

East Texas Baptist University
HEALTHCARE BENEFITS PLAN

PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION

Effective: January 1, 2000

Restated: January 1, 2009

Third Party Administrator:
Mutual Assurance Administrators, Inc.
4004 Belt Line Rd, Suite 160
Addison, TX 75001

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GENERAL PLAN INFORMATION

What is the purpose of the Plan?

The *Plan Sponsor* has established the *Plan* for your benefit, on the terms and conditions described herein. The *Plan Sponsor's* purpose in establishing the *Plan* is to help to offset, for you, the economic effects arising from an *injury* or *illness*. To accomplish this purpose, the *Plan Sponsor* must be cognizant of the necessity of containing health care costs through effective plan design, and the *Plan Administrator* must abide by the terms of the *summary plan description*, to allow the *Plan Sponsor* to allocate the resources available to help those individuals participating in the *Plan* to the maximum feasible extent.

The *Plan* is not a contract of employment between you and your *participating employer* and does not give you the right to be retained in the service of your *participating employer*.

The purpose of this *summary plan description* 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 medical expenses. The *summary plan description* is maintained by the *Plan Administrator* and may be inspected at any time during normal working hours by any *covered person*.

General Plan Information You Should Know

Name of Plan: East Texas Baptist University Healthcare Benefits Plan

Plan Sponsor: East Texas Baptist University
1209 N. Grove
Marshall, TX 75670
903 923-2120

Plan Administrator: East Texas Baptist University
(Named Fiduciary) 1209 N. Grove
Marshall, TX 75670
903 923-2120

Plan Sponsor ID No. (EIN): 75-0859801

Plan Year: January 1 through December 31

Plan Number: 501

Plan Type: Medical
Prescription Drug

Source of Contributions: Employee Contributory

Third Party Administrator: Mutual Assurance Administrators, Inc.
4004 Belt Line Rd., Suite 160
Addison, TX 75001
972 774-1100

Participating Employer(s): East Texas Baptist University
1209 N. Grove
Marshall, TX 75670
903 923-2120

ELIGIBILITY FOR PARTICIPATION

Am I eligible to participate in the Plan?

Class I: As a full-time *employee* regularly scheduled to work at least 30 hours per week, you are eligible for coverage when you begin *active employment*.

You must actually begin work for the *participating employer* in order to be eligible. If you are unable to begin work as scheduled, then your coverage will become effective on the date when you begin work.

Class II: Employees who are eligible for Medicare and are enrolled in Medicare Part A and Part B which elect a Supplemental policy will be eligible for the Drug Card plan under this policy.

Retirees: Employees grandfathered prior to January 15, 2006 and only covered to age 65.

After you become covered under the Plan, if your employment ends and you return to *active employment* you will be required to satisfy all eligibility and enrollment requirements as a new hire.

You are not eligible to participate if you are a part-time, temporary, leased or seasonal employee, or an independent contractor.

Are my dependents eligible to participate in the Plan?

Your *dependents* will become eligible for coverage on the latest of the following dates:

- The date you become eligible for coverage;
- The date coverage for *dependents* first becomes available under the *Plan*; and
- The first date upon which you acquire a *dependent*.

Please note: You must be covered under the Plan in order to cover any dependents.

No *dependent child* may be covered as a *dependent* of more than one *employee* who is covered under the *Plan*.

No person may be covered simultaneously under this *Plan* as both an *employee* and a *dependent*.

When will we become covered persons in the plan?

Coverage will become effective at 12:01 A.M. (except for newborn *children*) on the date specified below, subject to the conditions of this section.

- Coverage will become effective on the date you or your *dependents* are eligible, provided you and your *dependents* have enrolled for coverage on a form satisfactory to the *Plan Administrator* within 31 days following the date of eligibility.
- For a *dependent child* who is born after the date your coverage becomes effective:

You must make written application and agree to any required contributions during the first 31 days from the *child's* birth. Coverage for the *dependent child* will then become effective from the moment of birth, and no *pre-existing condition* limitation will apply.

- If you acquire a *dependent* while you are eligible for coverage for *dependents*, coverage for the newly acquired *dependent* will be effective on the date the *dependent* becomes eligible, provided you make written application for the *dependent* and agree to make any required contributions, within 31 days of the date of eligibility.

ELIGIBILITY FOR PARTICIPATION (Continued)

The *pre-existing condition* limitation will be waived for your adopted *child*, under age 18, and for a *child*, under age 18, placed in your home in anticipation of adoption, provided the adoption (or placement for adoption) occurs while you are covered under the *Plan* and provided that *child* has any *creditable coverage* during the first 30 days following the adoption (or placement for adoption) that is not followed by a *significant break in coverage*.

What if I do not enroll during my original eligibility period and later decide to apply for coverage?

You and your *dependents* may enroll for coverage during the *Plan's* annual open enrollment period, which is the month of December in each *plan year*. If you or your *dependents* enroll during an open enrollment period, coverage will be effective at 12:01 A.M. on the first day of the month following the open enrollment period, unless you have not satisfied the *waiting period*. In that case, coverage for you and your eligible *dependents* will be effective on the first day following your completion of the *waiting period*.

The *Plan's pre-existing condition* limitation will apply to this coverage. Please refer to the section entitled "Pre-existing Condition Limitation" for more information.

Are there any other exceptions for enrollment?

Special Enrollment Periods

This *Plan* provides two special enrollment periods that allow you to enroll in the *Plan*, even if you declined enrollment during an initial or subsequent eligibility period..

Loss of Other Coverage

If you declined enrollment for yourself or your *dependents* (including your spouse) because of other health coverage, you may enroll for coverage for yourself and/or your *dependents* if the other health coverage is lost. You must make written application for special enrollment within 30 days of the date the other health coverage was lost. For example, if you lose your other health coverage on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on October 16.

The following conditions apply to any eligible *employee* and *dependents*:

You may enroll during this special enrollment period:

- If you are eligible for coverage under the terms of this *Plan*;
- You are not currently enrolled under the *Plan*;
- When enrollment was previously offered, you declined because of coverage under another group health plan. You must have provided a written statement that other health coverage was the reason for declining enrollment under this *Plan*, and
- If the other coverage was terminated due to loss of eligibility for the coverage (including due to legal separation, divorce, death, termination of employment, or reduction in the number of hours), or because employer contributions for the coverage were terminated.

An *employee* who is already enrolled in a benefit package may **not** enroll in another benefit package under the *Plan* if a *dependent* of that *employee* has a special enrollment right in the *Plan* because the *dependent* lost eligibility for other coverage.

You are not eligible for this special enrollment right if:

ELIGIBILITY FOR PARTICIPATION (Continued)

- The other coverage was *COBRA* continuation coverage and you did not exhaust the maximum time available to you for that *COBRA* coverage, or
- The other coverage was lost due to non-payment of premium or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan).

If the conditions for special enrollment are satisfied, coverage for you and/or your *dependent(s)* will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the *Plan*.

New Dependent

If you acquire a new *dependent* as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your *dependents* during a special enrollment period. You must make written application for special enrollment no later than 30 days after you acquire the new *dependent*. For example, if you are married on September 15, you must notify the *Plan Administrator* and apply for coverage by close of business on October 16.

The following conditions apply to any eligible *employee* and *dependents*:

You may enroll yourself and/or your *eligible dependents* during this special enrollment period if:

- You are eligible for coverage under the terms of this *Plan*, and
- You have acquired a new *dependent* through marriage, birth, adoption or placement for adoption.

If the conditions for special enrollment are satisfied, coverage for you and your *dependent(s)* will be effective at 12:01 A.M.:

- For a marriage, on the first day of the calendar month following enrollment.
- For a birth, on the date of birth.
- For an adoption or placement for adoption, on the date of the adoption or placement for adoption.

What if a court orders coverage for a *child*?

Federal law requires the *Plan*, under certain circumstances, to provide coverage for your *children*. The details of these requirements are summarized below. Be sure you read them carefully

The *Plan Administrator* shall enroll for immediate coverage under this *Plan* any *alternate recipient* who is the subject of a “*medical child support order*” (“*MCSO*”) or “*national medical support notice*” (“*NMSN*”) that is a “*qualified medical child support order*” (“*QMCSO*”) if the *child* named in the *MCSO* is not already covered by the *Plan* as an *eligible dependent*, once the *Plan Administrator* has determined that the order or notice meets the standards for qualification set forth below.

