photochromic or Tinted Tint Coat Pink 1 or 2 Photogray/brown Transition Plastic	 $24 $20 $85 $79
Coated or Laminated Polarized Progressive	 $108 $162
UV Protection	$5
Frame Allowance	$90 after $25 Co-Pay
Limited to 1 pair of lenses or frames every 12 months, if needed.	
Contact Lens	$250
Covered when necessary following cataract surgery, to correct extreme visual deficit, certain Anesometropia conditions and keratoconus. NOTE: Elective or Medically Necessary contact lenses may be chosen instead of frames and lenses.	
Cosmetic (Elective) Lenses	$130
Limited to 1 pair every 12 months, if needed. Includes no charge for exam. Maximum applies to disposable or extended wear lenses. NOTE: Elective or Medically Necessary contact lenses may be chosen instead of frames and lenses.	

THIS IS ONLY A SUMMARY. SEE THE **VISION LIMITATIONS AND EXCLUSIONS** SECTION FOR MORE INFORMATION.

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

VISION LIMITATIONS AND EXCLUSIONS

Except as expressly stated below, no vision benefits will be provided for:

Consultations - Consultations, charges for failure to keep a scheduled visit, or charges for completion of claim forms.

Employment-Required Services - Any eye examination, or any corrective eyewear that is required by an employer as a condition of employment.

Non-Professional Care - A vision examination performed other than by a licensed ophthalmologist or optometrist.

Orthoptics - Services or supplies in connection with orthoptics, vision training or other special procedures.

Non-Prescription Lenses - Lenses that do not correct refractive error (plano lenses) or that are not obtained upon prescription by an ophthalmologist, optometrist or optician.

Radial Keratotomy - Surgery to correct refractive error.

Replacement - Replacement of lost or broken lenses or frames (except in accordance with the allowable frequencies as shown in the **Vision Benefit Summary**).

Safety Goggles or Sunglasses - Safety goggles or sunglasses (tint other than No. 1 or 2), including prescription type.

Vision Training - Vision training or education programs. Subnormal vision aids.

*- (See also **General Exclusions** section) -*

IMPORTANT: CERTAIN ELIGIBLE MEDICAL EXPENSES ARE SUBJECT TO BENEFIT LIMITS. SEE THE **MEDICAL BENEFIT SUMMARY** FOR THAT INFORMATION.

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Alcohol – Any injuries or illnesses that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for substance abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Confined Persons – Charges that are for services, supplies, and/or treatment of any Participant that Incurred while confined and/or arising from confinement in a prison, jail or other penal Institution with said confinement exceeding 24 consecutive hours.

Cosmetic Surgery – **Charges** that Incurred in connection with the care and/or treatment of Surgical Procedures which are performed for plastic, reconstructive or cosmetic purposes or any other service or supply which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons, except to the extent where it is needed for: (a) repair or alleviation of damage resulting from an Accident; (b) because of infection or Illness; (c) because of congenital Disease, developmental condition or anomaly of a covered Dependent Child which has resulted in a functional defect. A treatment will be considered cosmetic for either of the following reasons: (a) its primary purpose is to beautify or (b) there is no documentation of a clinically significant impairment, meaning decrease in function or change in physiology due to Injury, Illness or congenital abnormality. The term “cosmetic services” includes those services which are described in IRS Code Section 213(d) (9).

Criminal Activities - Any injury resulting from or occurring during a Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Custodial Care – Charges for care, supplies, treatment, and/or services that do not restore health, unless specifically mentioned otherwise.

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

Deductible Applicable – Charges that are not payable due to the application of any specified deductible provisions contained herein.

Error – Charges for care, supplies, treatment, and/or services that are required to treat injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

Excess Charges - Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator’s determination as set forth by and within the terms of this document.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

Approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and

Reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and

Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual*.

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

Government – Charges that are expenses to the extent paid, or which the Participant is entitled to have paid or obtain without cost, in accordance with the laws or regulations of any government.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments and for which the Covered Person has no legal obligation to pay.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Hazardous Pursuit, Hobby or Activity – Charges for care, supplies, treatment, and/or services that are related to injury or sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Participant's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm **including but not limited to:** hang gliding, skydiving, bungee jumping, parasailing, use of all-terrain vehicles, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

Illegal Drugs or Medications – Services, supplies, care or treatment to a Participant for Injury or Sickness resulting from that Participant's voluntary taking of or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for substance abuse treatment as specified in this Plan. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Incurred by Other Persons – Expenses actually incurred by other persons.

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

Medical Necessity – Charges for care, supplies, treatment, and/or services that are not Medically Necessary.

Medicare – Charges for benefits that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the sections entitled "Coordination of Benefits" and "Medicare."

Military Service - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

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

Negligence - Injuries resulting from any Physician's negligence, misfeasance, malfeasance, nonfeasance or malpractice.

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

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

Non-Prescription Drugs – Charges for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription Drug must be covered under Preventive Care, subject to the Patient Protection and Affordable Care Act.

Not Acceptable – Charges for care, supplies, treatment, and/or services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Actually Rendered – Charges for care, supplies, treatment, and/or services that are not actually rendered.

Not Listed Services or Supplies - Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

Not Specifically Covered – Charges for care, supplies, treatment, and/or services that are not specifically covered under this Plan.

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

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

Other than Attending Physician – Charges for care, supplies, treatment, and/or services that are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

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

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

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

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

Sales Tax, Etc. - Sales or other taxes or charges imposed by any government or entity. However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

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

Telecommunications - Advice or consultation given by or through any form of telecommunication.

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

Vehicle Accident – Charges for care, supplies, treatment, and/or services for treatment of any Injury where it is determined that a Participant was involved in a motorcycle accident while not wearing a helmet or in an automobile accident while not wearing a seatbelt.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not

prohibited by law. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

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

COORDINATION OF BENEFITS (COB)

Benefits Subject to This Provision
This provision shall apply to all benefits provided under any section of this Plan.

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

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

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third party;
4. Workers' compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

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

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO Provider has agreed to accept as payment in full. Further, when an HMO is primary and the Participant does not use an HMO Provider, this Plan will not consider as Allowable Expenses any charge that would have been covered by the HMO had the Participant used the services of an HMO Provider.

Claim Determination Period
"Claim Determination Period" shall mean each Calendar Year.

Effect on Benefits

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to one hundred percent (100%) of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than fifty percent (50%) of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal Injury protection (PIP) coverage with the automobile insurance carrier.

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

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

***COORDINATION OF BENEFITS**, continued*

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

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

   Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and
4. When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

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

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

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

SUBROGATION AND REIMBURSEMENT PROVISIONS

Payment Condition - The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where another party may be responsible for expenses arising from an incident, and /or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

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

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

Subrogation - As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

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

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

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

Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

Any policy of insurance from any insurance company or guarantor of a third party;

Worker's compensation or other liability insurance company; or

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

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

Right of Reimbursement - The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

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

The Plan's benefits shall be excess to:

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

Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

Any policy of insurance from any insurance company or guarantor of a third party;

Worker's compensation or other liability insurance company; or

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

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

Wrongful Death - In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

Obligations - It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

To provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;

To take such action and execute such documents as the Plan may require facilitating enforcement of its subrogation and reimbursement rights;

To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

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

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

Minor Status - In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

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

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

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees
To participate as an Employee in the Plan coverage's that are described herein, an individual must be in active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work at least twenty-four (24)) hours per week. Once an employee has established his/her eligibility for Health and Welfare benefits, they shall retain their eligibility for the ensuing full calendar quarter, regardless of hours being worked in that quarter. Similarly, an employee who has lost their eligibility on account of not averaging 24 hours per week in the prior quarter will not re-qualify for Health and Welfare benefits until they meet the average of 24 hours per week standard for an entire calendar quarter. Other eligibility requirements shall be as provided in the terms of the plan.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non - Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

The estimated monthly premium contribution/cost will be calculated in July of each year based on the experience of the plan over the prior 18 months (last full plan year plus January thru June of the current plan year), adjusted for changes in stop-loss insurance and other fixed costs, and an estimated 8% increase in cost of medical services for the upcoming plan year. Any such changes shall be effective January 1 at each plan year.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

Effective Date - Employees
An Employee's coverage is effective upon completion of a waiting period to the first day of the month following his completion of sixty (60) days of continuous active employment in an eligible status.

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage can become effective only in accordance with the "Late Enrollment/Re-Enrollment" or "Special Enrollment Rights & Mid-Year Election Change Allowances" provisions below. However, if employment is terminated and the Employee returns to active employment within thirty (30) days of such termination, then the waiting period will be waived and coverage will take effect on the first day the Employee returns to active employment.

