PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

SOUTH TEXAS HEALTH COOPERATIVE

MEDICAL BENEFIT PLAN

EFFECTIVE: SEPTEMBER 1, 2002
RESTATED: September 1, 2012

SOUTH TEXAS HEALTH COOPERATIVE
EMPLOYEE MEDICAL BENEFIT PLAN
ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

It is the intention of the Plan Sponsor, South Texas Health Cooperative, to hereby amend and restate the South Texas Health Cooperative Employee Medical Benefit Plan, a program of benefits constituting a self-funded "Employee Welfare Benefit Plan".

Effective Date
The Plan Document is effective as of the date first set forth below, and each amendment is effective as of the date set forth therein (the "Effective Date").

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description. This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has executed, and the Claims Administrator has acknowledged, this Plan Document as of the Plan effective date shown herein.

Effective date of the Plan: September 1, 2002; Amended and restated effective: September 1, 2012

Anneliese McMinn 2/26/13 Date

For Plan Sponsor:
Anneliese McMinn, Co-op Board President
South Texas Health Cooperative

Lori Brown 2.28-13 Date

For Claims Administrator:
Lori Brown, Vice President
Maxor Administrative Services

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GENERAL INFORMATION AND PURPOSE

This Plan Document describes the benefits for the Employees of **South Texas Health Cooperative**.

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

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

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain covered expenses for medical benefits. The Plan Document is maintained by South Texas Health Cooperative and may be inspected at any time during normal working hours by any Covered Person.

Name of the Plan
South Texas Health Cooperative Employee Medical Benefit Plan
Group to Which This Statement Applies: LaFeria Independent School District
Rio Hondo Independent School District

Plan Sponsor
South Texas Health Cooperative
1212 E. Harrison, Suite 282
Harlingen, Texas 78550
956-428-7006

Plan Administrator
South Texas Health Cooperative
1212 E. Harrison, Suite 282
Harlingen, Texas 78550
956-428-7006

Type of Plan
Self-Funded Employee Welfare Benefit Plan

Agent for Service of Legal Process
Legal Process may also be served on the Plan Administrator
Anneliese McMinn, Co-op Board President
South Texas Health Cooperative
1212 E. Harrison, Suite 282
Harlingen, Texas 78550
956-428-7006

Claims Administrator
Maxor Administrative Services
320 S. Polk St Ste 900
Amarillo, TX 79101
(806) 322-5920 • (855)629-6787

The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Utilization Review Company
Managed Care Concepts
416 Donnell Dr
Orange, TX 77630
(866) 750-2723

Plan Year
The twelve (12) month period beginning September 1 and ending August 31 of the next Calendar Year

Employer Tax ID Number
51-0555204

Maxor Group Number
20001

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

INTRODUCTION

South Texas Health Cooperative, hereafter referred to as "Co-op," hereby amends and restates the South Texas Health Cooperative Employee Medical Benefit Plan, a self-funded Employee Welfare Benefit Plan, hereafter referred to as the "Plan." The Plan benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction. The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the Plan, and this Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

PLAN ADMINISTRATOR AND CLAIMS DELEGATE

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

Notwithstanding anything in this Plan Document and Summary Plan Description to the contrary, the Plan Sponsor has the power and authority to, and hereby does allocate, delegate and grant to TrueFACS, LLC (the "Claims Delegate" or "Delegate") primary responsibility and authority for all Hospital and Facility Claims review, evaluation, benefits determinations and second level appeals, as well as for review and evaluation or second level appeals determinations for other claims or appeals referred to Delegate by the Plan Administrator and/or the Claims Administrator. The responsibilities, powers and authority granted to the Claims Delegate are more specifically set forth below, in the subsection labeled "Powers and Duties of the Claims Delegate" and in the Plan sections entitled "Claim Review and Validation Program" and "Procedures for Claims and Appeals" and the various other related provisions of the Plan (collectively, the "Review and Appeals Provisions"). The Claims Delegate shall have no authority, responsibility or liability other than as referenced above.

The Plan Administrator shall establish the policies, practices and procedures of this Plan. The Plan Administrator and the Claims Delegate shall administer this Plan in accordance with its terms. It is the express intent of this Plan that the Plan Administrator and the Claims Delegate shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of which services, supplies, care and treatment are Experimental/Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions within their respective scopes of authority of the Plan Administrator and the Claims Delegate as to the facts related to any Claim for benefits and the meaning and intent of any provision of the Plan, or its application to any Claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator or the Claims Delegate, as appropriate, decides in its discretion that the Covered Person is entitled to them. Plan Administrator shall have discretionary authority over Claims Delegate such that ultimate discretionary authority resides with the Plan Administrator except with regard to Delegated Claims Decisions (as such term is defined below in the "Duties and Powers of Claims Delegate" subsection of the Plan), in which case Claims Delegate shall have ultimate discretionary authority.

DUTIES AND POWERS OF THE PLAN ADMINISTRATOR

The duties of the Plan Administrator include the following (except to the extent that any such duties or powers are specifically assigned or granted to the Claims Delegate under the Plan):

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

DUTIES AND POWERS OF THE CLAIMS DELEGATE

The Claims Delegate shall have the following powers and duties, specifically with respect to and in connection with Hospital and Facility Claims review, evaluation, benefits determinations and appeals:

1. When applicable, regarding Delegated Claims Decisions (as defined below in item 4), to administer the Plan in accordance with its terms;
2. To determine all questions of coverage and make all Benefit Determinations on Hospital and Facility Claims ("HFC Benefit Determinations"), in accordance with the terms of the Plan, and exercise full and final discretionary authority and ultimate decision-making power as to all HFC Benefit Determinations, including identifying and making decisions regarding benefits availability and coverage, Invalid Charges, whether services and supplies provided to Claimants are Medically Necessary or Experimental/Investigational, and whether or not or to what degree charges for services and supplies provided to Claimants constitute Covered Medical Expenses under the Plan;
3. To handle all second level administrative appeals of HFC Benefit Determinations ("HFC Level II Appeals") and provide a full and fair review, in accordance with the terms of the Plan, to any covered individual whose claim for benefits has been denied in whole or in part in connection with any first level appeals of HFC Benefit Determinations ("HFC Level I Appeals"), and to exercise full and final discretionary authority and ultimate decision-making power to uphold or reverse such denials in full or in part, and make any other decisions regarding HFC Level II Appeals;
4. To handle second level administrative appeals of Adverse Benefit Determinations on Claims other than Hospital and Facility Claims that are specifically identified and referred to Delegate by the Plan Administrator and/or Claims Administrator ("Referred Appeals") and provide a full and fair review, in accordance with the terms of the Plan, to any covered individual whose claim for benefits has been denied in whole or in part in connection with any first level appeals of such Adverse Benefit Determinations, and to exercise full and final discretionary authority and ultimate decision-making power to uphold or reverse such denials in full or in part, and make any other decisions regarding Referred Appeals;
5. To exercise full and final discretionary authority to interpret the Plan with respect to and in connection with Hospital and Facility Claims, HFC Benefit Determinations, HFC Level II Appeals, Referred Claims and Referred Appeals, including the authority to (i) remedy possible ambiguities, inconsistencies, disputed terms and/or omissions in the Plan and related documents, (ii) decide disputes that may arise relative to a Plan Participants' rights, and (iii) determine all questions of fact and law arising under the Plan (collectively, the "Delegated Claims Decisions");
6. To make factual findings related to or in connection with Delegated Claims Decisions and to exercise the authority to request and require any person to furnish such reasonable information as Delegate deems necessary or desirable for the proper administration of the Plan in connection with Delegated Claims, and as a condition to receiving any Hospital and Facility Claims benefits under the Plan;
7. To undertake, provide for, manage and oversee (i) the assessment and validation of Hospital and Facility Claims and Referred Claims, and the services and supplies provided and fees charged in

connection therewith, (ii) such level of Claims Review as Delegate deems appropriate and desirable under the circumstances for Hospital and Facility Claims and Referred Claims, and (iii) the selection and engagement of such Billing Review Specialists, Medical Review Specialists, health care professionals and subject matter experts as Delegate deems appropriate and desirable under the circumstances, for Claims Review purposes or otherwise in connection with the Review and Appeals Provisions, and make final decisions regarding all such matters;

8. To designate other persons to carry out any duty or power that would otherwise be a responsibility of the Claims Delegate under the terms of the Review and Appeals Provisions and retain such consultants, service providers, legal counsel, or other specialists, as the Claims Delegate may deem appropriate and necessary in connection with the Review and Appeals Provisions and Delegated Claims Decisions;
9. To keep and maintain, or cause to be kept and maintained, such records pertaining to Delegated Claims Decisions as may be required by the Plan or applicable law; and
10. To perform such other duties and functions as are necessary or required in connection with the Review and Appeals Provisions, Designated Claims Decisions and Claims Review.

The duties and powers of the Claims Delegate shall be limited to those referenced above.

Except as may be otherwise specified or plainly required by the context, any reference made in this Plan to the Plan Administrator "and/or" the Claims Delegate, or to the Claims Delegate "and/or" the Plan Administrator, shall be interpreted and deemed to mean: (i) the Claims Delegate, with regard to Hospital and Facility Claims and Delegated Claims Decisions; and (ii) the Plan Administrator, with regard to other Claims and any matters not directly related to Delegated Claims Decisions.

PHYSICIAN-PATIENT RELATIONSHIP

The Plan is not intended to disturb the Physician-Patient relationship. Physicians and other healthcare providers are not agents or delegates of the Plan Sponsor, Co-op, Plan Administrator, Employer or Claims Administrator. The delivery of medical and other healthcare services on behalf of any Covered Person remains the sole prerogative and responsibility of the attending Physician or other healthcare provider.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a Hospital or to make a free choice of the attending Physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the Covered Person may have higher out-of-pocket expenses if the Covered Person uses the services of a Non-Contracted Provider Physician.

EFFECTIVE DATE

Effective date of the Plan: September 1, 2002; Amended and restated effective: September 1, 2012

CLAIMS ADMINISTRATOR

The Claims Administrator of the Plan is shown in the General Information section.

NAMED FIDUCIARY

The named Fiduciary for limited purposes relating specifically to Delegated Claims Decisions is the Claims Delegate. The named fiduciary for all other purposes is **South Texas Health Cooperative** (the "Co-op"), who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Co-op may delegate responsibilities for the operation and administration of the Plan. The Co-op shall have the authority to amend or terminate the Plan, to determine its policies, to

appoint and remove service providers, adjust their compensation (if any), and exercise general administrative authority over them. The Co-op has the sole authority and responsibility to review and make final decisions on all Claims to benefits hereunder, except with regard to Claims to benefits for Hospital and Facility Claims and HFC Benefit Determinations, for which the Claims Delegate has the sole authority and responsibility to review and make final decisions.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made on the following basis:

The Co-op shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed by each Covered Employee.

Notwithstanding any other provision of the Plan, the Co-op's obligation to pay Claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said Claims in accordance with these procedures shall discharge completely the Co-op's obligation with respect to such payments.

In the event that the Co-op terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims incurred after the termination date of the Plan.

CLAIMS PROCEDURE

The Plan Administrator and/or the Claims Delegate shall provide or cause to be provided adequate notice in writing to any covered Plan Participant whose Claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator and/or the Claims Delegate shall afford a reasonable opportunity to any Plan Participant, whose Claim for benefits has been denied, for a fair review of the decision denying the Claim by the person designated by the Plan Administrator and/or the Claims Delegate for that purpose. Details of the Claims procedure are found in this Plan Document under the "Procedures for Claims and Appeals" section.

PROTECTION AGAINST CREDITORS

No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. If the Plan Administrator shall find that such an attempt has been made with respect to any payment due or to become due to any Plan Participant, the Plan Administrator in its sole discretion may terminate the interest of such Plan Participant or former Plan Participant in such payment. And in such case the Plan Administrator shall apply the amount of such payment to or for the benefit of such Plan Participant or former Plan Participant, his/her spouse, parent, adult Child, guardian of a minor Child, brother or sister, or other relative of a Dependent of such Plan Participant or former Plan Participant, as the Plan Administrator may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care providers.

AMENDING AND TERMINATING THE PLAN

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

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

If the Plan is terminated, the rights of the Covered Persons are limited to expenses incurred before termination. Previous contributions by the Employer shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to Claims arising before such termination.

All amendments to this Plan shall become effective as of a date established by the Plan Sponsor. Copies of all amendments shall be furnished by the Plan Administrator to the Trustees (if any) and any outside provider of Plan administrative services.

SUMMARY OF MATERIAL REDUCTION (SMR)

A Material Reduction generally means any modification that would be considered by the average participant to be an important reduction in covered services or benefits. Examples include reductions in benefits or increases in deductibles or copayments.

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Material Reduction in covered services or benefits provided by the Plan as soon as administratively feasible after its adoption, but no later than sixty (60) days after the date of adoption of the reduction. Covered Employees and beneficiaries must be furnished a summary of such reductions, and any changes so made shall be binding on each Covered Person. The sixty (60) day period for furnishing a Summary of Material Reduction does not apply to any Employee covered by the Plan who would reasonably expect to receive a summary through other means within the next ninety (90) days.

Material Reduction disclosure provisions are subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and any related amendments.

SUMMARY OF MATERIAL MODIFICATIONS (SMM)

A Summary of Material Modifications reports changes in the information provided within the Summary Plan Description. Examples include a change to deductibles, eligibility or the addition or deletion of coverage.

The Plan Administrator shall notify all Covered Employees of any Plan Amendment considered a Summary of Material Modifications by the Plan as soon as administratively feasible after its adoption, but no later than within two hundred and ten (210) days after the close of the Plan Year in which the changes became effective.

PLAN IS NOT A CONTRACT

This Plan Document constitutes the entire Plan. The Plan will not be deemed to constitute a contract of employment or give any Covered Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge or otherwise terminate the employment of any Covered Employee.

FEDERAL LAWS

Certain Federal laws apply to most group health programs. The following is an overview of the laws and their impact. The effect of these laws on the Plan is reflected in the provisions of the Plan. Should there be any conflict between the law and Plan provisions, the law will prevail.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)

The Health Insurance Portability and Accountability Act (HIPAA) was enacted, among other things, to improve portability and continuity of health care coverage.

HIPAA also requires that Plan Participants and beneficiaries receive a summary of any change that is a "material reduction in covered services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

PREGNANCY DISCRIMINATION ACT OF 1978

Most employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other sickness. This requirement applies to Pregnancy expenses of an Employee or a Covered Dependent spouse of an Employee.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (P.L. 103-3)

If a Covered Employee ceases active employment due to an employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993: PL 103-66)

OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or Covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies QMCSO requirements.

Participants may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn children following delivery, as follows:

Statement of Rights under the Newborns' and Mothers' Health Protection Act

"Under Federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (i.e., your

Physician, Nurse Midwife, or Physician Assistant), after consultation with the mother, discharges the mother or newborn earlier."

Also, under Federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour or ninety-six (96) hour stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under Federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) or ninety-six (96) hours. However, to use certain providers or Facilities, or to reduce your out-of-pocket costs, you may be required to give notification. For information on notification, contact your Plan Administrator.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you are receiving covered benefits for a mastectomy, you should know that your Plan complies with the Women's Health and Cancer Rights Act of 1998. The Act provides for:

1. Reconstruction of the breast(s) on which a covered mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and physical complications related to all stages of covered mastectomy, including lymphedema.

All applicable benefit provisions still apply, including existing Deductibles, Copays and/or Coinsurance.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")

GINA prohibits the group health Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.

2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as long as the results are not used for underwriting purposes.

3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts, application of any Pre-existing Condition exclusion under the Plan, and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains genetic information <u>incidental</u> to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes.

GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA?

Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);

2. The manifestation of a disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first,

second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and

3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

Genetic Information does not include the sex or age of an individual.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008
Requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, then benefits for such conditions must be provided in the same manner as benefits for any sickness. In addition, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES
If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, your Employer's health plan is required to permit you and your Dependents to enroll in the Plan - as long as you and your Dependents are eligible, but not already enrolled in the Employer's Plan. This is called a "Special Enrollment" opportunity, and **you must request coverage within sixty (60) days of being determined eligible for premium assistance.**

If you live in one of the following States, you may be eligible for assistance to pay your Employer health premiums. The following list of States is current as of January 31, 2011. You should contact your State for further information on eligibility:

ALABAMA - Medicaid
Website: http://www.medicaid.alabama.gov
Phone: 1-800-362-1504

ALASKA - Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/
Phone (Outside of Anchorage): 1-888-318-8890
Phone (Anchorage): 907-269-6529

ARIZONA - CHIP
Website: http://www.azahcccs.gov/applicants/default.aspx
Phone (Outside of Maricopa County): 1-877-764-5437
Phone (Maricopa County): 602-417-5437

ARKANSAS - CHIP
Website: http://www.arkidsfirst.com/ Phone: 1-888-474-8275

CALIFORNIA - Medicaid
Website: http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Phone: 1-866-298-8443

COLORADO - Medicaid and CHIP
Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943 CHIP Website: http://www.CHPplus.org CHIP Phone: 303-866-3243

FLORIDA - Medicaid
Website: http://www.fdhc.state.fl.us/Medicaid/index.shtml Phone: 1-877-357-3268

GEORGIA - Medicaid
Website: http://dch.georgia.gov/ Click on Programs, then
Medicaid Phone: 1-800-869-1150

IDAHO - Medicaid and CHIP
Medicaid Website: www.accesstohealthinsurance.idaho.gov
Medicaid Phone: 1-800-926-2588
CHIP Website: www.medicaid.idaho.gov
CHIP Phone: 1-800-926-2588

INDIANA - Medicaid
Website: http://www.in.gov/fssa Phone: 1-800-889-9948

IOWA - Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562

KANSAS - Medicaid
Website: https://www.khpa.ks.gov Phone: 1-800-792-4884

KENTUCKY - Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570

LOUISIANA - Medicaid
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-342-6207

MAINE - Medicaid
Website: http://www.maine.gov/dhhs/OIAS/public-assistance/index.html Phone: 1-800-321-5557

MASSACHUSETTS - Medicaid and CHIP
Medicaid and CHIP Website: http://www.mass.gov/MassHealth Medicaid and CHIP Phone: 1-800-462-1120

MINNESOTA - Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone (Outside of Twin City area): 1-800-657-3739
Phone (Twin City area): 651-431-2670

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005

MONTANA - Medicaid
Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website: http://www.dhhs.ne.gov/med/medindex.htm Phone: 1-877-255-3092

NEVADA - Medicaid and CHIP
Medicaid Website: http://dwss.nv.gov
Medicaid Phone: 1-800-992-0900
CHIP Website: http://www.nevadcheckup.nv.gov/
CHIP Phone: 1-877-543-7669

NEW HAMPSHIRE - Medicaid
Website: www.dhhs.nh.gov/ombp/index.htm Phone: 603-271-4238

NEW JERSEY - Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-800-356-1561
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

NEW MEXICO - Medicaid and CHIP
Medicaid Website: http://www.hsd.state.nm.us/mad/index.html
Medicaid Phone: 1-888-997-2583
CHIP Website: http://www.hsd.state.nm.us/mad/index.html
Click on Insure New Mexico CHIP Phone: 1-888-997-
2583

NEW YORK - Medicaid
Website: http://www.nuhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

NORTH CAROLINA - Medicaid Website:
http://www.nc.gov Phone: 919-855-4100

NORTH DAKOTA - Medicaid
Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604

OKLAHOMA - Medicaid
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742

OREGON - Medicaid and CHIP
Medicaid & CHIP Website: http://www.oregonhealthykids.gov
Medicaid & CHIP Phone: 1-877-314-5678

PENNSYLVANIA - Medicaid
Website:
http://www.dpw.state.pa.us/partnersproviders/medicalassistance/doingbusiness/003670053.htm
Phone: 1-800-644-7730

RHODE ISLAND - Medicaid
Website: www.dhs.ri.gov
Phone: 401-462-7730

SOUTH CAROLINA - Medicaid
Website: http://www.scdhhs.gov
Phone: 1-888-549-0820

TEXAS - Medicaid
Website: https://www.gethipptexas.com/
Phone: 1-800-440-0493

UTAH - Medicaid
Website: http://health.utah.gov/upp
Phone: 1-866-435-7414

VERMONT - Medicaid
Website: http://www.greenmountaincare.org/
Phone: 1-800-250-8427

VIRGINIA - Medicaid and CHIP
Medicaid Website: http://www.dmas.virginia.gov/rcp-IPP.htm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.famis.org/
CHIP Phone: 1-866-873-2647

WASHINGTON - Medicaid
Website: http://hrsa.dshs.wa.gov/premiumpymt/Apply.shtm
Phone: 1-800-562-3022 ext. 15473

WEST VIRGINIA - Medicaid
Website:
http://www.wvrocovery.com/hipp.htm Phone:
304-342-1604

WISCONSIN - Medicaid
Website: http://www.badgercareplus.org/pubs/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website:
http://www.health.wyo.gov/healthcarefin/index.html Phone:
307-777-7531

To see if any more States have added a premium assistance program since January 22, 2010, or for more information on Special Enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

Or

U.S. Department of Health and Human Services Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)
Effective April 14, 2004, the Plan will not use or disclose PHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 (the “HIPAA Privacy Standards”), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor’s receipt of “summary health information,” as described in the HIPAA Privacy Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING PROTECTED HEALTH INFORMATION (PHI)

Effective April 14, 2004, the Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of PHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor may use or disclose PHI for Plan enrollment purposes, including information as to whether an individual is enrolled in the Plan.

2. The Plan Sponsor may use or disclose PHI for Plan administration functions, including for payment or health care operations purposes (as those terms are defined by the HIPAA Privacy Standards), and including quality assurance, Claims processing, auditing and monitoring of the Plan.

3. The Plan Sponsor may not use or further disclose PHI other than as permitted or required by the Plan documents or by law.

4. The Plan Sponsor must ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to the PHI.

5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.

6. The Plan Sponsor must report to the Plan any use or disclosure of the PHI of which the Plan Sponsor becomes aware that is inconsistent with the uses or disclosures provided for under the terms of the Plan.

7. The Plan Sponsor must make PHI available for access in accordance with the HIPAA Privacy Standards regarding an individual's right to access his/her PHI.

8. The Plan Sponsor must make PHI available for amendment and, if required by the HIPAA Privacy Standards, incorporate any amendment made to PHI in accordance with the HIPAA Privacy Standards regarding an individual's right to have his PHI amended.

9. The Plan Sponsor must make available information necessary to provide an accounting to an individual in accordance with the HIPAA Privacy Standards regarding an individual's right to receive an accounting of disclosures of his/her PHI.

10. The Plan Sponsor must make internal practices, books, and records relating to the use and disclosure of PHI available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Standards.

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

12. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by restricting access to and use of the PHI to only those Employees of the Plan Sponsor with responsibilities related to the administrative functions the Plan Sponsor performs for the Plan, as such Employees may be designated or identified, by name, job title, or classification, from time to time in various Business Associate Agreements between the Plan and the Plan's Business Associates or in other documents governing the administration of the Plan.

13. The Plan Sponsor must ensure adequate separation between the Plan and the Plan Sponsor by maintaining a procedure for resolving any issues of noncompliance with provisions of the Plan document by persons described in paragraph 12 above through training, sanctions and other disciplinary action, as necessary.

14. The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for

remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

Effective April 20, 2006, the Plan will not use or disclose ePHI except as permitted by this section or as otherwise permitted or required by law, including but not limited to the requirements of 45 C.F.R. Sections 164.314(b)(1) and (2) and its implementing regulations, 45 C.F.R. parts 160, 162, and 164 of the Security Standards of the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Security Standards"), as they may be amended from time to time. Nothing in this section shall be construed to prohibit the Plan Sponsor's receipt of "summary health information," as described in the HIPAA Security Standards, for certain Plan Sponsor-related purposes, including obtaining premium bids for health insurance, making Plan design and funding decisions, and modifying, amending or terminating the Plan.

PLAN SPONSOR'S OBLIGATIONS REGARDING ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

Effective April 20, 2006, the Plan will disclose ePHI to the Plan Sponsor only upon receipt of an amendment to the Plan that the Plan has been amended to provide for the Plan Sponsor's receipt of ePHI and that the Plan Sponsor agrees to comply with the following provisions:

1. The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan.

2. The Plan Sponsor shall ensure the adequate separation that is required by 45 C.F.R. Section 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures.

3. The Plan Sponsor shall ensure any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate security measures to protect such information.

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

   a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's ePHI.

   b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis semi-annually, or more frequently upon the Plan's request.

BREACH AND SECURITY INCIDENTS

Effective September 23, 2009, the Health Information Technology for Economic and Clinical Health Act (HITECH) of the American Recovery and Reinvestment Act of 2009 (ARRA) imposes notification in the event of a Breach of unsecured Protected Health Information (PHI).

The Plan Sponsor will report to the Privacy Official of the Plan any use or disclosure of PHI not permitted by HIPAA, along with any Breach of unsecured Protected Health Information. The Plan Sponsor will treat the Breach as being discovered in accordance with HIPAA's requirements. The Plan Sponsor will make the report to the Privacy Official not more than thirty (30) calendar days after the Plan Sponsor learns of such non-permitted use or disclosure. If a delay is requested by a law enforcement official in accordance with 45 C.F.R. § 164.412, the Plan Sponsor may delay notifying the Privacy Official for the time period specified by such regulation. The Plan Sponsor's report will at least:

1. Identify the nature of the Breach or other non-permitted use or disclosure, which will include a brief description of what happened, including the date of any Breach and the date of the discovery of any Breach;

2. Identify Protected Health Information that was subject to the non-permitted use or disclosure or Breach (such as whether full name, Social Security number, date of birth, home address, account number or other information was involved) on an individual-by-individual basis;

3. Identify who made the non-permitted use or disclosure and who received the non-permitted disclosure;

4. Identify what corrective or investigational action the Plan Sponsor took or will take to prevent further non-permitted uses or disclosures, to mitigate harmful effects and to protect against any further Breaches;

5. Identify what steps the individuals who were subject to a Breach should take to protect themselves; and

6. Provide such other information, including a written report, as the Privacy Official may reasonably request.

The Plan Sponsor will report to the Privacy Official within thirty (30) calendar days any attempted or successful: a) unauthorized access, use, disclosure, modification, or destruction of Electronic Protected Health Information; and b) interference with the Plan Sponsor's system operations in the Plan Sponsor's information systems, of which the Plan Sponsor becomes aware. The Plan Sponsor will make this report upon the Privacy Official's request, except if any such Security Incident resulted in a disclosure or Breach of Protected Health Information or Electronic Protected Health Information not permitted by the HITECH Act, the Plan Sponsor will make the report in accordance with the above.