“*Alternate recipient*” shall mean any *child* of a *covered person* who is recognized under a *MCSO* as having a right to enrollment under this *Plan* as the *covered person’s eligible dependent*. “*MCSO*” shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

ELIGIBILITY FOR PARTICIPATION (Continued)

- Provides for child support with respect to a *covered person's child* or directs the *covered person* to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
- Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

“*NMSN*” shall mean a notice that contains the following information:

- Name of an issuing state agency;
- Name and mailing address (if any) of an *employee* who is a *covered person* under the *Plan*;
- Name and mailing address of one or more *alternate recipients* (i.e., the *child* or *children* of the *covered person* or the name and address of a substituted official or agency that has been substituted for the mailing address of the *alternate recipients(s)*); and
- Identity of an underlying child support order.

“*QMCSO*” is an *MCSO* that creates or recognizes the existence of an *alternate recipient's* right to, or assigns to an *alternate recipient* the right to, receive benefits for which a *covered person* or eligible *dependent* is entitled under this *Plan*. In order for such order to be a *QMCSO*, it must clearly specify the following:

- The name and last known mailing address (if any) of the *covered person* and the name and mailing address of each *alternate recipient* covered by the order;
- A reasonable description of the type of coverage to be provided by the *Plan* to each *alternate recipient*, or the manner in which such type of coverage is to be determined;
- The period of coverage to which the order pertains; and
- The name of this *Plan*.

In addition, a *NMSN* shall be deemed a *QMCSO* if it:

- Contains the information set forth above in the definition of “*NMSN*”;
 - Identifies either the specific type of coverage or all available group health coverage. If the employer receives a *NMSN* that does not designate either specific type(s) of coverage or all available coverage, the employer and the *Plan Administrator* will assume that all are designated; or
 - Informs the *Plan Administrator* that, if a group health plan has multiple options and the *covered person* is not enrolled, the issuing agency will make a selection after the *NMSN* is qualified, and, if the agency does not respond within 20 days, the *child* will be enrolled under the *Plan's* default option (if any); and
- Specifies that the period of coverage may end for the *alternate recipient(s)* only when similarly situated *dependents* are no longer eligible for coverage under the terms of the *Plan*, or upon the occurrence of certain specified events.

ELIGIBILITY FOR PARTICIPATION (Continued)

However, such an order need not be recognized as “qualified” if it requires the *Plan* to provide any type or form of benefit, or any option, not otherwise provided to *covered persons* without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSO’s, as described in Social Security Act §1908.

Upon receiving a *MCSO*, the *Plan Administrator* shall, as soon as administratively possible:

- Notify the *covered person* and each *alternate recipient* covered by the order (at the address included in the order) in writing of the receipt of such order and the *Plan’s* procedures for determining whether the order qualifies as a *QMCSO*; and
- Make an administrative determination if the order is a *QMCSO* and notify the *covered person* and each affected *alternate recipient* of such determination.

Upon receiving a *NMSN*, the *Plan Administrator* shall:

- Notify the state agency issuing the notice with respect to the child whether coverage of the *child* is available under the terms of the *Plan* and, if so:
 - Whether the *child* is covered under the *Plan*; and
 - Either the *effective date* of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
- Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the *Plan Administrator* shall:

- Establish reasonable, written procedures for determining the qualified status of a *MCSO* or *NMSN*; and
- Permit any *alternate recipient* to designate a representative for receipt of copies of the notices that are sent to the *alternate recipient* with respect to the order.

When you and your spouse are both *covered persons*

When both you and your spouse are covered *employees*, and you have family coverage for *dependent children*, the *Plan* will allow one spouse to be treated as a *dependent* for purposes of calculating the *family unit deductible* and *out-of-pocket expense* amount. This will allow for the full benefit of family coverage and reduce the *out-of-pocket expenses* for the *family unit*. The spouse with the later date of hire will be treated as a *dependent* for the purposes stated in this section unless the *Plan Administrator* determines otherwise.

Changing status

When you change your coverage status between that of an *employee* and a *dependent*, and there is no break in coverage, full credit will be given for any amounts applied toward satisfaction of the current *calendar year deductible* and *out-of-pocket expense* limit, and any amounts applied toward *Plan* maximums will be carried forward.

PRE-EXISTING CONDITION LIMITATION

Will the Plan cover a pre-existing condition?

A *pre-existing condition* limitation applies for all *employees* and *dependents* entering or reentering the *Plan* after the *effective date*, except as set forth under *HIPAA*. The pre-existing condition limitation will apply to the following benefits of the Plan:

- Medical;

“*Pre-existing condition*” means any *illness* or *injury* (other than *pregnancy*), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care *provider* or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the 3 months immediately prior to your first day of coverage (the “*enrollment date*”).

No coverage is provided for expenses in connection with a *pre-existing condition*.

Full *Plan* coverage will be available for such condition on the day immediately following the expiration of 12 months after the *enrollment date*. You have the right to demonstrate any *creditable coverage*, and the applicable period will be reduced by any *creditable coverage* unless it occurred before a *significant break in coverage*.

“*Late enrollee*” means a *covered person* who enrolls in the *Plan* other than:

- On the earliest date on which coverage can become effective for the individual under the terms of the *Plan*; or
- Through special enrollment.

You may prove *creditable coverage* by either of two methods:

- For *creditable coverage* effective on or after July 1, 1996, you may present a written *certificate of coverage* from the source that provided the coverage showing:
 - The date the *certificate of coverage* was issued;
 - The name of the group health plan that provided the coverage;
 - The name of the individual to whom the *certificate of coverage* applies;
 - The name, address, and telephone number of the plan administrator or issuer providing the *certificate of coverage*;
 - A telephone number for further information (if different);
 - Either:
 - A statement that the individual has at least 12 months (365 days) of *creditable coverage*, not counting days of coverage before a *significant break in coverage*; or
 - The date any *waiting period* (and affiliation period, if applicable) began and the date *creditable coverage* began; and
 - The date *creditable coverage* ended, unless the *certificate of coverage* indicates that coverage is continuing; or

PRE-EXISTING CONDITION LIMITATION (Continued)

- If for any reason you are unable to obtain a *certificate of coverage* from another plan (including because the *creditable coverage* was effective prior to July 1, 1996), you may demonstrate *creditable coverage* by other evidence, including documents, records, third-party statements, or telephone calls by this *Plan* to a third-party *provider* of medical services. This *Plan* will treat an individual as having provided a *certificate of coverage* if that individual:
 - Attests to the period of *creditable coverage*;
 - Presents relevant corroborating evidence of some *creditable coverage* during the period; and
 - Cooperates with the *Plan Administrator's* efforts to verify his status.

You have the right to request a *certificate of coverage* from your current or prior health plan, and the *Plan Administrator* will help you in obtaining the *certificate of coverage*.

If, within a reasonable time after receiving the information about *creditable coverage*, the *Plan Administrator* determines that a limitation for *pre-existing conditions* applies, it will notify you of that conclusion and will specify the source of any information on which it relied in reaching that determination. The notification will also explain the *Plan's* appeals procedures and give you a reasonable opportunity to present additional evidence.

SELECTION OF YOUR HEALTH CARE PROVIDER

Overview of PPO/Non-PPO Option - Applicable to Medical Benefits Only

The *Plan Administrator* has entered into an agreement with one or more networks of *hospitals* and *physicians*, called “*PPO networks*.” These *PPO networks* offer *covered persons* health care services at discounted rates. Using a *PPO network provider* will normally result in a lower cost to the *Plan* as well as to the *covered person*. There is no requirement for any *covered person* to seek care from a *provider* who participates in the *PPO network*. The choice of *provider* is entirely up to the *covered person*.

If you reside or travel outside the *PPO network* area, (100 miles from the nearest *PPO provider*), and use a non-*PPO network provider*, your benefits will be based on the “PPO level shown in the “Schedule of Benefits”, not including the co-payments, and will be subject to the PPO deductible and PPO maximum out-of-pocket expense. **This also applies to dependent children who are covered by this Plan, and reside outside the network area.**

Services which are covered by this *Plan* and which are **not available** through a *PPO network provider* are paid at the *PPO network provider* percentage payable for *usual, customary and reasonable fees*, even when the services are provided by an non-*PPO network provider*.