Eligibility Requirements - Dependents
Except as noted at the end of this provision, an eligible Dependent of an Employee is:

A legally married spouse possessing a marriage license and who is not divorced from the Employee;

A common law spouse based upon a common law marriage which is legally recognized in the jurisdiction in which the Employee has his/her principal residence;

A domestic partner who shares the same principal place of residence with the Employee for more than one-half of the Calendar Year and who relies on the Employee for more than one half of his or her support for the Calendar Year in which the domestic partner is enrolled for coverage hereunder;

A child who is under age 26 (i. e., through age 25). The child need not: (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee or financially dependent on the Employee or any other person, (4) be unmarried, or (5) be unemployed.

An eligible "child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted child, a child who is placed with the Employee for legal adoption, or a foster child). An eligible child also includes one for whom coverage is required due to a Qualified Medical Child Support Order.

NOTE: An eligible Dependent does not include:

A spouse following legal separation or a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage);

Any person who is on active duty in any military service, except where eligibility is required by U.S. law;

Any person who is a resident of a country outside the United States;

Any person who is enrolled as an Employee;

Any person who is covered as a Dependent of another Employee;

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

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date. See the "Special Enrollment Rights…" provision for additional details as well as instances when the loss of other coverage and other circumstances can allow a Dependent to be enrolled. Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment/Re-Enrollment" provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Newborn or Adopted Children - Limited Automatic 31-Day Benefit Period
An Employee's newborn child will be eligible for benefits for Eligible Expenses that are incurred within the first thirty-one (31) days after the child's birth. Benefits for such child will be available for the 31-day period only. The child will become a Covered Person only if the child is enrolled within the limited 31-day benefit period – see “Entitlement Due to Acquiring New Dependent(s)” in the **Special Enrollment Rights**.

NOTE: During the limited 31-day benefit period, a newborn child is <u>not</u> a Covered Person. Any extended coverage periods or coverage continuation options that are available to Covered Persons <u>will not apply</u> to a newborn child who is provided with these thirty-one (31) days of limited benefits and who is not enrolled within such 31-day period.

Dual Coverage Not Permitted
No person can be simultaneously covered as both an Employee and a Dependent.

Special Enrollment Rights & Mid-Year Election Change Allowances
<u>Entitlement to Enroll Due to Loss of Other Coverage</u> - An individual who did not enroll in the Plan when previously eligible, will be allowed to apply for coverage hereunder at a later date if:

He was covered under another group health plan or other health insurance coverage (including Medicaid or a State Children’s Health Insurance Plan (CHIP)) at the time coverage was initially offered or previously available to him. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

The Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

The individual lost the other coverage as a result of a certain event and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage (and within sixty (60) days with regard to Medicaid or CHIP - see last sub-entry below). A loss of coverage event includes but is not limited to:

- Loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment;

- Loss of eligibility when 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);
- Loss of eligibility when 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;
- Loss of eligibility when an individual incurs a claim that would meet or exceed a lifetime limit on all benefits. An individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim is denied due to the operation of the lifetime limit;
- Loss of eligibility when a plan no longer offers any benefits to a class of similarly situated individuals. For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- Loss of eligibility when employer contributions toward an employee's or dependent's coverage terminates. This is the case even if an individual continues the other coverage by paying the amount previously paid by the employer;
- Loss of eligibility when COBRA continuation coverage is exhausted; and
- Loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or the date the individual becomes eligible for State premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement to Drop Due to CHIP Eligibility - If an Employee's child(ren) become eligible for CHIP (known as "Healthy Families" in California), Employee has the ability to drop the child(ren) from the group health coverage

Entitlement to Enroll Due to Health Care Reform - Any child of a covered Employee who is currently under age 26, who meets the above criteria but who is not currently enrolled, will be provided with an opportunity to enroll (a "special enrollment right") with coverage effective on the Plan Year anniversary on or after September 23, 2010. The special enrollment right also applies to an Employee/parent who is eligible to participate in the health plan. In this case, the Employee/parent may join the plan (or change coverage options, if any), and enroll the child accordingly.

Entitlement to Enroll Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, domestic partnership, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

where Employee's marriage or domestic partnership is the "triggering event" - the spouse's or partner's coverage (and the coverage of any newly eligible children) will be effective on the first day of the month following the date of event;

where acquisition of a child is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within 31 days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment allowances.

Court or Agency Ordered Coverage - If an Employee or an Employee's spouse is required to provide coverage for a child under a Medical Child Support Order, coverage for the child shall be effective as of the date specified in such order provided that such order is qualified according to the Plan Sponsor's written procedures and provided that a request for coverage is made on a form acceptable to the Plan Sponsor. A request to enroll the child may be made by the Employee, the Employee's spouse, the child's other parent, or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with an MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

Open Enrollment
If an Employee does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an Open Enrollment period that will be held annually. Coverage for Employees enrolling during Open Enrollment will become effective on January 1 unless the Employee has not satisfied the waiting period, in which case coverage for the Employee and his/her Dependent(s) will become effective on the day following completion of the waiting period.

Reinstatement / Rehire
If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). To avoid interruption of coverage during the leave, the Plan Sponsor will have the right to keep coverage in force at its own expense and can require that unpaid coverage contribution costs be repaid by the Employee at the end of the FMLA leave.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage hereunder immediately upon returning from military service. See "Extension of Coverage during U.S. Military Service" in the **Extensions of Coverage** section for more information.

NOTES: Except in the above instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered hereunder, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

Transfer of Coverage
If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to immediately enroll under the remaining Employee's coverage. Such transferred coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

Acquired Companies
Employees of an acquired company who were covered under the plan of the acquired company and who meet the eligibility requirements of this Plan will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of this Plan's waiting period. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

Restatement / Replacement of Benefits
This Benefit Document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. The health coverage(s) described herein are an immediate restatement or replacement of such prior benefits. Except to the extent that benefits are expressly modified, any deductibles satisfied or benefits paid with respect to covered persons under the prior benefits will be deemed to be Deductibles satisfied or benefits paid under the Benefit Document for a person who is eligible as an active enrollee or a COBRA enrollee under the Benefit Document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered under this Benefit Document.

TERMINATION OF COVERAGE

Employee Coverage Termination
Except as noted, an Employee's coverage will terminate upon the earliest of the following:

Termination of the Plan or termination of the Plan benefits as described herein;

Employee's election to terminate participation, unless prohibited by law (i.e., when election changes cannot be made due to IRC section 125 "change in status" guidelines);

At midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the **Extensions of Coverage** section;

The date the Employee dies.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

NOTE: Unused vacation days or severance pay following cessation of active work will not count as extending the period of time coverage will remain in effect.

An Employee otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his health status or need for health services.

Dependent Coverage Termination
Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

Termination of the Plan or these Plan benefits or discontinuance of Dependent coverage hereunder;

Termination of the coverage of the Employee;

At midnight of the last day the Dependent meets the eligibility requirements of these Plan benefits, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

On the date the Employee requests that Dependent coverage be terminated unless prohibited by law (i.e., when election changes cannot be made due to IRC section 125 "change in status" guidelines). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination;

The date the Dependent dies.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

NOTE: A Dependent otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his health status or need for health services.

- *(See **COBRA Continuation Coverage**)* -

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the **Termination of Coverage** date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employee's coverage ceases.

Extension of Coverage for Handicapped, Retarded or Disabled Dependent Children
If an already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation, disability or physical handicap, and:

Such condition commenced on or before the child attained an age that would otherwise terminate his eligibility;

The child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

Such child is primarily dependent upon the Employee for support and maintenance;

Then such child's status as a "Dependent" will continue, irrespective of his attaining a limiting age, so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of a limiting age, and as may reasonably be required thereafter, but not more frequently than once a year.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, or is eligible for an extension required by law, etc.), he may be permitted to continue health care coverage's for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non -discriminatory basis.

Except where the Family and Medical Leave Act (FMLA) may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

On the date coverage terminates as specified in the Employer's written personnel policies and employee communications. Such documents are incorporated herein by reference;

The end of the period for which the last contribution was paid, if such contribution is required;

The date of termination of the Plan or these benefits of the Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA if it is engaged in commerce or in any industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA is allowed for up to 12 workweeks of unpaid leave in any 12 -month period. Such leave must be for one or more of the following reasons:

The birth of an Employee's child and in order to care for the child;

The placement of a child with the Employee for adoption or foster care;

To care for a spouse, child or parent of the Employee where such relative has a serious health condition;

Employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

The Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered service member. "Covered service member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Extension of Coverage During U.S. Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled "Maximum Period of Coverage" below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee fails to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

24 months; or

The duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

An employee returning from military leave must notify their employer of their intent to return to work. Notification (application for reemployment) must be made:

Within 14 days after active military service ceases for military leave of 31-180 days; or

Within 90 days of completion of military service for military leave of more than 180 days.