BUY-UP PLAN SCHEDULE OF BENEFITS

Major Medical Benefits for Covered Persons

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

FACILITY PROVIDERS – Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics

PHYSICIAN PROVIDERS – Physicians and all other Providers of service

ANCILLARY PROVIDERS – If the Plan Participant receives treatment from a non-contracted, ancillary provider because no contracted provider is available or the plan participant was in one of the above listed Facility Providers, the Plan will process such charges at the Contracted Benefit percentage applying Permitted Payment levels. Ancillary providers include but are not limited to:

- Pathologists
- Radiologists
- Anesthesiologist
- Assistant Surgeons
- Emergency Room (ER) Physicians

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Lifetime Maximum Benefit	UNLIMITED		
Annual Plan Year Maximum	$1,250,000		
Calendar Year Deductible (Combined for all benefits) **Individual/Family*** (Individual deductible carryover applies)	$500/$1500*		
Annual Out-of-Pocket Max (In addition to Deductible and Copayments) **Individual/Family***	$2500/$7500*		

*The Family Deductible and Out-of-Pocket amounts apply collectively to all Covered Persons in the same Family

BUY-UP PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Inpatient Confinement Copay	$100 per day Copay to a maximum of $500 per Confinement	N/A	N/A
Inpatient Hospital Expenses Notification to Managed Care Concepts (Utilization Review Company) is required within 48 hours of hospital admission	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Benefit Reduction Penalty (For failure to notify the UR Company following Hospital Admission)	50%	N/A	N/A
Radiologist, Pathologist, Anesthesiologist and Assistant Surgeon	N/A	80%; Deductible waived	80%; Deductible waived
Hospital Emergency Room (Copay waived if admitted) Notification to Utilization Review (UR) Company is required if admitted InPatient (all related charges)	80% of Permitted Payment Level after $250 Copay; Deductible waived	80%; Deductible waived	80%; Deductible waived
Ambulance	100% of Permitted Payment Level	100%	80% after Deductible
Physician Office Visit (Includes exam, treatment, lab, x-ray, tests and supplies provided by and billed by physician at time of office visit except Surgery, Chemo, Radiation Therapy, Infusion Therapy, Physical Therapy, Occupational Therapy and Speech Therapy)	For Purposes of this plan, Physicians considered Primary Care are: Family Practitioner, General Practitioner, Internist, Pediatrician, Nurse Practitioner and OB/GYN. All other Physicians are considered Specialists. A referral from a Primary Care Physician to a Specialist is not required.		
Primary Care Physician	N/A	100% after $15 Copay	80% after Deductible
Specialist	N/A	100% after $30 Copay	80% after Deductible
Office Surgery	N/A	100% after $15 Copay PCP or $30 Copay Specialist	80% after Deductible

BUY-UP PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Allergy Testing, Serum and Injections	N/A	100% after $15 Copay PCP or $30 Copay Specialist	80% after Deductible
Contraceptive Injections	N/A	100% after $15 Copay PCP or $30 Copay Specialist	80% after Deductible
Contraceptive Devices and Implants	N/A	100%	80% after Deductible
Voluntary Sterilization Procedures	N/A	100%	80% after Deductible
Other Office Services (without Office visit billed)	N/A	100% after $15 Copay PCP or $30 Copay Specialist	80% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	100% after $25 copay	80% after Deductible
MRI's, Cat Scan's and Pet Scans	100% of Permitted Payment Level after $150 Copay	100% after $50 Copay	80% after Deductible
Lab/X-ray (Procedures performed in an Outpatient Hospital, Independent Lab)	80% of Permitted Payment Level after $100 Copay; Deductible waived	100%	80% after Deductible
Outpatient Hospital/Ambulatory Surgical Facility (Includes All related charges)	80% of Permitted Payment Level after $100 Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Maternity Facility Charges Contact the Utilization Review Company for coordination of care	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Maternity Physician Charges (including prenatal and postnatal care)	N/A	80%; Deductible waived	80% after Deductible
Routine Newborn Care Including inpatient Hospital Nursery charges and pediatric care to date of baby's discharge)	100%	100%	80% after Deductible
Maximum number of Days	4	4	4

BUY-UP PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	**All other Physicians, Non Contracted**
Bariatric Procedures See major medical expense benefits for covered services, **Lifetime Maximum Benefits $5,000**	Applicable Inpatient and/or Outpatient Confinement Copay applies; then 80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Mental & Nervous and Chemical Dependency, Drug and Substance Abuse Conditions (Plan Benefits Apply)			
Inpatient	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Outpatient/Day Treatment Facility	80% of Permitted Payment Levels after Outpatient confinement Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Psychological Testing - Performed in Facility	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Psychological Testing - Performed in Office	N/A	100% after $15 Copay	80% after Deductible
Office visit/Outpatient Therapy (including Group Therapy)	N/A	100% after $15 Copay	80% after Deductible
Physical Therapy/Occupational Therapy/Speech Therapy/Cardiac Rehabilitation	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Chiropractic Services Calendar Year Maximum Benefit - **$1,500**	N/A	100% after $15 Copay	80% after Deductible

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Sleep Disorders (Covered Services including sleep studies/diagnostic testing, surgery, devices & equipment)	Applicable Inpatient and/or Outpatient Confinement Copay applies; then 80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Sleep Office Visit Only	N/A	100% after $15 Copay PCP, $30 Copay Specialist	80% after Deductible
Pain Management-Calendar Year Maximum Benefit $15,000 Office Visit Only	N/A	100% after $15 Copay PCP, $30 Copay Specialist	80% after Deductible
All other covered Facilities/Services (Maximum Applies)	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Home Health Care: Maximum number of covered visits 120 per calendar year	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Home Infusion Therapy	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Skilled Nursing Facility 60 days per Cal Yr	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Chemotherapy, Radiation and Infusion Therapy	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Dialysis Treatment	80% of Permitted Payment Levels after $100 Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Hospice Bereavement Counseling Lifetime Maximum - $20,000 (UR required)	100% of Permitted Payment Levels N/A	100% 100% after $15 Copay	80% after Deductible 80% after Deductible
DME, Medical Supplies (includes Prosthetics)	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible

BUY-UP PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Colonoscopy (Diagnostic)	80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Annual Routine Preventive Care			
Routine Physical Exam	N/A	100%	80% after Deductible
Annual Well Woman Exam	N/A	100%	80% after Deductible
Annual Routine Pap Smear and other related lab work	100% of Permitted Payment Levels; Copay waived	100%	80% after Deductible
Routine Annual Mammogram	100% of Permitted Payment Levels; Copay waived	100%	80% after Deductible
Routine Annual PSA Test	N/A	100%	80% after Deductible
Well Baby/Well Child Care	N/A	100%	80% after Deductible
Routine Immunizations	N/A	100%	80% after Deductible
Flu Vaccine/Pneumonia Vaccine	N/A	100%	80% after Deductible
Lab/X-ray and routine diagnostic testing & other medical screenings	100% of Permitted Payment Levels; Copay waived	100%	80% after Deductible
Routine Colonoscopy (Routine-age 50 and older or family history of colon cancer) not subject to Preventive Cal Yr maximum benefit	100% of Permitted Payment Levels; Copay waived	100%	80% after Deductible

BASE PLAN

SCHEDULE OF BENEFITS

Major Medical Benefits for Covered Persons

NOTE: All Claims are subject to review and/or audit to ensure that charges are payable in accordance with the terms and limitations of this Plan.

FACILITY PROVIDERS– Facilities and Providers billing as a Facility to include, but not limited to:

- Hospitals (Inpatient and Outpatient treatment)
- Inpatient Facilities (such as Rehabilitation Facilities, Skilled Nursing Facilities and Hospice)
- Inpatient and Outpatient Facilities for treatment of Mental and Nervous Disorders, Chemical Dependency, Drug and Substance Abuse
- Ambulatory Surgery Centers
- Dialysis Clinics

PROVIDERS – Physicians and all other Providers of service

ANCILLARY PROVIDERS – If the Plan Participant receives treatment from a non-contracted, ancillary provider because no contracted provider is available or the plan participant was in one of the above listed Facility Providers, the Plan will process such charges at the Contracted Benefit percentage applying Permitted Payment levels. Ancillary providers include but are not limited to:

- Pathologists
- Radiologists
- Anesthesiologist
- Assistant surgeons
- Emergency room (ER) physicians)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Lifetime Maximum Benefit	UNLIMITED		
Annual Plan Year Maximum	$1,250,000		
Calendar Year Deductible (Combined for all benefits) **Individual/Family** (Individual deductible carryover applies)	LaFeria ISD - $1000/$3000* Rio Hondo ISD - $500/$1500*		
Annual Out-of-Pocket Max (In addition to Deductible and Copayments) Individual/Family*	$2500/$7500*		

*The Family Deductible and Out-of-Pocket amounts apply collectively to all Covered Persons in the same Family

BASE PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Inpatient Confinement Copay	$500	N/A	N/A
Inpatient Hospital Expenses Notification to Managed Care Concepts (Utilization Review Company) is required within 48 hours of hospital admission	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Benefit Reduction Penalty (For failure to notify the UR Company following Hospital Admission)	50%	N/A	N/A
Radiologist, Pathologist, Anesthesiologist and Assistant Surgeon	N/A	80%; Deductible waived	80%; Deductible waived
Hospital Emergency Room (Copay waived if admitted) Notification to Utilization Review (UR) Company is required if admitted InPatient (all related charges)	80% of Permitted Payment Levels after $500 Copay; Deductible waived	80%; Deductible waived	80%; Deductible waived
Ambulance	100% of Permitted Payment Levels after $500 Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Physician Office Visit (Includes exam, treatment, lab, x-ray, tests and supplies provided by and billed by physician at time of office visit except Surgery, Chemo, Radiation Therapy, Infusion Therapy, Physical Therapy, Occupational Therapy and Speech Therapy)	For Purposes of this plan, Physicians considered Primary Care are: Family Practitioner, General Practitioner, Internest, Pediatrician, Nurse Practitioner and OB/GYN. All other Physicians are considered Specialists. A referal from a Primary Care Physician to a Specialist is not required.		
Primary Care Physician	N/A	100% after $25 Copay	80% after Deductible
Specialist	N/A	100% after $50 Copay	80% after Deductible
Office Surgery	N/A	100% after $25 Copay PCP or $50 Copay Specialist	80% after Deductible

BASE PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Allergy Testing, Serum and Injections	N/A	100% after $25 Copay PCP or $50 Copay Specialist	80% after Deductible
Contraceptive Injections	N/A	100% after $25 Copay PCP or $50 Copay Specialist	80% after Deductible
Contraceptive Devices and Implants	N/A	100%	80% after Deductible
Voluntary Sterilization Procedures	N/A	100%	80% after Deductible
Other Office Services (without Office visit billed)	N/A	100% after $25 Copay PCP or $50 Copay Specialist	80% after Deductible
Urgent Care Facility (Minor Emergency Medical Clinic)	N/A	100% after $50 Copay	80% after Deductible
MRI's, Cat Scan's and Pet Scans	100% of Permitted Payment Levels after $300 Copay	100% after $50 Copay	80% after Deductible
Lab/X-ray (Procedures performed in an Outpatient Hospital, Independent Lab)	80% of Permitted Payment Levels after $250 Copay; Deductible waived	100%	80% after Deductible
Outpatient Hospital/Ambulatory Surgical Facility (Includes All related charges)	80% of Permitted Payment Levels after $250 Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Maternity Facility Charges Contact the Utilization Review Company for coordination of care	80% of Permitted Payment Levels; inpatient confinement copay applies; Deductible waived	80%; Deductible waived	80% after Deductible
Maternity Physician Charges (including prematal and postnatal care)	N/A	80%; Deductible waived	80% after Deductible
Routine Newborn Care Including inpatient Hospital Nursery charges and pediatric care to date of baby's discharge)	100% of Permitted Payment Levels	100%	80% after Deductible
Maximum number of Days	4	4	4

BASE PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Bariatric Procedures See major medical expense benefits for covered services, **Lifetime Maximum Benefits $5,000**	Applicable Inpatient and/or Outpatient Confinement Copay applies; then 80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible
Inpatient for Mental & Nervous and Chemical Dependency, Drug and Substance Abuse Conditions	80% of Permitted Payment Levels after $500 confinement Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Outpatient/Day Treatment Facility for Mental & Nervous and Chemical Dependency, Drug and Substance Abuse Conditions	80% of Permitted Payment Levels after $250 confinement Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Psychological Testing - Performed in Facility	80% of Permitted Payment Levels after $500 confinement Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Psychological Testing - Performed in Office	N/A	100% after $25 Copay	80% after Deductible
Office visit/Outpatient Therapy (including Group Therapy) for Mental & Nervous and Chemical Dependency, Drug and Substance Abuse Conditions	N/A	100% after $25 Copay	80% after Deductible
Physical Therapy/Occupational Therapy/Speech Therapy/Cardiac Rehabilitation	80% of Permitted Payment Levels after Deductible	80% after Deductible	80% after Deductible
Chiropractic Services Calendar Year Maximum Benefit - **$1,500**	N/A	100% after $15 Copay	80% after Deductible
Sleep Disorders (Covered Services including sleep studies/diagnostic testing, surgery, devices & equipment)	Applicable Inpatient and/or Outpatient Confinement Copay applies; then 80% of Permitted Payment Levels; Deductible waived	80%; Deductible waived	80% after Deductible

BASE PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Sleep Office Visit Only	N/A	100% after $25 Copay PCP or $50 Copay Specialist	80% after Deductible
Pain Management-Calendar Year Maximum Benefit $15,000 Office Visit Only	N/A	100% after $25 Copay PCP or $50 Copay Specialist	80% after Deductible
All other covered Facilities/Services (Maximum Applies)	80% after $500 confinement Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Home Health Care: Maximum number of covered visits 120 per calendar year	80% after Deductible	80% after Deductible	80% after Deductible
Home Infusion Therapy	80% after Deductible	80% after Deductible	80% after Deductible
DME, Medical Supplies (includes Prosthetics)	80% after $250 Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Colonoscopy (Diagnostic)	80% after $250 Copay; Deductible waived	80%; Deductible waived	80% after Deductible
Annual Routine Preventive Care			
Routine Physical Exam	N/A	100%	80% after Deductible
Annual Well Woman Exam	N/A	100%	80% after Deductible
Annual Routine Pap Smear and other related lab work	100%; Copay waived	100%	80% after Deductible
Routine Annual Mammogram	100%; Copay waived	100%	80% after Deductible
Routine Annual PSA Test	N/A	100%	80% after Deductible
Well Baby/Well Child Care	N/A	100%	80% after Deductible
Routine Immunizations	N/A	100%	80% after Deductible
Flu Vaccine/Pneumonia Vaccine	N/A	100%	80% after Deductible
Lab/X-ray and routine diagnostic testing & other medical screenings	100%; Copay waived	100%	80% after Deductible

BASE PLAN
SCHEDULE OF BENEFITS (CONT'D.)

MEDICAL CARE BENEFITS	Facility Benefits	Physician Benefits	
		STHC Physician Benefit, Contracted	All other Physicians, Non Contracted
Routine Colonoscopy (Routine-age 50 and older or family history of colon cancer) not subject to Preventive Cal Yr maximum benefit	100%; Copay waived	100%	80% after Deductible
Prescription Coverage			
Supply Limit	30 days or 90 Days if Mail Order used		
Generic Drug	80% after Deductible		
Brand Name Drug purchased in US	80% after Deductible		
Drug purchased in Mexico	50% after Deductible		

ALTERNATE PLAN
(EMPLOYEE ONLY)

HOSPITAL INDEMNITY
BENEFITS All Covered Inpatient Confinements

Maximum Daily Benefit	$250
Maximum Benefit per Admission	30 days

CLAIMS FILING DEADLINE

All claims for eligible expenses must be filed within six (6) months following the date expenses are incurred.

COVERED BENEFITS

The Daily Benefit Amount will be paid for each day of a Covered Employee's period of confinement in a Hospital. The period of confinement must:

a. Be due to Illness or Injury; and
b. Begin while the Covered Employee is covered under the Plan.

Benefits will be payable for a period of confinement if the Covered Employee is:

a. Under a Physician's care; and
b. An Inpatient in the Hospital of confinement.

The Daily Benefit Amount will be payable from the first day of the period of confinement, for each full day of confinement, not to exceed the Maximum Benefit per Calendar Year (30 days).

EXCLUSIONS

1. Outpatient Hospital treatment
2. Treatment in a Minor Emergency Clinic
3. Treatment in a Psychiatric Day Treatment Facility

COORDINATION OF BENEFITS

There is no Coordination of Benefits for this Plan with other plans. Benefits are payable even if the Covered Employee has other coverage.

ALL USUAL PLAN PROVISIONS REGARDING ELIGIBILITY, DEFINITIONS, LIMITATIONS AND EXCLUSIONS APPLY TO THE HOSPITAL INDEMNITY BENEFIT PLAN.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Employees shall be in accordance with the Eligibility, Effective Date and Termination provisions as stated in this Plan Document.

ORGAN TRANSPLANT BENEFITS

Benefits are available for a human organ, tissue and bone marrow transplant subject to the following conditions:

1. Benefits will be provided subject to determination made on an individual case by case basis in order to establish Medical Necessity;
2. Benefits will be provided only when the Hospital and Physician customarily bill for the medical care and services involved in the human organ, tissue or bone marrow transplant;
3. Under no circumstances will benefits be available for any "personal service" fee, organ, tissue or bone marrow fee or any other similar charge or fee;
4. Only those necessary Hospital and Physician's medical care and service expenses, with respect to the donation, will be considered for benefits; and
5. Benefits will be provided for the appropriate Hospital standard organ, tissue or bone marrow acquisition costs (live donor or cadaver), storage and transportation of human organ, tissue or bone marrow donation.

When a Hospital's or a Physician's medical care and services are required for any type of human organ, tissue or bone marrow transplant from a living donor (to a transplant recipient) which requires surgical removal of the donated organ, tissue or bone marrow, coverage under the Plan is available only under the following circumstances:

1. When only the transplant recipient is a Covered Person, the benefits of the Plan will be provided to the donor to the extent that benefits are not provided to the donor under any other available coverage;
2. When only the donor is a Covered Person, the donor will receive benefits for care and services necessary to the extent such benefits are not provided to the donor under any other coverage available. Benefits will not be provided to any recipient who is not a Covered Person; or
3. When the transplant recipient and the donor are both Covered Persons, benefits will be provided for both in accordance with the recipient's Covered Expenses.

Transplant Benefits will be payable as follows:

	Transplant Program	**Non-Transplant Program**
Organ, Tissue and Bone Marrow Transplants		
(Non-experimental transplants only) UR Notification required for a transplant procedure or penalty applies. Contact the Utilization Review Company upon transplant evaluation for coordination of care. Calendar Year Deductible and Inpatient Copay apply.		
- Buy-Up Plan 1	70%; Deductible waived	50% after $500 Deductible
- Base Plan	70%; Deductible waived	50% after $1,000 Deductible
Donor Expenses UR Notification required or penalty applies. Donor expenses covered if recipient is covered by this Plan. Payable under recipient's Claim.		
- Buy-Up Plan	80%; Deductible waived	50% after $500 Deductible
- Base Plan	80%; Deductible waived	50% after $1,000 Deductible
Maximum Donor Benefit	N/A	$10,000
Organ Transplant Travel/Lodging Benefit	100% Deductible waived	Not Covered
Maximum Travel/Lodging Benefit	$10,000	Not Covered

NOTIFICATION TO UTILIZATION REVIEW COMPANY REQUIRED*

Expenses incurred in connection with any Organ or Tissue Transplant will be covered subject to notification and referral to the Plan Administrator's authorized review specialist. (Cornea transplants and heart valve replacements are not subject to this notification provision, but will be considered on the same basis as any other medical expense coverage under this Plan.) Transplant coverage is offered under this Plan through a Preferred Provider Transplant Program of specialized professionals and facilities. Coverage is also provided for transplant services obtained outside of the Preferred Provider Transplant Program at a reduced benefit level.

As soon as reasonably possible, but in no event more than ten (10) days* after a Covered Person's attending Physician has indicated that the Covered Person is a potential candidate for a transplant, the Covered Person or his Physician should notify the Plan Administrator's Utilization Review Company for referral to the program's Medical Review Specialist for evaluation and coordination of care. A comprehensive treatment plan must be developed for this Plan's medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure (i.e., name and address of the Hospital), any secondary medical complications, a five (5) year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (one (1) or both confirming second opinions may be waived by the Plan's Medical Review Specialist). Additional attending Physicians' statements may also be required. The Covered Person may provide a comprehensive treatment plan independent of the Preferred Provider Transplant Program, but this will be subject to a medical appropriateness review and may result in Non-Transplant Program benefit coverage.

All potential transplant cases will be assessed for their appropriateness by Case Management.

*** Failure to notify the Utilization Review Company of a transplant procedure will result in the application of a $5,000 penalty to all Covered Expenses incurred by the transplant recipient. If a non-compliance penalty is imposed for failure to notify the Utilization Review Company, that amount will never be included as part of the Calendar Year Deductible, Copay or Annual Out-of-Pocket Maximum.**

ORGAN TRANSPLANT PROGRAM

As a result of the medical review, the Covered Person will be asked to consider obtaining transplant services at a participating Center of Excellence facility with the Transplant Program arranged by the Plan Administrator's authorized review specialist. The purpose of designating Centers of Excellence facilities is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome and reduce the average cost of the procedures.

There is no obligation for the patient to use a Participating Transplant Program Facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the Transplant Program. If a transplant is performed in a Non-Transplant Program facility but the Covered Person has received approval from the Plan's Medical Review Specialist for Non-Transplant Program services, then Transplant Program Benefits will apply to the transplant and its related expenses. If services are provided in a Non-Transplant Program facility without approval from the Medical Review Specialist, then Non-Transplant Program Benefits will apply.

TRANSPLANT BENEFIT PERIOD

Covered Transplant Expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period Maximums, if any, shown in the Transplant Schedule of Benefits. The term "Transplant Benefit Period" means the period beginning on the date of the initial evaluation and ending on the date twelve (12) consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)

COVERED TRANSPLANT EXPENSES

The term "Covered Expenses" with respect to transplants includes the Usual and Customary expenses for services and supplies which are covered under this Plan (or which are specifically identified as covered only under this provision) and which are Reasonable and Medically Necessary and appropriate to the transplant, including:

1. Charges incurred in the evaluation, screening and candidacy determination process.

2. Charges incurred for organ transplantation.

3. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.

   Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.

   Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.

   If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or the donor's marrow (allogeneic). Coverage will also be provided for search charges to identify an unrelated match and treatment and storage cost of the marrow, up to the time of re-infusion. (The harvesting of the marrow need not be performed within the Transplant Benefit Period.)

4. Charges incurred for follow up care, including immunosuppressant therapy.

5. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one (1) other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered up to a Maximum of $10,000 per transplant period.

   NOTE: The Travel and Lodging Benefit is payable only if the Transplant Program is used.

RE-TRANSPLANTATION

Re-transplantation will be covered up to two (2) re-transplants, for a total of three (3) transplants per person, per lifetime. Each transplant will be subject to the Notification and review requirement for organ transplant. Each transplant and re-transplant will have a new Benefit Period and a new Maximum Benefit, subject to the Plan's overall per person Lifetime Maximum Benefit.

ACCUMULATION OF EXPENSES

Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the Plan's overall per person Lifetime Maximum Benefit.

DONOR EXPENSES

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this Plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a Covered Person under this Plan are limited to a Maximum of $10,000 per transplant benefit period when the transplant services are provided in a Non-Transplant Program facility. This limit does not apply to the donor's transportation and lodging expenses described above under Covered Transplant Expenses.

PRE-EXISTING CONDITION LIMITATION

Transplant charges will be subject to the Plan's Pre-existing Condition Exclusion Limitation.

PRESCRIPTION DRUG PLAN
(BUY-UP PLAN)

All Brand Drugs have a $100 Prescription Deductible that will be taken before any copays apply. Once the Prescription Deductible is met then the Copays will apply. This deductible is combined for Retail, Mail Order, and Specialty Brand Drugs.

Prescription Card Service	**100% after applicable Copay**
Supply Limit	30 days
Generic Drugs	$0 Copay
Brand Name Drugs	$35 or 50% Copay* (after Deductible up to $200, whichever is greater
Mail Order Service	**100% after applicable Copay**
Supply Limit	90 days
Generic Drugs	$0 Copay
Brand Name Drugs	$70 or 50% Copay* (after Deductible) up to $400, whichever is greater
Specialty Pharmacy Drugs**	**100% after applicable Copay**
Supply Limit	30 days
Generic Drugs	$0 Copay
Brand Name Drugs	$35 or 50% Copay*(after Deductible) up to $200, whichever is greater

* Diabetic Drugs and supplies are covered at $0 Copay Generic and $50 Copay Brand (after Deductible).

PRESCRIPTION DRUG PLAN
(BASE PLAN)

All Drugs for the Base Plan are covered under the Major Medical Plan subject to Deductible and Coinsurance (see Schedule of Benefits – Base Plan).

** All Specialty Pharmacy Drugs must be obtained through the Specialty Pharmacy.

If the pharmacy charge is less than the Brand Copay, then the actual charge will become the Copay. Brand Name Copayments apply separately to each prescription and refill and do not apply to the Calendar Year Deductible or Annual Out-of-Pocket Maximum. To be covered, Prescription Drugs must be:

1. Purchased from a participating licensed pharmacist;
2. Dispensed to the Covered Person for whom they are prescribed; and
3. Legally prescribed by a Qualified Prescriber.

DEFINITIONS

Brand Name Drugs
Trademark drugs or substances marketed by the original manufacturer.

Generic Drugs
Drugs or substances which:

1. Are not trademark drugs or substances; and
2. May be legally substituted for trademark drugs or substances.

Over the Counter (OTC) Drugs
Drugs that do not require a prescription from a Qualified Prescriber.

Prescription Drugs
Legend drugs or medicines that are prescribed by a Qualified Prescriber for the treatment of Illness, Injury, or Pregnancy.

Qualified Prescriber
A licensed Physician, Dentist, or other health care Practitioner who may, in the legal scope of his/her practice, prescribe drugs or medicines.

Specialty Drugs
Specialty pharmaceuticals include biotech drugs produced using living organisms which are high cost or injectable drugs that require heightened patient management and support.

Maximum Allowable Cost

The pharmacist substitutes more economically priced generic equivalent drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug. Under this program if the prescribing Physician does not specify the Brand Name, but the Covered Person requests the Brand product when there is a Generic substitute available, the Covered Person is required to pay the difference in cost between the Brand and Generic products in addition to the usual Brand Copay (applies to Prescription Card and Mail Order).

Most pharmacists, as a courtesy to the patient, will ask whether a Generic Drug is acceptable to the Covered Person if the Physician has specified "product selection permitted" on the prescription. If the Physician has specified "dispense as written," no choice is given to the patient, and only the applicable Copay will be charged.