Some *PPO network provider hospitals* have arrangements through which the benefit payable is more than the actual charges, e.g., per diem or diagnosis-related group (DRG) charges. When this occurs, the *Plan* will reimburse the *hospital* based upon the agreed per diem or DRG rates.

A current list of *PPO network providers* is available, without charge, through the website located at www.texastruechoice.com for Texas providers and www.beechstreet.com for providers in states other than Texas. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your employer. You may also contact your *PPO network* at the phone number on your *Plan ID card*.

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

Many *PPO network providers* will require that the *Plan* offer incentives, or “steerage,” in order to encourage *covered persons* to use their member *providers*. This *Plan* defines “steerage” as lower costs to the *covered person* through reduced charges, resulting in lower out-of-pocket amounts, or higher rates of reimbursement under the *Plan*. The *Plan Administrator* reserves the right to negotiate discounts with *providers* of service, and those discounts will be used to reduce the amount of otherwise *covered expenses* considered for payment by the *Plan*. In certain cases, the *Plan Administrator*, in its sole discretion, may determine that the benefit payable for a discounted claim will be at the *PPO network provider* reimbursement level, and such payments will be considered to be in full compliance with the terms of the *Plan*.

YOUR COSTS

You must pay for a certain portion of the cost of *covered expenses* under the *Plan*, including *deductibles*, copayments and the coinsurance percentage that is not paid by the *Plan*. This is called “*out-of-pocket expense*.”

Deductibles and copayments are shown in the “Schedule of Benefits.” A separate deductible applies to charges from *PPO network providers* and another for *non-PPO network providers*. If you use a combination of *PPO network providers* and *non-PPO network providers*, your total *deductible* amount required will not exceed the amount shown for *non-PPO network providers*. In other words, the amount of *deductible* expense you pay for both *PPO network providers* and *non-PPO network providers* will be combined, and the total will not exceed the amount shown for *non-PPO network providers* during a single *calendar year*. The *Plan* limits the amount of *deductible* and *out-of-pocket expense* you must pay for your *family unit*, as shown in the “Schedule of Benefits.”

There may be differences in the coinsurance percentage payable by the *Plan* depending upon whether you are using a *PPO network provider* or a *non-PPO network provider*. These payment levels are also shown in the “Schedule of Benefits.”

The *Plan* contains a limit for the amount of *out-of-pocket expense* you must pay toward *covered expenses*, shown in the “Schedule of Benefits,” and your *out-of-pocket expense* limit may be higher for *non-PPO network providers* than for *PPO network providers*. The amount of *out of pocket expense* you pay for both *PPO network providers* and *non-PPO network providers* will **not** be combined. Please note, however, that not all *covered expenses* are eligible to accumulate toward your *out-of-pocket expense* limit. These types of expenses include:

- *Chiropractic care*
- Prescription *drug* copayments
- *Substance abuse treatment*
- Amounts applied toward *deductibles*
- Physician office visit copayments
- Hospital Pre-certification Penalties.
- Any charge determined to be above the Usual and Customary charge for a drug, service, device, procedure or treatment; or
- Any expenses associated with Plan Exclusions, Limitations, or copayments.

Reimbursement for these types of *covered expenses* will continue at the percentage payable shown in the “Schedule of Benefits,” subject to the *Plan* maximums.

In addition, certain types of expenses may be subject to dollar maximums or limited to a certain number of visits in a given year. This information is contained in the “Schedule of Benefits” section. Expenses in excess of these *plan* limits will not accumulate toward the *out-of-pocket expense* limit.

Once you have paid the *out-of-pocket expense* limit for eligible expenses *incurred* during a calendar year, the *Plan* will reimburse additional eligible *covered expenses incurred* during that year at 100%.

The *Plan* will not reimburse any expense that is not a *covered expense*. In addition, you must pay any expenses to which you have agreed that are in excess of the *usual, customary and reasonable fees*, and any penalties for failure

YOUR COSTS (Continued)

to comply with requirements of the “Cost Containment Provisions” section or penalties that are otherwise stated in the *Plan*. None of these amounts will accumulate toward your *out-of-pocket expense* limit.

If you have any questions about whether an expense is a *covered expense*, or whether it is eligible for accumulation toward your *out-of-pocket expense* limit, please contact the *third party administrator* for assistance.

SCHEDULE OF MEDICAL BENEFITS

This schedule is provided as a convenience only and is not all-inclusive. Important information is contained in sections, “Medical Benefits” and “Exclusions and Limitations.” You may find the “Definitions” section helpful in understanding some of the italicized terms used throughout this *summary plan description*. In addition, the *Plan* has other requirements and provisions that may affect benefits, such as “Cost Containment Provisions,” and it is strongly recommended that you read the entire *summary plan description* to ensure a complete understanding of the *Plan* provisions. You may also contact the *third party administrator* or the *Plan Administrator* for assistance.

Lifetime Maximum Benefits

The following lifetime maximums apply to each *covered person*:

Lifetime Maximum Benefits for:	
Lifetime Maximum Benefit for All Benefits	\$1,000,000
Hospice Care	\$10,000
Substance Abuse Treatment	\$25,000
Temporomandibular Joint (TMJ) Disorder	\$2,500

Any separate lifetime maximums are included in, and are not in addition to, the Lifetime Maximum Benefit for All Benefits, shown above. The total payments for all benefits under the Plan will not exceed that maximum, whether or not the covered person is continuously covered under the Plan.

Calendar Year Maximum Benefits

The following *calendar year* maximums apply to each *covered person*:

Calendar Year Maximum Benefits for:	
<i>Chiropractic Care</i>	\$2,000
<i>Home Health Care</i>	100 visits or 10,000
<i>Bereavement Counseling</i>	\$2,000
<i>Inpatient Rehabilitation Facility Services</i>	60 days
<i>Mental Disorders (Inpatient and Partial Hospitalization)</i>	30 days
<i>Mental Disorders (Outpatient)</i>	50 visits
<i>Occupational Therapy, Physical Therapy, Speech Therapy (combined)</i>	60 visits
<i>Skilled Nursing Facility – Inpatient Services</i>	180 days
<i>Sleep Disorders (obstructive sleep apnea only)</i>	\$2,000
<i>Substance Abuse (Inpatient and Partial Hospitalization)</i>	30 days and \$10,000
<i>Substance Abuse (Outpatient)</i>	50 visits and \$10,000
<i>Well Care – Age 7 and over</i>	\$600
<i>Well Child Care – Age 7 and under</i>	\$600

Calendar year maximum benefits will accumulate toward any applicable lifetime maximum limits.

SCHEDULE OF MEDICAL BENEFITS (Continued)

Deductibles, Percentage Payable and Out-of-Pocket Expense Limits

The following amounts are applied per *covered person* per *calendar year*:

	\$1,000 Deductible PPO Network Providers	\$1,000 Deductible Non- PPO Network Providers	\$1,500 Deductible PPO Network Providers	\$1,500 Deductible Non- PPO Network Providers
<i>Deductible</i>				
• Individual	\$1,000	\$1,000	\$1,500	\$1,500
• <i>Family Unit</i>	\$2,000	\$2,000	\$3,000	\$3,000
Percentage Payable (unless otherwise stated)	80%	60 %	80 %	60 %

Covered expenses incurred during the last three months of a *calendar year* that were applied toward the *deductible* will be allowed as credit toward satisfaction of the *deductible* in the following *Calendar year*.

	Both Plans PPO Network Providers	Both Plans Non-PPO Network Providers
<i>Out-of-Pocket Expense Limit*</i>		
• Individual	\$2,000	\$8,000
• <i>Family Unit</i>	\$4,000	\$16,000
* Certain types of expenses are not accumulated toward this <i>out-of-pocket expense</i> limit. These expenses are identified in the section, "Your Costs." For " Out of Area " benefits see information identified in the section, " <i>Selection of Your Health Care Provider</i> ".		

Carry-Over Feature: If a Covered Person is confined in a hospital on January 1 and the confinement began in the previous calendar year, any covered expenses which counted toward that person's individual deductible and out-of-pocket maximum for the previous calendar year will continue to be counted toward that person's individual and out-of-pocket maximum for the current calendar year for that confinement until the Covered Person is no longer hospital confined.