No reemployment application is required if the military leave is less than 31 days. In that case, generally the employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an injury or illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage hereunder is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous. No waiting period or preexisting condition exclusion can be imposed on a returning employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

- *(See **COBRA Continuation Coverage**)* -

CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, ERISA, or any other applicable law, such law shall control.

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) **A Pre-Service Claim** is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

   Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) **A Post-Service Claim** is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within one (1) year of the date a service or supply is received. Unless the Claimant is legally incapacitated, a late claim will not be covered if it is filed after the deadline.

   A Post-Service Claim should be submitted to:

   Humboldt Del Norte Foundation for Medical Care
   2662 Harris St.
   Eureka, CA 95503

   NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable hereunder will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due hereunder, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

In the event the Plan fails to pay benefits to a provider in respect of a claim incurred by a Covered Person, the Employee or Covered Person will be responsible for paying the provider any amounts due for the services received.

No covered Employee or Dependent may, at any time, either while covered hereunder or following termination of coverage, assign his right to sue to recover Plan benefits or to enforce rights hereunder or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid -eligible beneficiary due to the state's having paid Medicaid benefits that were payable hereunder.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (e.g., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA.

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Urgent Claim - defined below	
Claimant Makes Initial ";.ete Claim Request	Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial Complete Claim Request	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant's appeal.
An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed.	
Where the "Time Limit or Allowance" stated above reflects "or sooner if possible," this phrase means that an earlier response may be required, considering the urgency of the medical situation.	

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.

Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.

A "concurrent care claim" is a Claimant's request to extend a previously-approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.

Non-Urgent Claim

Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request. Claimant may request a written notification.
Plan Receives Completing Information	Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.

"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.
Plan Receives Completing Information	Plan approves or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

The specific reason(s) for the decision to reduce or deny benefits;

Specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

A description of any additional information needed to change the decision and an explanation of why it is needed;

A description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA;

For adverse determinations based on medical necessity, experimental treatment or other similar exclusions or limits, an explanation of the scientific or clinical judgment used in the decision, or a statement that an explanation will be provided free of charge upon request;

For adverse determinations involving urgent care, a description of the expedited review process for such claims. This notice can be provided orally within the timeframes for the expedited process, as long as written notice is provided no later than three (3) days after the oral notice.

APPEAL PROCEDURES

Filing an Appeal
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

The specific reason(s) for the decision;

Reference to the pertinent Plan provisions on which the decision is based;

A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

Identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

A statement describing any voluntary appeal procedures offered by the Plan, if any, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a).

A Plan participant and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact the Local U.S. Department of Labor Office and the State insurance regulatory agency.

Authorized Representative May Act for Claimant
Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

Full and Fair Review
During the internal claims and review process, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

During the internal claims and appeals process, the Claimant may review the claim file and present evidence and testimony as part of the process. The Plan will provide the Claimant, free of charge, with any new or additional evidence considered, relied upon or generated by the Plan, or new rationale used in making its determination in connection with the claim, sufficiently in advance of the notice of Final Internal Adverse Benefit Determination in order to give the Claimant a reasonable opportunity to respond prior to that date.

ADVERSE BENEFIT DETERMINATIONS

Notice of Adverse Benefit Determination
If a claim is wholly or partially denied, or there is a reduction, or termination of, or a failure to provide or make payment for (in whole or in part), a benefit, or a rescission of coverage (as defined in Treas. Reg. § 54.9815 -2712T) whether or not there is an adverse impact on a claim or benefit, the individual will be given written or electronic notification of such determination within the time frames required by law - see "Claims Time Limits and Allowances." The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

Date of service, provider, and claim amount (if applicable);

The specific reason(s) for the decision to reduce or deny benefits;

Specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

A statement that the individual is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Adverse Benefit Determination;

A description of any additional information needed to change the decision and an explanation of why it is needed;

A description of the Plan's procedures and time limits for appealed claims, including a statement of the individual's right to bring a civil action under section 502(a) of ERISA.

Effective July 1, 2011 or such later date pursuant to guidance issued by the Department of Labor, any notice of Adverse Benefit Determination will be provided in a culturally and linguistically appropriate manner and include:

Name of health care provider;

The diagnosis code and its corresponding meaning;

The treatment code and its corresponding meaning;

The reason or reasons for the Adverse Benefit Determination or Final Internal Adverse Benefit Determination including the denial code and corresponding meaning;

A description of the Plan's standard, if any, used in denying the claim and, with respect to a Final Internal Adverse Benefit Determination, a discussion of the decision;

A description of available internal appeals and external review processes;

Disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist with the Internal Claims and Appeals and External Review processes.

INTERNAL APPEAL PROCEDURES

Filing an Internal Appeal
Within 180 days of receiving notice of an Adverse Benefit Determination, an individual may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal.

Deemed Exhaustion of Internal Claims and Appeals Process
Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures. Effective July 1, 2011, in the event the Plan fails to strictly adhere to all the requirements of the internal claims and appeals procedures with respect to a claim, the Claimant may initiate a n External Review or pursue any available remedies under ERISA 502(a) or State law, as applicable, on the basis that the Plan has failed to provide a reasonable internal claims and appeals process that would yield a decision on the merits of the claim.

Decision on Internal Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances."

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

The specific reason(s) for the decision;

Reference to the pertinent Plan provisions on which the decision is based;

A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

Identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

A statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a); and

Information about the external appeals process.

A Plan participant and the Plan may have other voluntary alternative dispute resolutions options, such as mediation. One way to find out what may be available is to contact the Local U.S. Department of Labor Office and the State insurance regulatory agency.

Any New Evidence During the Appeal Process
If any new evidence is considered, relied upon or is generated during the appeal process, or a determination is based on a new rationale, the Claimant must be furnished with the new evidence or rationale as soon as possible and free of charge. This documentation must be provided sufficiently in advance of the final determination so that the Claimant has a reasonable opportunity to respond before the final determination is made.

Avoidance of Conflicts of Interest
Claims and appeals will be adjudicated by individuals who are independent and impartial. This means that the fiduciary deciding an appeal will be different from (and not subordinate to) the individual who decided the initial claim, and that any medical expert consulted regarding an appeal will be different from (and not subordinate to) the expert consulted in connection with the initial claim. Moreover, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to a claims adjudicator or medical expert cannot be based upon the likelihood such individual will deny a claim.

Continued Coverage Pending Appeals Outcome
Coverage must continue during the appeal process, pending the outcome of the review. This requirement is intended to be consistent with current ERISA regulations for claims involving concurrent care (i.e., where the Plan has previously approved an ongoing course of treatment for a specified period of time or number of treatments, it cannot reduce the period/number without first providing the Claimant advance notice and an opportunity to appeal.

EXTERNAL REVIEW PROCEDURES

Filing an External Review
An individual may file a request for an external review if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt (e.g. February 28), the request must be filed by the first day of the fifth month following receipt of the notice. The request is filed as described in the notice.

Preliminary Review
Within five (5) business days after the date of the receipt of the external review request, a preliminary review must be completed to determine whether:

The Claimant is or was covered by the Plan at the time the health care service was requested;

The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the Claimant's failure to meet the requirements for eligibility under the terms of the Plan;

The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to exhaust the internal appeals process; and

The Claimant has provided all of the information and forms required to process an external review.

Within one (1) business day after completing the preliminary review, a written notification must be issued to the Claimant. If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefit Security Administration (EBSA).

If the request is not complete, the notification must describe the information needed to make the request complete, and the Plan must let a Claimant perfect the request for external review within the four-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

External Review Process
The external review process is independent and without bias and may be assigned to and conducted by an independent review organization (an "IRO") that is accredited by a nationally recognized accrediting organization or may be conducted in another manner that ensures an independent and unbiased external review. If an IRO will be assigned to conduct the review, then at least three IROs must be under contract for assignments which must be rotated among them. The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

The IRO shall notify the Claimant, in a timely manner, of its acceptance of the review and inform the Claimant of the deadlines for submissions of additional information which shall be no later than ten business days following receipt of this notice.

Within five business days of assignment of the external review to the IRO, the Plan shall provide to the IRO any documents and information it used in making its Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

Notice of Final Review Decision
The IRO must provide written notice of the Final External Review Decision within 45 days after receiving the request for the external review. The notice must be delivered to the Claimant and to the Plan.