Drug Review

The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Prescription Drug Plan – Covered Drugs

1. Legend drugs (drugs requiring a prescription either by Federal or State law). See Exclusion list below for exceptions;
2. Insulin on prescription;
3. Disposable insulin needles/syringes, test strips and lancets on prescription;
4. Tretinoin, all dosage forms (i.e., Retin-A), for individuals to the age of nineteen (19) years;
5. Compounded medications of which at least one ingredient is a prescription legend drug;
6. Legend oral contraceptives;
7. Seasonale (3 Copays apply);
8. Contraceptive patches;
9. Contraceptive rings;
10. Injectable contraceptives;
11. Prenatal vitamins;
12. Injectable form of covered legend drugs;
13. ADD (Attention Deficit Disorder)/ADHD (Attention Deficit Hyperactivity Disorder) drugs for individuals to the age of nineteen (19) years;
14. Imitrex;
15. Epipen;
16. Gleevec;
17. Specialty Drugs; and
18. Smoking Cessation prescribed medications, limited to a 90 day supply per Lifetime.

Prescription Drug Plan – Drugs Requiring Authorization

1. Actiq*
2. Oxycodone*
3. Stadol*
4. Tretinon, all dosage forms (i.e. Retin-A), for individuals nineteen (19) years of age and older,* and
5. ADD/ADHA drugs for individuals nineteen (19) years of age and older.

* Covered with authorization if Medically Necessary

Prescription Drug Plan – Excluded Drugs

1. Prescription vitamins except prenatal;
2. Contraceptive implants;
3. Contraceptive devices (unless listed as covered);
4. Emergency contraceptives (i.e., Plan B);
5. Abortifacients/RU-486;
6. Fertility drugs;
7. Drugs prescribed for impotence/sexual dysfunction;
8. Weight loss medications;
9. Growth hormones;
10. Immunization agents, biological sera, blood or blood plasma;
11. Drugs for the treatment of alopecia (baldness);
12. Non-legend drugs other than those listed above;
13. Therapeutic devices or appliances, including needles, syringes, support garments and other non-medical substances, regardless of intended use, except those listed above;
14. Charges for the administration or injection of any drug;
15. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws;
16. Drugs labeled "Caution-limited by Federal law to investigational use," or experimental drugs, even though a charge is made to the individual;
17. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, extended care facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals; and
18. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order.

NOTE: Covered Drugs, Drugs Requiring Authorization and Excluded Drugs listings may not be all inclusive.

Prescription Drugs covered under the Prescription Drug Plan are not subject to the Pre-existing Condition Exclusion Limitation of the Plan.

A Prescription Drug dispensed by a retail pharmacy, Mail Order Service or Specialty Pharmacy for which a Copay applies is not considered a Claim for benefits under this Plan and, therefore, is not subject to the Plan's Claim Filing Procedures.

The Plan reserves the right, in its sole discretion, to authorize alternative care and treatment as Covered Charges.

PRESCRIPTION DRUG UTILIZATION REVIEW

The Prescription Drug benefit does not have unlimited coverage. As with all medical and Hospital services, Prescription Drug utilization is subject to determinations of Medical Necessity and appropriate use. Drug Utilization Review may be concurrent, retrospective or prospective.

Concurrent Drug Utilization Review generally occurs at the time of service and may include electronic Claim audits which may help to protect patients from potential drug interactions or drug-therapy conflicts or overuse/under use of medications.

Retrospective Drug Utilization Review generally involves Claim review and may include communication by the Prescription Drug Plan and/or the Utilization Review Company with the prescribing Physician to coordinate care and verify diagnoses and Medical Necessity. It may include a peer review by a Physician of like specialty to the prescribing Physician reviewing the medical and pharmacy records to determine Medical Necessity.

Should Medical Necessity not be determined by the peer review Physician, the treating Physician and Plan Participant will be notified and provided with the peer review results. The Plan Participant and Physician will be forwarded information on the appeal process as outlined in this Plan.

Prospective Drug Utilization Review may include, among other things, Physician or pharmacy assignment in which one Physician and/or one pharmacy is selected to serve as the coordinator of prescription drug services and benefits for the eligible Plan Participant. The Plan Participant will be notified in writing of this and will be required to designate a Physician and pharmacy as his/her providers.

UTILIZATION REVIEW (UR) PROGRAM

The Utilization Review program is designed to help all Plan Participants receive Medically Necessary health care. The Utilization Review Company is Managed Care Concepts. Notification must be provided to the Utilization Review Company of all Inpatient Hospital/Facility admissions and confinements, as detailed below. It is important to remember that there is no need to contact the Plan or the Utilization Review Company for prior approval of such admissions and confinements and Outpatient Surgery.

HOSPITAL/FACILITY ADMISSION NOTIFICATION

Notification of all Inpatient Hospital/Facility admissions (including admissions for treatment of Mental and Nervous Disorders or Substance Abuse), Skilled Nursing Facilities and Rehabilitation Facilities is required. **Notification to the Utilization Review Company must be made within forty-eight (48) hours following any Hospital/Facility admission (or the next business day if holiday or weekend admission). Notification to the Utilization Review Company is required for all Hospital/Facility admissions in Mexico.**

The Utilization Review Company Nurse may discuss with the Physician and/or Hospital/Facility the diagnosis, the need for hospitalization versus alternative treatment, and length of any Hospital/Facility confinement. The Utilization Review Company will notify the Physician and/or Hospital/Facility verbally or electronically of the outcome of the Utilization Review.

Failure to notify the Utilization Review Company or comply with these requirements will result in benefit paid at 50% for all Covered Hospital/Facility Expenses for that admission. If this non-compliance penalty is imposed for failure to notify the Utilization Review Company, that amount will not be included as part of the Calendar Year Deductible, Copay or Annual Out-of-Pocket Maximum.

NOTE: Please refer to the Plan Participant identification card for name and phone number of the Utilization Review Company. While notification of a Hospital/Facility admission is required under the Plan, that notice does not constitute a Claim and any such action taken by the Utilization Review Company does not constitute a Benefit Determination. This service is being provided as a convenience for Plan Participants in an attempt to ensure that services provided will be Covered Medical Expenses under the Plan. All Claims are subject to all Plan requirements, such as Medical Necessity, Pre-existing Condition Exclusion Limitation,

Major Medical Expense Benefits, Plan Exclusions and Limitations and Eligibility provisions at the time care and services are provided.

See Organ Transplant Program section for notification requirements for transplants.

CONCURRENT REVIEW

Following notification of a Hospital/Facility admission, a concurrent review of treatment will be conducted by the Utilization Review Company. “Concurrent Review” means the Utilization Review Company will monitor the Covered Person’s Hospital stay and periodically evaluate the need for continued hospitalization. In addition, the Utilization Review Company may assist with discharge planning and address the health care needs of the patient upon release. This may involve consultation with the Covered Person’s Physician and comparison of clinical information to nationally accepted criteria.

CASE MANAGEMENT

During the Utilization Review process, catastrophic cases such as transplants, burns, spinal cord Injuries, cancer and other large cases will be identified and Case Management may be initiated. Case Management is provided by Nurses with specialized training and/or advanced national certification. The Nurse may monitor the medical care, consult with the Physicians, coordinate with the health care providers and Facilities, and communicate with the patient and Family to promote receipt of appropriate, cost effective care to expedite the recovery process. Referrals to Centers of Excellence and Non-Contracted fee negotiations may be included in the Case Management process.

When Non-Contracted fees are negotiated by Case Management and/or the Utilization Review Company on behalf of the Plan, Non-Contracted Covered Charges may be considered at the Contracted Benefit level.

ALTERNATIVE CARE

Through alternative care, Case Management may help the patient and the Plan Administrator obtain care/treatment for a serious illness or injury that is medically necessary and appropriate for the diagnosis. When alternative care and treatment are identified by Case Management as Medically Necessary and approved by the Plan Administrator, the Plan may pay for all or part of the charges not shown as a Covered Expense or as a Covered Prescription Drug in this Plan Document. These expenses will be considered on the same basis as the care and treatment for which they are substituted. This Plan reserves the right in its sole discretion to authorize alternative care and treatment as Covered Charges. In exercising its authority, this Plan will act in a way so as not to discriminate against any Plan Participant. If the care is not being substituted for other Covered Expenses, it will be considered on the same basis as a same or similar Covered Expense or Covered Prescription Drug shown in this Plan Document, as determined by the Claims Administrator.

An Alternative Care Plan will be developed and signed by the Plan in cases that are considered alternative care or a Medically Justified Variance. This Alternative Care Plan will be signed by the Utilization Review Company’s Medical Director, the Plan Administrator, and submitted to the applicable parties. All benefits provided in this section are subject to Medical Necessity, Reasonableness, and Usual and Customary charges or the Permitted Payment Levels under the Claim Review and Validation Program.

DISEASE MANAGEMENT

Disease Management is an Employer sponsored voluntary program that is designed to help individuals with certain chronic health conditions to better manage their care. The Utilization Review Company supports the relationship between the Physician and the patient by providing information regarding optimal

treatment options. The objective is to help individuals stay healthy by providing customized health education information for the most appropriate medical care for their Illness.

PRE-EXISTING CONDITION EXCLUSION LIMITATION

A Pre-existing Condition is any physical or mental Illness or Injury (regardless of the cause) for which medical advice, diagnosis, care or treatment was recommended or received, for which prescribed drugs were taken, for which a Physician was consulted or for which medical expenses were incurred during the six (6) month period immediately prior to the Covered Person's Enrollment Date in the Plan. Medical advice, diagnosis, care or treatment is taken into account only if it is recommended by, or received from, an individual licensed or similarly authorized to provide such services under State law and operating within the scope of practice authorized by State law. Taking prescribed drugs during the six (6) month look-back period constitutes medical care or treatment even if prescribed more than six (6) months before the Enrollment Date.

Coverage for a Pre-existing Condition will be provided on:

1. The date on which the Covered Person completes a **twelve (12) month** exclusion period beginning with the Covered Person's Enrollment Date in the Plan; or
2. In the case of a Late Enrollee, the date on which the Late Enrollee completes a twelve (12) month exclusion period beginning with the Late Enrollee's Enrollment Date in the Plan.

ENROLLMENT DATE FOR DETERMINING PRE-EXISTING CONDITION EXCLUSION PERIOD

The Enrollment Date determines when the six (6) month Pre-existing Condition look-back period begins and when the twelve (12) month Pre-existing Condition exclusion period begins and ends.

The Enrollment Date for an Eligible Employee who enrolls in the Plan during his/her initial eligibility period is the Employee's Date of Hire. The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan.

See Effective Date of Coverage sections of this Plan for Special Enrollment qualifications, enrollment limitations and requirements for Late Enrollees.

EXCEPTIONS

The Pre-existing Condition exclusion limitation does not apply to any Covered Person that has not yet reached age nineteen (19).

The Pre-existing Condition exclusion limitation will not apply to those Covered Persons covered on the restated date of this Plan, who were also covered by the terms of the prior Plan and who would not be subject to an exclusion or reduction of benefits because of the Plan's Pre-existing Condition limitation.

The Pre-existing Condition exclusion limitation does not apply to the Alternate Plan.

The Pre-existing Condition exclusion limitation will not apply to Prescription Drugs covered under the Prescription Drug Plan.

Pregnancy and Genetic Information will not be considered a Pre-existing Condition even if medical advice, diagnosis, care or treatment was recommended or received prior to the Covered Person's Enrollment Date in the Plan.

The Pre-existing Condition exclusion limitation may be reduced or eliminated by periods of Creditable Coverage. See Portability and Creditable Coverage section.

The Pre-existing Condition exclusion limitation is subject to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as amended.

PORTABILITY AND CREDITABLE COVERAGE

The Plan shall reduce the Pre-existing Condition exclusion limitation period for a Covered Person by any periods of Creditable Coverage that an individual proves he/she had without a Significant Break in Coverage. A Certificate of Coverage (Certificate of Group Health Plan Coverage) from the prior plan(s) must be provided to the Plan Administrator at the time of enrollment in this Plan to verify Creditable Coverage.

CREDITABLE COVERAGE

Creditable Coverage includes most health coverage (subject to HIPAA Rules for Creditable Coverage), such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare, State Children's Health Insurance Program and any plan established and maintained by a State, the U.S. government or a foreign country. Creditable Coverage does not include coverage consisting solely of dental or vision benefits.

SIGNIFICANT BREAK IN COVERAGE

A Significant Break in Coverage is a period of sixty-three (63) consecutive days or more during which the Employee or Dependent did not have any Creditable Coverage. If a Covered Person has a Significant Break in Coverage, any days of coverage that occurred prior to the Significant Break in Coverage will not be counted by the Plan to reduce the Pre-existing Condition exclusion period.

CERTIFICATE OF COVERAGE

To verify Creditable Coverage, a Certificate of Coverage will be issued without charge to an individual who terminates coverage with a group health plan or individual plan. A Certificate of Coverage provides evidence of the date coverage began and the date coverage ended.

The Plan will assist an Employee in obtaining a Certificate of Coverage from a prior plan if requested. If, upon review of the dates of coverage, a Pre-existing Condition exclusion limitation will still be imposed on an individual, the person will be notified in writing of this decision.

AUTOMATIC CERTIFICATE OF COVERAGE

A Certificate of Coverage should be provided automatically by group health plans and health insurance issuers under these circumstances:

1. If termination of coverage is a result of a COBRA Qualifying Event and the individual is a Qualified Beneficiary, a Certificate of Coverage must be provided within the same period of time as the notice of COBRA rights;

2. If an individual has elected COBRA continuation coverage or the Plan has provided continued coverage after the COBRA Qualifying Event, the Plan must provide another Certificate of Coverage automatically within a reasonable period of time after COBRA continuation coverage ceases; and

3. If the termination of coverage is not a COBRA Qualifying Event, the Certificate of Coverage must be provided within a reasonable time period.

CERTIFICATE OF COVERAGE UPON REQUEST

The Plan will furnish a Certificate of Coverage within a reasonable period of time if the request is made by or on behalf of an individual within twenty-four (24) months after health coverage ceases. A Certificate of

Coverage will also be issued upon request even if health coverage remains in force. To request a Certificate of Coverage, contact the Human Resources Manager or the Plan Administrator at 956-428-7006.

COMPREHENSIVE MEDICAL BENEFITS

COVERED MEDICAL EXPENSES (COVERED EXPENSES)

Covered Medical Expenses mean Reasonable Claims for Usual and Customary charges, within Permitted Payment Levels, incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under the Major Medical Exclusions and Limitations section of this Plan.

COVERED CHARGES

If a Covered Person incurs Covered Medical Expenses as the result of an Illness or Injury, all treatment is subject to benefit payment provisions shown in the Schedule of Benefits and as determined elsewhere in this document.

HOSPITALS, AMBULATORY SURGERY CENTERS AND OTHER FACILITIES

Charges for services rendered in these Facilities will be evaluated under the Claim Review program, and Covered Charges will be determined based upon the Permitted Payment Levels. Please refer to the Claim Review and Validation Program section of the Plan for additional information about Claim Review and Permitted Payment Levels.

PHYSICIANS AND ALL OTHER COVERED PROVIDERS

The Physician fees cover the cost of medical services/procedures provided by a Physician or for professional fees provided by a Physician for the supervision, interpretation and consultation involved in the care and treatment of a patient. Each fee may be billed separately by the Physician providing the service. STHC Contracted Providers will be reimbursed according to contract provisions. All other Physicians will be reimbursed at 80% of Medicare.

DIRECTLY CONTRACTED PROVIDER SERVICES

“Directly Contracted Provider Services” are health care services and supplies provided by Hospitals and/or Facilities who are directly contracted with the Co-op, the Plan Administrator and/or the Claims Delegate to provide services at negotiated rates and fees (“Directly Contracted Providers” and each a “Directly Contracted Provider”).

SEPARATE DEDUCTIBLE AMOUNTS

The Deductible amount for each Covered Person is the amount of Covered Expenses which must be incurred each Calendar Year before benefits are payable for Covered Medical Expenses incurred during the remainder of that year. The Calendar Year Deductible is the amount shown in the Schedule of Benefits.

COMMON ACCIDENT DEDUCTIBLE

This applies when two (2) or more Covered Persons in the same Family are injured in the same accident. These persons need not meet separate Deductibles for treatment of Injuries incurred in this accident; instead, only one (1) Deductible for the Calendar Year in which the accident occurred will be required for them as a Family.

DEDUCTIBLE FAMILY LIMIT
The Maximum Deductible amounts to be applied each Calendar Year to a Covered Employee and his/her covered Dependents will not be more than the Family Limit shown in the Schedule of Benefits. As soon as that limit is met (collectively) in the same Calendar Year, no further Deductibles will be applied to Covered Medical Expenses for any covered Family member during the remainder of that Calendar Year. To satisfy the Deductible Family Limit, each covered Family member can contribute no more than his/her own individual Deductible.

DEDUCTIBLE CARRYOVER PROVISION
Covered Medical Expenses incurred and applied to the Calendar Year Deductible during the last three (3) months (October, November and December) of a Calendar Year will be carried over and credited toward satisfaction of the next year's Calendar Year Deductible. The carryover provision applies to the individual Deductible only and not the Family Deductible Limit.

INPATIENT HOSPITAL/FACILITY COPAY
The Inpatient Hospital/Facility per Confinement Copay is the amount of covered Hospital/Facility charges payable by the Covered Person each time he/she is confined in a Hospital/Facility before benefits are payable. Charges used to meet this Copay will not be used to meet the Calendar Year Deductible or Annual Out-of-Pocket Maximum (if applicable). The Maximum Amount that will apply to Inpatient Hospital/Facility Copays per Calendar Year is shown in the Level I Schedule of Benefits. When this amount is incurred, no further Inpatient Hospital/Facility Copays will apply to Covered Charges.

DIALYSIS COPAY
The Dialysis Copay is the amount of covered Dialysis Facility charges payable by the Covered Person each time he/she has Dialysis services before benefits are payable. Charges used to meet this Copay will not be used to meet the Calendar Year Deductible or Annual Out-of-Pocket Maximum (if applicable). The Maximum Amount that will apply to Dialysis Copays per Calendar Year is shown in the Schedule of Benefits. When this amount is incurred, no further Dialysis Copays will apply to Covered Charges.

COINSURANCE
Coinsurance is the portion of Covered Medical Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20% and/or 70%/30%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by the Covered Person is applied to satisfy the Covered Person's Annual Out-of-Pocket Maximum.

SEPARATE ANNUAL OUT-OF-POCKET MAXIMUMS
The separate Annual Out-of-Pocket Maximum does not include expenses that are in excess of the Permitted Payment Levels. Please refer to the Claim Review and Validation Program section for additional information regarding Permitted Payment Levels. Separate Annual Out-of-Pocket Maximums apply to Covered Charges. The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses each Calendar Year. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- The Calendar Year Deductible;
- Inpatient Hospital/Facility per Confinement Copay
- Benefit reductions;
- Outpatient Surgery Copay;
- Copays (Office Visit, Urgent Care Facility, Hospital Emergency Room);
- Prescription Copays;
- Any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits;
- Charges in excess of Usual and Customary, Permitted Payment Levels or charges for services that do not meet the Plan's definition of Reasonable; and
- Any non-compliance penalty applied when a Covered Person fails to notify the Utilization Review Company of a Hospital admission or transplant procedure.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT
The Annual Out-of-Pocket Maximum Family Limit is met when all covered Family members (collectively) incur the amount shown in the Schedule of Benefits as the Annual Out-of-Pocket Maximum Family Limit. To satisfy the Family Limit, each Covered Family member can contribute no more than his/her own Annual Out-of-Pocket Maximum.

HOSPITAL EMERGENCY ROOM COPAY (PER VISIT)
The portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges each time the Covered Person is treated in a Hospital Emergency Room. The Emergency Room Copay is waived if admitted Inpatient.

OUTPATIENT SURGERY COPAY (PER SURGERY)
The Copay per Outpatient Surgery is the amount of covered Hospital/Ambulatory Surgery Center charges payable by the Covered Person each time he/she undergoes Outpatient Surgery in a Facility before benefits are payable. Charges used to meet this Copay will not be used to meet the Calendar Year Deductible or Annual Out-of-Pocket Maximum.

OUTPATIENT COPAY
The Outpatient Copay is the amount of Outpatient Facility Covered Charges payable by the Covered Person each time he/she undergoes Outpatient Services in a Hospital or other Outpatient Facility before benefits are payable. Charges used to meet this Outpatient Copay will not be used to meet the Calendar Year Deductible or Annual Out-of-Pocket Maximum. The Maximum Amount that will apply for Outpatient Copays per Calendar Year is shown in the Schedule of Benefits. When this amount is incurred, no further Outpatient Copays will apply to Covered Charges.

URGENT CARE FACILITY COPAY (PER VISIT)
The Urgent Care Facility Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges each time the Covered Person is treated by a Physician in an Urgent Care Facility (Minor Emergency Medical Clinic) when such services are billed by either a Physician or Urgent Care Facility. The Urgent Care Facility Copay cannot be used to satisfy the Calendar Year Deductible or Annual Out-of-Pocket Maximum.

STHC CONTRACTED OFFICE VISIT COPAY (PER VISIT)
The Office Visit Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person for Covered Charges provided by and billed by the Physician at the time of each Contracted Physician Office Visit and for services rendered at each Physician visit at an Urgent Care Facility when such services are billed by either a Contracted Physician or Contracted Urgent Care Facility.

Office Visit Copays for a Primary Care Physician and a Specialist are specified in the Schedule of Benefits. A referral from a Primary Care Physician to a Specialist is not required.

CALENDAR YEAR MAXIMUM BENEFIT
The Maximum Amount payable for Covered Expenses during a Calendar Year Benefit Period for each Covered Person is limited to a specific dollar amount, number of days or visits as specified in the Schedule of Benefits. The Calendar Year is from January 1 through December 31 of the same year. The initial Calendar Year Benefit Period is from a Covered Person’s effective date through December 31 of the same year.

LIFETIME MAXIMUM BENEFIT
The Maximum Amount payable for all Covered Expenses incurred during each Covered Person's lifetime is as specified in the Schedule of Benefits. The word "Lifetime," as used herein, means the duration of participation in this Plan maintained by the Co-op, either as an Employee, Dependent or COBRA Qualified Beneficiary (including prior Plan Years).

MAJOR MEDICAL EXPENSE BENEFITS

The following are Covered Medical Expenses under this Plan, unless specifically excluded under the Major Medical Plan Exclusions and Limitations. Benefits for these Covered Expenses will be payable as shown in the Schedule of Benefits. Charges are subject to the Reasonable and Usual and Customary amount, the Permitted Payment Levels under the Claim Review and Validation Program, and/or the negotiated fee schedule of the South Texas Health Cooperative (STHC).

Covered Medical Expenses are subject to any Maximum Benefit and/or limitation specified in the Schedule of Benefits.

Admit Kits. The charges for Hospital "admit kits."

Allergy Testing. The charges for Allergy testing and treatment as specified in the Schedule of Benefits.

Ambulance Services. The charges for professional licensed ambulance service as follows:

1. Ground transportation when Medically Necessary and used locally to or from the nearest Facility qualified to render treatment;
2. Air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest Facility qualified to render treatment (excluding commercial flights); or
3. "CARE" and "LIFE" flights in a life-threatening situation.

Ambulatory Surgery Center. The charges made by an Ambulatory Surgery Center, Minor Emergency Medical Clinic and Birthing Center.

Anesthesia. The charges for the cost and administration of an anesthesia and/or anesthetic.

Assistant Surgeon. When services of an assistant surgeon and/or licensed surgical assistant are required to render technical assistance at an operation, the Covered Expense for such services shall be limited to 25% of the allowable surgical fee. See definition of Practitioner for covered providers.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). The charges for the diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD) with the exclusion of charges for education and training.

Audiologist. The charges of an Audiologist under direct supervision of a Physician to restore hearing loss or correct an impaired hearing function.

Bariatric Procedures. The charges for Bariatric Procedures to include Adjustable Gastric Banding, Vertical Banded Gastroplasty, Gastric Bypass Roux-en-Y Gastroenterostomy and Sleeve procedure, only when the treatment meets the Utilization Review Company's criteria for Medical Necessity subject to the Maximums specified in the Schedule of Benefits.

Blood or Blood Components. The charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if the Facility receives any replacement of blood used for which the patient is not financially responsible.

Cardiac Rehabilitation. The charges for cardiac rehabilitation as deemed Medically Necessary provided services are rendered:

1. Under the supervision of a Physician;
2. In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery;
3. Initiated within twelve (12) weeks after other treatment for the medical condition ends; and
4. In a Facility whose primary purpose is to provide medical care for an Illness or Injury.

Chemical Dependency, Drug and Substance Abuse. The charges for treatment of Chemical Dependency, Drug and Substance Abuse. Inpatient/Outpatient Chemical Dependency/Drug Treatment Facility expenses shall be payable as specified in the Schedule of Benefits.

Chiropractic Services. The charges for Chiropractic Services subject to the Maximum specified in the Schedule of Benefits, to include x-rays.

Clinical and Pathological Laboratory Tests. The charges for clinical and pathological laboratory tests and examinations including fees for professional interpretation of their results.

Contraceptive Implants. The charges for insertion and removal of contraceptive implants and IUDs in a Physician's office and the cost and fitting of diaphragms.

Cornea Transplants and Heart Valve Replacements. The charges for services and supplies in connection with cornea transplants and heart valve replacements on the same basis as any other Illness.

Cosmetic Surgery. The charges for Cosmetic Surgery only in the following situations:

1. Reconstructive Surgery as a result of an accidental bodily Injury;
2. The surgical correction required as a result of a congenital disease or anomaly;
3. Reconstructive Surgery following neoplastic (cancer) surgery;
4. Reconstruction of the breast on which a mastectomy has been performed;
5. Surgery and reconstruction of the other breast to produce symmetrical appearance;
6. Coverage for prostheses and physical complications related to all stages of covered mastectomy including lymphedema, in a manner determined in consultation with the attending Physician and patient; and
7. Removal of breast implants if deemed to be Medically Necessary and reconstructive breast surgery after implant removal. Breast reconstruction is not covered if the original implants were for cosmetic reasons. However, the removal of the implant is covered, if Medically Necessary, even if the original implant was for cosmetic reasons.

   NOTE: The Plan's breast reconstruction surgery benefits are subject to the requirements of the Mastectomy Provision of the Women's Health and Cancer Rights Act of 1998.

Covered Wellness Procedures. The charges for Covered Wellness Procedures listed as Preventive and Wellness Care Benefits.

Custom Bras for Prostheses. The charges for custom bras for prostheses following a mastectomy, limited to six (6) per Plan Calendar Year.

Dental Expenses and Oral Surgical Procedures. The charges for the following Dental expenses and Oral Surgical Procedures:

1. Excision of impacted or partially impacted teeth;
2. Cutting procedures in the oral cavity for excision of tumors and cysts of the jawbone;
3. External incision and drainage of cellulitis;
4. Open or closed reduction of a fracture or dislocation of the jaw; and
5. Treatment necessitated by Accidental Injury to sound natural teeth.