Payment Levels and Limits

The *deductible* will not apply to *covered expenses* unless otherwise noted in this section. Maximums stated apply to the amount of benefit payments unless otherwise indicated. **If a covered person seeks treatment from a Participating Provider Facility then all Non-PPO ancillary covered charges, and covered charges by a surgeon, radiologist, anesthesiologist, assistant surgeon, pathologist and emergency room physician are payable at the PPO Benefit level.**

Hospital Inpatient Services			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits:
Medical/Surgical Room & Board & Ancillary	80% for semi-private room and ancillary charges subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> for semi-private room and ancillary charges subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Hospital Inpatient Services			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits:
<i>Intensive Care Unit Room & Board</i>	80% <i>Intensive Care Unit</i> rate subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> of <i>Intensive Care Unit</i> rate subject to <i>deductible</i>	
Personal Items	Not Covered	Not Covered	
Extended Skilled Nursing Facility, Room & Board & Ancillary	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 180 days per <i>calendar year</i> maximum Confinement must follow 3 days in a <i>hospital</i> and must be for continued treatment
Rehabilitation Facility Room & Board & Ancillary	80% for semi-private room and ancillary charges subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> for semi-private room and ancillary charges subject to <i>deductible</i>	Limited to 60 days per <i>calendar year</i> maximum Confinement must follow 3 days in a <i>hospital</i> and must be for continued treatment

Hospital Newborn Care			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits:
Neo-Natal Room & Board & Ancillary	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fee</i> subject to <i>deductible</i>	
Newborn Nursery & Ancillary	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fee</i> subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Hospital Mental or Nervous Disorder & Substance Abuse			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
<i>Mental or Nervous Disorder Partial Hospitalization</i> ❖ 2 days equal to 1 inpatient day	80% for semi-private room and ancillary charges subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> for semi-private room and ancillary charges subject to <i>deductible</i>	Limited to 30 days per <i>Calendar year</i> maximum for <i>inpatient</i> stays <i>Not Combined with Substance Abuse</i>
<i>Mental or Nervous Disorder Inpatient Room & Board & Ancillary</i>	80% for semi-private room and ancillary charges subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> for semi-private room and ancillary charges subject to <i>deductible</i>	Limited to 30 days per <i>Calendar year</i> maximum <i>Not Combined with Substance Abuse</i>
<i>Substance Abuse Care Partial Hospitalization</i> ❖ 2 days equal to 1 inpatient day	80% for semi-private room and ancillary charges subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> for semi-private room and ancillary charges subject to <i>deductible</i>	Limited to 30 days and \$10,000 per <i>Calendar year</i> maximum and \$25,000 Lifetime for <i>inpatient</i> stays <i>Not Combined with Mental Nervous</i>
<i>Substance Abuse Care Inpatient Room & Board & Ancillary</i>	80% for semi-private room and ancillary charges subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> for semi-private room and ancillary charges subject to <i>deductible</i>	Limited to 30 days and \$10,000 per <i>Calendar year</i> maximum and \$25,000 Lifetime for <i>inpatient</i> stays <i>Not Combined with Mental Nervous</i>

Physician In-Hospital Services			
Services Provided in an “In network” facility, by an “out of network” doctor should be treated as “in network”			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
<i>Physician Medical Hospital Visit</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
<i>Physician Newborn Visit</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Physician In-Hospital Services Services Provided in an “In network” facility, by an “out of network” doctor should be treated as “in network”			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
<i>Consultant Visit</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
<i>Mental or Nervous Disorder Hospital Visit</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 30 days per <i>Calendar year</i> maximum for <i>inpatient</i> stays <i>Not Combined with Substance Abuse</i>
<i>Substance Abuse Hospital Visit</i> ❖ 2 partial days equal to 1 <i>inpatient</i> day	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 30 days and \$10,000 per <i>Calendar year</i> maximum and \$25,000 Lifetime for <i>inpatient</i> stays <i>Not Combined with Mental Nervous</i>

Surgical Inpatient Services Services Provided in an “In network” facility, by an “out of network” doctor should be treated as “in network”			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Anesthesia	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Assistant Surgeon	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Obstetrical	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Surgeon	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Surgical Outpatient Services Services Provided in an “In network” facility, by an “out of network” doctor should be treated as “in network”			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Anesthesia	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Assistant Surgeon	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Obstetrical	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Surgeon	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

Professional Interpretation Services <i>Inpatient</i> Services Provided in an “In network” facility, by an “out of network” doctor should be treated as “in network”			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Pathologist Fee	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Radiologist Fee	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Hospital Emergency Room Services Services Provided in an “In network” facility, by an “out of network” doctor should be treated as “in network”			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Medical Emergency <i>Emergency Room</i>	80% after \$50 Copay per visit Deductible Waived	60% after \$50 Copay per visit of <i>usual, customary and reasonable fees</i> Deductible Waived	Co-pay is waived if admitted
Medical Emergency <i>Emergency Room Physician</i>	80% Deductible and Copay Waived	60% of <i>usual, customary and reasonable fees</i> Deductible and Copay Waived	
Non Medical Emergency <i>Emergency Room</i>	80% Subject to Deductible	60% of <i>usual, customary and reasonable fees</i> Subject to Deductible	
Non Medical Emergency <i>Emergency Room Physician</i>	80% Subject to Deductible	60% of <i>usual, customary and reasonable fees</i> Subject to Deductible	

Outpatient Surgery and Diagnostic Services (Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility)			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Outpatient Surgery	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Outpatient Diagnostic Services (Includes Lab, x-ray, and radiology)	80% subject to <i>deductible</i> When in conjunction with an office visit then paid at 100% deductible waived	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Outside of the Physician’s office

SCHEDULE OF MEDICAL BENEFITS (Continued)

Outpatient Surgery and Diagnostic Services <i>(Covered Health Services received on an outpatient basis at a Hospital or Alternate Facility)</i>			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Outpatient Diagnostic (CT Scans, Pet Scans, MRI, and Nuclear Medicine)	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	In or outside of the Physician's office
<i>Pre-Admission Testing</i> Prior to admission	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

Outpatient Facility Fees			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
<i>Ambulatory Surgery Center</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

Outpatient Therapy Services			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Biofeedback — Medical	Not Covered	Not Covered	
Cardiac Rehabilitation	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Chemotherapy	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	In or outside of the Physician's office

SCHEDULE OF MEDICAL BENEFITS (Continued)

Outpatient Therapy Services			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Dialysis <i>All dialysis claims are managed by Ethicare Medical Claim Management</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	In or outside of the Physician's office
Intravenous Therapy	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	In or outside of the Physician's office
Occupational Therapy	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 60 visits per <i>Calendar year</i> maximum and combined with Physical and Speech Therapy
Physical Therapy	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 60 visits per <i>Calendar year</i> maximum and combined with Occupational and Speech Therapy
Radiation Therapy	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	In or outside of the physician's office
Speech Therapy	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 60 visits per <i>Calendar year</i> maximum and combined with Occupational and Physical Therapy

SCHEDULE OF MEDICAL BENEFITS (Continued)

Physician's Office Services			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
<p>Physician Office Services (Includes services rendered in a physician's office located in a Hospital)</p> <p>Physician Office Visit</p> <p>Copayment per visit (applied to office visit only)</p> <p>All other Physician office services</p>	<p>100% after copayment (deductible Waived)</p> <p>subject to copayment of \$25 per visit</p> <p>100% Deductible Waived</p>	<p>60% of <i>usual, customary and reasonable fees</i> subject to deductible</p> <p>No Copayment</p> <p>60% of <i>usual, customary and reasonable fees</i> subject to deductible</p>	<p>Includes office surgery</p>
<p>Allergy Care</p> <p>Injections, testing, and serum</p> <p>Copayment per visit (Copayment waived if billed with an office visit)</p>	<p>100% after Copayment (deductible waived)</p> <p>\$25</p>	<p>60% of <i>usual, customary and reasonable fees</i> subject to deductible</p> <p>No copayment</p>	
<p>Diagnostic X-ray</p>	<p>100% Deductible Waived</p>	<p>60% of <i>usual, customary and reasonable fees</i> subject to deductible</p> <p>Related outpatient Non PPO diagnostic x-ray and lab services that are incurred as a result of a PPO physician office visit will be payable at the PPO level of benefits</p>	<p>In or outside of the physician's office when in conjunction with a physician's office visit</p>

SCHEDULE OF MEDICAL BENEFITS (Continued)