Expedited External Review
External review procedures may be expedited for cases where completion of an expedited internal appeal would seriously jeopardize the life or health of the Claimant or would jeopardize his or her ability to regain maximum function, an admission, availability of care, continued stay, or health care item or service for which the Claimant received Emergency Services, but has not been discharged from a facility. For an expedited review, the IRO must provide notice of the Final External Review Decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice to the Claimant is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the Claimant and the Plan.

RECOVERY OF PAYMENTS

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

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

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

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

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

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

An Accidental Injury will also include injuries suffered by a Covered Person who is the victim of domestic violence.

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

Ambulatory Surgical Center - Any public or private establishment that:

Complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

Has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

Provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

Does not provide services or other accommodations for patients to stay overnight.

Assignment of Benefits - An arrangement whereby the Covered Person, at the discretion of the Plan Administrator, assigns their right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and the coinsurance percentage that is not paid by the Plan, in strict accordance with the terms of this Plan document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Covered Person, and are limited by the terms of this Plan document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" and deductibles, co-payments and the coinsurance percentage that is the responsibility of the Participant, as consideration in full for services, supplies, and/or treatment rendered. The Plan Administrator may revoke or disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole beneficiary.

Benefit Document - A document that describes one (1) or more benefits of the Plan.

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

Is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

Is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

Have organized facilities for birth services on its premises;

Provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

Has 24-hour-a-day registered nursing services;

Maintains daily clinical records.

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

Claimant - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., processing of claims for payment) in accordance with the terms and conditions of the

Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

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

Convalescent Hospital - see "Skilled Nursing Facility"

Covered Person - An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)). See **Eligibility and Effective Dates, Extensions of Coverage** and the **COBRA Continuation Coverage** sections for further information.

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

Covered Provider - An individual who is:

Licensed to perform certain health care services that are covered hereunder and who is acting within the scope of his license; or

In the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

And who is a/an:

Advanced Clinical Practitioner (LMSW-ACP)
Acupuncturist (CA)
Audiologist
Certified or Registered Nurse Midwife
Certified Registered Nurse Anesthetist (CRNA)
Chiropractor (DC)
Dentist (DDS or DMD)
Dietician
Enterostomal therapist
Licensed Clinical Psychologist (PhD or EdD)
Licensed Clinical Social Worker (LCSW)
Licensed Practical Nurse (LPN)
Licensed Professional Counselor (LPC)
Licensed Vocational Nurse (LVN)
Massage Therapist
Marriage and Family Therapists
Nurse Practitioner
Occupational Therapist (OTR)
Optometrist (OD)
Physical Therapist (PT or RPT)
Physician - see definition of "Physician"
Physician Assistant (PA)
Physiotherapist
Podiatrist or Chiropodist (DPM, DSP, or DSC)
Psychiatric /Mental Health Nurse
Psychiatrist (MD)
Registered Nurse (RN)
Respiratory Therapist
Speech Therapist
Speech Language Pathologist

A "Covered Provider" will also include the following when appropriately-licensed and providing services that are covered hereunder:

Any practitioner of the healing arts who is licensed and regulated by a state or federal agency, is providing services or supplies that are covered hereunder, and is acting within the scope of his license;

Facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, clinics;

Licensed Outpatient mental health facilities;

Freestanding public health facilities;

Hemodialysis and Outpatient clinics under the direction of a Physician (MD);

Enuresis control centers;

Home infusion therapy providers;

Durable medical equipment providers;

Prosthetists and prosthetist-orthotists;

Portable X-ray companies;

Independent laboratories and lab technicians;

Diagnostic imaging facilities;

Blood banks;

Speech and hearing centers;

Ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **General Exclusions**, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Dependent - see **Eligibility and Effective Dates** section

Eligible Expense(s) - Expense that is: (1) covered by a specific benefit provision of the Benefit Document, and (2) incurred while the person is covered by the Plan.

Emergency Medical Condition - A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of 1867(e)(1)(A) of the Social Security Act.

Employee - An individual who is employed by the Employer and who meets the Plan's eligibility criteria. See "Eligibility Requirements – Employees" in the **Eligibility and Effective Dates** section.

Employer(s) - The Employer or Employers participating in these Plan benefits as reflected in the **General Plan Information** section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Fiduciary - An entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Home Health Care Agency - An agency or organization that:

Is approved as a Home Health Care Agency under Medicare;

Is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;

Has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

Provides for full-time supervision of its services by a Physician or by a registered nurse;

Maintains a complete medical record on each patient;

Has a full-time administrator;

Its employees are bonded and it provides malpractice insurance.

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

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

Hospital - An institution that:

Is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;

Complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

Is primarily engaged in providing medical treatment to sick and injured persons as registered bed patients and maintains permanent facilities for five or more such patients;

Is operated under the supervision of a staff of Physicians;

Continuously provides 24-hour-a-day nursing service by registered nurses;

Maintains a daily medical record for each patient;

Maintains facilities for diagnosis of injury or disease;

Maintains permanent facilities for major surgical operations on its premises; and

Is not, other than incidentally: (1) a place of rest, for custodial care, for the aged, or for the care of senile persons, (2) a nursing home, (3) a hotel, or (4) a school or similar institution.

For treatment of mental health conditions or substance abuse, a "Hospital" will also include a facility that is appropriately licensed to provide such specialty care in the area in which it is located and that is operating within the scope of that license.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (e.g., Hospital, or Skilled Nursing Facility) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

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

Lifetime - All periods an individual is covered hereunder, including prior periods of coverage under any prior statements of these Plan benefits. It does not mean a Covered Person's entire lifetime.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

It is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury or a covered mental health condition or a covered substance use disorder;

The prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;

It is furnished by a provider with appropriate training and experience, acting within the scope of his or her license; and

It is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition

requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: *The American Hospital Formulary Service Drug Information* and *The United States Pharmacopoeia Dispensing Information* ; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

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

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

Participating Employer - An Employer who is participating in the Plan coverage's described herein. See **General Plan Information** section for the identity of the Participating Employer(s).

Physician - A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

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

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Plan Administrator - see "Plan Sponsor"

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

Plan Sponsor - The entity sponsoring the Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Pregnancy - The state of a female after conception and until termination of the gestation. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Reasonable - In the administrator's discretion, services or supplies, or fees for services or supplies which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

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

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

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

Rehabilitation Center - A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

Carries out its stated purpose under all relevant state and local laws; or

Is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or

Is approved for its stated purpose by Medicare.

Residential Treatment Facility - A state-licensed facility and community-based facility that is not a Hospital, but that provides residential care for persons with serious and persistent mental health conditions or substance abuse disorders. The facility must be operated 24-hours-per day to provide psychiatric and/or substance abuse and dependency treatment to its resident patients.

Semi-Private Room Charge - The standard charge by a facility for a semi-private room and board accommodation (2 or more beds), or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for a single bed room and board accommodation where the facility does not provide any semi-private accommodations.

Sickness - Bodily illness or disease (including covered mental health conditions and covered substance use disorders), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician or other appropriate Covered Provider in order to be considered a Sickness hereunder.

Skilled Nursing Facility - An institution that:

Is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

Is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day for convalescing persons;

Is under the full-time supervision of a Physician or a registered nurse;

Admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

Has established methods and procedures for the dispensing and administering of drugs;

Has an effective utilization review plan;

Is approved and licensed by Medicare;

Has a written transfer agreement in effect with one or more Hospitals; and

Is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Urgent Care Facility - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

A board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

X-ray and laboratory equipment and a life support system.

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

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

The term “Usual” refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent

that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

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

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

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

GENERAL PLAN INFORMATION

Name of Plan:	**North Coast Cooperative, Inc. Health and Dental Plan**
Plan Sponsor / Plan Administrator: Address: Business Phone Number:	**North Coast Cooperative, Inc.** 811 "I" Street Arcata, CA 95521-6123 (707) 826-8670
Participating Employer(s):	**North Coast Cooperative, Inc.**
Plan Sponsor ID Number (EIN):	**94-2227181**
Plan Number:	**501**
Plan Status:	**Grandfathered**
Original Effective Date of Plan:	**January 1, 1988**
Plan Year:	**January 1 through December 31**
Named Fiduciary: Address: (See also definition of "Fiduciary")	**North Coast Cooperative, Inc.** 811 "I" Street Arcata, CA 95521-6123
Agent for Service of Legal Process: Address: Phone:	**North Coast Cooperative, Inc.** Attn: Plan Administrator 811 "I" Street Arcata, CA 95521-6123 (707) 826-8670
Type of Plan:	**An employee welfare benefit plan providing group benefits**
Applicable Collective Bargaining Agreement(s):	**None**
Plan Benefits Described in this Benefit Document:	**Self-Funded Medical, Dental, Vision & Prescription Drug Benefits**
Type of Administration for Benefits Described herein:	**Contract Administration** – see "Administrative Provisions" for additional information
Contract Administrator: Address: Phone:	**Humboldt Del Norte Foundation for Medical Care** **2662 Harris St.** **Eureka, CA 95503** **707-443-4563 or 800-443-4563**

PATIENT PROTECTION AND AFFORDABLE CARE ACT

This group health plan believes this plan 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 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 the following address:

North Coast Cooperative, Inc.
811 "I" Street

Arcata, CA 95521-6123

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.