If Medically Necessary for Dental work or Oral Surgery to be performed at an Outpatient Facility or Hospital, only the Facility and related anesthesia fees are Covered Charges.

Diabetic Supplies. The charges for insulin, insulin syringes, test strips and lancets on prescription are covered by the Prescription Drug Card and Mail Order Service in Buy-Up Plan 1, and under Major Medical Expense Benefits in Base Plan for drugs other than Generic that are covered by the Prescription Drug Card. The charges for glucometers and insulin pumps/supplies when ordered by a Physician.

Diabetic Training. The charges for diabetic self-management medical and nutritional training for diagnosed cases of diabetes rendered by a licensed Practitioner when recommended as a course of treatment by a Physician.

Diagnostic Tests. The charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well established diagnostic tests generally approved by Physicians throughout the United States.

Diagnostic X-Rays. The charges for radiation services including diagnostic X-rays and interpretation.

Dietitian. The charges for services of a licensed Dietitian when recommended by a licensed M.D. or D.O. except for services which are otherwise excluded by the Plan.

Drugs. The charges for drugs requiring the written prescription of a licensed Physician; such drugs must be Medically Necessary for the treatment of an Illness or Injury. See Prescription Drug Plan section. Under Buy-Up Plan, Prescription Drugs are covered by the Prescription Drug Card, Mail Order Service or Specialty Pharmacy and are payable under Major Medical Expense Benefits only if the Prescription Drugs were purchased in Mexico, subject to the benefits specified in the Schedule of Benefits. Base Plan Prescription Drugs which are determined to be Medically Necessary and Covered Charges are payable under Major Medical Expense Benefits, subject to the benefits specified in the Schedule of Benefits.

Durable Medical Equipment. The charges for rental or purchase of a wheelchair, Hospital bed and other Durable Medical Equipment prescribed by a Physician and required for temporary therapeutic use, whichever is most cost effective. Benefits will be provided for the repair, adjustment or replacement of purchased Durable Medical Equipment or components only within a reasonable time period of purchase subject to the life expectancy of the equipment.

Genetic Testing. The charges for Genetic testing, if Medically Necessary and indicated under nationally accepted guidelines.

Home Health Care. The charges by a Home Health Care Agency for care for a homebound patient in accordance with a Home Health Care Plan subject to the Maximum and the Benefit Percentage specified in the Schedule of Benefits. Home Health Care Visit means a visit by a member of a home health care team. Each visit that lasts for a period of four (4) hours or less is treated as one (1) home health care visit. If the visit exceeds four (4) hours, each period of four (4) hours is treated as one (1) visit and any part of a four (4) hour period that remains is treated as one (1) home health care visit.

Home Health Care Plan Covered Services and Supplies:

1. Part-time or intermittent nursing care visits by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.), a Licensed Vocational Nurse (L.V.N.), or Public Health Nurse who is under the direct supervision of a Registered Nurse;
2. Part-time or intermittent Home Health Aide services which consist primarily of caring for the patient;
3. Physical, occupational, speech and respiratory therapy services by licensed therapists;
4. Services of a Licensed Clinical Social Worker (L.C.S.W.); and
5. Medical supplies, drugs and medications prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the patient had remained in the Hospital. NOTE: Home Infusion Therapy is a separate benefit and charges are not subject to the Home Health Care Maximum.

Home Health Care Plan Exclusions:

1. Services and supplies not included in the Home Health Care Plan;
2. Services of a person who is a close relative of the Covered Person;
3. Services of any social worker unless designated L.C.S.W.;
4. Transportation services;
5. Food or home delivered meals;
6. Custodial care and housekeeping; and

7. Charges for service in excess of the maximum specified Schedule of Benefits.

Home Infusion Therapy. The charges for Home Infusion Therapy by a licensed provider to include intravenous infusion or injection of fluids, nutrition or medication furnished in the home setting.

Hospice care. The charges relating to Hospice care provided that the Covered Person has a life expectancy of six (6) months or less, subject to the Maximum specified in the Schedule of Benefits. Covered Hospice expenses are limited to:

1. Room and Board for confinement in a Hospice.
2. Ancillary charges furnished by the Hospice while the Covered Person is confined therein, including rental of Durable Medical Equipment which is used solely for treating an Injury or Illness.
3. 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.
4. Physician services and/or nursing care by a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or a Licensed Vocational Nurse (L.V.N.).
5. Home health aide services.
6. Charges for 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 a Registered Nurse, a Licensed Practical Nurse, a Licensed Vocational Nurse or a home health aide.
7. Medical social services by licensed or trained social workers, psychologists or counselors.
8. Nutrition services provided by a licensed Dietitian.
9. Bereavement counseling not to exceed a period of six (6) months following the death of a Covered Person for members of such person's immediate Family. Bereavement counseling is not subject to the Hospice Maximum.

Hospital. The Hospital charges for:

1. The actual Room and Board expenses incurred for a Semi-Private room or 100% of the most common Private room rate for a Hospital that does not have Semi-Private accommodations.
2. The actual expense incurred for confinement in an Intensive Care Unit, a Cardiac Care Unit or Burn Unit.
3. Miscellaneous Hospital services and supplies during Hospital confinement.
4. Inpatient Charges for nursery Room and Board.
5. Outpatient Hospital services and supplies and Emergency Room treatment.

Immunizations. The charges for complications incurred as a result of immunizations.

Injectable Contraceptive Serum. The charges for injectable contraceptive serum administered in a Physician's office.

Jobst Elastic Stockings. The charges for Jobst elastic stockings when ordered by a Physician, limited to three (3) pairs per Calendar Year.

Maternity Care. The charges for Maternity care, on the same basis as any Illness covered under this Plan, for Covered Employees and covered Dependent spouses only. Other Dependents are not eligible for benefits under this provision. Plan coverage for a Hospital stay in connection with childbirth for both the mother and the newborn Child will be no less than: forty-eight (48) hours following a normal vaginal delivery, or ninety-six (96) hours following a cesarean section, unless a shorter stay is agreed to by both the mother and her attending Physician.

Medical Services in Mexico. The charges for medical services incurred in Mexico provided that:

1. Treatment and services are Medically Necessary and recognized as usual treatment for that condition;
2. Medical expenses are considered Reasonable and Usual and Customary based on the nearest U.S. geographic location to point of service;

3. Procedures are approved by the AMA;
4. All usual Plan provisions, Annual, Calendar Year and Lifetime Maximum Benefits, exclusions and limitations apply;
5. Expenses must be filed in U. S. dollar amounts;
6. Services must be translated into English; and
7. Benefits may not be assigned to a provider.

Medical Supplies. The charges for dressings, sutures, casts, splints, trusses, crutches, braces (except dental braces), corrective shoes and other necessary medical supplies.

Mental and Nervous Disorders. The charges for treatment of Mental and Nervous Disorders payable as specified in the Schedule of Benefits. Benefits for Mental and Nervous Disorders are subject to the provisions of the Mental Health Parity Act and any related amendments.

Midwife. The charges for the services of a Certified Nurse Midwife.

Multiple Surgical Procedures. When two (2) or more Surgical Procedures are performed during the same operation, the Covered Expenses for all charges are as follows:

1. When multiple or bilateral Surgical Procedures that increase the time and amount of patient care are performed, the Covered Expense is the allowable fee for the major procedure plus 50% of the allowable fee for each of the lesser ones or the actual fee charged, whichever is less. This provision will not apply to those procedures that are not subject to the Multiple Procedures Reduction Rules per Medicare.
2. When an incidental procedure is performed through the same incision, the Covered Expense is the fee for the major Surgical Procedure only. Examples of incidental procedures are: excision of a scar, appendectomy, lysis of adhesions, etc.

Nerve Stimulators. The charges for nerve stimulators and TENS units.

Occupational Therapy. The charges for Occupational Therapy for treatment rendered by a licensed Occupational Therapist under supervision of a Physician at a Facility whose primary purpose is to provide medical care for an Injury or Illness.

Organ, Tissue and Bone Marrow Transplant. The charges for services and supplies in connection with non-experimental human Organ, Tissue and Bone Marrow Transplant procedures subject to special conditions and provisions and subject to the Maximum Benefits specified in the Organ Transplant Program. See the Organ Transplant Program section for information regarding benefits and participation requirements for organ transplants, organ donors and travel and lodging.

Oxygen. The charges for oxygen and other gases and their administration.

Pain Management. The charges for Pain Management subject to the Maximums specified in the Schedule of Benefits.

Phenylketonuria. The charges for formulas necessary for the treatment of phenylketonuria or other heritable diseases. The benefits will be paid on the same basis that benefits would be paid for drugs ordered by a Physician. Phenylketonuria means an inherited condition that may cause severe mental retardation if not treated.

Physical Therapy. The charges for Physical Therapy for the treatment or services rendered by a licensed Physical Therapist under direct supervision of a Physician at a Facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

Physician. The charges for the services of a legally qualified Physician for medical care and/or surgical treatment including office visits, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care and second/third opinion consultations.

Prosthetics. The charges for Prosthetics including artificial limbs and eyes to replace natural limbs and eyes and other necessary prosthetic devices, but not the replacement thereof, unless the replacement is necessary because of physiological changes.

Psychological Testing and Group Therapy. The charges for psychological testing and group therapy payable as specified in the Schedule of Benefits.

Radiation Therapy, Chemotherapy, Infusion Therapy and Dialysis. The charges for Radiation Therapy, Chemotherapy, Infusion Therapy and Dialysis. Dialysis charges may be subject to Medicare rules and reimbursement rates.

Reduction Mammoplasty. The charges for a reduction mammoplasty, if Medically Necessary.

Rehabilitation Facility. The charges incurred for confinement in a Rehabilitation Facility.

Routine Newborn Care. The charges for Routine Newborn Care for a well newborn Child for nursery Room and Board and routine Inpatient services required for the healthy newborn following birth. Covered Expenses will also include charges for pediatric services, newborn hearing exams and circumcision. Subject to the Maximum number of covered days specified in the Schedule of Benefits, benefits will be payable from the date of birth until the date the Child is discharged, provided the baby is added to the Plan as a Dependent within thirty-one (31) days after the Child's date of birth unless Dependent coverage is in force. Covered Charges are subject to a separate Calendar Year Deductible and considered an expense of the Child.

Sales Tax. The applicable sales tax for covered services and supplies.

Second or Third Surgical Opinion. The charges incurred for a second or third surgical opinion when Surgery or other non-surgical treatment has been recommended, payable as specified in the Schedule of Benefits.

Skilled Nursing Facility/Extended Care Facility. The charges incurred for confinement in a Skilled Nursing Facility/Extended Care Facility subject to the Maximum and the Benefit Percentage specified in the Schedule of Benefits; however, such expenses are limited as follows:

1. The attending Physician certifies that confinement is Medically Necessary. Only charges incurred in connection with care related to the Injury or Illness for which the Covered Person was confined will be eligible.
2. Semi-Private daily Room and Board limit.

Sleep Disorders. The charges for the treatment of Sleep Disorders to include sleep studies/diagnostic testing, Surgery, facility, devices and equipment subject to the Maximum payable as specified in the Schedule of Benefits.

Smoking/Tobacco Use Cessation. The charges for Smoking/Tobacco Use Cessation subject to the Maximums specified in the Schedule of Benefits.

Speech Language Pathologist/Speech Therapy. The charges of a legally qualified Speech Language Pathologist under direct supervision of a Physician for restorative Speech Therapy for speech loss or speech impairment due to an Illness, Injury or Congenital Anomaly or due to surgery performed because of an Illness or Injury, other than a functional nervous disorder (i.e., stuttering, repetitive speech).

Sterilization. The charges for services for voluntary Sterilization for Covered Employees and Covered Dependent spouses.

Surgical Lens Implants. The charges for surgical lens implants for cataracts and other diseases of the eye.

Surgical Procedure. The charges incurred for a Medically Necessary Surgical Procedure.

Total Parenteral Nutrition (TPN). The charges for hyperalimentation or total parenteral nutrition (TPN) for persons recovering from or preparing for surgery.

MAJOR MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

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

Adoption. Charges for adoption fees, completion of form fees, missed appointment fees or late fees.

Alternate Therapies. Charges for acupuncture, hypnotherapy, behavior training, biofeedback and similar programs.

Blood Procurement. Charges incurred for procurement and storage of one's own blood except for procurement and storage of one's own blood if obtained within three (3) months prior to a scheduled surgery.

Botox injections. Charges for Botox injections unless Medically Necessary for the following diagnoses: achalasia, hemifacial spasm (once brain tumor is ruled out), neurogenic incontinence secondary to spinal cord Injury when other treatments have failed, blepharospasm, spasmodic torticollis or cervical dystonia, or strabismus (patient specific).

Chiropractic Services. Charges for Chiropractic Services in excess of the Maximum as specified in the Schedule of Benefits and maintenance therapy in accordance with the Utilization Review Company's criteria for maintenance care.

Claim Filing Deadline. Charges for a Claim received after twelve (12) months from the date the service was rendered.

Consultations Online/Telephone. Charges for telephone or online consultations with a Physician and/or other providers.

Continuous Passive Motion. Charges for purchase or rental of Continuous Passive Motion (CPM) equipment, unless used for post surgical rehabilitation.

Contraception. Charges for any form of contraception that does not require the services of a Physician or a prescription.

Cosmetic. Charges incurred in connection with the care or treatment of, or operations which are performed for, Cosmetic purposes of any kind, including treatment or Surgery for complications or correction of Cosmetic Surgery or treatment, *except* for Cosmetic Surgery procedures listed as covered in Major Medical Expense Benefits.

Counseling. Charges for marriage counseling and Family counseling.

Custodial Care. Charges for Custodial Care and maintenance care. Unless specifically mentioned otherwise, the Plan does not provide benefits for services and supplies intended primarily to maintain a level of physical or mental function.

Deductible/Coinsurance. Any portion of the billed charges for services or supplies which the provider offers to waive, such as the portion which would not be paid by the Plan due to Deductible or Coinsurance provisions.

Dental. Charges incurred for treatment on or to teeth, the nerves or roots of the teeth, the gingival tissue or alveolar processes; however, benefits will be payable for covered Oral Surgical Procedures and treatment required because of Accidental Injury to sound natural teeth. This exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture or bridgework. Injury to teeth from chewing or biting is not considered an Accidental Injury.

Durable Medical Equipment. Charges for repair, adjustment or replacement of rented Durable Medical Equipment or components.

Education. Charges for education or training of any type including those for learning disabilities, except diabetic self-management medical training for diagnosed cases of diabetes.

Elective Abortion. Charges for services or supplies rendered to any Covered Employee or Dependent in connection with the voluntary interruption of a Pregnancy, unless the voluntary interruption of Pregnancy is Medically Necessary and the life of the Covered Person would be endangered if the fetus were carried to term, or if Pregnancy was the result of a criminal act such as rape or incest, or if a fetal or chromosomal abnormality existed which was diagnosed prior to the abortion. Benefits for treatment of complications arising from, or as the result of, any voluntary interruption of Pregnancy will be payable on the same basis as an Illness.

Excess. Charges that exceed the Maximum Allowable Charge, are not payable under the Plan due to application of any Plan maximum or limit or because the charges are not Reasonable and/or are in excess of the Usual and Customary amount, that exceed applicable Permitted Payment Levels, or are otherwise determined to be Invalid Charges, or are for services not deemed to be Medically Necessary, based upon the Plan Administrator's and/or Claims Delegate's determination as set forth by and within the terms of this document.

Experimental. Charges for research studies and Experimental medical procedures, treatment, drugs, devices and related services considered to be Experimental/Investigational in nature as defined in the Plan Definitions. The Claims Administrator retains the right to have such medical expenses reviewed by an independent panel of peer reviewers to determine whether such expenses are considered accepted, standard medical treatment or are Experimental/Investigational.

Experimental Transplants. Charges related to or in connection with Experimental Organ, Tissue and Bone Marrow Transplants including any animal organ transplants.

Eye Surgery. Charges for any surgical procedure for the correction of a visual refractive problem including radial keratotomy, Lasik or similar surgical procedures.

Foot Care. Charges for callus or corn paring or excision, toenail trimming, any manipulative procedure for weak or fallen arches, flat or pronated foot, foot strain, orthopedic shoes (unless attached to a brace), Orthotic insoles or other devices for support of the feet, except for:

1. An open cutting operation for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions;
2. Removal of nail roots; and
3. Foot treatment required because of a metabolic or peripheral vascular disease.

Government. Charges for Hospital confinement, medical or surgical services or other treatment furnished or paid for by or on behalf of the United States, or any State, province or other political subdivision unless there is an unconditional requirement to pay such charges whether or not there is insurance.

Hearing Exams. Charges incurred in connection with routine hearing exams and charges for the purchase or fitting of hearing aids or such similar aid devices. This exclusion does not apply to Routine Newborn hearing exams, hearing screenings for Well Baby/Well Child Care and the initial purchase of a hearing aid if the loss of hearing is a result of an Illness, Accidental Injury, Congenital Anomaly or Surgical Procedure.

Illegal Acts. Charges paid for Injury or Illness incurred as a result of illegal acts involving violence or threat of violence to another person, or in which the Covered Person illegally used a firearm, explosive or other weapon likely to cause physical harm or death, whether or not the Covered Person was charged, convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Illegal in the United States. Charges for any services or supplies not considered legal in the United States.

Incurred by Other Persons. Charges for expenses actually incurred by other persons.

Infertility. Charges related to or in connection with the testing and treatment of infertility to include fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination or in-vitro fertilization or other similar procedures.

I.Q. testing. Charges for I.Q. testing.

Massage. Charges for massage therapy unless services are provided under a Physical Therapy Treatment Plan.

Medicare. Charges for benefits that are provided, or which would have been provided had the Participant enrolled in, 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.”

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

Newborns of Dependents. Charges related to or in connection with newborns of Dependent children, unless the newborn Child meets the definition of an Eligible Dependent.

Not Acceptable. Charges that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Attending Physician. Charges for treatment, services or supplies that are not certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or Disease, and performed by an appropriate Practitioner.

Not Connected with Active Illness. Charges for hospitalization primarily for X-rays, laboratory tests, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active Illness or Injury.

Not Legally Obligated to Pay. Charges incurred for which the Covered Person, in the absence of this coverage, is not legally obligated to pay, or for which a charge would not ordinarily be made in the absence of this coverage.

Not Medically Necessary. Charges incurred in connection with services and supplies which are not Medically Necessary for treatment of an active Illness or Injury unless listed as Covered Wellness Procedures in the Preventive and Wellness section of the Schedule of Benefits.

Not Specifically Covered. Charges that are not specifically covered under this Plan.

Nutritional Supplements. Charges for nutritional supplements and related supplies, whether or not prescribed by a Physician. The Plan will consider charges for nutritional supplements, feeding tubes and related supplies only if a Covered Person is unable to get nutrition by any other means.

Obesity. Charges for the treatment of obesity or Morbid Obesity and charges related to weight control, except for covered Bariatric Procedures as specified in the Major Medical Expense Benefits in excess of the Maximum specified in the Schedule of Benefits.

Occupational. Charges arising out of or in the course of any occupation for wage or profit, whether or not the Covered Person is entitled to benefits under any Workers' Compensation or Occupational Disease Law, or any such similar law.

Organ Donor Expenses. Charges related to or in connection with Organ Donor expenses in excess of the Maximum Donor Benefit as specified in the Organ Transplant Program.

Organ, Tissue and Bone Marrow Transplants. Charges related to or in connection with Organ, Tissue and Bone Marrow Transplants in excess of the Maximums specified unless the Transplant is performed at a facility participating in the Organ Transplant Program.

Personal Convenience. Charges incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or charges in connection with Custodial Care or expenses actually incurred by other persons.

Portable Uterine Monitors. Charges for portable uterine monitors unless approved by the Utilization Review Company and/or Case Management.

Pre-existing Conditions. Charges subject to the Pre-existing Condition Exclusion Limitation of the Plan; except charges for Prescription Drugs covered under the Prescription Drug Plan are not subject to the Pre-existing Condition Exclusion Limitation. The Pre-existing Condition Exclusion limitation does not apply to any Plan Participant that has not yet reached age nineteen (19). For a complete list of Pre-existing Condition exceptions, refer to the Pre-existing Condition Exclusion Limitation section.

Pregnancy of Dependents. Pregnancy and maternity charges incurred by Dependents other than Covered Dependent Spouses including Complications of Pregnancy.

Prior to Coverage. Charges for services that are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein.

Prior to Effective Date. Charges incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

Private Duty Nursing. Charges for Private Duty Nursing.

Provider Error. Charges for services required as a result of unreasonable provider error.

Relative. Charges for treatment, services and supplies provided by a Close Relative of the Covered Person, as defined in this Plan.

Residential Treatment. Charges for services rendered by or in connection with a Residential Treatment Center.

Riot/Civil Insurrection. Charges resulting from or sustained as a result of participation in a riot or civil insurrection.

Routine Eye Care. Charges incurred in connection with routine vision exams or eye refractions, and the purchase or fitting of eyeglasses and contact lenses. This exclusion/limitation shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.

Self-inflicted. Charges incurred in connection with any self-inflicted Injury or Illness unless the Injury or Illness is a result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

Services Not Rendered by Physician. Charges for Physicians' fees for any treatment which is not rendered by or provided under the supervision of a Physician.

Sex Change. Charges related to or in connection with sex change procedures and charges for sexual dysfunctions or inadequacies that do not have a physiological or organic basis.

Smoking/Tobacco Use Cessation. Charges for smoking/tobacco use cessation in excess of the Maximum specified in the Schedule of Benefits.

Speech Therapy. Charges for Speech Therapy to correct pre-speech deficiencies or therapy to improve speech skills not fully developed unless related to an Illness or Injury.

Sterilization Reversal. Charges resulting from or in connection with the reversal of a sterilization procedure.

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

Surrogate. Charges for adoption or surrogate fees, completion of form fees, missed appointment fees or late fees.

Temporomandibular Joint Dysfunction (TMJ) Syndrome. Charges for medical, dental and orthodontic services related to Temporomandibular Joint (TMJ) Syndrome, disorders of mastication, malocclusion of teeth, misalignment of mandible and maxilla and jaw pain to include services, supplies and splints unless treatment is a result of an Accidental Injury.

Travel. Charges related to or in connection with travel and lodging expenses associated with an Organ Transplant in excess of the Maximum specified in the Organ Transplant Program.

Travel Outside the United States. Charges incurred as the result of travel outside the United States or its territories or Mexico specifically to receive medical treatment.

War. Charges incurred as a result of war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

Weight Loss. Charges for weight loss programs even when recommended by a Physician.

Wigs. Charges for treatment of hair loss including wigs, hairpieces and hair transplants.

COORDINATION OF BENEFITS

The Coordination of Benefits provision is intended to prevent the payment of benefits which exceed Covered Expenses. It applies when the Plan Participant is also covered by another plan or plans. When more than one coverage exists, one plan (primary plan) normally pays its benefits in full and the other plans (secondary plans) pay a reduced benefit. This Plan may pay either its benefits in full or at a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed the benefits payable under this Plan had this Plan been primary. Only the amount paid by this Plan will be charged against the Plan Maximums.

The Coordination of Benefits provision applies whether or not a Claim is filed under the other plan or plans. If needed, authorization must be given to this Plan to obtain information as to benefits or services available from the other plan or plans, or to recover overpayments.

All benefits contained in the Plan Document are subject to this provision.

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.

For purposes of this Coordination of Benefits provision, the term "plan" as used herein will mean any plan providing benefits or services for medical or dental treatment, and such benefits or services are provided by:

1. Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:
    a. Hospital indemnity benefits; and
    b. Hospital reimbursement-type plans which permit the Covered Person to elect indemnity at the time of Claims;
2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;
3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;
4. A Licensed Health Maintenance Organization (HMO);
5. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a governmental program, and any coverage required or provided by any statute;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or
9. Any individual automobile insurance, including no-fault automobile insurance on an individual basis.

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

"Allowable Expense" is the Usual and Customary charge within Permitted Payment Levels for any Medically Necessary, Reasonable, eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, 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.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is

primary and the Covered Person does not use an HMO provider, this Plan will not consider as Allowable Expenses any charges that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

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

COORDINATION PROCEDURES

Notwithstanding the other provisions of this Plan, benefits that would be payable under this Plan will be reduced so that the sum of benefits payable under this Plan and all benefits payable under all other plans will not exceed the amount payable under this Plan had this Plan been primary during any Claim Determination Period with respect to Covered Persons eligible for:

1. Benefits, either as an insured person or employee or as a dependent, under any other plan which has no provision similar in effect to this provision.

2. Dependents' benefits under this Plan who are also eligible for benefits:

    a. As an insured person or employee under any other plan; or
    b. As a dependent Child of an insured person or employee covered under any other plan.

3. A Covered Person under this Plan who is also eligible for benefits as an insured person or employee under any other plan and has been covered continuously for a longer period of time under such other plan.

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

ORDER OF BENEFIT DETERMINATION

Each plan makes its Claim payment according to where it falls in this order, if Medicare is not involved:

1. If a plan contains no provision for Coordination of Benefits, then it pays primary before all other plans.

2. The plan which covers the Covered Person as an employee (or named insured) pays primary as though no other plan existed; remaining recognized charges are paid under a secondary plan which covers the Claimant as a Dependent.

3. If the Covered Person is a Dependent Child:

    a. Whichever parent has a birthday anniversary which occurs earlier in the Calendar Year shall be considered to have the primary plan;
    b. If birthday anniversaries are the same, then the plan of the parent who has been covered under his/her plan for the longer period of time will be primary; and
    c. If the plan with which this Plan is to be coordinated does not include the requirements shown above, then the plan without such requirements will be primary.

4. If the Covered Person is a Dependent Child and the parents are divorced, then:

a. The plan of the parent with custody pays first, unless a court order or decree specifies the other parent to have financial responsibility, in which case that parent's plan would pay first; or
b. The plan of a step-parent with whom the Child lives pays second (if applicable).

5. If the order set out in 1, 2, 3 or 4 above does not apply in a particular case, then the plan which has covered the Covered Person for the longest period of time will pay first.

FACILITY OF PAYMENT

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

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

RIGHT OF RECOVERY

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

COORDINATION WITH DENTAL PLAN

In the event of duplicate coverage under the Co-op's Medical Plan and Dental Plan, the Medical Plan is Primary and pays first.