Physician's Office Services			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Diagnostic Laboratory	100% Deductible Waived	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i> Related outpatient Non PPO diagnostic x-ray and lab services that are incurred as a result of a PPO physician office visit will be payable at the PPO level of benefits	In or outside of the physician's office when in conjunction with a physician's office visit

<i>Urgent Care Center</i>			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
<i>Urgent Care Centers (Includes all services provided at the Urgent Care)</i>	80% subject to copayment of \$50 per visit (Deductible Waived)	60% of <i>usual, customary and reasonable fees</i> subject to copayment of \$50 per visit (Deductible Waived)	

Chiropractic Services			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Chiropractic Visit, Therapy and X-rays	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to \$2,000 per calendar year maximum

Outpatient <i>Mental or Nervous Disorder and Substance Abuse Services (Not Combined)</i>			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Biofeedback – <i>Mental or Nervous Disorder or Substance Abuse</i>	Not Covered	Not Covered	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Outpatient <i>Mental or Nervous Disorder</i> and <i>Substance Abuse</i> Services (Not Combined)			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
<i>Mental or Nervous Disorder</i> Office Visit - Outpatient	50% subject to <i>deductible</i>	50% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to a maximum of 50 visits per calendar year / Not combined with Substance Abuse
<i>Mental or Nervous Disorder</i> Testing and Evaluation	50% subject to <i>deductible</i>	50% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to a maximum of 50 visits per calendar year / Not combined with Substance Abuse
Social Worker Visit	50% subject to <i>deductible</i>	50% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to a maximum of 50 visits per calendar year / Not combined with Substance Abuse
<i>Substance Abuse</i> Visit Outpatient	50% subject to <i>deductible</i>	50% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to a maximum of \$10,000 and 50 visits per calendar year and \$25,000 Lifetime Not combined with Mental and Nervous

SCHEDULE OF MEDICAL BENEFITS (Continued)

Preventive Care Services Well Care – Age 7 and over			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Well Care – Age 7 and over (Limited to \$600 Maximum per calendar year)			
Physician Visit	100% after Copayment (deductible waived)	Not Covered	
Copayment per visit	\$25	Not Covered	
All other physician services	100% (deductible waived)	Not Covered	
Coverage includes: <ul style="list-style-type: none"> ● routine physical exams ● school physical ● sports physical ● hearing exam ● vision exams (including refractions) ● gynecological exam ● pap smear ● mammogram, limited to ages 35-39 one baseline exam; age 40 and over one every year ● bone density tests ● prostate exam and related laboratory tests (e.g., PSA) ● x-rays ● laboratory tests (e.g., urinalysis and blood tests) ● immunizations 			
<u>NOTE:</u> The following benefits are NOT subject to the \$600 calendar year maximum: <ul style="list-style-type: none"> ● contraceptive exams ● contraceptives: devices (diaphragms, patches, and IUDs), Implantable (Norplant) and injectables (Depo-Provera) 			

SCHEDULE OF MEDICAL BENEFITS (Continued)

Preventive Care Services Well Child Care – Age 6 and under			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Well Care – Age 6 and under (Limited to \$600 Maximum per calendar year)			
Physician Visit	100% after Copayment (deductible waived)	Not Covered	
Copayment per visit	\$25	Not Covered	
All other physician services	100% (deductible waived)	Not Covered	
Coverage includes: <ul style="list-style-type: none"> ● routine physical exams ● school physical ● sports physical ● hearing exam ● vision exams (including refractions) ● x-rays ● laboratory tests (e.g., urinalysis and blood tests) 			
<u>NOTE:</u> The following benefit is NOT subject to the \$600 calendar year maximum: <ul style="list-style-type: none"> ● immunizations 			

Second Surgical Opinion Services			
Percentage Payable For:	<i>PPO Network Providers</i>	<i>Non-PPO Network Providers</i>	Limits
Office Visit For Second Surgical Opinion	80% after Copayment (deductible waived)	60% of <i>usual, customary and reasonable fees</i>	Not required
Copayment per visit	\$25	subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Other Covered Expenses			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Ambulance — Air Transportation	80% subject to <i>deductible</i>	80% of <i>usual, customary and reasonable fees</i> subject to PPO <i>deductible</i>	
Ambulance — Ground Transportation	80% subject to <i>deductible</i>	80% of <i>usual, customary and reasonable fees</i> subject to PPO <i>deductible</i>	
Colonoscopy and Exams <i>Colon exam limited to age 50 and over (colonoscopy and related services) and related laboratory tests (e.g. occult blood screening)</i> <i>Colonoscopy is limited to age 50 and over unless medically necessary or due to family history.</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
<i>Durable Medical Equipment</i>	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Home Health Services	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to 100 visits and \$10,000 per calendar year maximum (whichever comes first)
Hospice	100% subject to <i>deductible</i>	100% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Hospice Care is limited to \$10,000 Maximum per Lifetime
Bereavement Counseling	100% subject to <i>deductible</i>	100% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Bereavement is limited to \$2,000 maximum per calendar year
Blood and Administration	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	

SCHEDULE OF MEDICAL BENEFITS (Continued)

Other Covered Expenses			
Percentage Payable For:	PPO Network Providers	Non-PPO Network Providers	Limits
Nuclear Medicine	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Oxygen and Administration	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
RN & LPN Services Outpatient	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Prosthetic Devices	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	
Sleep Disorders (Obstructive Sleep Apnea only) Coverage is provided for diagnostic services and non-surgical procedures.	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	<i>In or Outside of the physician's office and limited to \$2,000 maximum per calendar year.</i>
Temporomandibular Joint (TMJ) Syndrome Coverage provided for diagnostic services, surgical procedures and non-surgical procedures.	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to \$2,500 maximum per Lifetime
Lenses Following Cataract Surgery	80% subject to <i>deductible</i>	60% of <i>usual, customary and reasonable fees</i> subject to <i>deductible</i>	Limited to Initial pair

SCHEDULE OF MEDICAL BENEFITS (Continued)

Replacement of Organs/Tissues (Transplant Procedures)			
Percentage Payable For:	<i>PPO Network Provider</i>	<i>Non-PPO Network Provider</i>	Limits
Organ procurement and acquisition	Transplant required at Center of Excellence	Not Covered	<i>Will be limited as stated in the "Medical Covered Expenses" under Replacement of Organs/Tissues and Related Services</i>
Transplant Procedure	Transplant required at Center of Excellence	Not Covered	<i>Will be limited as stated in the "Medical Covered Expenses" under Replacement of Organs/Tissues and Related Services</i>

MEDICAL COVERED EXPENSES

Please refer to the “Cost Containment Provisions” section for important information concerning any requirements of the *Plan* for prior approval of certain services. The following *covered expenses* must be *incurred* while coverage is in force under this *Plan*. Reimbursement will be made according to the “Schedule of Benefits,” and will be subject to all *Plan* maximums, limitations, exclusions and other provisions.

Hospital Inpatient Benefits

Inpatient Care

For medical or *surgical* care of an *illness* or *injury*, the *Plan* will reimburse *covered expenses* for semi-private *room and board* and necessary ancillary expenses. If the *hospital* does not have semi-private accommodations, the *Plan* will allow coverage for the cost of the private accommodations.

Covered expenses will include *cardiac care units* and *intensive care units*, when appropriate for the *covered person's illness or injury*.

Maternity Care

Dependent children are not eligible for coverage for any expenses in connection with *pregnancy*.

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Benefits are payable in the same manner as for medical or *surgical* care of an *illness*, shown in the “Schedule of Benefits” and this section, and subject to the same maximums.

Newborn Care

Coverage for a newborn *child* will be available only if you have satisfied the requirements for coverage in the “Eligibility for Participation” section.

Covered expenses for newborn *children* include nursery and neo-natal intensive care *room and board*, necessary ancillary expenses, and routine newborn care during the period of *hospital* confinement, including circumcision.

Skilled Nursing (or Extended Care) Facilities Benefits

Covered expenses for *inpatient skilled nursing* or (extended care) *facilities* include semi-private *room and board* accommodations, and necessary ancillary charges. The confinement must begin following an *inpatient* stay of at least 3 days in a *hospital* and must be for continued treatment of the *illness* or *injury* being treated in the *hospital*.

Rehabilitation Facilities Benefits

Covered expenses for *inpatient rehabilitation facilities* include semi-private *room and board* accommodations and necessary ancillary charges. The confinement must begin following an *inpatient* stay of at least 3 days in a *hospital* and must be for continued treatment of the *illness* or *injury* being treated in the *hospital*.