FUNDING - SOURCES AND USES

Plan benefits described herein are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees are handled through a Section 125 pre-tax premium plan.

See the **COBRA Continuation Coverage** section for more information.

ADMINISTRATIVE PROVISIONS

Administration (type of)
The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Administrator's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan
Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

Reduce, modify or terminate retiree health care benefits hereunder, if any;

Alter or postpone the method of payment of any benefit;

Amend any provision of these administrative provisions;

Make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and

Terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those Plan benefits to which he has become entitled.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Creditable Coverage Certificates
Under the Health Insurance Portability and Accountability Act of 1996 (commonly known as HIPAA), an individual has the right to receive a certificate of prior health coverage, called a “certificate of creditable coverage” or “certificate of group health plan coverage,” from the Plan Sponsor or its delegate. If Plan coverage or COBRA continuation coverage terminates (including termination due to exhaustion of all lifetime benefits under the Plan), the Plan Sponsor will automatically provide a certificate of creditable coverage. The certificate is provided at no charge and will be mailed to the person at the most current address on file. A certificate of creditable coverage will also be provided, on request, in accordance with the law (i.e., a request can be made at any time while coverage is in effect and within twenty-four (24) months after termination of coverage). Written procedures for requesting and receiving certificates of creditable coverage are available from the Plan Sponsor.

Discrepancies
In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document, the Benefit Document will prevail.

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

All decisions and determinations of the Plan Administrator with respect to any matter hereunder shall be conclusive and binding on Plan Participants and Dependents and all other interested parties, except where expressly prohibited by applicable laws or regulations.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other r person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Administrator in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefor under the Plan.

Fiduciary Responsibility & Authority
Fiduciaries will serve at the discretion of the Plan Administrator and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

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

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

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use

reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice - versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under the Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the time written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the **Claims Procedures** section for more information.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

An employee's cessation of active service for the employer;

A Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;

A dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

A Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

A claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Mental Health Parity & Addiction Equity Act
The Mental Health Parity & Addiction Equity Act includes an increased cost exemption under which, if certain requirements are met, a plan that incurs increased costs above a certain threshold as a result of the application of the parity requirements of the law can be exempt from the statutory parity requirements. Plans that comply with the parity requirements for one full Plan Year and that satisfy the conditions for the increased cost exemption can be exempt from the parity requirements for the following Plan Year.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility,

benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

A medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
Claims experience
Receipt of health care
Medical history
Evidence of insurability Disability
Genetic information

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the **General Plan Information** section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator or the delegated Contract Administrator shall make determinations regarding Plan Benefits.

Privacy Rules, Security Standards & Breach Notification Rules
To the extent required by law, the Plan is amended and will comply with: (1) the Standards for Privacy of Individually Identifiable Health Information (i.e., the “Privacy Rules”) of the Health Insurance Portability and Accountability Act (HIPAA), and (2) the HIPAA Security Standards with respect to electronic Protected Health Information.

HIPAA’s Privacy Rules and Security Standards apply to group medical and dental benefits as well as health flexible spending account (Health FSA) benefits offered through a Section 125 cafeteria plan.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

The 2009 breach notification regulations and the Health Information Technology for Economic and Clinical Health (HITECH) Act, require HIPAA covered entities and their business associates to provide notification to an affected individual following a breach of unsecured protected health information. Such individual notification must be provided within a reasonable period of time and in no case later than 60 days following the discovery of a breach. To the extent possible, such affected individual must also be provided with a description of the breach, a description of the types of information that were involved in the breach, the steps the individual should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity. More information is available on the U.S. Department of Health & Human Services’ website.

NOTES: The Privacy Rules requirements do not apply to “summary health information” which is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. “Summary health information” is health-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating

Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Administrator may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefor from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rescission of Coverage
The Plan may not rescind an individual’s coverage under the Plan (e.g., cancelling coverage after a Covered Person has submitted a claim). However, the Plan may rescind coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact. Failure to provide timely notice of loss of eligibility will be considered intentional representation.

Rights Against the Plan Sponsor or Employer
Except for those rights expressly granted under ERISA §502, neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Termination for Fraud or Intentional Misrepresentation
An individual's Plan coverage or eligibility for coverage may be terminated if:

The individual makes an intentional misrepresentation of a material fact;

The individual submits any claim that contains false or fraudulent elements under state or federal law;

A civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

An individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Titles or Headings
Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

STATEMENT OF RIGHTS

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

Receive Information About His/Her Plan and Benefits. This includes the right to:

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and

Receive a summary of a 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. This includes:

The right to continue health care coverage for himself/herself, spouse or dependents if there is a loss of coverage under a Plan as a result of a Qualifying Event. The employee or his/her dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights; and

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under a plan, if he/she has creditable coverage from another plan. An individual should be provided a certificate of creditable coverage, free of charge, from his/her group health plan or health insurance issuer when he/she loses coverage under a plan, when he/she becomes entitled to elect COBRA continuation coverage, when his/her COBRA continuation coverage ceases, if he/she requests it before losing coverage or if he/she requests it up to 24 months after losing coverage. Without evidence of creditable coverage, he/she may be subject to a preexisting condition exclusion of up to 12 months (18 months for late enrollees) after his/her enrollment date in the Plan.

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 a Plan (the fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the employer, may fire a Plan participant or discriminate against him/her to prevent him/her from obtaining a welfare benefit or exercising rights under ERISA.

Enforce His/Her Rights

If an individual's claim for a welfare benefit is denied in whole or in part, he/she must receive a written explanation of the reason for the denial. He/she has the right to have the Plan Administrator review and reconsider his/her claim.

Under ERISA there are steps a Plan participant can take to enforce the above rights. For instance, if he/she requests materials from a Plan and does not receive them within 30 days, he/she may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him/her up to $110 a day until he/she receives the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If he/she has a claim for benefits which is denied or ignored, in whole or in part, he/she may file suit in a state or Federal court. In addition, if he/she disagrees with the Plan decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he/she may file suit in Federal court.

If it should happen that Plan fiduciaries misuse the Plan's money, or if he/she is discriminated against for asserting his/her rights, he/she may seek assistance from the U.S. Department of Labor, or he/she may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he/she is successful, the court may order the person he/she has sued to pay these costs and fees. If he/she loses, the court may order him/her to pay these costs and fees, for example, if it finds his/her claim is frivolous.

Assistance With His/Her Questions

If a Plan participant has any questions about a Plan, he/she should contact the Plan Administrator. If he/she has any questions about this statement or about his/her rights under ERISA, he/she should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his/her telephone directory, or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Plan participant may also obtain certain publications about his/her rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse (as defined by the federal Defense of Marriage Act) or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverage's the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

NOTE: A Domestic Partner is not a Qualified Beneficiary and does not have independent COBRA election rights.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

Voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

Reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

For an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;

For an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

For an Employee's spouse or child, the death of the covered Employee;

For an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notice Responsibilities – If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event. If the Employer is not the Plan Administrator, then the Employer's notification to the

Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary is also responsible for other notifications. See the section entitled **COBRA Notice Requirements for Plan Participants** (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(ies) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage. See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost that is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries will be charged 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. If payment is not made within such time period, the COBRA election is null and void. The initial premium payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30 -day grace period allowed for payment. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase during the Plan's 12-month determination period if:

The cost previously charged was less than the maximum permitted by law;

The increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

The Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than $50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

If the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

If the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

For any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title I I or XVI of the Social Security Act to be disabled in the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable period. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

The last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

The date on which the Employer ceases to provide any group health plan to any Employee;

The date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any preexisting condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

The date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;

In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

HIPAA Creditable Coverage Credit

With respect to any TAA-Eligible Individual who elects COBRA continuation of coverage as a Nonelecting TAA Individual, the period beginning on the date the TAA-Related Loss of Coverage, and ending on the first day of the TAA-Related Election Period shall be disregarded for purposes of determining the 63-day break-in-coverage period pursuant to HIPAA rules regarding determination of prior creditable coverage for application to a plan's preexisting condition exclusion provision.