COORDINATION WITH MEDICARE

Notwithstanding all other provisions of this Plan, Covered Persons who are eligible for Medicare benefits may be entitled to benefits under this Plan which will be coordinated with Medicare in accordance with the Coordination of Benefits provision of this Plan and subject to the rules and regulations as specified by the Tax Equity and Fiscal Responsibility Act of 1982 as they may be amended from time to time. This Plan is primary to Medicare coverage for all active Employees and Dependents (regardless of age) unless Medicare states otherwise for certain medical conditions. In the event that this Plan is secondary to Medicare, benefits payable under this Plan will be reduced by benefits that would be payable for the same services under Medicare Parts A and B whether or not the Covered Person is enrolled in Medicare Parts A and B.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

The Plan's liability for expenses arising out of an automobile accident is based on the type of automobile insurance law enacted by the Covered Person's State. Nationally, there are three types of State automobile insurance laws:

1. No-fault automobile insurance laws;

2. Financial responsibility laws; or
3. Other automobile liability insurance laws.

COORDINATION WITH AUTO NO-FAULT COVERAGE

Except as required by law, the Plan is secondary to any no-fault automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault automobile insurance policy nor does it intend to be primary in order to reduce the premiums or cost of no-fault automobile coverage.

If the Covered Person or his/her Covered Dependent incur Covered Charges as a result of an automobile accident (either as driver, passenger or pedestrian), the amount of Covered Charges that the Plan will pay is limited to:

1. Any Deductible under the automobile coverage;
2. Any Copayment under the automobile coverage;
3. Any expense properly excluded by the automobile coverage that is a Covered Charge; and
4. Any expense that the Plan is required to pay by law.

An individual is considered to be covered under an automobile insurance policy if he/she is either:

1. An owner or principal named insured of the policy;
2. A Family member of a person insured under the policy; or
3. A person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

COORDINATION WITH FINANCIAL RESPONSIBILITY LAW

The Plan is secondary to automobile coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile accident.

If the Covered Person's State has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile accident for the Covered Person or their Dependents.

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If the Covered Person's State does not have a no-fault automobile insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile accident.

COORDINATION WITH UNDERINSURED/UNINSURED MOTORIST COVERAGE

If the Covered Person is involved in an automobile accident and, as a result of the accident, the Plan pays benefits, and if the Covered Person receives a settlement from their underinsured or uninsured motorist policy, the Plan is entitled to receive, from the proceeds of the settlement with the underinsured or uninsured motorist coverage, the expenses of the Plan. The Plan is not entitled to receive any recovery that is in excess of its expenses. The Plan agrees to payment of benefits prior to the receipt by the Covered Person of any recovery from their underinsured or uninsured motorist policy. The Covered Person agrees to notify the Plan of the existence of a recovery from an underinsured or uninsured motorist policy and further agrees to remit to the Plan the proceeds of any recovery received from an underinsured or uninsured motorist policy up to the expenditures made by the Plan. Any expenses by the Plan which are in excess of the proceeds received by the underinsured/uninsured motorist policy will be the responsibility of the Plan pursuant to the terms and conditions of the Plan.

SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

1. 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 hereafter 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 grantor(s) of a third party (collectively “Coverage”).

2. A Covered Person(s), his/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 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 his/her attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

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

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

SUBROGATION

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

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

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

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

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

   then 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 cooperate fully with the Plan in the prosecution of any such Claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a Claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

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

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

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

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

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable 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 Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

1. the responsible party, its insurer, or any other source on behalf of that party;
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.

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 CLAIMS

In the event that the Covered Person(s) dies as a result of his/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.

OBLIGATIONS

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

    a. cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. provide the Plan with pertinent information regarding the sickness, Disease, disability or Injury, including accident reports, settlement information and any other requested additional information;
    c. take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
    f. 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.

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

3. The Plan's right to reimbursement and/or subrogation is 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/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/her obligation.

MINOR STATUS

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

LANGUAGE INTERPRETATION

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

SEVERABILITY

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

CLAIM REVIEW AND VALIDATION PROGRAM

Pursuant to and in accordance with the specific authority granted by the Plan Sponsor to the Claims Delegate, the Plan has arranged for the Delegate to establish, implement and oversee an ongoing program of Claim Review and validation for all Hospital and Facility Claims, and other Claims that may be specifically identified and referred to the Delegate by the Plan Administrator and/or Claims Administrator ("Referred Claims"), in order to identify charges and fees that are not Reasonable, were billed in error, exceed Usual and Customary amounts or were billed for services which were not Medically Necessary and/or appropriate. This program may include both Billing Review and Medical Record Review (the "Review Program"). Benefits for Claims will be reduced for any charges that are determined under this Review Program to be in excess of "Permitted Payment Levels" (as defined below). The determination of Permitted Payment Levels under this Review Program will supersede any other Plan provisions related to application of a Reasonableness and/or Usual and Customary fee determination.

Medical care Providers will be given a fully detailed explanation of any charges that are found to be in excess of Permitted Payment Levels. Assignment of Benefits will remain in force, will constitute consideration in full for services rendered, and in exchange for the Provider's agreement not to bill the Plan Participant for charges which were not covered as a result of the Review Program, will be allowed the rights and privileges to file an appeal of the determination in accordance with the same rights and privileges accorded to Plan Participants.

Any Plan Participant who continues to receive billings from the medical care provider for charges which were not covered as a result of the Review Program should contact the Claims Delegate right away for assistance. The Claims Delegate may be contacted at:

TrueFACS, LLC
5300 Broken Sound Blvd., NW
Suite 200
Boca Raton, FL 33487
Phone: 888-657-2558
Fax: 561-491-6564

A Plan Participant who is unable to contact the Claims Delegate after making reasonable attempts to do so should contact the Plan Administrator. The Plan Administrator is identified in the General Information section of this Summary Plan Description.

The Plan Participant must pay for any normal cost-sharing features of the Plan, such as Deductibles, Coinsurance and Copayments, and any amounts otherwise excluded or limited according to the terms of the Plan, except for Invalid Charges.

The success of this Review Program will be achieved through a comprehensive review of detailed records including, for example, itemized statements of charges and descriptions of the services and supplies provided. Without this detailed information, the Plan will be unable to make a determination of the amount of Covered Medical Expenses that may be eligible for reimbursement. Any additional information required

for the Claim Review will be requested directly from the provider of service and the Claimant. In the event that the Claims Delegate does not receive information adequate for the Review Program within the time limits required, it will be necessary to deny the Claim. Should such a denial be necessary, the Claimant and/or the provider of service may appeal the denial in accordance with the provisions which may be found in the "Procedures for Claims and Appeals" section of this Summary Plan Description.

"Permitted Payment Level(s)" means the charges for services and supplies listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that the fees charged therefore are within applicable limits established in this Plan, which limits include, but are not limited to, the following:

1. Hospitals and Affiliated Facilities. The Permitted Payment Level for charges by Hospitals and Affiliated Facilities (collectively, "Hospital Facilities") shall be based upon the greater of Medicare allowable reimbursement plus 20% or AP-DRG reimbursement plus 20% for the services in the geographic region, or 120% of the Hospital's costs reflected in the Hospital's most recent departmental cost ratio report to the Centers for Medicare and Medicaid Services ("CMS") and as published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio").

2. Ambulatory Health Care Centers and Other Independent Facilities. The Permitted Payment Level for ambulatory health care centers and other Independent Facilities, including those Ambulatory Surgery Centers that are Independent Facilities (and/or for which no Medicare based reimbursement is available), may be based upon the Medicare allowed amount for comparable services in other facilities in the same geographic region, and/or the Medicare Outpatient Prospective Payment System (OPPS), plus an additional 20%.

3. Other Medical and/or Surgical Services. The Permitted Payment Level for any covered general medical and/or surgical services not covered under #1 and #2 above may be calculated based upon industry-standard resources including, but not limited to Usual and Customary rates, taking into consideration CMS Cost Ratios, Medicare allowed fees (by geographic region), Medicare OPPS allowed fees published and publicly available fee and cost lists and comparisons, any resources listed in the categories above, or any combination of such resources that results in the determination of a Reasonable expense under the Plan, in the opinion of the Claims Delegate. The Permitted Payment Level for these services will be calculated using one or more of the industry-standard resources, plus an additional 20%.

4. Facilities Lacking Requisite External Benchmarks. In the event that for technical reasons Permitted Payment Levels cannot be determined in accordance with the guidelines set forth above, the Permitted Payment Level may be determined based upon the following:

   (i) Pharmaceuticals. The Permitted Payment Level for pharmacy charges may be determined by applying the Average Acquisition Cost ("AAC") as defined by the National Average Drug Acquisition Cost (NADAC) (as determined by CMS), the Predictive Acquisition Cost (PAC) (Glass Box Analytics), or other comparable and recognized data source at the rate of 120% of AAC.

   (ii) Medical and Surgical Supplies, Implants, Devices. The Permitted Payment Level for charges for medical and surgical supplies, implants and devices may be based upon the provider supplied invoice price (cost) to the provider, plus an additional 12%, or in the absence of a provider supplied invoice other documentation such as, but not be limited to, comparable invoices, receipts, cost lists or other documentation as deemed appropriate by the Claims Delegate.

   (iii) Clinical and Other Services and Procedures. The Permitted Payment Level for charges for clinical care and services may be based upon Resource-based relative value scale (RBRVS) and rates in the same geographic plus an additional 100%.

5. Physician Medical and Surgical Care, Laboratory, X-ray and Therapy. The Permitted Payment Level for physician medical and surgical care, freestanding laboratory, x-ray and other diagnostic or therapeutic radiology services may be determined based upon the fees for comparable services in the geographic region at the ninetieth (90^{th}) percentile of the Physician Fee Reference ("PFR").

6. Unbundling. The Permitted Payment Level will not include charges for any items billed separately that are customarily included in a global billing procedure code in accordance with the American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS ("Unbundling").

7. Errors. The Permitted Payment Levels will not include charges for any Identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, charges for care, supplies, treatment, and/or services not actually rendered or performed, or charges otherwise determined to be invalid, impermissible or improper based on any applicable law, regulation, rule or professional standard ("Errors"). Industry accepted foreseeable risks of Covered Services, in the Plan Administrator's discretion, may not be deemed to be an Error. The Plan Administrator retains discretionary authority to determine whether an industry accepted foreseeable risk of a given Covered Service shall be considered an Error.

8. Misidentification and Unclear Description. In the event that the Plan, based upon a Claims Review, determines that any treatment, service or type or quantity of a drug or supply shown on a bill is not supported in the billing and medical records, and that different treatment, service or type or quantity of a drug or supply was actually provided (a "Misidentification"), then the Claims Delegate may determine the Permitted Payment Level according to the Claims Review findings. Furthermore, the Permitted Payment Levels will not include any charges for which the Claims Delegate cannot clearly identify or understand the item(s) being billed (an "Unclear Description").

9. Directly Contracted Providers. The Permitted Payment Levels for Directly Contracted Providers will be the negotiated rates as agreed under the applicable contracts.

If the Claims Delegate determines that insufficient information is available to identify the Permitted Payment Level for a specific treatment, service or supply using the above-listed guidelines, then in establishing the Permitted Payment Level, consideration will be given to fees for the most comparable treatment, service or supply, as well as comparative severity and/or geographic location. In the event that the Permitted Payment Level exceeds the actual charge billed for the treatment, service or supply in question, the Plan will not be required to cover more than the actual billed charge. Notwithstanding anything herein to the contrary, the Claims Delegate has the right, in its sole discretion, to establish Permitted Payment Levels for any particular conditions, treatments, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Person.

Additionally, in the event that a determination of a Permitted Payment Level exceeds the actual charge billed for the service or supply, the Plan will consider the lesser of the actual billed charge or the Permitted Payment Level determination.

PROCEDURES FOR CLAIMS AND APPEALS

The procedures outlined below must be followed by Claimants to obtain payment of benefits under this Plan.

NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. Claims must be filed within six (6) months from the date of service to be covered by the Plan. If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage **must** be filed within six (6) months from the date of service, or the Claims will not be covered by the Plan.

Claims must be filed sooner in certain circumstances:

- If the Plan is terminated, all Claims incurred prior to the Plan termination must be received within ninety (90) days after the termination or the Claims will not be covered.

Any Claims incurred after termination of Plan coverage for any reason are not covered under the Plan.

Customarily, there are four types of Claims: Pre-service (Urgent), Pre-service (Non-urgent), Concurrent Care, and Post-service.

- A "Pre-service Claim" is a Claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. Because the Plan does not require Claimants to obtain approval of a medical service prior to getting treatment on an urgent or non-urgent basis, there are no "Pre-service Claims." The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

- A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. Because the Plan does not require Claimants to obtain approval of medical services prior to getting treatment, there is no need to contact the Utilization Review Company to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

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

A Post-service Claim is considered to be filed when the following information is received by the Claims Administrator with a Form CMS-1500 or Form UB92 or any successor forms:

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

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Claims Delegate and/or the Plan Administrator in its sole discretion may require, written proof that the expenses were incurred, or that the benefit is covered under the Plan. This includes any substantiating documentation, Coordination of Benefits information or other information that may be required by the Plan as proof. If the Claims Delegate and/or Plan Administrator, in its sole discretion, determines that the Claimant has not incurred a Covered Expense, or that the benefit is not covered under the Plan, or if the Claimant fails to furnish such proof as is requested, no benefits shall be payable under

the Plan.,, Notwithstanding anything herein to the contrary, the Claims Delegate and/or the Plan Administrator may, on a case-by-case basis, determine that it is reasonable under the circumstances to make a decision as to whether a Claimant has incurred a Covered Expense, in spite of the absence of any particular form of written proof or item(s) of substantiating documentation.

CLAIMS DETERMINATION

The Claims Delegate and/or the Plan Administrator shall, in accordance with the provisions set forth below, notify the Claimant or cause the Claimant to be notified of any Adverse Benefit Determination within the following timeframes:

- If the Claimant has provided all of the information needed to process the Claim in a reasonable period of time, but not later than thirty (30) days after receipt of the Claim. This period may be extended by the Plan for up to fifteen (15) days, provided that the Claims Delegate and/or the Plan Administrator: (a) determines that such an extension is necessary due to matters beyond the control of the Plan, and (b) notifies the Claimant, prior to the expiration of the initial thirty (30) day processing period, of the circumstances requiring the extension of time, and the date by which the Plan expects to render a decision. If an extension has been requested, then the Claimant will be notified of any Adverse Benefit Determination prior to the end of the fifteen (15) day extension period.

- If additional information is requested from the Claimant to process the Claim during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period. If additional information is requested from the Claimant during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Claims Delegate and/or the Plan Administrator and the Claimant.

- Notice to the Claimant of a rescission of coverage will be provided at least thirty (30) days in advance of the retroactive termination of coverage by the Plan.

A Benefit Determination is required to be made within the period of time beginning when a Claim is deemed to be filed in accordance with the procedures of the Plan.

For purposes of the Plan's provisions for internal Claims and appeals and external review processes, a "Claim" for benefits is defined as a request for a plan benefit made by a Claimant in accordance with a plan's Reasonable procedure for filing benefit Claims. A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure or treatment is a covered expense before the treatment is rendered, is not a "Claim" since an actual Claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a Claim.

An "Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment for a Claim that is based on:

1. A determination of an individual's eligibility to participate in a plan or health insurance coverage;

2. A determination that a benefit is not a covered benefit;

3. The imposition of a Pre-existing Condition exclusion, source-of-injury exclusion, or other limitation on otherwise covered benefits; or

4. A determination that a benefit is Experimental, Investigational, or not Reasonable, Medically Necessary or appropriate;

5. Invalid Charges.

Although it is not a Claim for benefits, the definition of an Adverse Benefit Determination also includes a rescission of coverage under the Plan. A "rescission of coverage" is defined as a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

NOTICE OF ADVERSE BENEFIT DETERMINATION

If the initial Benefit Determination is an Adverse Benefit Determination, notification will be sent to the Claimant and will include the following information:

1. Information sufficient to identify the Claim involved, including the date of the service, the health care provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

2. The reason or reasons for the Adverse Benefit Determination or final internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the Claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision;

3. References to the Plan specific provisions on which the Adverse Benefit Determination is based;

4. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

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

7. The identity of any medical or vocational experts consulted in connection with a Claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided upon request);

8. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion, or a statement that such information was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request; and

9. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether the treatment was Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon written request.

PHYSICAL EXAMINATION

The Claims Delegate or the Plan Administrator or Claims Administrator has the right to have the Claimant examined as often as reasonably necessary while a Claim is pending. Benefits are payable under this Plan only if they are Medically Necessary for the Illness or Accidental Injury of the Covered Person. This Plan reserves the right to make a Utilization Review to determine whether services are Medically Necessary for the proper treatment of the Covered Person. All such information will be confidential.

CLAIMS REVIEW

Once a written Claim for benefits is received, in the case of Hospital and Facility Claims, the Claims Delegate shall cause such Claim to go through a Claims Review. In the case of any other Claims, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim go through the Review Program. Please refer to the section entitled "Claim Review and Validation Program" for information regarding Plan provisions related to the review and adjudication of certain Claims under the Review Program.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of a Claim, to pay directly the health care provider rendering such services. The Claimant, in accordance with the terms of this Plan, compensates Providers of healthcare services with such an Assignment of Benefits. Payment of benefits from the Plan to a health care provider pursuant to written direction of the Claimant is subject to the approval of the Claims Delegate and/or the Plan Administrator, and shall be made as consideration in full for services rendered.

Any Provider which accepts Assignment of Benefits and/or such payment of benefits from the Plan must agree, and shall for all purposes be deemed to have agreed: (i) to accept such Assignment of Benefits in accordance with this Plan, as consideration in full for the services rendered; (ii) to pursue reimbursement for Covered Medical Expenses directly from the Plan, waiving any right to recover such expenses from the Claimant; and (iii) to be bound by the rules and provisions set forth within the terms of this document. The Claimant is specifically intended to and shall be a third party beneficiary of the agreements referenced in (i), (ii) and (iii) above. Any Provider who has accepted Assignment of Benefits and/or such payment of benefits from the Plan and then pursues recovery from the Claimant, on any theory, shall be acting in violation of this Plan and shall be required to immediately refund in full any and all amounts paid to or for the benefit of such Provider by or on behalf of the Plan in connection with the Claim in question.

The Claimant, in accordance with the terms of this Plan, compensates Providers of healthcare services with an Assignment of Benefits. By accepting an Assignment of Benefits in lieu of billing the Claimant directly, the Provider waives its right to balance bill and acknowledges that the Assignment of Benefits is adequate consideration to compensate for the services rendered. Any Provider who has accepted Assignment of Benefits and/or payment of benefits from the Plan and then pursues recovery from the Claimant, on any legal or equitable theory, shall be acting in violation of this Plan and shall be required to immediately refund in full any and all amounts paid to such Provider by or on behalf of the Plan in connection with the Claim in question.

Providers should accept an Assignment of Benefits as consideration in full for services rendered, and submit claims directly to the Plan. The Plan will pay the scheduled benefit amount, less any required deductibles and copayments, and subject to any limits or exclusions, directly to the Provider. When available, benefits will be limited by the terms of the Plan, including provisions which limit benefits to Reasonable claims for the Usual and Customary amount, and if applicable may not exceed the Maximum Allowable Charge and Permitted Payment Level.

If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

The Plan provides for two (2) levels of appeal following an Adverse Benefit Determination. The Claimant has one hundred eighty (180) days following an initial Adverse Benefit Determination to file an appeal of that determination, and sixty (60) days following a second Adverse Benefit Determination to file an appeal of that determination. The appeal process will provide the Claimant with a reasonable opportunity for a full and fair review of the Claim and Adverse Benefit Determination and will include the following:

1. Receipt of written request by the Claims Administrator from the Claimant, or an Authorized Representative of the Claimant, with the proper form for review of Adverse Benefit Determination, which initiates the appeal process.

2. The Claimant will have the opportunity to submit written comments, documents, records, and other information relating to the Claim.

3. The Claimant will have the opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process.

4. The Claimant will be provided, free of charge and sufficiently in advance of the date that the notice of final internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

5. The Claimant will be provided, on request and free of charge: (a) reasonable access to, and copies of all documents, records, and other information relevant to the Claimant's Claim in possession of the Plan Administrator, the Claims Delegate or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information regarding any voluntary appeals procedures offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

6. The review of the Adverse Benefit Determination will take into account all comments, documents, records and other information submitted by the Claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial Benefit Determination.

7. No deference will be afforded to the previous Adverse Benefit Determination.

8. The party reviewing the appeal may be neither the party who made the prior Adverse Benefit Determination, nor a subordinate of the party who made the prior Adverse Benefit Determination.

9. In deciding an appeal on which the Adverse Benefit Determination was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Claims Administrator, the Claims Delegate or the Plan Administrator, as appropriate depending on the level of appeal, will consult with a health care professional who has appropriate training and experience in the field of medicine involving the medical judgment. The health care professional consulted for the appeal will not be the health care professional or a subordinate of the health care professional consulted in connection with the Adverse Benefit Determination that is the subject of the appeal.

10. Medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Benefit Determination will be identified, even if the Plan did not rely upon their advice.

11. The first level of appeal will be the responsibility of the Claims Administrator and will be decided within thirty (30) days of the Claims Administrator's receipt of the request. The second level of appeal will be the responsibility of the Claims Delegate and will be decided within thirty (30) days of the Plan's receipt of the request.

For questions about appeal rights or for assistance, claimants can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272). Consumer assistance may be available in your State. Contact your State Department of Insurance to find out if consumer assistance for claim appeals is available. Texas Department of Insurance can be contacted at 855-839-2427 (855-TEX-CHAP). See Appendix I for additional information.

The Plan Sponsor has allocated, delegated and granted to the Claims Delegate primary responsibility and authority for all second level appeals of benefits determinations for Hospital and Facility Claims, as specifically set forth in the Review and Appeals Provisions of the Plan.

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal, in writing, within one-hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination.

The Claimant's second level appeal of an Adverse Benefit Determination on any Hospital and Facility Claim must be addressed as follows:

Appeals Department
TrueFACS, LLC
5300 Broken Sound Blvd., NW
Suite 200
Boca Raton, FL 33487
Phone: 888-657-2558
Fax: 561-491-6564

The Claimant's first level appeal of an Adverse Benefit Determination on any Hospital and Facility Claim and any appeal of an Adverse Benefit Determination on any Claim other than a Hospital and Facility Claim must be addressed as follows:

Appeals Department
Maxor Administrative Services
320 S. Polk St.
Suite 900
Amarillo, TX 79101
Phone: 806-322-5920
Fax: 806-324-5590

It shall be the responsibility of the Claimant to submit proof that the Claim is covered and payable under the provisions of the Plan. An appeal must include:

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

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

Timing of Notification of Benefit Determination on First Appeal
The Plan shall notify the Claimant of the Plan's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Notice of Benefit Determination on First Appeal
The Claimant will be notified of the Benefit Determination on appeal. If there is an Adverse Benefit Determination on appeal, the notification will include the following information:

1. The reason or reasons for the Adverse Benefit Determination;

2. References to the Plan provisions on which the Adverse Benefit Determination is based;

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;

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

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an Adverse Benefit Determination on final review;

6. A description of voluntary appeal procedures offered by the Plan and, upon the Claimant's request, any additional information about the voluntary appeal procedures;

7. If an internal rule, guideline, protocol, or other similar criterion was relied on in making the Adverse Benefit Determination, either the specific rule, guideline, protocol or other similar criterion or a statement that such was relied on in making the Adverse Benefit Determination, and that a copy of the rule, guideline, protocol or other criterion will be provided free of charge on request;

8. If the Adverse Benefit Determination is based on a medical judgment (such as Medical Necessity or whether or not treatment is Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge on request;

9. The identity of any medical or vocational experts consulted in connection with the Claim, even if the Plan did not rely upon their advice; and

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your State Insurance Regulatory Agency."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on review, the Claims Administrator and/or the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

SECOND APPEAL LEVEL

Adverse Decision on First Appeal; Requirements for Second Appeal
Upon receipt of notice of the Plan's Adverse Benefit Determination regarding the first appeal, the Claimant has sixty (60) days to file a second appeal of the denial of benefits. The Claimant again is entitled to a "full and fair review" of any denial made at the first appeal, which means the Claimant has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the Claimant's second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal."

Timing of Notification of Benefit Determination on Second Appeal
The Plan shall notify the Claimant of the Claims Delegate's Benefit Determination on review within a reasonable period of time, but not later than thirty (30) days after receipt of the second appeal.

The period of time within which the Plan's determination is required to be made shall begin at the time the second appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim

and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination
In the case of an Adverse Benefit Determination on the second appeal, the Claims Delegate and/or the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in the section relating to the Notice of Benefit Determination on First Appeal, as appropriate.

Decision on Second Appeal to be Final
If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision will be final, binding and conclusive, and will be afforded the maximum deference permitted by law. All Claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within three (3) years after the Plan's Claim review procedures have been exhausted. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within three (3) years after the date of service.

Appointment of Authorized Representative
A Claimant is permitted to appoint an Authorized Representative to act on his behalf with respect to a benefit Claim or appeal of an Adverse Benefit Determination; provided, however, that an Assignment of Benefits by a Claimant to a provider will not constitute appointment of that provider as an Authorized Representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Claims Delegate or the Plan Administrator or the Claims Administrator. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Claimant, unless the Claimant directs the Claims Delegate or the Plan Administrator to the contrary, in writing.

PROVIDER OF SERVICE APPEAL RIGHTS

As noted above, while a Claimant may appoint the provider of service as the Authorized Representative with full authority to act on his or her behalf in the appeal of a denied Claim, an Assignment of Benefits by a Claimant to a provider of service will not constitute appointment of that provider as an Authorized Representative. However, in an effort to facilitate a full and fair review of the denied Claim, the Plan will consider an appeal received from the provider as a Claimant's appeal, and will respond to the provider (and the Claimant) with the results of the review accordingly. Any such appeal must be made within the time limits and under the conditions for filing an appeal specified under the section, "Appeal Process," above. Any Provider which accepts Assignment of Benefits, in accordance with this Plan, has agreed to accept and is deemed for all purposes to have accepted such Assignment of Benefits as consideration in full for services rendered, and has agreed to and shall be bound by the rules and provisions set forth within the terms of this document. Similarly, **Providers filing an appeal of an Adverse Benefit Determination under the Plan, other than as a formally appointed Authorized Representative, must agree, and by filing an appeal shall be deemed to agree (i) to pursue reimbursement for Covered Medical Expenses directly from the Plan, further waiving any right to recover such expenses from the Claimant, and (ii) to comply with the conditions of the section "Requirements for First Appeal" above. The Claimant is specifically intended to be and shall be a third party beneficiary of the agreements referenced in (i) and (ii) above.** Any Provider filing an appeal of an Adverse Benefit Determination under the Plan that then pursues recovery from the Claimant, on any legal or equitable theory, shall be acting in violation of this Plan and shall be required to immediately refund in full any and all amounts paid to or for the benefit of such Provider by or on behalf of the Plan in connection with the Claim in question.