MEDICAL COVERED EXPENSES (Continued)

Mental or Nervous Disorder and Substance Abuse Inpatient and Partial Hospitalization Services

Mental or Nervous Disorder Inpatient and Partial Hospitalization

Covered expenses for *inpatient* care of a *mental or nervous disorder* include semi-private *room and board* and necessary ancillary charges. Treatment must be rendered in a *hospital* or *psychiatric treatment facility*. If the *hospital* or *psychiatric treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for the cost of the private accommodations.

Substance Abuse Inpatient and Partial Hospitalization

Covered expenses for *inpatient* care of *substance abuse* include semi-private *room and board* and necessary ancillary charges. Treatment must be rendered in a *hospital* or *substance abuse treatment facility*. If the *hospital* or *substance abuse treatment facility* does not have semi-private accommodations, the *Plan* will allow coverage for the cost of the private accommodations.

Physicians' In-Hospital Services

In-Hospital Medical Services

Covered expenses include professional services rendered by the attending *physician* while the *covered person* is *hospitalized*.

In-Hospital Concurrent Medical Care

Covered expenses include services rendered concurrently by a *physician* other than the attending *physician* when the *covered person* is being treated for multiple, unrelated *illnesses* or *injuries*, or which require the skills of a *physician* specialist.

In-Hospital Consultant Services

Covered expenses include the services of a *physician* consultant when required for the diagnosis or treatment of an *illness* or *injury*.

Mental or Nervous Disorder In-Hospital Medical Care Services

Covered expenses include professional services rendered by the attending *physician* while the *covered person* is *hospitalized*.

Substance Abuse In-Hospital Medical Care Services

Covered expenses include professional services rendered by the attending *physician* while the *covered person* is *hospitalized*.

Surgical Inpatient and Outpatient Services

Anesthesia Services

Covered expenses include the administration of spinal, rectal or local anesthesia, or a *drug* or other anesthetic agent by injection or inhalation, rendered by a licensed *provider*. Benefits are also payable for these services when rendered by a Certified Registered Nurse Anesthetist (CRNA).

Surgical Assistants

Covered expenses include services by a licensed *physician* who actively assists the operating surgeon in the performance of *surgical procedures* when the condition of the patient and complexity of the *surgery* warrant such assistance. Benefits are also provided for these services when rendered by a licensed *surgical physician's* assistant.

Obstetrical Services

Dependent children are not eligible for coverage for any expenses in connection with *pregnancy*.

MEDICAL COVERED EXPENSES (Continued)

Covered expenses include obstetrical services rendered by the *physician* in charge of the case, including services customarily rendered as prenatal and postnatal care. Benefits for obstetrical care will be based upon the *Plan* provisions in effect on the date the services are rendered.

Surgical Services

Covered expenses include *surgical procedures*, including treatment for fractures and dislocations and routine pre- and post-operative care.

When more than one *surgical procedure* is performed during the same operative session, the allowed expense is calculated as follows:

- 100% of the *covered expense*, after any *PPO network provider* discount, for the most complex procedure.
- 50% of the *covered expense*, after any *PPO network provider* discount, for the second procedure.
- 25% of the *covered expense* for each subsequent procedure.
- No benefit is payable for incidental procedures (such as an appendectomy during abdominal *surgery*).

Professional Interpretation Services Inpatient and Outpatient

Covered expenses include interpretation and reporting by a licensed radiologist or pathologist for covered diagnostic tests. Benefits are provided only for testing required for the diagnosis or treatment of an *illness* or *injury*, unless otherwise provided under "Preventive Care."

Hospital Emergency Room Services

Covered expenses include:

- *Emergency* treatment of an *accidental injury*.
- *Emergency* treatment of an *illness*.

Covered expenses also include *physician's* charges, and charges for radiology and pathology, for *emergency surgical* or medical care rendered in the *hospital* emergency room.

Outpatient Facility Fees

Covered expenses include the following services when provided in an outpatient department of a *hospital* or other *institution*:

Outpatient Diagnostic Examinations

Benefits are provided for services such as X-ray and laboratory examinations, electrocardiograms (EKG), venous Doppler studies, magnetic resonance imaging (MRI), computerized axial tomography (CAT scan), basal metabolism tests, and electroencephalograms (EEG), when the study is directed toward the diagnosis of an *illness* or *injury*.

Pre-Admission Testing

Benefits are provided for *pre-admission testing* for expenses *incurred* prior to the scheduled *hospital* admission, and only when the testing is not duplicated on admission.

MEDICAL COVERED EXPENSES (Continued)

Outpatient Surgery/Ambulatory Surgery Center

Benefits are provided for charges by a *hospital, ambulatory surgical center, or in a physician's office*, for services required for a *surgical procedure*. The facility fees may include both services and supplies required for the *surgery*.

Biofeedback Services

Benefits are not provided for biofeedback

Cardiac Rehabilitation

Benefits are provided for cardiac rehabilitation program services when certified as *medically necessary* by the attending *physician* in a treatment program that is appropriate for the *covered person's illness*.

Chemotherapy Services

Benefits are provided for administration of chemotherapy treatment, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment.

Dialysis

Benefits are provided for kidney dialysis treatment, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment.

Intravenous Therapy

Benefits are provided for administration of intravenous therapy, including the *usual, customary and reasonable fee* for *drugs* and supplies used during the treatment..

Occupational Therapy

Benefits are provided for occupation therapy to restore a *covered person* to health, or to social or economic independence. These services must be performed by a licensed occupational therapist, who evaluates the performance skills of well and disabled persons of all ages, and who plans and implements programs designed to restore, develop, and maintain the *covered person's* ability to accomplish satisfactorily normal daily tasks. Occupational therapy must be ordered by the attending *physician* as part of a treatment plan that is appropriate for the *covered person's illness or injury*.

Physical Therapy

Benefits are provided for rehabilitation concerned with restoration of function and prevention of disability following *illness, injury* or loss of a body part. The services must be performed by a licensed physical therapist as part of a treatment program which is appropriate for the *illness or injury*, and which is ordered by the attending *physician*.

Radiation Therapy

Benefits are provided for treatment by X-ray, radium, external radiation, or radioactive isotopes, including the *usual, customary and reasonable fee* for materials.

Speech Therapy

Benefits are provided for the evaluation and treatment of *covered persons* who have voice, speech, language, swallowing, cognitive or hearing disorders. These services must be performed by a licensed and certified speech therapist as part of a treatment program which is appropriate for the *illness or injury*, and which is ordered by the attending *physician*.

Physician's Office Services

Covered expenses include the following services rendered in a *physician's office*:

MEDICAL COVERED EXPENSES (Continued)

Office Visits

Benefits are provided for services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury*. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Allergy Care

Benefits are provided for allergy care, including injections, serums and extracts, given in a *physician's* office. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Injections

Benefits are provided for therapeutic injections given in a *physician's* office which are required for the treatment of an *illness* or *injury*. Immunizations and other injections which are not for the treatment of an *illness* or *injury* are not covered unless specified under "Preventive Care." Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Diagnostic X-ray and Laboratory Services

Benefits are provided for diagnostic x-ray and laboratory services given in a *physician's* office which are required for the diagnosis or treatment of an *illness* or *injury*. Covered services include the services of a *physician's* assistant ("P.A.") rendered under the supervision of the *physician*, and billed by the *physician*.

Chiropractic Care Services

Covered expenses include spinal manipulation and other related therapy treatments, and X-rays. *Chiropractic care* must be rendered for the active treatment of an *illness* or *injury*. Maintenance care is not covered

Outpatient Mental or Nervous Disorder and Substance Abuse Services

Outpatient Mental or Nervous Disorder Care

Covered expenses include outpatient *mental or nervous disorder* care by a licensed psychologist, psychiatrist, or social worker, if the social worker services are under the direct supervision of a *physician*.

Outpatient Substance Abuse Care

Covered expenses include outpatient *substance abuse* care by a licensed *provider*.

Preventive Care Benefit

Covered expenses include these listed services and as listed on the "Schedule of Benefits" for preventive care for each *covered person*. The Preventive Care Benefits are subject to any limits described in the "Schedule of Benefits" section.