Applicable Cost of Coverage Payments

Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in IRS regulations 54.4980B-8, A-5(d), the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

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COBRA NOTICE REQUIREMENTS FOR PLAN PARTICIPANTS

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that

is: A Dependent child's ceasing to be eligible (e.g., due to reaching the maximum age limit);

The divorce or legal separation of the Employee from his/her spouse;

The occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to **COBRA Continuation Coverage** with a maximum duration of 18 (or 29) months;

Where a Qualified Beneficiary entitled to receive **COBRA Continuation Coverage** with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled in the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in "(a)" has subsequently been determined by the Social Security Administration to no longer be disabled.

It is also important that the Plan Administrator be kept informed of the current addresses of all Plan participants or beneficiaries who are or may become Qualified Beneficiaries.

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date the document was prepared and a Qualified Beneficiary should make certain that procedure changes have not occurred before relying on this information. The most current information should be included in the Employer's COBRA Initial General Notice that is provided to new hires.

Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content & Delivery - Notification of the Qualifying Event must in writing.

Notification must include evidence that a Qualifying Event or other event extending coverage has occurred (e.g., copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

Notification must be received by the claims office: CBA Administrators at 4704 West Jennifer Avenue, Suite 104, Fresno, CA 93722.

Time Requirements for Notification - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice by way of the Summary Plan Description or the Plan Sponsor's General COBRA Notice. If Notice is not made within the 60-day period, **COBRA Continuation Coverage** will not be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available – see "Effect of the Trade Act" in the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary is advised of the Notice obligation through the SPD or the Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice if the Qualified Beneficiary does not comply with a request by the Plan for more complete information within a reasonable period of time following the request.

APPENDIX FOR FEDERALLY-REQUIRED PREVENTIVE CARE BENEFITS

When the following covered preventive care services are provided by a Network provider, a Covered Person will not have to a meet a deductible, pay a Co-Pay or pay a percentage share of the cost. See **IMPORTANT DETAILS** at the end of this section for coverage information when non-Network providers are used.

Note: The following lists are subject to change periodically. Check the website references at the end of this section for the most up-to-date information.

COVERED PREVENTIVE SERVICES FOR ADULTS (AGE 18 & OLDER)			
Abdominal Aortic Aneurysm	One-time screening for men of specified ages who have ever smoked		
Alcohol Misuse	Screening and counseling		
Blood Pressure	Screening for all adults		
Cholesterol	Screening for adults of certain ages or at higher risk		
Colorectal Cancer	Screening for adults over age 50		
Depression	Screening for adults		
Diabetes (Type 2)	Screening for adults with high blood pressure		
Diet	Counseling for adults at higher risk for high cholesterol or heart disease		
HIV	Screening for all adults at higher risk		
Immunizations & Vaccines Doses, recommended ages and recommended populations vary	Hepatitis A Hepatitis B Herpes Zoster Human Papillomavirus Influenza	Measles Mumps Meningococcal Pneumococcal Tetanus	Diphtheria Pertussis Varicella Rubella
Obesity	Screening and counseling for all adults		
Sexually-Transmitted Infection (STI)	Prevention counseling for adults at higher risk		
Syphilis	Screening for all adults at higher risk		
Tobacco Use	Screening only		

ADDITIONAL COVERED PREVENTIVE SERVICES FOR WOMEN (AGE 18 & OLDER)	
BRCA Gene	Counseling about genetic testing for women at higher risk
Breast Cancer Mammography	Screenings every 1 to 2 years for women over 40
Breast Cancer Chemoprevention	Counseling for women at higher risk
Cervical Cancer	Screening for sexually-active women
Chlamydia Infection	Screening for younger women and other women at higher risk
Folic Acid	Supplements for women who may become pregnant
Gonorrhea	Screening for all women at higher risk
Osteoporosis	Screening for women over age 60 depending on risk factors

PREVENTIVE SERVICES FOR COVERED PREGNANCIES	
Anemia	Screening on a routine basis for pregnant women
Bacteriuria	Urinary tract or other infection screening for pregnant women
Breast Feeding	Interventions to support and promote breast feeding
Hepatitis B	Screening for pregnant women at their first prenatal visit
Rh Blood Typing	Screening for all pregnant women
Tobacco Use	Screening, interventions and expanded counseling for pregnant tobacco users
Syphilis	Screening for all pregnant women or other women at increased risk

COVERED PREVENTIVE SERVICES FOR CHILDREN (BIRTH TO AGE 18)		
Alcohol & Drug Use Assessment	Adolescents	
Autism Screening	18 and 24 months	
Behavioral Assessments	All children throughout development	
Cervical Dysplasia Screening	Sexually active females	
Congenital Hypothyroidism Screening	All newborns	
Developmental Screening	Children under age 3 and surveillance throughout childhood	
Dyslipidemia Screening	Children at higher risk of lipid disorders	
Fluoride Chemoprevention Supplements	Children without fluoride in their water source	
Gonorrhea Preventive Eye Medication	All newborns	
Hearing Screening	All newborns	
Height, Weight & Body Mass Index	All children throughout development	
Hematocrit or Hemoglobin Screening	All children	
Hemoglobinopathies/Sickle Cell Screening	All newborns	
HIV Screening	Adolescents at higher risk	
Immunizations & Vaccines	Diphtheria Tetanus Pertussis Haemophilus Influenza (Type b) Hepatitis A Hepatitis B Human Papillomavirus Inactivated Poliovirus	Influenza Measles Mumps Rubella Meningococcal Pneumococcal Rotavirus Varicella
Iron Supplements	Children ages 6 to 12 months at risk for anemia	
Lead Screening	Children at risk of exposure	

***COVERED PREVENTIVE SERVICES FOR CHILDREN**, continued* (BIRTH TO AGE 18)	
Medical History	All children throughout development
Obesity Screening & Counseling	All children throughout development
Oral Health Risk Assessment	Young children
Phenylketonuria (PKU) Genetic Screening	All newborns
Sexually Transmitted Infection (STI) Prevention Counseling	Adolescents at higher risk
Tuberculin Testing	Children at higher risk of tuberculosis
Vision Screening	All children

IMPORTANT DETAILS:

- If the group health plan uses a network of providers, be aware that the plan is only required to provide these preventive services through a network provider. The plan may allow a Covered Person to receive these services from a non-network provider, but the Covered Person may have to pay all or part of the cost.
- A doctor may provide a preventive service, such as a cholesterol screening test, as part of an office visit. Be aware that the plan can require the Covered Person to pay some costs of the office visit if the preventive service is not the primary purpose of the visit, or if the doctor bills the claimant for the preventive service separately from the office visit.
- For questions about whether these provisions apply to this group health plan, contact the Plan Sponsor or Contract/Claims Administrator.
- A Covered Person should ask his health care provider to help him understand which covered preventive services are right for him – based on his age, gender and health status.
- If the plan is a "grandfathered" plan, these benefits may not be available.

WEBSITE REFERENCES:

- **Regulation**: http://www.healthcare.gov/center/regulations/prevention/regs.html
- **Overview:** http://www.healthcare.gov/law/provisions/preventive/index.html

ADDENDUM FOR PRESCRIPTION DRUGS

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and a prescription program vendor.

Prescription coverage includes a retail program with participating retail pharmacies and a mail order option. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Plan participants.

A retail prescription is limited to a 30-day supply or a 31-unit dose. A mail order prescription can be obtained in up to a 90-day supply. Refills are allowed only up to the number of times specified by a Physician and obtained within one year from the date of the Physician's order.

COVERED DRUGS

Legend & Compound Drugs - Most prescription drugs (i.e., federal legend drugs and compounded drugs that are prescribed by a Physician and that require a prescription either by federal or state law).

Accutane & **Retin A** - Accutane (isotretinoin) for acne control & cosmetic anti-aging.

Allergy Sera

Blood & Blood Plasma

DESI Drugs

Diabetic Supplies - Insulin, insulin syringes and needles, diabetics supplies-legend, diabetic supplies-over-the-counter, non-insulin syringes and needles, and glucose test strips when prescribed by a Physician.

Gleevec - Gleevec for treatment of any of the following conditions: CML myeloid blast crisis, CMB accelerated phase, or CML in chronic phase after failure of interferon treatment.

NOTE: Prior authorization is required. In order to obtain authorization, the patient's Physician must provide the Plan with information on the condition being treated.

Imitrex Injection - Migraine auto-injector.