For purposes of this section, the Provider's waiver to pursue Covered Medical Expenses does not include the following amounts, which will remain the responsibility of the Claimant:

- Deductibles;
- Copayments;
- Coinsurance;
- Penalties for failure to comply with the terms of the Plan; and

- Charges for services and supplies which are not included for coverage under the Plan. **Note: This does not apply to amounts found to be in excess of Permitted Payment Levels, as defined in the section, "Claim Review and Validation Program."** The Claimant will not be held responsible for any amounts found to be in excess of Permitted Payment Levels.

Also, for purposes of this section, if a Provider indicates on a Form UB92 or on a Form CMS-1500 (or similar Claim form) that the Provider has an Assignment of Benefits, then the Plan will require no further evidence that benefits are legally assigned to that Provider.

Contact the Claims Administrator, the Claims Delegate or the Plan Administrator for additional information regarding provider of service appeals.

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS

When the internal appeals procedures have been exhausted, the Claimant may elect to have an additional and final opportunity for a review of an Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by an independent review organization (IRO). The IRO will be accredited by URAC or a similar nationally recognized accrediting organization for the purpose of conducting an independent and unbiased review.

The request for an external review must be filed by the Claimant within four (4) months following the Claimant's receipt of the notice of Adverse Benefit Determination or final internal Adverse Benefit Determination. However, if the Plan fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a Claim, the Claimant will be deemed to have exhausted the internal claims and appeals process, and the Claimant may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The Plan's external review process applies to any Adverse Benefit Determination or final internal Adverse Benefit Determination on appeal, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary failed to meet the requirements for eligibility under the terms of the Plan is not eligible for the external review process.

There are two (2) types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the Claimant received emergency services but has not yet been discharged from the Facility. In such cases, the Plan will consider the external review to be an expedited review.

EXPEDITED EXTERNAL REVIEW FOR URGENT OR EMERGENCY CARE

This Plan does <u>not</u> require a Claimant to obtain prior approval for pre-service urgent care Claims or emergency care services before getting treatment; therefore, neither the internal appeals nor the external review procedures will apply to these Claims. In an emergency or urgent care situation, the Claimant should follow instructions from his/her health care provider, and file the Claim as a post-service Claim. If the post-service Claim results in an Adverse Benefit Determination, the Claimant may file an appeal in accordance with the Plan's provisions for "Appeal Process," which are explained above.

Appeals of Claims involving concurrent care will be subject to the Plan's provisions for expedited external review, as explained below.

PROCEDURES FOR INITIATION OF AN EXTERNAL REVIEW

Standard External Review

A request for an external review must include the same information that is required for an internal appeal, listed above in the section, "Appeal Process."

Once the request for a standard external review is filed, the Plan will have five (5) business days to do a preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided.

Within one (1) business day following completion of the preliminary review, the Plan will notify the Claimant in writing whether the request is eligible for external review.

- If the request is complete but is not eligible for external review, the notice will contain an explanation of the reason that the request is ineligible.

- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The claimant must submit the information or materials needed within forty-eight (48) hours following receipt of the notice, or the expiration of the original four (4) month filing period, whichever is later.

An eligible request which is complete and timely filed will be assigned to an independent review organization (IRO) by the Plan. The Plan will have arrangements to access at least three (3) accredited IROs to which external reviews will be assigned on a random or rotated basis to ensure an independent and unbiased review.

The assigned IRO will notify the Claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the Claimant may submit to the IRO, in writing and within ten (10) business days following receipt of the notice, any additional information that the IRO must consider when conducting the external review.

Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination. Failure by the Plan to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the Adverse Benefit Determination or final internal Adverse Benefit Determination. In this case, the IRO will notify the Plan and the claimant within one (1) business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the Claimant to the Plan, and the Plan may reconsider its Adverse Benefit Determination or final internal Adverse Benefit Determination; however, reconsideration by the Plan will not delay the external review. If the Plan decides to reverse its Adverse Benefit Determination or final internal Adverse Benefit Determination, it may terminate the external review and notify the IRO and the Claimant within one (1) business day of the decision.

The IRO will provide written notice to the Claimant and the Plan of the final external review decision within forty-five (45) days following receipt of the request for review. The notice will contain:

- A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial;

- The date the IRO received the request for external review and the date on which it made the decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

- A discussion of the principal reason or reasons for its decision, including the rationale for its decision and the evidence-based standards that were relied on in making the decision;

- A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to the Claimant;

- A statement that judicial review may be available to the claimant; and

- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793. Texas Department of Insurance can be contacted at 855-839-2427 (855-TEX-CHAP).

Expedited External Review

A final internal Adverse Benefit Determination concerning an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services but has not yet been discharged from the Facility will be considered for an expedited external review. These are considered to be pre-service non-urgent care Claims and concurrent Claims.

The procedures that apply to standard external reviews will apply to expedited external reviews, except that:

- The preliminary review of the request to determine whether it is eligible and whether all of the information and forms required to process the external review have been provided must be conducted immediately, and the Plan must immediately notify the Claimant regarding the eligibility determination;

- Upon a determination that a request is eligible for external review following the preliminary review, the Plan will immediately assign an IRO pursuant to the requirements set forth for standard external reviews;

- The Plan must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically, by phone, facsimile or any other available expeditious method; and

- 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 seventy-two (72) hours after the IRO received the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan within forty-eight (48) hours following the notice.

DECISION FOLLOWING AN EXTERNAL REVIEW

Upon receipt of a notice from the IRO reversing the decision of an Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will immediately provide coverage or payment for the Claim. An external review decision is binding on the Plan as well as the Claimant, except to the extent other remedies are available under State or Federal law.

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 Claims Delegate and/or 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 Covered Person or Dependent on whose behalf such payment was made.

A Covered Person, 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 Claims Delegate and/or 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 Claims Delegate and/or 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 Covered Person or other entity does not comply with the provisions of this section, the Claims Delegate and/or the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Claims Delegate and/or 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, agree 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 Claims Delegate and/or 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 Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Covered Persons and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Covered Persons) 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 Covered Person(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 Covered Person 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 Covered Person or by any of his Covered Dependents if such payment is made with respect to the Covered Person or any person covered or asserting coverage as a Dependent of the Covered Person.

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 is the result of the Provider's misstatement, said

Provider shall, as part of its assignment of benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

GENERAL PROVISIONS

RIGHT OF RECOVERY

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, 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 amount, and any future benefits payable to the Covered Person or his or her Dependents. See the Recovery of Payments provision for full details.

MISSTATEMENT OF AGE

If the age of a Covered Person has been misstated and if the amount of contribution is based on age, an adjustment of contributions shall be made based on the Covered Person's true age. If age is a factor in determining eligibility or amount of coverage and there has been a misstatement of age, the coverages or amounts of benefits, or both, for which the person is covered shall be adjusted in accordance with the Covered Person's true age. Any such misstatement of age shall neither continue coverage otherwise validly terminated, nor terminate coverage otherwise validly in force. Contributions and benefits will be adjusted on the contribution due date next following the date of the discovery of such misstatement.

WAIVER OR ESTOPPEL

No term, condition or provision of the Plan shall be waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written direction of the Plan Administrator. No such waiver shall be deemed a continuing waiver unless specifically stated. Each waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than that specifically waived.

WORKERS' COMPENSATION NOT AFFECTED

This Plan is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance or, where permitted and applicable, any other alternative form of Workers' Compensation benefits.

CONFORMITY WITH LAW

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes that are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

NOTICES

All payments or notices of any kind to Employees, Participants, beneficiaries, or Plan officials may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been: (a) duly delivered on the date postmarked; and (b) duly received three (3) calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail, to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

STATEMENTS

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

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

FRAUD

The following actions by a Covered Person or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate indefinite and permanent termination of all coverage under this Plan for the entire Family unit of which the Covered Person is a member:

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

MISCELLANEOUS

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

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

ALLOCATION AND APPORTIONMENT OF BENEFITS

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

FACILITY OF PAYMENT

If a Claimant is a minor or is physically or mentally incapable of giving a valid release for payment, the Claims Administrator, at its option, may make payment to a party who has assumed responsibility for the care of such person. Such payments will be made until Claim is made by a guardian. If a Claimant dies while benefits remain unpaid, benefits will be paid at the Claim Administrator's option to:

1. The person or institution on whose charges Claim is based; or
2. A surviving relative (wife, husband, mother, father, Child or children, brother or brothers, sister or sisters).

Such payment will release the Plan Administrator and Claims Administrator of all further liability to the extent of payment.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Employees and their Dependents shall be in accordance with the Eligibility, Effective Date, and Termination provisions as stated in this Plan Document as follows.

NOTE: A Covered Person previously terminated under this Plan due to fraud, or the actions being taken by another which constituted fraud, as addressed within the Fraud section of this Plan, will be immediately, indefinitely and permanently terminated from all coverage under this Plan and ineligible for future enrollment in this Plan

EMPLOYEE ELIGIBILITY

An Employee will be considered eligible for coverage on the first day of the month following the Date of Hire provided he/she is regularly scheduled to work for the Employer on a Full-time Employment basis for at least twenty (20) hours per week. This requirement is suspended during any member district sponsored holiday period as long as the Employee is within their contract period.

DEPENDENT ELIGIBILITY

A Dependent, **as defined in the Plan Definitions,** will be considered eligible for coverage on the date the Employee becomes eligible for Dependent coverage or the date the Dependent is acquired, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. **For Employees with coverage for Dependent children in effect**: A newborn Child of a Covered Employee will be considered eligible and will be covered from the moment of birth for thirty-one (31) days for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, Routine Newborn Care and Well Baby Care. Written notification must be received by the Plan Administrator within thirty-one (31) days after the Child's date of birth for continued coverage. A newborn of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an eligible Dependent.

2. **For Employees with no coverage for Dependent children in effect**: A newborn Child of a Covered Employee will be considered eligible and will be covered from the moment of birth for Injury or Illness, including the Medically Necessary care and treatment of medically diagnosed congenital defects, birth abnormalities and prematurity, Routine Newborn Care and Well Baby Care **if written**

notification to add the Child is received by the Plan Administrator within thirty-one (31) days following the Child's date of birth. If written notification to add a newborn Child is received by the Plan Administrator AFTER the thirty-one (31) day period immediately following the Child's date of birth, the Child is considered a Late Enrollee and not eligible for the Plan until the next Annual Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an Eligible Dependent.

3. A new spouse of a Covered Employee and any dependent children of a new spouse who meet the Plan's definition of "Dependent" will be considered eligible and will be covered on the date of the Covered Employee's marriage, provided the spouse and/or his/her children are enrolled as Dependents of the Covered Employee within thirty-one (31) days after the date of marriage.

4. A Child of a Covered Employee who meets the Plan's definition of a Dependent will be considered eligible if the Child is under twenty-six (26) years of age.

5. A Child placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child.

6. A Child of a non-custodial parent who is a Plan Participant will be considered eligible if the Plan Participant is required to provide benefit coverage for the Child in accordance with applicable requirements of a Qualified Medical Child Support Order (QMCSO).

7. If a Dependent of a Covered Employee is to be enrolled in the Plan, other than at the time of his/her eligibility or birth, adoption, court order or marriage to the Covered Employee, that Dependent would be considered a Late Enrollee unless he/she qualifies for a Special Enrollment or there is a Status Change.

8. A spouse and/or Child of a Covered Employee who previously was not eligible for the Plan will be considered eligible on the date he/she meets the Plan's definition of "Dependent."

The Eligibility provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993, as the same may be later amended.

If an Employee or Dependent has a change in eligibility while covered under this Plan (i.e., from Employee to Dependent, from Dependent to Employee) and no interruption in coverage has occurred, the Plan will consider that coverage has been continuous with respect to the Pre-existing Condition Exclusion Limitation and Eligibility Waiting Period.

If both the husband and wife are employed by the Co-op, and both have Dependent(s) eligible for coverage, either the husband or wife, but not both, may elect Dependent coverage for their Eligible Dependents.

NOTE: A Dependent who was enrolled on the most recent restated date of this Plan, September 1, 2011, and who was previously covered by the Plan, will also be considered eligible to continue coverage under this Plan.

TRANSFERS

If an Employee terminates employment with a participating Co-op school district and is hired as an Employee under one of the other participating Co-op school districts, coverage for the Employee and/or any covered Dependents will continue as usual as long as there is NO GAP in coverage. Proper enrollment forms must be completed with the new Employer (school district) in order to identify the Employee with the appropriate Employer (school district).

QUALIFIED MEDICAL CHILD SUPPORT ORDERS / PLACEMENT FOR ADOPTION

The Plan will comply with the rules relating to adopted children, children placed for adoption, Qualified Medical Child Support Orders ("QMCSO"), and National Medical Support Notices (“NMSN”). The Plan will use the following rules related to children placed for adoption, QMCSOs and NMSNs.

This Plan will provide benefits in accordance with the applicable requirements of any QMCSO or NMSN. A QMCSO is a Medical Child Support Order of a court or of certain administrative agencies that creates, recognizes or assigns to a Child of a Plan Participant the right to receive health benefit coverage under the Plan. A NMSN is an order issued by a State agency requiring the Plan to cover a Child. To be qualified, a Medical Child Support Order must comply with State and Federal laws and contain the following:

1. The name and last known mailing address (if any) of both the Plan Participant and the Child covered under the order except that, to the extent provided in the order, the name and mailing address of an official of a State or a political subdivision thereof may be substituted for the mailing address of any such alternate recipient.

2. A reasonable description of the type of coverage to be provided by the Plan for each Child (or the manner in which the type of coverage will be determined).

3. The period of coverage to which the order applies.

In addition, a QMCSO or NMSN will generally not be considered qualified if it requires the Plan to provide certain benefits or options which are not otherwise provided by the Plan. The Plan Administrator will notify the Plan Participant of the receipt of a Medical Child Support Order and the procedures for determining whether it is a Qualified Medical Child Support Order or a NMSN. The Plan Administrator will then determine within a reasonable period of time whether the Medical Child Support Order is a QMCSO or NMSN.

Plan Participants may request and receive, free of charge, a copy of Plan procedures relating to QMCSOs and NMSNs.

If an Employee is not enrolled in the Plan, and the Employee would otherwise be eligible for coverage, the Plan must enroll the child (ren) and the Eligible Employee covered by the QMCSO.

This Plan will also provide benefits to Dependent children placed for adoption on the same basis as natural children even prior to the adoption becoming final. A Child will be considered "Placed for Adoption" with a Plan Participant if the Plan Participant has assumed a legal obligation for total or partial support of the Child in anticipation of adoption of the Child. For this reason, if a Child is placed with a Plan Participant for adoption by an adoption agency or other entity, the Plan Participant must provide to the Plan Administrator documentation (e.g., signed court order) that the adoption agency or other entity had legal custody of the Child on the date that the Child was placed with the Plan Participant for adoption. The Plan Administrator will determine within a reasonable period of time whether a Child has been "Placed for Adoption."

The Plan Administrator has final, discretionary authority to determine: (1) whether a Medical Child Support Order qualifies as a QMCSO or NMSN; and (2) whether a Child has been "Placed for Adoption.”

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

An Eligible Employee, properly enrolled in the Plan, will be referred to as a "Covered Employee."

Each Employee's coverage under the Plan shall become effective on the first day of the month following the Date of Hire provided the Employee completes the eligibility requirement of the Plan and written application for coverage is made on or before or within thirty-one (31) days after the date the Employee eligibility requirement is met.

DEPENDENT EFFECTIVE DATE

Dependent coverage under the Plan shall become effective on the date Dependent eligibility requirements are met, provided the Employee makes written application for Dependent coverage on or before or within thirty-one (31) days after the date Dependent eligibility requirements are met subject to the enrollment requirements as follows:

1. In order to become covered under the Plan, Eligible Dependents must be identified on an Enrollment and/or Change form.

2. If the Employee makes a request for Dependent coverage on or before or within thirty-one (31) days immediately following his/her own effective date, then each Eligible Dependent will become effective on the same date the Employee's coverage is effective.

3. If an Employee makes a request to add a Dependent Child to the Plan in accordance with a Qualified Medical Child Support Order (QMCSO), the effective date of coverage for the Dependent Child will be the date specified in the QMCSO. Child(ren) covered by QMCSO's may be enrolled in this Plan if the Employee would otherwise be eligible for coverage regardless of whether the Employee is currently enrolled. The Plan must enroll the child (ren) and the Eligible Employee covered by the Notice without any enrollment restrictions (i.e., they will not be considered Late Enrollees).

4. If the Covered Employee makes a request to add a Dependent spouse and/or Child who previously was not eligible for the Plan within thirty-one (31) days following a Status Change, the effective date of coverage is the date the individual meets the Plan's definition of Dependent.

LATE ENROLLEE

An Employee or Dependent who enrolls in the Plan more than thirty-one (31) days after the date of his/her initial eligibility is considered a Late Enrollee unless he/she qualifies for a Special Enrollment or there is a Status Change.

EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS

The Plan provides Special Enrollment rights and Special Enrollment Periods for Employees and their Dependents who previously declined to enroll in the Plan and who remain eligible for the Plan.

SPECIAL ENROLLMENT PERIOD FOR LOSS OF ELIGIBILITY FOR OTHER COVERAGE

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of other health coverage and subsequently lose eligibility for that other coverage (except for cause or nonpayment of premium) have Special Enrollment rights. Special Enrollment in this Plan must be requested within thirty-one (31) days after the date eligibility for other coverage ends. If an individual

enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Individuals who previously declined coverage in the Plan because of other coverage may be eligible to enroll in the Plan during the Special Enrollment Period if eligibility for other coverage is lost as a result of one of the following:

1. Legal separation, divorce, death, termination of employment or reduction in the number of hours worked;
2. Loss of dependent status;
3. The plan no longer offers any benefits to a class of similarly situated individuals;
4. An individual incurs a Claim that would meet or exceed a lifetime limit on all benefits;
5. Moving out of an HMO service area with no other coverage option available;
6. Termination of a benefit package option, unless a substitute is offered;
7. Employer contributions were terminated; or
8. COBRA continuation coverage was exhausted.

Loss of coverage due to an individual's failure to pay premiums or contributions does not qualify for a Special Enrollment Period. Voluntarily dropping coverage does not trigger Special Enrollment rights because there is no loss of eligibility.

Length of Special Enrollment Period for Loss of Eligibility for Other Coverage

A request for a Special Enrollment due to loss of eligibility for other coverage must be made no later than thirty-one (31) days after the exhaustion of COBRA coverage or the termination of other non-COBRA coverage as a result of the loss of eligibility or termination of employer contributions toward that coverage.

Effective Date of Coverage Following Special Enrollment for Loss of Eligibility for Other Coverage

The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written application for coverage during a Special Enrollment Period will be the day following the date of loss of other coverage.

SPECIAL ENROLLMENT PERIOD FOR NEW DEPENDENT

1. An Employee who previously declined enrollment and who remains eligible for coverage under the Plan has Special Enrollment rights when the Eligible Employee acquires a new Dependent through marriage, birth, adoption or Placement for Adoption.

2. A new spouse is entitled to Special Enrollment rights when he/she becomes the spouse of a Covered Employee or when a Child becomes a Dependent of a Covered Employee through birth, adoption or Placement for Adoption.

3. A person is entitled to Special Enrollment rights when the person becomes a Dependent of a Covered Employee through marriage, birth, adoption or Placement for Adoption.

4. An Employee who previously declined enrollment and remains eligible for coverage under the Plan has Special Enrollment rights for himself/herself and the Employee's spouse if a Child becomes a Dependent of the Employee through birth, adoption or Placement for Adoption.

Length of Special Enrollment Period for New Dependents

A request for a Special Enrollment due to acquiring New Dependents must be made no later than thirty-one (31) days after the date of marriage, birth, adoption or Placement for Adoption.

Effective Date of Coverage Following New Dependent Special Enrollment

The effective date of coverage for an Eligible Employee and his/her Eligible Dependents who make written application for coverage during a New Dependent Special Enrollment Period will be as follows:

1. In the case of marriage: the date of marriage;

2. In the case of a Dependent's birth: the date of birth; or

3. In the case of a Dependent's adoption or Placement for Adoption: the date of such adoption or Placement for Adoption.

NOTE: Proof of Qualifying Event for Special Enrollment will be required.

SPECIAL ENROLLMENT PERIOD UNDER THE CHILDREN'S HEALTH INSURANCE PROGRAM REAUTHORIZATION ACT OF 2009 (CHIPRA)

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of the Eligible Employee's and/or Eligible Dependent's coverage under Medicaid or a State's Children's Health Insurance Program (CHIP) and subsequently lose eligibility for Medicaid or CHIP coverage have Special Enrollment rights. Special Enrollment in this Plan must be requested within sixty (60) days after the date eligibility for Medicaid or CHIP ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity but become eligible for a premium assistance subsidy under Medicaid or CHIP have Special Enrollment rights. Special Enrollment in this Plan must be requested within sixty (60) days after the date eligibility for Medicaid or CHIP premium assistance is determined. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

ANNUAL OPEN ENROLLMENT PERIOD FOR THE EMPLOYEE MEDICAL BENEFIT PLAN

The Annual Open Enrollment Period for the Plan is the month of August of each year for coverage to become effective September 1, provided written application for coverage is made on or before the end of the Open Enrollment Period or within thirty-one (31) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. Re-enrollment for Covered Employees is not required unless a Covered Employee requests a coverage change or a Plan Option change.

The Plan allows a choice of Plan Options: Buy-Up Plan 1, Base Plan and Alternate Plan IV. An Eligible Employee can elect one (1) Plan Option for himself/herself and the same option for his/her Eligible Dependents. The Alternate Plan, however, is available only to an Eligible Employee.

LATE ENROLLEE

A Late Enrollee is an Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan. A Late Enrollee can only enroll once a year during the Annual Open Enrollment Period for the Plan unless he/she qualifies for a Special Enrollment or if there is a Status Change.

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written application for coverage under the Plan more than thirty-one (31) days after the date of his/her initial eligibility;

2. He/she is not eligible for a Special Enrollment or enrollment as a result of a Status Change; or.
3. He/she failed to enroll by the end of a Special Enrollment Period or enrollment period for a Status Change.

Effective Date of Coverage for Employee Late Enrollees
The effective date of coverage for an Employee who is a Late Enrollee will be the effective date of the Annual Open Enrollment for the Plan.

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

1. The Covered Employee makes written application for Dependent coverage after the thirty-one (31) day period immediately following his/her effective date of coverage and the Dependent was not enrolled by the end of a Special Enrollment Period;

2. The Covered Employee makes a written request to add a Dependent after the thirty-one (31) day period immediately following the date of birth, date of marriage, date of adoption or date of Placement for Adoption; or

3. An Eligible Employee (not currently enrolled in the Plan) makes a written request to add a new Dependent more than thirty-one (31) days after the Dependent's date of birth, date of marriage, date of adoption or date of Placement for Adoption.

Effective Date of Coverage for Dependent Late Enrollees
The effective date of coverage for each Dependent who is a Late Enrollee will be the effective date of the Annual Open Enrollment for the Plan.

The Eligibility and Effective Date provisions are subject to the requirements of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA) as they may be amended.

COVERAGE CHANGES

FOR EMPLOYEES PARTICIPATING IN THE SECTION 125 PLAN

Contributions to the Plan are made on a "Salary Reduction" basis under Section 125 of the Internal Revenue Code. This allows premium contributions to be withheld from the Employee's paycheck on a "pre-tax" basis before any Federal Income Tax or FICA taxes are calculated.

Once an election is made to participate, this election can only be changed during the next year's Annual Open Enrollment Period for the Plan.

A coverage change or Plan Option change is allowed in the Medical Plan if there is a change in status due to certain events including, but not limited to, any of the following:

Status Changes
- Marriage
- Divorce or legal separation (in those States recognizing legal separation)
- Birth or adoption of a Child
- Death of spouse or Child
- Commencement of spouse's employment
- Termination of spouse's employment
- Open enrollment for spouse's/Dependent's employer plan
- Significant cost or coverage changes for Employee or spouse
- Change from part-time to full-time employment (or vice-versa)/reduction or increase in hours
- Unpaid leave of absence
- Change in the residence or worksite

- Dependent satisfies or ceases to satisfy the eligibility requirements for coverage
- Qualified Medical Child Support Order (QMCSO)
- Entitlement to or loss of eligibility for Medicare or Medicaid
- Entitlement to or loss of eligibility for a State's Children's Health Insurance Program (CHIP)

An election change may be made only if a recognized Status Change for cafeteria plans will result in the gain or loss of eligibility for coverage of the Employee, the Employee's spouse or Dependent.

A written request for addition or deletion of coverage due to a Status Change must be made within thirty-one (31) days of that change or the exception will not apply. However, a request for addition or deletion of coverage due to a change in eligibility under Medicaid or a State Children's Health Insurance Program (CHIP) must be made within sixty (60) days of that change.

Tag Along Rule: If, due to a Status Change, an Eligible Employee enrolls in health coverage or a Covered Employee elects to increase health coverage, at that time, the Eligible Employee or the Covered Employee may also enroll his/her spouse and/or eligible Dependents who were not previously covered for health care regardless of whether such individuals personally experienced the Status Change.

Effective Date of Coverage Following Status Change
Most Status Changes qualify for Special Enrollment. See the Employee and Dependent Special Enrollment Periods section.

If there is a Status Change which does not qualify for a Special Enrollment Period as outlined in the Employee and Dependent Special Enrollment Periods, the effective date of coverage under the Medical Plan will be the date of the Status Change.

PLAN OPTION CHANGES

The Plan allows a choice of Plan Options. Plan Option changes can only be made once a year during the Annual Open Enrollment Period for the Plan unless there is a Status Change that qualifies for a Special Enrollment.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION

An Employee's coverage shall automatically terminate at midnight on the earliest of the following dates:

1. The last day of the month immediately following the month in which the Employee's employment terminates or the last day of the period in which the Employee's contract ends (for example, if the Employee's employment terminates in January, the coverage shall terminate on the last day of February);
2. The last day of the month immediately following the month in which the Employee ceases to be eligible or ceases to be in a class of Employees eligible for coverage;
3. The date the Employee fails to make any required contribution for coverage;
4. The date the Plan is terminated; or with respect to any Employee's benefit of the Plan, the date of termination of such benefit;
5. The date the Employee enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
6. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
7. The date the Employee takes an unapproved leave of absence from work; or
8. The date the Employee dies.

DEPENDENT COVERAGE TERMINATION

The Dependent coverage of an Employee shall automatically terminate at midnight on the earliest of the following dates:

1. The last day of the month in which the Dependent ceases to be an Eligible Dependent as defined in the Plan;
2. The date of termination of the Employee's coverage under the Plan;
3. The last day of the month in which the Employee ceases to be in a class of Employees eligible for Dependent coverage;
4. The date the Employee fails to make any required contribution for Dependent coverage;
5. The date the Plan is terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit;
6. The date the Employee or Dependent enters the Uniformed Services of the United States or armed forces of any country or international organization on a full-time active duty basis if active duty is to exceed thirty-one (31) days;
7. The date the Employee fails to return to Full-time Employment following an approved Leave of Absence. See Coverage During Leave of Absence section;
8. The date the Employee takes an unapproved leave of absence from work;
9. The date the unmarried adult Dependent Child age twenty-six (26) or older for whom coverage is being continued due to the Child being Physically or Mentally Handicapped and incapable of earning his/her own living, upon the earliest to occur of: a. cessation of such inability; b. failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; c. the Child no longer being dependent on the Employee for his/her support; or d. the Child's marriage; or
10. The last day of the month following the date the Employee dies.