- **Bone Density Test**
- **Gynecology Examination;**
- **Immunizations;**
- **Mammogram Test;**
- **Pap Test;**
- **Preventive Laboratory Screenings;**

MEDICAL COVERED EXPENSES (Continued)

- **General Medical Examination by a *Physician*;**
- **Eye Examinations;**
- **Hearing Examinations;**
- **Preventive X-rays;**
- **Prostate Exam;** and
- **Well *Child* Care.**

Second Surgical Opinions

Covered expenses include a second opinion to determine the *medical necessity* for a recommended *surgical procedure*. The *physician* rendering the second opinion must not be affiliated with the *physician* who recommended the *surgical procedure*. A third opinion will be covered if the two opinions differ, and if it is performed by a *physician* who is not affiliated with the *physicians* who have rendered opinions.

Other Covered Expenses

Ambulance Service

Covered expenses include local professional ambulance service from your home to a *hospital*, or from the scene of an *accident* or medical *emergency*, to the nearest *institution* able to treat the condition.

Air ambulance services will be covered when *medically necessary* to transport the *covered person* to the nearest *institution* capable of treating the *illness* or *injury*.

Durable Medical Equipment

Covered expenses include rental of *durable medical equipment*. The *Plan* may approve purchase of the equipment at the *Plan Administrator's* discretion. Benefits for rental will not exceed the *usual, customary and reasonable fee* for purchase.

Home Health Care

Covered expenses include home health services when rendered by a licensed and accredited *home health care agency*. These services must be provided through a formal, written home health care treatment plan, certified as *medically necessary* by the attending *physician*, and approved by the *Plan*. Benefits are provided for:

- Skilled nursing care as provided by a licensed practical nurse or registered nurse who does not ordinarily live in your home and who is not a member of your immediate family.
- Physical, occupational, and speech therapy.
- Services provided by a licensed social worker (M.S.W.).
- Services provided by a home health aide.

On-going home health services will require re-certification by the attending *physician* and approval by the *Plan*, at the *Plan Administrator's* discretion, in order to qualify for continued coverage.

The total benefits paid for home health care on a weekly basis may not exceed the amount the *Plan* would have paid if the *covered person* had been confined in a *hospital, skilled nursing facility* or other *institution*.

MEDICAL COVERED EXPENSES (Continued)

Hospice Care

Covered expenses include hospice care services for a terminally ill *covered person* when provided by a *hospice care agency*. The services must be provided through a formal, written hospice care treatment program and certified by the attending *physician* as *medically necessary*. Benefits are provided for:

- *Room and board* for confinement in a licensed, accredited hospice facility.
- Services and supplies furnished by the hospice while the patient is confined.
- Part-time nursing care by or under the supervision of a registered nurse.
- Nutrition services and/or special meals.
- Respite services.
- Counseling services by a licensed social worker or a licensed counselor.
- Bereavement counseling by a licensed social worker or a licensed counselor for the *employee* and/or *covered dependent(s)*.

The attending *physician* must certify that the *covered person* is expected to continue to live for six months or less in order to qualify for this benefit.

If the *covered person* lives beyond six months, the *Plan* will approve additional hospice care benefits on receipt of satisfactory evidence of the continued *medical necessity* of the services.

Infertility Testing

Covered expenses will be limited to infertility testing only.

Other Covered Expenses Also Include:

- **Blood transfusions and blood products**, to the extent not replaced. The Plan will not cover expenses in connection with autologous blood acquisition and storage.
- **Oxygen**.
- **R.N. and L.P.N.** private duty nursing services for outpatient care when medically necessary.
- **Prosthetic devices and supplies**, including initial purchase price, fitting, adjustment and repairs. Replacements of prosthetic devices are not covered unless due to a significant change in the *covered person's* physical structure and the current device cannot be made serviceable.
- **Surgical dressings, splints, casts**, and other devices used in the reduction of fractures and dislocations, as well as other similar items that serve only a medical purpose, excluding items usually stocked in the home, or that have a value in the absence of an *illness* or *injury*.
- **One set of lenses** (contact or frame-type) following *surgery* for cataracts.
- **Reconstruction of a breast** following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including

MEDICAL COVERED EXPENSES (Continued)

lymphademas, in a manner determined in consultation with the attending *physician* and the *covered person*. Reimbursement will be made according to the “Schedule of Benefits” section by type of service.

- **Birth control *drugs* or devices.** Covered expenses include birth control *drugs* or devices, which require a prescription. Also see provisions of your Prescription *Drug* Card Program.
- **Cochlear implant.**
- **Genetic testing and/or counseling.** For genetic testing or counseling.
- **Midwives.**
- **Orthotics**
- **Growth hormone therapy** as part of a treatment program approved by the *Plan Administrator*.
- **Surgical extraction of bone-impacted teeth.**
- **Prenatal vitamins.**
- **Sterilization procedures, elective.**
- **Oral surgical procedures**, including:
 - Excision of tumors and cysts of the jaws, cheeks, lips, tongues, roof and floor of the mouth.
 - *Emergency* repair due to *injury* to sound natural teeth.
 - *Surgery* needed to correct accidental *injuries* to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
 - Excision of benign bony growths of the jaw and hard palate.
 - External incision and drainage of cellulitis.
 - Incision of sensory sinuses, salivary glands or ducts.
- **Treatment of temporomandibular joint dysfunction.** Treatment will be limited according to the “Schedule of Benefits” section.
- **Chelation therapy** for a diagnosis of lead poisoning, or a diagnosis of anemia for a *child*.

Replacement of Organs/Tissues and Related Services

Human organ and tissue benefits are provided by a separate policy, as explained in full in the AIG Life Organ & Tissue Transplant Policy. All eligible Employees and their eligible Dependents requiring human organ and tissue transplant services will have transplant-related charges covered under this separate AIG Life policy, according to its terms and conditions, from the time of their evaluation through 365 days post transplant operation. All transplant-related charges ineligible under the separate policy will revert to the terms and conditions of health coverage under this health plan document.

MEDICAL COVERED EXPENSES (Continued)

Benefits available for Human Organ and Tissue Transplants are subject to the following:

- 1) the Employee or Dependent is eligible for medical benefits under the group's plan document;
- 2) the Employee or Dependent meets all the terms and conditions outlined in the AIG Life Organ and Tissue Policy /Certificate;
- 3) the Employee or Dependent does not have a pre-existing condition as defined in the AIG Life Organ and Tissue Policy /Certificate.

Those Employees and their Dependents who are initially excluded from human organ and tissue transplant coverage under the AIG Life Organ & Tissue Transplant policy (due to a pre-existing condition) will continue to receive health care benefits as they relate to transplantation according to the terms and conditions of the company health plan document until eligible for benefits under the separate AIG Life policy.

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this plan will be reduced by those payable under the donor's plan. Donor charges include those for:

- 1) evaluating the organ or tissue;
- 2) removing the organ or tissue from the donor; and
- 3) transportation of the organ or tissue from within the United States and Canada to place where the transplant is to take place.

The *Plan Administrator* strongly recommends that any *covered person* who is a candidate for any transplant procedure contact Mutual Assurance Administrators, Inc. before making arrangements for the procedure. This communication may identify certain types of procedures, or expenses associated with the procedures, which will not be covered under the *Plan*, before the actual services are rendered.

MEDICAL EXCLUSIONS AND LIMITATIONS

This Plan will not reimburse any expense that is not a *covered expense*. This *Plan* does not cover any charge for services or supplies:

- **Abortion.** Expenses that are *incurred* directly or indirectly as the result of an abortion except when the life of the mother would be threatened if the fetus were carried to term, or when complications arise.
- **Acupuncture.**
- **Corrective shoes.** For corrective shoes.
- **Counseling.** For counseling, except as specifically the result of a *mental or nervous condition*, for:
 - Marital difficulties
 - Social maladjustment
 - Pastoral issues
 - Financial issues
 - Behavioral issues
 - Lack of discipline or other antisocial action.
- **Custodial care.** For *custodial care*, except as specified.
- **Dental hospital admissions.** Related to dental *hospital* admissions, unless determined to be *medically necessary* because of a concomitant condition.
- **Dental prescriptions.** For dental prescriptions (e.g., Peridex, fluoride.)]
- **Dental.** Expenses that are related to dental treatment, except as specifically provided in this *Plan*.
- **Developmental delay.** For developmental disorders, including learning disabilities, mental retardation or autism.
- **Eating disorders.** That are related to eating disorders (e.g., anorexia and bulimia). This does not apply to any care for an underlying *mental or nervous condition*.
- **Educational.** Expenses that are related to education or vocational training.
 - This exclusion does not apply to educational services rendered for diabetic counseling, peritoneal dialysis, or any other educational service deemed to be *medically necessary* by the *Plan*.
- **Excess over semi-private rate.** That are in excess of the semi-private room rate, except as otherwise noted.
- **Experimental.** That are *experimental*.