Impotency Medications - Impotency medications, including Viagra.

Injectables

Legend Drugs - Class V Drugs, diagnostics, legend drugs with over-the-counter equivalents, pre-natal vitamins, and vitamins.

Over-the-Counter Drugs - Class V drugs and diagnostics.

Prescription Contraceptives

Smoking Deterrents - Drugs or aids for smoking cessation including, but not limited to, nicotine gum and smoking cessation patches.

Steroids - Anabolic steroids.

EXPENSES NOT COVERED

Administration - Any charge for the administration of a covered drug.

Anorexiants - Weight loss drugs.

Bee Sting Kits - Charges for EPI PEN and Ana-Kit.

Compounded Prescriptions - Compounded prescription containing at least one prescription ingredient in a therapeutic quantity.

Consumed Where Dispensed - Any drug or medicine that is consumed or administered at the place where it is dispensed.

Devices - Devices of any type, even though such devices may require a prescription. These include but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.

Excess Refills - Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the initial prescription order.

Experimental & Non-FDA Approved Drugs - Experimental drugs and medicines, even though a charge is made to the Covered Person. Drugs not approved by the Food and Drug Administration.

Fertility Drugs

Growth Hormones

Immunizations Agents / Immunologicals - Immunization agents or biological sera & vaccines.

Institutional Medications - Any drug or medicine that is to be taken, in whole or in part, while the Covered Person is confined in an institution, including any institution that has a facility for dispensing drugs and medicines on its premises.

Investigational Drugs - A drug or medicine labeled: "Caution – limited by federal law to investigational use."

Job-Related Drugs - Prescription drugs which a person is entitled to receive without charge under any workers' compensation or similar law.

Medical Devices & Supplies - Legend and over-the-counter medical devices and supplies.

No Charge - A charge for drugs that may be properly received without charge under a local, state or federal program.

Non-Prescription Drugs - A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

OTC Equivalents - Drugs for which there is an over-the-counter drug equivalent: pre-natal vitamins and vitamins.

Rogaine

Vitamins, except for prenatal vitamins.

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NOTE: A Covered Person cannot get tax-free reimbursements for medicines or drugs purchased after December 31, 2010, unless the medicine or drug:

(1) Requires a prescription;

(2) Is available without a prescription (i.e., an over-the-counter or "OTC" drug) and the individual obtains a prescription; or

(3) Is insulin.

A prescription for a medicine or drug must be a written or electronic order that satisfies the legal requirements for a prescription in the state of purchase.

The above restrictions do not apply to over-the-counter items other than medicines and drugs (e.g., equipment, supplies, and medical devices). Such equipment, supplies and medical devices must, however, be for medical care and not merely beneficial to an individual's general health.

DISCLAIMER: THIS IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED BY THE PLAN. THE ACTUAL CONTROLLING PROVISIONS AND LISTS OF COVERED AND EXCLUDED DRUGS, ETC., MUST BE OBTAINED DIRECTLY FROM THE PLAN SPONSOR OR THE PRESCRIPTION PROGRAM PROVIDER.

ADOPTION OF THE BENEFIT DOCUMENT

Adoption
The Plan Sponsor hereby adopts this document on the date shown below.

This document replaces any and all prior statements of the Plan benefits that are described herein and in that respect this document is adopted as the Benefit Document.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Restatement / Replacement of Benefits
This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan. Except to the extent benefits are expressly added, removed or modified, any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2014.

North Coast Cooperative, Inc.

By: _____

Title: _____

WITNESS:

By: _____

Title: _____

AMENDMENT NO. 1
to the
BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION
OF THE MEDICAL, DENTAL, VISION & RX BENEFITS
for
NORTH COAST COOPERATIVE, INC.

Effective July 1, 2014, the Benefit Document and Summary Plan Description of the Medical, Dental, Vision and RX Benefits for North Coast Cooperative, Inc. (the "Plan Document") is amended as follows:

SCHEDULE OF MEDICAL BENEFITS		
	Silver	Bronze
Dialysis Treatment - Outpatient	100% after all applicable deductibles and coinsurance Please refer to Dialysis Treatment Outpatient Description, See Addendum	100% after all applicable deductibles and coinsurance Please refer to Dialysis Treatment Outpatient Description, See Addendum

The following additions and changes are hereby made to the plan document:

EXTERNAL REVIEW PROCEDURES

Usual, Customary and Reasonable (UCR) - A charge made by a provider that does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross section of the level of charges.

For any covered service or supply, the Plan will recognize the actual charge as the Eligible Expense if the actual charge is less than the Usual, Customary and Reasonable (UCR) allowance.

To the extent that a "Network" of providers is available to Plan participants, the UCR allowance will be based on the Network negotiated rates, except as provided by the outpatient dialysis provision.

Administrative Previsions

Plan Administration - The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan member's rights, and to decide questions of Plan interpretation and those of fact relating to

the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

The Plan Administrator has the discretionary authority to decide whether a charge is Usual and Reasonable. Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Plan member is entitled to them.

Secondary Coverage - Plan members who are eligible for secondary coverage by any other health plan are encouraged to obtain such coverage. Failure to obtain secondary coverage may result in the Plan member incurring costs, which are not covered by the Plan and which would otherwise be covered by the secondary coverage. The Plan will not pay for any costs which would have been payable by such secondary coverage, except to the extent that such costs are payable in any event by the Plan.

Addendum for Dialysis Treatment – Outpatient

Dialysis Treatment - Outpatient

This Section describes the Plan's Dialysis Benefit Preservation Program (the "Dialysis Program"). The Dialysis Program shall be the exclusive means for determining the amount of Plan benefits to be provided to Plan members and for managing cases and claims involving dialysis services and supplies, regardless of the condition causing the need for dialysis.

A. Reasons for the Dialysis Program. The Dialysis Program has been established for the following reasons:

(1) the concentration of dialysis providers in the market in which Plan members reside may allow such providers to exercise control over prices for dialysis-related products and services,

(2) the potential for discrimination by dialysis providers against the Plan because it is a non-governmental and non-commercial health plan, which discrimination may lead to increased prices for dialysis-related products and services charged to Plan members,

(3) evidence of (i) significant inflation of the prices charged to Plan members by dialysis providers, (ii) the use of revenues from claims paid on behalf of Plan members to subsidize reduced prices to other types of payers as incentives, and (iii) the specific targeting of the Plan and other non-governmental and non-commercial plans by the dialysis providers as profit centers, and

(4) the fiduciary obligation to preserve Plan assets against charges which (i) exceed reasonable value due to factors not beneficial to Plan members, such as market concentration and discrimination in charges, and (ii) are used by the dialysis providers for purposes contrary to the Plan members' interests, such as subsidies for other plans and discriminatory profit-taking.

B. Dialysis Program Components. The components of the Dialysis Program are as follows:

(1) Application. The Dialysis Program shall apply to all claims filed by, or on behalf of, Plan members for reimbursement of products and services provided for purposes of outpatient dialysis, regardless of the condition causing the need for dialysis ("dialysis-related claims").

(2) Claims Affected. The Dialysis Program shall apply to all dialysis-related claims received by the Plan on or after July 1, 2014, regardless when the expenses related to such claim were incurred or when the initial claim for such products or services was received by the Plan with respect to the Plan member.

(3) Mandated Cost Review. All dialysis-related claims will be subject to cost review by the Plan Administrator to determine whether the charges indicate the effects of market concentration or discrimination in charges. In making this determination the Plan Administrator shall consider factors including:

i. Market concentration: The Plan Administrator shall consider whether the market for outpatient dialysis products and services is sufficiently concentrated to permit providers to exercise control over charges due to limited competition, based on reasonably available data and authorities. For purposes of this consideration multiple dialysis facilities under common ownership or control shall be counted as a single provider.

ii. Discrimination in charges: The Plan Administrator shall consider whether the claims reflect potential discrimination against the Plan, by comparison of the charges in such claims against reasonably available data about payments to outpatient dialysis providers by governmental and commercial plans for the same or materially comparable goods and services.