Coverage may be continued under COBRA, but continuation of coverage is not automatic upon the occurrence of a Qualifying Event. A Covered Employee or a Covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of certain Qualifying Events (including loss of coverage due to divorce, legal separation, or a Dependent Child ceasing to qualify as a Dependent). A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage. See Continuation of Group Health Coverage (COBRA) section for further information.

NOTE: The Termination provisions are subject to the requirements of the Consolidated Omnibus Budget Reconciliation Act (COBRA), Public Law 99-272 and the Co-op's Section 125 Plan.

COVERAGE DURING LEAVE OF ABSENCE

If, after depletion of sick leave and vacation time, active work ceases due to approved Personal Leave of Absence or approved Family and Medical Leave Act (FMLA) or approved Family, Medical, Disability and/or other temporary leave required by applicable State law, the Plan Administrator may, while the Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of active work based on the Leaves and Absences Policy of the applicable member school district.

If a condition upon which an approved Leave of Absence would be based starts during a district sponsored holiday period, the approved Leave of Absence will start on the first day the district reconvenes school.

If the Employee has not returned to Full-time Employment after completion of an approved Family and Medical Leave or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), or if the Employee notifies the Employer that he/she will not be returning to Full-Time Employment following the Family and Medical Leave or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), coverage under the Plan terminates without the need for further action, subject to COBRA continuation rights. See Continuation of Group Health Coverage (COBRA) section. Failure of the Employee to make any required Employee contributions for continued coverage under the Plan during an approved FMLA or other Leave of Absence will also result in termination of coverage.

Family and Medical Leave are subject to the requirements of the Family and Medical Leave Act (FMLA).

ACTIVE DUTY IN THE ARMED FORCES

If a Covered Employee and/or his/her Covered Dependent(s) would lose Plan coverage as a result of the Employee being called for active duty in the armed forces of the United States, such a reduction in hours (or termination of employment) would be a COBRA Qualifying Event. Any coverage mandated under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended by the Veterans Benefits Improvement Act of 2004, will run concurrently with federally mandated COBRA coverage. For additional information, see the sections entitled Continuation of Group Health Coverage (COBRA) and Continuation of Coverage under USERRA.

REHIRES / REINSTATEMENT OF COVERAGE

A terminated Employee on COBRA who is rehired and returns to work does not have to satisfy the Pre-existing Condition exclusion provisions of the Plan including the Plan's Waiting Period for new Employees.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the United States, and who qualifies for military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), will be reinstated on the date he/she resumes employment with the Co-op provided that such resumption of employment is within the time period specified in USERRA. The Pre-existing Condition Exclusion Limitation will not apply to an Employee who is entitled to military leave, and is reinstated immediately after military service, under USERRA. (This waiver does not provide coverage for an Illness or Injury incurred in or aggravated during the performance of military service as determined by the Veterans Administration).

The reinstatement procedures following a USERRA military leave are subject to the requirements of USERRA.

FAMILY AND MEDICAL LEAVE (FMLA)

All Employers employing at least fifty (50) workers within a seventy-five (75) mile radius of the work place must provide Eligible Employees with up to twelve (12) weeks or twenty-six (26) weeks, in the case of #5 below, of job-protected leave of absence during a twelve (12) month period, as determined by the Employer, generally for any of the following situations:

1. The birth or adoption of a Child;

2. The serious Illness of the Employee's spouse, Child, or parent;

3. The Employee's own disabling serious Illness;

4. The qualifying exigency (as defined by the Secretary of Labor) of the Employee's spouse, Child or parent service member who is on active duty or has been notified of an impending call or order to active duty; or

5. The serious Illness or Injury of the Employee's spouse, Child, parent or next of kin service member whose Illness or Injury was incurred in the line of duty that may render the member unfit to perform the duties of the service member's office, grade, rank or rating.

ELIGIBLE EMPLOYEES: Employees who have been employed by the Employer for at least twelve (12) months and who have worked at least 1,250 hours for the Employer during the previous twelve (12) months are eligible for Family and Medical Leave.

BENEFIT REQUIREMENT: The Employer must provide the same group health plan during the leave under the same level of contribution required during active employment.

RETURN TO EMPLOYMENT: Although the leave is unpaid, the Employee must be guaranteed return to the same or equivalent position with equivalent Employee benefits, pay, and other terms of employment. (Note: An Employer may deny job restoration under the leave law to Employees who are in the highest paid 10% of Employees.)

Employee benefits may include:

Group life
Educational benefits
Sick leave
Medical
Annual leave
Disability
Dental
Pensions

If an Employee chooses not to retain Plan coverage during Family and Medical Leave, Plan coverage may be restored upon return to active service as an Eligible Employee. Employees must be treated as though no service interruption had occurred. This means that Pre-existing Condition Limitations will not be applied. Any period of coverage provided for disability may run concurrently with Family and Medical Leave.

The above listing of Employee benefits may or may not be applicable to every Co-op member school district's Plan of benefits. This section is intended as a summary of the Family and Medical

Leave Act of 1993 (FMLA), effective August 5, 1993, as amended, not as a complete interpretation of the law.

NOTE: An Eligible Employee must refer to the Co-op member school district's Leaves and Absences Policy for complete information.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

CONTINUATION OF COVERAGE

(Applies to Medical and Prescription Drug Coverage)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or Covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents under the Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus an administrative fee of 2%.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

Qualified Beneficiary	**Qualifying Event**	**Maximum Coverage Period**
Covered Employee and/or Covered Dependent	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18 months
Disabled Covered Employee and/or Disabled Covered Dependent and each Qualified Beneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	29 months*
Covered Dependent	Loss of coverage due to divorce, legal separation, or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent Child losing eligibility as a Dependent Child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare (See Special Medicare Entitlement Rule section.)	36 months

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a Child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted children of former Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on the Plan even if the former Covered Employee/Qualified Beneficiary drops coverage.

*SOCIAL SECURITY DISABILITY

If a Covered Employee or a Covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment or reduction in hours, or at any time during the

first sixty (60) days of COBRA continuation coverage, the disabled person may be entitled to continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, during the initial eighteen (18) month coverage period, that the individual is disabled. To qualify for the eleven (11) month extension of the maximum coverage period, the disabled person must provide the Plan Administrator with a copy of the Social Security Administration determination letter within sixty (60) days of receipt of same, and not later than the expiration of the original eighteen (18) month initial coverage period.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security Disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150% of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a Covered Dependent based on the Covered Employee's loss of coverage due to termination of employment or reduction in hours and a second Qualifying Event (divorce, legal separation, death or a Dependent Child losing eligibility as a Dependent Child) occurs during the eighteen (18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2008, the Employee's Covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2010 (that is prior to the end of the original eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2011.

SPECIAL MEDICARE ENTITLEMENT RULE

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a Covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a Covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the Covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential eighteen (18) month COBRA continuation period for all Qualified Beneficiaries. While the Covered Employee is only entitled to eighteen (18) months of COBRA continuation coverage, the other Qualified Beneficiaries (spouse and/or Dependent children) are entitled to eighteen (18) months or thirty-six (36) months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

EMPLOYEE RESPONSIBILITIES

COBRA coverage <u>is not automatic</u> upon the occurrence of a Qualifying Event. COBRA coverage must be elected as described below. In addition, a Covered Employee or a Covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event if the Qualifying Event is the loss of coverage due to divorce, legal separation, or a Dependent Child losing eligibility as a Dependent Child. A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligible individual is sent an election form describing his/her right to elect continuation coverage (COBRA Election Period). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed election form must be returned to the Plan Administrator, signed and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage was elected. Initial payment must cover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage will not become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section, an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of $50 or 10% of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously described upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRA election, unless the other plan contains any exclusion or limitation with respect to a Pre-existing Condition of the individual;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;
3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a Child who is born to, or a Child who is placed for adoption with, the Covered Employee Qualified Beneficiary. If the newborn or adopted Child is added to the Covered Employee's COBRA continuation coverage, then, unlike a new spouse, the newborn or adopted Child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted Child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents can be found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are available for similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction in hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage or, when applicable, the Plan Administrator must notify the COBRA Administrator within thirty (30) days of the Qualifying Event, and the COBRA Administrator has fourteen (14) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

CONTINUATION OF COVERAGE UNDER USERRA

This section summarizes continuation of coverage under this Plan for employees absent from work due to military service. The Plan intends to provide benefits as a result of military leave of absence as mandated by USERRA, as it may be amended from time to time.

As an Employee, you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work to determine the Employee's fitness for any of the designated types of duty.

Employees who are dishonorably discharged from the military are not eligible for continuation of coverage under USERRA.

Under the law, the Employee must give the Employer written or verbal advance notice of the military leave, if it is practical to do so, and failure to do so may result in the departing Employee's coverage being cancelled, unless the Employee is excused from giving advance notice of service under USERRA's provisions because it was impossible, unreasonable, or precluded by military necessity. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice directly to the Employer.

Coverage also may be cancelled if a departing Employee leaves for a period of service that exceeds thirty (30) days and gives advance notice of service, but fails to elect continuation coverage. However, should the Employee pay all unpaid amounts due within sixty (60) days from the date the Employee left for such service, then the Employee will be retroactively reinstated with uninterrupted coverage to the Employee's date of departure.

If the Employee chooses Continuation of Coverage under USERRA, the Employer is required to offer coverage identical to that provided under the Plan prior to the Employee's military leave. If the Employee takes military leave on or after December 10, 2004, and the Employee lost coverage due to that military service, the Employee has the right to elect to extend coverage for the Employee, the Employee's spouse and the Employee's Dependents who are covered by the Plan for up to twenty-four (24) months while the Employee remains on active duty, or during the period that the Employee's reemployment rights are protected. During the first thirty (30) days of leave, the cost of the coverage the Employee elects is the same as the rate that the Employee paid as an employee. After that time, the rate is the same rate that the Plan charges for COBRA continuation coverage. If the Employee or another member of the Employee's Family covered by the Plan becomes disabled during the first sixty (60) days of such coverage, and the Employee provides to the Plan a copy of the Social Security Administration determination of disability before the end of the twenty-four (24) months of coverage, the coverage by the Plan for the Employee, as well as the Employee's spouse and other Family members, can be extended to twenty-nine (29) months. The Employee will have to pay a higher rate for this additional five (5) months of coverage. In addition, if there is an event that would allow the Employee's spouse or Dependent to receive thirty-six (36) months of COBRA coverage, as described above under the COBRA continuation coverage provisions, then the Employee's spouse or Dependent will be entitled to elect such coverage if they notify the Plan within sixty (60) days after the event occurs.

If the Employee does not make timely premium payments, then the Plan will provide the Employee with thirty (30) days written notice to pay the premiums. If the Employee fails to pay the requested premium(s) within the thirty (30) days, the Plan has the right to cancel the Employee's continuation of coverage.

If an Employee's or a Dependent of an Employee's health plan coverage was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment, unless the Plan imposes an exclusion or waiting period as to Illnesses or Injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service.

If you feel you might have continuation rights under USERRA, please contact Human Resources as soon as possible.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Plan, only if used in this Plan. Terms defined, but not used in this Plan, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Plan that are capitalized or set forth in bold type but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases based on the context in which they are used.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

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

Accident: A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury: See definition of “Injury.”

Actively at Work: As applied to an Employee: the Employee will be considered "Actively at Work" on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed "Actively at Work" on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was "Actively at Work" on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, subject to the Plan’s Leave of Absence provisions.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit, including any such denial, reduction, rescission of coverage, termination or failure to provide or make payment that is based on a determination of an individual’s eligibility to participate in the Plan.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Expense: The Usual and Customary charge within Permitted Payment Levels for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, 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.

Alternate Recipient: Any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant’s Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements an Alternate Recipient shall have the same status as a participant.

Alternative Care Plan: In circumstances where cost of care savings are available for standard of care medical treatment, medication, or other services, and this alternative care can be substituted for more costly care while remaining the treatment of choice, an Alternative Care Plan will be developed to optimize the savings obtained by the services substituted. Example: Substituting Home Health Private Duty Nursing for care in an Inpatient Skilled Nursing Facility.

AMA: The American Medical Association.

Ambulatory Surgery Center: An institution or facility, either free-standing or as a part of a Hospital with permanent Facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted and from which a patient is discharged within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered as an Ambulatory Surgery Center.

Ancillary Services: Incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Annual: Yearly; occurring once each Calendar Year.

Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses, in addition to the Calendar Year Deductible, Copays, non-compliance penalties and any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Assignment of Benefits: An arrangement whereby the Claimant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a Provider accepts said arrangement, Providers' rights to receive Plan benefits are equal to those of a Claimant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Authorized Representative: Person authorized to act on behalf of a Claimant for a benefit Claim or appeal of an Adverse Benefit Determination.

Benefit Determination: A determination by the Claims Delegate or the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: The portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as shown on the Schedule of Benefits. It is the basis used to determine any out-of-pocket expenses in excess of the Calendar Year Deductible which are to be paid by the Employee.

Benefit Period: The time period shown on the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the period so established; or
2. The day the Lifetime Maximum Benefit applicable to the Covered Person becomes payable; or
3. The day the Covered Person ceases to be covered for Major Medical Expense Benefits.

Billing Review: The review of billing documentation and related medical records to uncover identifiable Invalid Charges, as necessary to allow the Claims Delegate to reasonably assess the accuracy and validity of billed charges submitted in connection with a Claim and to make determinations as to whether any such charge exceeds the Maximum Allowable Charge or whether such Claim exceeds Permitted Payment Levels.

Billing Review Specialist: An organization or individual engaged to provide Billing Review services, advice and recommendations for HFASC Claims. The Claims Delegate or the Plan Administrator will furnish the name, address, and phone number of the Medical Review Specialist.

Birthing Center: A facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Breach: A Breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the Protected Health Information such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Certificate of Coverage (Certificate of Group Health Plan Coverage): A certificate verifying the dates an individual's plan coverage began and ended. The certificate is used to determine how much Creditable Coverage an individual has to reduce the length of a Pre-existing Condition exclusion period under the Plan.

Chemical Dependency: The abuse of, or psychological or physical dependency on, or addiction to, alcohol or a controlled substance. A "controlled substance" means a toxic inhalant or a substance designated as a controlled substance in Chapter 481 of the Texas Health and Safety Code or equivalent State code where applicable.

Chemical Dependency Treatment Center: A facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and is also:

1. Accredited as such a facility by the Council on Accreditation (COA) or Joint Commission on Accreditation of Health Care Organizations or sponsored by the A.M.A. or A.H.A.;
2. Affiliated with a Hospital under contractual agreement with an established system for patient referral;
3. Licensed as a Chemical Dependency treatment program by the applicable State Commission on Alcohol and Drug Abuse; and
4. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other State agency having legal authority to so license, certify or approve.

Child: In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee has obtained legal guardianship.

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

CHIPRA: Refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic Services: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's reasonable procedure for filing benefit Claims.

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

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Plan.

Claims Review: Billing Review and/or Medical Record Review or Hospital and Facility Claims.

Clean Claim: A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment

which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and abuse or Claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

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

Close Relative: Includes the spouse, mother, father, sister, brother, Child, or in-laws of the Covered Person.

COBRA: Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage: Coverage under this Plan that satisfies an applicable COBRA continuation provision.

COBRA Election Period: The sixty (60) day period during which a COBRA Qualified Beneficiary, who would lose coverage as a result of a Qualifying Event, may elect continuation coverage under COBRA. This sixty (60) day period begins the later of:

1. The date of termination of coverage as a result of a Qualifying Event; or
2. The date of the notice of the right to elect COBRA continuation coverage under this Plan.

COBRA Qualified Beneficiary: A former Employee or Dependent covered under this Plan on the day before the Qualifying Event who is eligible for continuing coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. A COBRA Qualified Beneficiary has independent election rights.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%) after the Calendar Year Deductible has been satisfied. The amount of Coinsurance paid by or on behalf of the Covered Person is applied toward the Covered Person's or Family's Annual Out-of-Pocket Maximum.

Complications of Pregnancy: A disease, disorder or condition which is diagnosed as distinct from normal Pregnancy but adversely affected by or caused by Pregnancy. This includes, but is not limited to:

1. Inter-abdominal surgery, including cesarean section;
2. Excessive vomiting (hyperemesis gravidarum);
3. Toxemia with convulsions (eclampsia);
4. Extra-uterine Pregnancy (ectopic);
5. Postpartum hemorrhage;
6. Rupture or prolapse of the uterus;
7. Spontaneous termination of Pregnancy during a period of gestation in which a viable birth is not possible; or
8. Similar medical and surgical conditions of comparable severity.

Complications of Pregnancy will not include:

1. Elective abortion;
2. False labor;
3. Occasional spotting;

4. Physician prescribed rest;
5. Morning sickness; or
6. Similar conditions associated with the management of a difficult Pregnancy.

Concurrent Review: The Utilization Review Company's review of a Hospital stay, periodically evaluating the need for continued hospitalization.

Congenital Anomaly: A Congenital Anomaly may be viewed as a physical, metabolic or anatomic deviation from the normal pattern of development that is apparent at birth or detected during the first year of life.

Copay: The portion of Covered Expenses which is payable by the Covered Person and which is not applicable to the Calendar Year Deductible or the Annual Out-of-Pocket Maximum unless otherwise stated in this Plan Document.

Corrective Shoes: Shoes with a prescription correction which is a permanent and integral part of the shoe.

Cosmetic Procedure/Cosmetic Surgery: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

Covered Service / Covered Medical Expenses: Reasonable and Usual and Customary charges within Permitted Payment Levels and eligible for coverage in this Plan, which charges are incurred by or on behalf of a Covered Person for Hospital or other medical services, treatment or supplies that are:

1. Ordered by a Physician or licensed Practitioner;
2. Medically Necessary for the treatment of an Illness or Injury;
3. Not of a luxury or personal nature; and
4. Not excluded under Major Medical Exclusions and Limitations section of this Plan.

A Covered Service and/or Covered Medical Expense is or is for a service or supply provided in accordance with the terms of this document, whose applicable charge amount does not exceed the Maximum Payable Amount. It means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or participant's health, which is eligible for coverage in this Plan. Covered Medical Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Medical Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person: An Employee, a Dependent, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Plan, and who is properly enrolled in the Plan.

Creditable Coverage: Most health coverage (subject to HIPAA Rules for Creditable Coverage), such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid or Medicare, State Children's Health Insurance Program and any plan established and maintained by a State, the U.S. government or a foreign country. Creditable Coverage does not include coverage consisting solely of dental or vision benefits. Creditable Coverage is used to reduce the length of a Pre-existing Condition exclusion period under the Plan.

Custodial Care: That type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered. Unless specifically mentioned otherwise, treatment that does not restore health.

Date of Hire: The Employee's first day of full-time employment with the Employer.

Deductible: A specified dollar amount of Covered Expenses which must be incurred during a Calendar Year before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage. "Deductible" also means that dollar amount of the expense of a particular procedure or Covered Expense for which it is indicated in the Schedule of Benefits that a special Deductible will apply. The Plan Administrator reserves the right to allocate and apportion the Deductible and benefits to any Covered Persons and assignees.

Delegated Authority: The ultimate decision-making power and discretionary authority granted to and held by the Claims Delegate under this Plan to review, evaluate, make HFC Benefit Determinations and handle HFC Level II Appeals and other decisions relating to Hospital and Facility Claims.

Dependent:

1. The Covered Employee's legal spouse. Such spouse must have met all requirements of a valid marriage contract in accordance with the laws of the State of such parties. A common-law marriage recognized by the State in which the Covered Employee resides may be considered a legal marriage for this Plan. **NOTE:** Proof of legal status will be required by the Plan Administrator.
2. The Covered Employee's Child who meets all of the following conditions:
    a. Is less than twenty-six (26) years of age.
    b. Is either a:
    1. natural (biological) Child; or
    2. Child who has been legally adopted or placed for adoption with the Covered Employee; or
    3. Step-child; or
    4. Child who has been placed under the legal guardianship of the Covered Employee; or
    5. Grandchild.

    The age requirement above is waived for any unmarried Child who is Physically or Mentally Handicapped and incapable of sustaining his/her own living, who has the same legal residence as the Employee for more than one-half of the Calendar Year, and who does not provide more than one half of his/her own support for the Calendar Year in which the Child is enrolled for coverage under the Plan. Such Child must have been mentally or physically incapable of earning his/her own living prior to attaining the limiting age stated above. Proof of incapacity must be furnished to the Plan Administrator at the time of initial enrollment or within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated due to the age requirement In addition, the Claims Administrator reserves the right to request proof of continued incapacity at any time.

    NOTE: Proof of Dependent eligibility may be required.

Detoxification: The process whereby an alcohol-intoxicated person or person experiencing the symptoms of Substance Abuse is assisted, in a Facility licensed by the Department of Health, through the period of time necessary to eliminate, by metabolic or other means, the intoxicating alcohol, alcohol dependency factors or alcohol in combination with drugs as determined by a licensed Physician, while keeping the physiological risk to the patient at a minimum.

Diagnostic Service: A test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

Directly Contracted Provider(s): Hospitals and/or Facilities who are directly contracted with the Co-op, the Plan Administrator and/or the Claims Delegate to provide services at negotiated rates and fees.

Directly Contracted Provider Services: Health care services and supplies provided by a Directly Contracted Provider, the charges for which shall be in accordance with the negotiated rates and fees established in such Directly Contracted Provider's contract with the Co-op, the Plan Administrator and/or the Claims Delegate.

Disease: Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an employee under any Workers' Compensation law, occupational disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a sickness, Illness or Disease.

Donor: One who furnishes blood, tissue, or an organ to be used in another person.

Drug: Insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a Prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by Prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

Durable Medical Equipment: Equipment which is:

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

Elective Surgical Procedure/Elective Surgery: A non-emergency Surgical Procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Electronic Protected Health Information (ePHI): "Electronic Protected Health Information (ePHI)" has the meaning set forth in 45 C.F.R. Section 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Eligible Dependent: An Employee's Dependent who meets the Plan's eligibility requirements to enroll for coverage while the Employee is covered under the Plan.

Eligible Employee: An Employee who has satisfied the applicable Waiting Period and who is employed by the Employer on a full-time basis for at least twenty (20) hours per week, not to include seasonal or temporary employees.

Emergency: A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist. Some examples of an Emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple Injuries, convulsions, respiratory distress including asthma attacks, apparent poisoning or severe pain from the sudden onset of an Illness. Some examples of conditions that are not generally considered an Emergency are: colds, influenza, ear infections, nausea or headaches.

Emergency Services: With respect to an emergency medical condition:

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

Employee: A person who is regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Employer: The Co-op and any school districts adopting the Plan with the consent of the Co-op.

Enrollment Date: The Enrollment Date in the Plan for an Eligible Employee who enrolls in the Plan during his/her initial eligibility period is the Employee's Date of Hire. The Enrollment Date for a Special Enrollee or a Late Enrollee is the first day of coverage in the Plan. The term "Enrollment Date" is used to determine the Pre-existing Condition look-back and exclusion periods for the Plan.

Errors: As defined in the Claim Review and Validation Program section of the Plan.

Essential Health Benefits: "Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental/Investigational: Services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

Phase I and II clinical trials shall be considered Experimental.

A drug, device, or medical treatment or procedure is Experimental:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;

2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or

3. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, drug, or medicine is that the preponderance of current evidence does not support its efficacy, safety, or its efficacy as compared with the standard means of treatment or with regard to medication, has not determined its maximum tolerated dose.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating facility or by another facility studying substantially the same drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

Medical care and treatment, including prescriptions/diagnostics/labs that are **not related directly to a clinical trial** are considered for coverage under the plan for those patients participating in a clinical trial.

Facility: Any facility that provides medical services on an Outpatient basis, whether a Hospital-Affiliated Facility or Independent Facility.

Family: A Covered Employee and his/her Eligible Dependents.

Family and Medical Leave: A leave of absence pursuant to the provisions of the Family and Medical Leave Act (FMLA) of 1993, as amended.

Fiduciary: The Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

FMLA: The Family and Medical Leave Act of 1993, as amended.

Full-Time Employment: A basis whereby an Employee is employed by the Employer for the minimum number of hours shown in the Employee Eligibility section of this Plan Document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analyses of genes or chromosomes.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance, set standards for Pre-existing Condition exclusion periods and changed health status eligibility provisions for employee health plans.

HFC Level I Appeals: First level administrative appeals of HFC Benefit Determinations.

HFC Level II Appeals: Second level administrative appeals of HFC Benefit Determinations.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

Homebound: A patient's medical condition is such that it significantly restricts the ability to leave the home, and the patient is unable to drive a motor vehicle by himself/herself.

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

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

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one Physician and at least one Registered Nurse (R.N.) to

govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse;

3. It maintains a complete medical record on each individual; and

4. It has a full-time administrator.

Home Health Care Plan: A program for care and treatment of a Homebound Covered Person, established and approved by the Covered Person's attending Physician, which is in lieu of confinement as an Inpatient in a Hospital or other Inpatient facility in the absence of the services and supplies provided for under the Home Health Care Plan.

Home Infusion Therapy: The administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and family education; and
6. Nursing services.

Over-the-counter products which do not require a Physician’s or other provider’s prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Home Infusion Therapy Provider: An entity that is duly licensed by the appropriate State agency to provide Home Infusion Therapy.

Hospice: A health care program 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 diagnosis. A Hospice must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse, and it 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.

Hospice Benefit Period: A specified amount of time during which the Covered Person undergoes Hospice care. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end the earlier of six (6) months from this date or at the death of the Covered Person. A new benefit period may begin if the attending Physician certifies that the Covered Person is still terminally ill; however, additional proof may be required by the Claims Administrator before such a new benefit period can begin.

Hospital: An accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians;

2. It continuously provides twenty-four (24) hours per day nursing services by registered professional Nurses under the supervision of Physicians; and

3. It is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Hospital-Affiliated Facility/Affiliated Facility: A facility which provides medical services on an Outpatient basis that is owned, controlled, managed or otherwise affiliated with a Hospital.

Hospital and Facility Claims: Post-service Claims for charges by any Hospital, Hospital-Affiliated Facility or Free-Standing Facility.