(4) In the event that the Plan Administrator's charge review indicates a reasonable probability that market concentration and/or discrimination in charges have been a material factors resulting in an increase of the charges for outpatient dialysis products and/or services for the dialysis-related claims under review, the Plan Administrator may, in its sole discretion, determine that there is a reasonable probability that the charges exceed the reasonable value of the goods and/or services. Based upon such a determination, the Plan Administrator may subject the claims and all future claims for outpatient dialysis goods and services from the same provider with respect to the Plan member, to the following payment limitations, under the following conditions:

i. Where the Plan Administrator deems it appropriate in order to minimize disruption and administrative burdens for the Plan member, dialysis-related claims received prior to the cost review determination may, but are not required to be, paid at the face or otherwise applicable rate.

ii. Where the provider is or has been a participating provider under a Preferred Provider Organization (PPO) available to the Plan's members, upon the Plan Administrator's determination that payment limitations should be implemented, the rate payable to such provider shall be subject to the limitations of this Section.

iii. Maximum Benefit. The maximum Plan benefit payable to dialysis-related claims subject to the payment limitation shall be the Usual and Reasonable Charge for covered services and/or supplies, after deduction of all amounts payable by coinsurance or deductibles.

iv. Usual and Reasonable Charge. With respect to dialysis-related claims, the Plan Administrator shall determine the Usual and Reasonable Charge based upon the average payment actually made for reasonably comparable services and/or supplies to all providers of the same services and/or supplies by all types of plans in the applicable market during the preceding calendar year, based upon reasonably available data, adjusted for the national Consumer Price Index medical care rate of inflation. The Plan Administrator may increase or decrease the payment based upon factors concerning the nature and severity of the condition being treated.

v. Additional Information related to Value of Dialysis-Related Services and Supplies. The Plan member, or where the right to Plan benefits has been properly assigned to the provider, may provide information with respect to the reasonable value of the supplies and/or services, for which payment is claimed, on appeal of the denial of any claim or claims. In the event the Plan Administrator, in its sole discretion, determines that such information demonstrates that the payment for the claim or claims did not reflect the reasonable value, the Plan Administrator shall increase or decrease the payments (as applicable) to the amount of the reasonable value, as determined by the Plan Administrator based upon credible information from identified sources. The Plan Administrator may, but is not required to, review additional information from third-party sources in making this determination.

vi. All charges must be billed by a provider in accordance with generally accepted industry standards.

5. Provider Agreements. Where appropriate, and a willing appropriate provider acceptable to the Plan member is available, the Plan Administrator may enter into an agreement establishing the rates payable for outpatient dialysis goods and/or services with the provider, provided that such agreement must identify this Section of the Plan and clearly state that such agreement is intended to supersede this Section.

6. Discretion. The Plan Administrator shall have full authority and discretion to interpret, administer and apply this Section, to the greatest extent permitted by law.

This Amendment is accepted by

Kelli M Cobb 7/9/14

Signature of Authorized Representative Date

Notice to Plan Participant. Insert this amendment into your benefit booklet. It is an amendment to your summary plan description.

AMENDMENT NO. 2
to the
BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION
OF THE MEDICAL, DENTAL, VISION & RX BENEFITS
for
NORTH COAST COOPERATIVE, INC.

Effective 7-1-2017, the January 1, 2014 Benefit Document and Summary Plan Description of the Medical, Dental, Vision and RX Benefits for North Coast Cooperative, Inc. (the "Plan Document") is amended as follows:

The following additions and changes are hereby made to the plan document:

ORGAN TRANSPLANT STOP LOSS INSURANCE BENEFITS

Stop Loss Policy Reimbursable Transplant Expenses

The Plan benefits reimbursed by Westport Insurance Corporation under the Stop Loss Insurance Policy are limited to the following Transplants and listed Benefits. Anything additional to these items which may be included in the Plan Document will not be covered under the Stop Loss Insurance Policy specific to Transplants.

Services are covered for the following Transplants (Living/Deceased Donor):

- **Single Organ**: Kidney; Heart; Lung; Pancreas; Liver; Intestine
- **Multiple Organ**: Double Lung; Heart/Lung; Kidney/Liver; Kidney/Pancreas; Liver/Intestine; Pancreas/Intestine; Liver/Pancreas; Liver/Pancreas/Intestine; Multivisceral (liver/stomach/duodenum/pancreas/intestine); Pancreatic islet auto-transplant/Pancreatic islet allo-transplant
- **Bone Marrow/Stem Cell**: Autologous Bone Marrow/Peripheral Stem Cell; Allogeneic Bone Marrow/Peripheral Stem Cell (related); Allogeneic Bone Marrow/Peripheral Stem Cell (unrelated)
- **Other non-Experimental Transplants**

Treatments and services for Transplants not listed above are not covered under the Organ Transplant Stop Loss Policy.

Transplant Benefit Period:
Single or Multiple Solid Organ: 7 days prior to Transplantation through 365 days following Transplantation Bone Marrow/Stem Cell: 7 days prior to Bone Marrow/Stem Cell Infusion through 365 days following Infusion.

COVERED TRANSPLANT BENEFITS – WHEN THE PLAN HAS A PPO NETWORK

The following Benefits covered under the Organ Transplant Stop Loss Insurance Policy are reimbursable at 100% after the Specific Deductible (Per Covered Person) has been satisfied. Please note, the Organ Transplant Stop Loss Insurance Policy will not reimburse Out-of-Network Plan benefits paid in excess of a 75% Out-of-Network coinsurance, except when the Plan has an out-of-pocket maximum for Out-of-Network Providers and the covered person has reached the maximum.

Benefit	In-Network Provider	Out-of-Network Provider
Maximum Benefit for Search & Registry Fees	Covered up to $3,500 per search up to a maximum of $14,000.	Not Covered
Maximum Solid Organ Donor Procurement Benefit	Covered during the Transplant Benefit Period	Covered during the Transplant Benefit Period up to a maximum of $20,000
Maximum Bone Marrow/Stem Cell Harvesting Benefit	Covered during the Transplant Benefit Period or within 90 days of the beginning of the Transplant Benefit Period	Covered during the Transplant Benefit Period or within 90 days of the beginning of the Transplant Benefit Period up to a maximum of $15,000
Maximum Bone Marrow/Stem Cell Storage Benefit	Covered during the Transplant Benefit Period or during the 90 days prior to the beginning of the Transplant Benefit Period	Covered during the Transplant Benefit Period or during the 90 days prior to the beginning of the Transplant Benefit Period
Maximum Transportation Benefit	Covered during the Transplant Benefit Period up to a combined maximum of $10,000 for lodging, transportation and meals	Not Covered
Maximum Daily Benefit for Lodging and Meals	Covered during the Transplant Benefit Period up to a daily maximum of $200 with a combined maximum of $10,000 for lodging, transportation and meals	Not Covered
Maximum Air Ambulance	Covered during the Transplant Benefit Period up to a maximum of $10,000	Covered during the Transplant Benefit Period up to a maximum of $10,000
Maximum Private Duty Nursing Benefit	Covered during the Transplant Benefit Period up to a maximum of $10,000	Covered during the Transplant Benefit Period up to a maximum of $10,000
Maximum Hospital Confinement and Physician Benefit	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below
Maximum Skilled Nursing Facility Confinement Benefit	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below
Maximum Home Health Benefit	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below
Maximum Surgical Benefit	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below
Maximum Outpatient Treatment Benefit	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below	Covered, subject to the Lifetime Limit Per Transplant Benefit as shown in the Table below

LIFETIME LIMIT PER TRANSPLANT BENEFIT TABLE (per Covered Person)

Transplant Type	In-Network Provider	Out-of-Network Provider
Bone Marrow/Stem Cell – Allogeneic	Unlimited	$475,000
Bone Marrow/Stem Cell – Autologous	Unlimited	$175,000
Heart	Unlimited	$600,000
Intestine	Unlimited	$825,000
Kidney	Unlimited	$175,000
Liver	Unlimited	$400,000
Lung - Single	Unlimited	$350,000
Pancreas	Unlimited	$225,000
Lung - Double	Unlimited	$525,000
Heart/Lung	Unlimited	$825,000
Kidney/Liver	Unlimited	$625,000
Kidney/Pancreas	Unlimited	$200,000
Liver/Intestine	Unlimited	$825,000
Pancreas/Intestine	Unlimited	$825,000

Transplant Type	In-Network Provider	Out-of-Network Provider
Liver/Pancreas	Unlimited	$825,000
Liver/Pancreas/Intestine	Unlimited	$825,000
Multivisceral (liver/stomach/ duodenum/pancreas/intestine)	Unlimited	$825,000
Pancreatic islet auto-transplant/ Pancreatic islet allo-transplant	Unlimited	$825,000
Other Non-Experimental	Unlimited	$825,000

The Lifetime Limit per Transplant Benefit applies while this Organ Transplant Stop Loss Policy is in force and all subsequent Organ Transplant Stop Loss Policy Years.

This Amendment is accepted by

Melanie Bellenranso 7/1/2017

Signature of Authorized Representative Date

Notice to Plan Participant. Insert this amendment into your benefit booklet. It is an amendment to your summary plan description.