Hospital Expenses: Charges by a Hospital for Room and Board (including private room accommodations) and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

Hospital Miscellaneous Expenses: The actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for room and board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness: A bodily disorder, Disease, physical sickness, mental infirmity, or functional nervous disorder of a Covered Person.

Immunization: The protection of individuals or groups from specific Diseases by vaccination or the injection of immune globulins.

Incurred Date: The date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Independent Facility/Free-standing Facility: An independent facility which provides medical services on an Outpatient basis (e.g., an Ambulatory Surgery Center) that is not owned, controlled, managed or otherwise affiliated with a Hospital.

Injury: A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Inpatient: Refers to a patient admitted as a bed patient to a Hospital, Hospice, Rehabilitation Facility or Skilled Nursing Facility for treatment or observation; charges must be incurred for Room and Board or observation for a period of at least twenty-four (24) hours.

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

Invalid Charges: Charges that are found to be based on “Errors,” “Unbundling,” “Misidentification” or “Unclear Description” (as such terms are defined in the “Claim Review and Validation Program” section of the Plan) or are otherwise determined by the Claims Delegate or the Plan Administrator to be invalid or impermissible based on any applicable law, regulation, rule or professional standard, or for fees or services determined not to have been Medically Necessary, Usual and Customary and Reasonable.

Late Enrollee: An Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan and who enrolls in the Plan more than thirty-one (31) days after the date of his/her initial eligibility and who is not eligible for a Special Enrollment or enrollment as a result of a Status Change, or who has failed to enroll by the end of a Special Enrollment Period or enrollment period for a Status Change. Late Enrollees can only enroll once a year during the Annual Open Enrollment Period for the Plan.

Leave of Absence: A Leave of Absence of an Employee that has been approved by his/her Participating Employer, as provided for in the Participating Employer’s rules, policies, procedures and practices.

Licensed Practical Nurse/Licensed Vocational Nurse: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the State or regulatory agency responsible for such licensing in the State in which that individual performs such services.

Material Reduction: Material Reduction in covered services or benefits is any modification to the Plan or change in the information required to be included in the Summary Plan Description (SPD) that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Plan Participant to be an important reduction in covered services or benefits.

Maximum Amount or Maximum Allowable Charge: The benefit payable for a specific coverage item or benefit under the Plan, which will be the lesser of:

1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. The negotiated rate established in a contractual arrangement with a Provider; or
4. The actual billed charges for the covered services.

The Maximum Allowable Charge will not include any identifiable Invalid Charges and may be determined by the Claims Delegate or the Plan Administrator, as appropriate, according to the Medical Record Review and Billing Review results. The Plan will reimburse according to the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

Medical Care Benefits: Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of disease or amounts paid for the purpose of affecting any structure or function of the body.

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

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

Medical Record Review: The process by which the Plan, based upon a review and audit of medical records, determines that a different treatment or different quantity of a drug or supply was provided which is not supported in the billing or that treatment, drugs or other services or supplies, or fees therefore, were provided that were not clinically appropriate or were only necessary for the care and treatment of Illness or Injury that was caused by the treating Provider.

Medical Review Specialist: An organization under contract to the Claims Delegate or the Plan Administrator to provide the services required under the Cost Containment Features of Hospital Admission Notification/Continued Stay Review/Case Management or to assist with Medical Record Review. The Plan Administrator will furnish the name, address, and phone number of the Medical Review Specialist.

Medically Justified Variance: A rare occasion in which standard of care medical treatment (including medication) is not available outside of a clinical trial; or the medical care available outside a clinical trial is not appropriate for the patient's medical status or diagnosis. A physician advisor determines that a Medically Justified Variance situation is present and reviews proposed care for approval as Medically Necessary and a covered plan benefit. An Alternative Care Plan and written physician advisor report accompanies the determination of a Medically Justified Variance.

Medically Necessary/Medical Necessity: Refers to health care services ordered by a Physician or Dentist exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions and are at least as

likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's sickness or Injury without adversely affecting the Plan Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment.
2. Its purpose must be to restore health.
3. It must not be primarily custodial in nature.
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare).
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician or Dentist does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors or medical advisors to the Claims Delegate. Each of the Plan Administrator and the Claims Delegate have the discretionary authority to decide whether care or treatment is or was Medically Necessary.

Medicare Benefits: All benefits under Parts A, B and/or D of Title XVIII of the Social Security Act of 1965, as amended from time to time.

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

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

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

Midwife: A Practitioner who is certified as a Nurse Midwife (C.N.M.) by the American College of Nurse-Midwives and who is authorized to practice as a Nurse Midwife under State regulations.

Minor Emergency Medical Clinic: A Free-standing Facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical

Clinic, by whatever actual name it may be called; however, a clinic located on the premises of, or in conjunction with, or in any way made a part of, a regular Hospital shall be excluded from the terms of this definition.

Misidentification: As defined in the Claim Review and Validation Program section of the Plan.

Morbid Obesity: A diagnosed condition in which the body weight of an individual is the greater of 100 pounds or 100% over the medically recommended weight for a person of the same height, age and mobility and by a BMI (body mass index) greater than 40 (in accordance with the Utilization Review Company's criteria for morbid or severe obesity).

National Medical Support Notice or NMSN: A notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or children of the Participant or the name and address of an official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): A regulation restricting the extent to which group health plans may limit Hospital lengths of stays for mothers and newborn children following delivery. NMHPA regulations apply as of the first day of the first Plan Year beginning on or after January 1, 1998.

No-Fault Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the accident.

Nurse: An individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

OBRA: The coverage provided under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993.

Occupational Therapy: Treatment which is rendered for reasons other than restoration of bodily functions and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Oral Surgery: Maxillofacial Surgical Procedures include, but are not limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and pre-malignant lesions and growths;
2. Incision and drainage of facial abscess; and
3. Surgical Procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses.

Orthopedic Shoes: Special shoes designed for support of the feet or the prevention or correction of deformities of the feet.

Orthotic Devices: External devices used to support, align, prevent or correct deformities or to improve the function of movable parts of the body. An Orthotic insole is a foot supporting device prescribed by a Physician or licensed Practitioner. **The Plan has no benefits for Orthotic insoles for the foot.**

Outpatient: A patient who receives medical services at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours. This term can also be applicable to services rendered in a free-standing independent facility, such as an Ambulatory Surgery Center.

Outpatient Chemical Dependency/Drug Treatment Facility: An institution which provides a program for a diagnosis, evaluation and effective treatment of Chemical Dependency, and/or drug use or abuse; provides detoxification services needed with its effective treatment program; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a Physician; and meets applicable State and Federal, if any, licensing standards.

Outpatient Psychiatric Day Treatment Facility: An administratively distinct governmental, public, private or independent unit or part of such unit that provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Part-time Employee: An Employee who is not regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility Section of this Plan Document.

Permitted Payment Level(s): The charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees are within applicable limits established in this Plan, which limits include, but are not limited to, the terms set forth on page 103, in the “Claim Review and Validation Program” section of the Plan).

Physical Therapy: Management of the patient’s movement system. This includes conducting an examination; alleviating impairments and functional limitation; preventing Injury, impairment, functional limitation and disability; and engaging in consultation, education and research. Direct interventions include the appropriate use of patient education, therapeutic exercise and physical agents such as massage, thermal modalities, hydrotherapy and electricity.

Physically or Mentally Handicapped: The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the State or jurisdiction where the services are rendered.

Placement for Adoption: A Child placed with the Covered Employee for adoption, whether or not the adoption has become final, will be considered eligible and will be covered from the date of such adoption or Placement for Adoption. "Placement" means the assumption and retention by the Covered Employee of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child.

Plan: Without qualification, this Plan Document/Summary Plan Description, including any Plan Amendments thereto.

Plan Administrator: South Texas Health Cooperative, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process Claims and perform other Plan connected services.

Plan Amendment: A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan Participant: Eligible Employee, Eligible Dependent, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary’s Dependent properly enrolled in the Plan.

Plan Sponsor: South Texas Health Cooperative.

Plan Year: The twelve (12) month period beginning September 1 and ending August 31 of the next Calendar Year. The Plan Year is the year on which Plan records are kept.

Post-Service Claim: Any Claim for which payment is requested for medical care already rendered to the Claimant.

Practitioner: A Physician or person acting within the scope of applicable State licensure/certification requirements including the following:

1. Advanced Practice Nurse (A.P.N.)
2. Audiologist
3. Certified Diabetic Educator and Dietitian
4. Certified Nurse Midwife (C.N.M.)
5. Certified Operating Room Technician (C.O.R.T.)
6. Certified Registered Nurse Anesthetist (C.R.N.A.)
7. Certified Surgical Technician (C.S.T.)
8. Doctor of Chiropractic (D.C.)
9. Doctor of Dental Medicine (D.M.D.)
10. Doctor of Dental Surgery (D.D.S.)
11. Doctor of Medicine (M.D.)
12. Doctor of Optometry (O.D.)
13. Doctor of Osteopathy (D.O.)
14. Doctor of Podiatric Medicine (D.P.M.)
15. Licensed Clinical Social Worker (L.C.S.W.)
16. Licensed Occupational Therapist
17. Licensed or Registered Physical Therapist
18. Licensed Practical Nurse (L.P.N.)
19. Licensed Professional Counselor (L.P.C.)
20. Licensed Surgical Assistant (L.S.A.)
21. Licensed Vocational Nurse (L.V.N.)
22. Master of Social Work (M.S.W.)
23. Physician Assistant (P.A.)
24. Psychologist (Ph.D., Ed.D., Psy.D.)
25. Registered Nurse (R.N.)
26. Registered Nurse First Assistant (R.N.F.A.)
27. Speech Language Pathologist

Preexisting Condition: Any physical or mental Illness or Injury for which the Covered Person received medical care, advice, diagnosis or treatment, or for which a Physician was consulted or for which medical expenses were incurred or for which a Covered Person took prescribed drugs or medicines during the six (6) months immediately prior to the Covered Person's Enrollment Date in the Plan. The Pre-existing Condition limitation does not apply to Covered Person(s) who have not yet reached the age of nineteen (19)

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription Drugs: Licensed medicine that is government regulated which must be prescribed by a Qualified Prescriber before it can be obtained.

Preventive Care: Certain preventive care services.

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

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

Copies of the recommendations and guidelines may be found here:
http://www.healthcare.gov/center/regulations/prevention/recommendations.html.

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other Facility providing services on an Inpatient basis in which one (1) patient bed is available per room.

Private Duty Nursing: Continuous skilled care or intermittent care by a Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse while a patient is not confined in a Hospital. **The Plan has no benefits for Private Duty Nursing.**

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Provider: A provider of covered services and/or supplies to or for a Plan Participant, which may include, without limitation, a Hospital, Ambulatory Surgery Center, Facility, Physician or other Practitioner.

Psychiatric Treatment Facility: A mental health facility which:

1. Provides treatment for individuals who suffer from acute Mental and Nervous Disorders;
2. Uses a structured psychiatric program with individual treatment plans that have specified goals and appropriate objectives for the patient and treatment modality of the program; and
3. Is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Medical Child Support Order (QMCSO): As originally enacted in OBRA 1993, as amended, a Medical Child Support Order that satisfies the following requirements to be a Qualified Medical Child Support Order:

1. The name and last known mailing address of the Plan Participant.
2. The name and address of each alternate recipient. "Alternate recipient" means any Child of a Plan Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Plan Participant.
3. A reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined.
4. The period for which coverage must be provided.
5. Each plan to which the order applies.

Qualified Medical Child Support Orders include not only court orders, but also administrative processes established under State law.

Reasonable: In the Plan Administrator's or Claims Delegate'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 Claims Delegate or 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 consequences for patients, are not Reasonable. The Claims Delegate or the Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon

information presented to the Claims Delegate or 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 directly or indirectly from Provider error(s) and/or Facility-acquired conditions deemed "reasonably preventable" in accordance with evidence-based guidelines such as, but not limited to, CMS guidelines. By way of clarification, and without limitation, charges are not considered Reasonable if they are care, supplies, treatment, and/or services required or intended to treat Injuries sustained or Illnesses contracted while the Plan Participant was under and due to the care of a Provider, including infections and complications, when such injury, illness, infection or complication would not reasonably be expected to occur under the circumstances of a course of treatment and can be attributed to an error by the Provider, in the opinion of the Claims Delegate, in light of the medical records of the treatment.

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.

With regard to any provider or facility directly contracted with the Co-op and the Plan Administrator, the negotiated rates and fees specifically established under such contract for Directly Contracted Provider Services shall be presumed to be Reasonable.

Reconstructive Surgery: A procedure performed to restore the anatomy and/or functions of the body which were lost or impaired due to an Injury or Illness.

Referred Appeal: Any second level appeal of an Adverse Benefit Determination on a Claim other than a Hospital and Facility Claim which appeal is specifically identified and referred to the Delegate by the Plan Administrator and/or Claims Administrator for review and determination.

Referred Claim(s): Any Claim, other than a Hospital and Facility Claim, that is specifically identified and referred to the Delegate by the Plan Administrator and/or Claims Administrator for Claim Review.

Registered Nurse: An individual who has received specialized nursing training and is authorized to use the designation of "R.N.," and who is duly licensed by the State or regulatory agency responsible for such licensing **in the State in which the individual performs such nursing services.**

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory, or part-time care services, or an institution which primarily provides treatment of Mental and Nervous Disorders or Chemical Dependency, except if such Facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of mental conditions or drug addiction or Chemical Dependency in the jurisdiction where it is located, or it is accredited as such a Facility by the Joint Commission on the Accreditation of Health Care Organizations, or the Commission on the Accreditation of Rehabilitation Facilities.

Retrospective Review: A determination by the Utilization Review Company that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

Room and Board: All charges, by whatever name called, which are made by a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or other covered Facilities as a condition of Inpatient confinement as a bed patient. Such charges do not include the professional services of Physicians nor intensive nursing care, by whatever name called.

Routine Newborn Care: Inpatient charges for a well newborn Child for nursery room and board, related expenses following birth, including newborn hearing tests and Physician's pediatric services including circumcision. This term does not apply to a newborn Child's diagnosed Illness.

Security Incidents: "Security Incidents" has the meaning set forth in 45 C.F.R. Section 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

Semi-Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other facility providing services on an Inpatient basis in which at least two patient beds are available per room.

Series of Treatments: A Series of Treatments is a planned, structured program which may include Inpatient or Outpatient treatment and is complete when the Covered Person is discharged on medical advice from Inpatient care, Day Treatment or Outpatient Treatment without a lapse in treatment or when a person fails to materially comply with the treatment program for a period of thirty (30) days.

Significant Break in Coverage: A period of sixty-three (63) consecutive days or more during which the Employee or Dependent did not have any Creditable Coverage. Waiting Periods are not considered in determining Significant Breaks in Coverage.

Skilled Nursing Facility/Extended Care Facility: An institution that:

1. Primarily provides skilled, as opposed to custodial, nursing services to patients; and
2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations and/or Medicare.

Sleep Disorder: Medical/psychological condition that disrupts the patient's sleep on a chronic basis.

Special Enrollee: An Eligible Employee and his/her Eligible Dependents who have Special Enrollment rights and who enroll in the Plan during a Special Enrollment Period.

Special Enrollment Period: The period of thirty-one (31) days in which an Eligible Employee or Dependent who previously declined enrollment in the Plan by signing a waiver of coverage can enroll in the Plan. The Special Enrollment Period for both Employees and Dependents can be activated by:

1. Loss of eligibility for other coverage (except for cause or non-payment of premium);
2. A new Dependent acquired by an Employee through marriage, birth, adoption or Placement for Adoption;
3. Loss of eligibility under Medicaid or a State Children's Health Insurance Program (CHIP) (in which case the Special Enrollment Period is sixty (60) days); or
4. Gain of eligibility for a premium assistance subsidy under Medicaid or CHIP (in which case the Special Enrollment Period is sixty (60) days).

Speech Therapy: A program which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his/her social interaction skills, such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills, such as understanding abstract thought, making decisions, sequencing, etc. Therapy must be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic disease process.

Status Change: Cafeteria plans (under Section 125 of the Internal Revenue Code) permit coverage changes during a Plan Year when a change in status occurs that affects gain or loss of eligibility for coverage for the Employee, the Employee's spouse or Dependent. Some examples of a Status Change are: change in Employee's legal marital status, change in number of Employee's Dependents, change in employment status of Employee, spouse or Dependent and loss of other coverage.

Substance Abuse: The excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (i.e., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (i.e., driving an automobile or operating a machine when impaired by substance use);

    c. Recurrent substance-related legal problems (i.e., arrests for substance-related disorderly conduct); and
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e., arguments with spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center: An Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a Facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following:

1. Substance abuse (see above);
2. Continuation of use despite related problems;
3. Development of tolerance (more of the drug is needed to achieve the same effect); and
4. Withdrawal symptoms.

Surgery: Any of the following:

1. The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
2. The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
3. 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;
4. The induction of artificial pneumothorax and the injection of sclerosing solutions;
5. Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
6. Obstetrical delivery and dilatation and curettage; or
7. Biopsy.

Surgical Procedure: Surgical Procedures will include all CPT (Current Procedural Terminology) codes from 10000 to 69999.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint (TMJ) Syndrome: Also known as myofascial pain-dysfunction syndrome, is a disorder that affects the temporomandibular joints at either side of the jaw. **The Plan has no benefits for treatment of TMJ.**

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or

2. A Dependent or a COBRA Qualified Beneficiary from performing the normal activities of a person of that age and sex in good health.

Unbundling: As defined in the Claim Review and Validation Program section of the Plan.

Unclear Description: As defined in the Claim Review and Validation Program section of the Plan.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): A Federal law which applies to persons who have been absent from work because of "service in the uniformed services." "Uniformed services" consists of the United States Army, Navy, Marine Corps, Air Force or Coast Guard; Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve or Coast Guard Reserve; Army National Guard or Air National Guard; Commissioned Corps of the Public Health Service; any other category of persons designated by the President in time of war or emergency. "Service" in the uniformed services means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work for an examination to determine a person's fitness for any of the designated types of duty.

Usual and Customary: Eligible, covered expenses identified by the Claims Delegate or 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 or accepted 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 or for which a reimbursement is accepted. 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 or reimbursement does not exceed the common level of charges made or reimbursements accepted 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 nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge or reimbursement for any procedure, service, or supply, and whether a specific procedure, service or supply customary.

Usual and Customary charges and/or reimbursements may, at the Plan Administrator's or Claims Delegate'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.

For claim determinations made in accordance with the Claim Review and Validation Program, the Usual and Customary fee will be the Permitted Payment Levels. Please refer to the section, "Claim Review and Validation Program," for the definition of Permitted Payment Levels.

Utilization Review (UR): Process by which consistent and measurable standards are applied in which to evaluate and control health care utilization by determining appropriateness of care, setting and Medical Necessity.

Utilization Review (UR) Company: Managed Care Concepts or such other company as may subsequently, as of any particular point in time, be engaged by or on behalf of the Plan for purposes of providing the Utilization Review Program.

Well Baby Care or Well Child Care: Medical treatment, services or supplies rendered to a Child solely for the purpose of health maintenance and not for the treatment of an Illness or Injury, to include medical screenings for vision and hearing.

APPENDIX I

STATES WITH CONSUMER ASSISTANCE PROGRAMS UNDER PHS ACT SECTION 2793

** Current as of March 18, 2011 **

(Periodic updates will be posted at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html)

In addition to the State information provided in the chart below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to participants and beneficiaries in need of assistance. Plans and issuers are encouraged to include EBSA's contact information in their notices as well. (EBSA contact information is also included in the Department's model notices.)

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

State	Contact Information
Alabama	No program
Alaska	No program
American Samoa	Not yet operational
Arizona	No program
Arkansas	Arkansas Insurance Department, Consumer Services Division 1200 West Third St.
California	California Department of Managed Health Care Help Center 980 9th Street, Suite 500 Sacramento, CA 95814 (888) 466-2219 http://www.healthhelp.ca.gov helpline@dmhc.ca.gov
Colorado	No program
Connecticut	Connecticut Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 (866) 466-4446 www.ct.gov/oha healthcare.advocate@ct.gov
Delaware	Delaware Department of Insurance 841 Silver Lake Blvd Dover, DE 19904 (800) 282-8611 consumer@state.de.us

State	Contact Information
District of Columbia	DC Office of the Health Care Ombudsman and Bill of Rights 899 North Capitol Street, NE, 6th Floor, Room 6037 Washington, DC 20002 (877) 685-6391 healthcareombudsman@dc.gov
Florida	No program
Georgia	Georgia Office of Insurance and Safety Fire Commissioner Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 http://www.oci.ga.gov/ConsumerService/Home.aspx
Guam	Guam Department of Revenue and Taxation 1240 Army Drive Barrigada, Guam 96921 (671) 635-1844
Hawaii	No program
Idaho	No program
Illinois	Illinois Department of Insurance 100 Randolph St, 9th Floor Chicago, IL 60601 (877) 527- 9431, or Illinois Department of Insurance 320 W. Washington St, 4th Floor Springfield, IL 62727 http://www.insurance.illinois.gov DOI.Director@illinois.gov
Indiana	No program
Iowa	Iowa Consumer Advocate Bureau 330 Maple St Des Moines, IA 50319 (877) 955-1212
Louisiana	No program
Kansas	Kansas Insurance Department Consumer Assistance Division 420 SW 9th Street Topeka, KS 66612 (800) 432-2484 http://www.ksinsurance.org CAP@ksinsurance.org

State	Contact Information
Kentucky	Kentucky Department of Insurance, Consumer Protection Division P.O. Box 517 Frankfort, KY 40602 (877) 587-7222 http://insurance.ky.gov DOI.CAPOmbudsman@ky.gov
Maine	Consumer for Affordable Health Care 12 Church Street, PO Box 2490 Augusta, ME 04338-2490 (800) 965-7476 www.mainecahc.org consumerhealth@mainecahc.org
Maryland	Maryland Office of the Attorney General Health Education and Advocacy Unit 200 St. Paul Place, 16th Floor Baltimore, MD 21202 (877) 261-8807 http://www.oag.state.md.us/Consumer/HEAU.htm heau@oag.state.md.us
Massachusetts	Health Care for All 30 Winter Street, Suite 1004 Boston, MA 02108 (800) 272-4232 http://www.hcfama.org/helpline
Michigan	Michigan Office of Financial and Insurance Regulation MiCHAP P.O. Box 30220 Lansing, MI 48909 (877) 999-6442 http://michigan.gov/ofir ofir-ins-info@michigan.gov
Missouri	Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov consumeraffairs@insurance.mo.gov
Mississippi	Health Help Mississippi 800 North President Street Jackson, MS 39202 (877) 314-3843 www.healthhelpms.org healthhelpms@mhap.org
Montana	Montana Consumer Assistance Program 840 Helena Ave Helena, MT 59601 (800) 332-6148 http://www.csi.mt.gov

State	Contact Information
Nebraska	No program
Nevada	Office of the Governor, Consumer Health Assistance 555 East Washington Ave #4800 Las Vegas, NV 89101 (702) 486-3587 (888) 333-1597 http://www.govcha.state.nv.us cha@govcha.state.nv.us
New Hampshire	New Hampshire Department of Insurance 21 South Fruit Street, Suite 14 Concord, NH 03301 (800) 852-3416 www.nh.gov/insurance consumerservices@ins.nh.gov
New Jersey	New Jersey Department of Banking and Insurance 20 West State Street, PO Box 329 Trenton, NJ 08625 (800) 446-7467 (888) 393-1062 (appeals) http://www.state.nj.us/dobi/consumer.htm ombudsman@dobi.state.nj.us
New Mexico	New Mexico Public Regulation Commission Division of Insurance 1120 Paseo De Peralta Santa Fe, NM 87504 (888) 427-5772 http://nmprc.state.nm.us/id.htm mchb.grievance@state.nm.us
New York	Community Service Society of New York, Community Health Advocates 105 East 22nd Street, 8th floor New York, NY 10010 (888) 614-5400 http://www.communityhealthadvocates.org/
North Carolina	North Carolina Department of Insurance Health Insurance Smart NC 430 N. Salisbury Street Raleigh, NC 27603 (877) 885-0231 www.ncdoi.com
North Dakota	No program
Ohio	No program
Oklahoma	Oklahoma Insurance Department Five Corporate Plaza 3625 Northwest 56th Street, Suite 100 Oklahoma City, OK 73112 (800) 522-0071 (in-state only) (405) 521-2828 http://www.ok.gov/oid/Consumers/Consumer Assistance/index.html

State	Contact Information
Oregon	Oregon Health Connect P.O. Box 14480 Salem, OR 97309-0405 (855) 999-3210 www.oregonhealthconnect.org health.connect@state.or.us
Pennsylvania	Pennsylvania Department of Insurance 1326 Strawberry Square Harrisburg, PA 17111 (877) 881-6388 www.insurance.pa.gov
Puerto Rico	Puerto Rico Oficina de la Procuradora del Paciente 1215 Ponce de Leon PDA 18 Santurce, PR 00907 (800) 981-0031 www.pacientes.gobierno.pr querellas@opp.gobierno.pr
Rhode Island	Rhode Island Department of Business Regulation 1511 Pontiac Avenue, Bldg 69-2 Cranston, RI 02920 (401) 462-9520 www.dbr.state.ri.us and www.ohic.ri.gov InsuranceInquiry@dbr.ri.gov and HealthInsInquiry@ohic.ri.gov
South Carolina	South Carolina Department of Insurance Consumer and Individual Licensing Services Division P.O. Box 100105 Columbia, SC 29202 (800) 768-3467 http://www.doi.sc.gov consumers@doi.sc.gov
South Dakota	No program
Tennessee	Tennessee Department of Commerce and Insurance 500 James Robertson Pkwy Davy Crockett Tower, 4th floor Nashville, TN 37243 (800) 342-4029 www.tn.gov/commerce/insurance CIS.Complaints@state.tn.us
Texas	Texas Consumer Health Assistance Program Texas Department of Insurance Mail Code 111-1A 333 Guadalupe P.O. Box 149091 Austin, TX 78714 (855) 839-2427 (855-TEX-CHAP) www.texashealthoptions.com chap@tdi.state.tx.us
Utah	No program

State	Contact Information
Vermont	Vermont Legal Aid 264 North Winooski Ave. Burlington, VT 05402 (800) 917-7787 www.vtlegalaid.org
Virginia	Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov
Virgin Islands	Not yet operational
Washington	Washington Consumer Assistance Program 5000 Capitol Blvd Tumwater, WA 98501 (800) 562-6900 http://www.insurance.wa.gov cap@oic.wa.gov
West Virginia	West Virginia Office of the Insurance Commissioner Consumer Service Division P.O. Box 50540 Charleston, WV 25305 (888) 879-9842 http://www.wvinsurance.gov
Wisconsin	No program
Wyoming	No program

APPENDIX II

As it relates to this Plan, an Assignment of Benefits is prohibited to providers and facilities associated with providers on the following list:

1. Solara Facilities