MEDICAL EXCLUSIONS AND LIMITATIONS (Continued)

- In some cases, the application of an established procedure, as a course of treatment for a specific condition, may be considered *experimental*, and hence, not covered by this *Plan*.
- **Excluded providers and facilities.** That are rendered or provided by the following excluded providers or facilities:
 - Hypnotists;
 - Naturopaths;
 - Rolfers; and
 - Marriage counselors.
- **Eyeglasses, contact lenses, refractions.** For eyeglasses, contact lenses and refractions, or the examination for their prescription and fitting, except one pair of lenses following surgery for cataracts.
- **Eye exercises or training and orthoptics.** For eye exercises or training and orthoptics.
 - This exclusion does not apply to Aphakic patients.
 - This exclusion does not apply to soft lenses or sclera shells intended for use as corneal bandages.
 - This exclusion does not apply to one pair of lenses following cataract *surgery*.
- **Food supplements.** Related to food supplements or augmentation, in any form (unless *medically necessary* to sustain life in a critically ill person).
- **Foot care services, routine.** For routine foot care, including, but not limited to, cutting or removal of corns or calluses, the trimming of nails and other hygienic and preventive and maintenance care, performed in the absence of localized *illness, injury* or symptoms involving the foot.
- **Hearing aids.** For hearing aids or devices, or the examination for their prescription and fitting.
- **Impotence; sexual dysfunction.** For impotence and sexual dysfunction treatment and medications, including, but not limited to, penile implants, sexual devices or any medications or *drugs* pertaining to sexual dysfunction or impotence.
- **Infertility treatment.** For infertility treatment, including, but not limited to, in vitro fertilization, gamete intrafallopian transfer (GIFT), fertility *drugs*, artificial insemination, zygote intrafallopian transfer (ZIFT), reversal of a sterilization procedure, surrogate mother or donor eggs.
- **Marital counseling.** For marital counseling.
- **Massage therapy.** For massage therapy, unless applied in conjunction with other active physical therapy modalities for a specific covered *illness* or *injury*, and approved as *medically necessary* by the *Plan Administrator*.

MEDICAL EXCLUSIONS AND LIMITATIONS (Continued)

- **Medically unnecessary.** That are not *medically necessary* for the care and treatment of an *injury* or *illness*, except where otherwise specified, or are not accepted as standard practice by the American Medical Association or the Food and Drug Administration.
- **Non-prescription medicines and supplies.** That can be purchased without a prescription from a licensed *physician* unless otherwise noted by provisions of your Prescription *Drug* Card Program.
- **Obesity treatment.** For the purpose of weight loss. This exclusion also applies to benefits for surgical or non-surgical treatment of *morbid obesity*.
- **Orthognathic surgery** (jaw realignment *surgery*) to correct retrognathia, apertognathia, prognathism, open bite malocclusion, or transverse skeletal deformities.
- **Patient convenience.** Related to the modification of homes, vehicles or personal property to accommodate patient convenience. This includes, but is not limited to, the installation of ramps, elevators, air conditioners, air purifiers, TDD/TTY communication devices, personal safety alert systems, exercise equipment and cervical pillows. This exclusion also applies to any services or supplies that are provided during a course of treatment for an *illness* or *injury* that are solely for the personal comfort and convenience of the patient.
- **Personal hygiene.** For personal hygiene or convenience items.
- **Preventive care.** For physical examinations, routine and preventive care, except as specifically provided under this *Plan*.
- **Pre-existing conditions.** Related to a *pre-existing condition*, except as specifically provided under this *Plan* and as required by law.
- **Pregnancy of a dependent child.** Related to the Pregnancy of a *dependent child*, including pre-natal, delivery and post-natal care, treatment of miscarriage. This exclusion will apply to *complications of pregnancy*.
- **Vision correction.** For radial keratotomy, keratomileusis or other vision correction procedures.
- **Residential care facility.** Provided by or at a residential care facility or halfway house.
- **Sex change.** Expenses for all services and supplies in connection with sex change operations or procedures.
- **Smoking cessation.** For smoking cessation programs, nicorette gum, nicotine transdermal patches or other treatment of tobacco dependency.
- **Therapy.** That are related to aversion therapy, hypnosis therapy, primal therapy, rolfing, psychodrama or megavitamin therapy.
- **Travel.** For travel, even though prescribed by a *physician*. This exclusion may not apply to a *covered person* who is an organ transplant recipient to travel to and from the site of the transplant.
- **Trusses, corsets and other support devices.**

MEDICAL EXCLUSIONS AND LIMITATIONS (Continued)

- **Vitamins.** For vitamins, except as specifically provided under this *Plan*.
- **Without approval.** Furnished without recommendation and approval of a *physician* acting within the scope of his or her license.
- **Weekend admissions.** For weekend admission (Friday, Saturday or Sunday) to a *hospital* unless due to an *emergency* or if *surgery* is performed within 24 hours of admission.
- **Work-related illness or injury.** Related to an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, without regard to whether such *illness* or *injury* entitles the *covered person* to workers' compensation or similar benefits.

COST CONTAINMENT PROVISIONS

Pre-certification Program for *Inpatient Services*

Inpatient care is normally the greatest part of the *Plan's* expenses and can be the most critical part of your treatment. Through the *Plan's* Pre-certification Program, it is possible to work with your attending *physician* to arrange for care in a setting that is more comfortable for you, such as your home, and to save both you and the *Plan* unnecessary expense.

The program works by establishing a communication among you, your attending *physician* and the Pre-certification Program administrator to discuss the proposed course of treatment and any options that may be available for your treatment. The role of the Pre-certification Program is to establish the *medical necessity* for the **setting** of the treatment, not for the treatment itself. The Pre-certification Program does not establish your eligibility for coverage under the *Plan*, nor does it approve the services for coverage or reimbursement under the *Plan*. Those responsibilities rest with the *Plan Administrator*.

Because communication is the basis for the program, the *Plan* requires that you contact the Pre-certification Program administrator five (5) days before any non-*emergency inpatient* admission, surgeries, outpatient chemo, radiation, dialysis, infusion therapy, and inpatient rehab. The contact may be made by you, a friend or family member, or your *physician* or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.**

Urgent Care or *Emergency Admissions*

Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health because of the requirements of this Program. For urgent, *emergency* admissions, follow your *physician's* instructions carefully, and contact the Pre-certification Program administrator within 24 hours of the admission. No penalty will be applied to your benefits if contact is made within this time period.

Since the *Plan* does not require you or a covered *dependent* to obtain approval of a medical service prior to getting treatment for an urgent care or *emergency* situation, there are no "*pre-service urgent care claims*" under the *Plan*. In an urgent care or *emergency* situation, you or a covered *dependent* simply follow the *Plan's* procedures following the treatment and file the claim as a "*post-service claim*."

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn *child* to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending *provider*, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a *provider* obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notification is still encouraged at the time of admission, and is required for any *hospital* stay that is in excess of the minimum length of stay. Failure to notify the Pre-certification Program administrator of any stay that is in excess of the minimum length of stay will result in application of a penalty to the *hospital* expenses.

Concurrent *Inpatient Review*

Once the *inpatient* setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your *physician*, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

The Pre-certification Program administrator will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

COST CONTAINMENT PROVISIONS (Continued)

The Pre-certification Program administrator for this *Plan* is shown on your Identification (ID) Card.

Penalty

If you fail to notify the Pre-certification Program administrator within the time periods described in this section for *emergency* and *non-emergency inpatient* care, the benefits that otherwise would be available for the facility's expenses under the Plan will be reduced as follows:

- ***Covered expenses will be reduced by \$500 per admission, and this amount will not accumulate toward any out-of-pocket expense limits.***

Any amount of reduction due to a penalty will not accumulate toward any out-of-pocket expense limits under the Plan.

A pre-certification or concurrent review determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Voluntary Second Surgical Opinions

This is a service offered by the *Plan* to help you determine, in advance, whether a proposed *surgical* procedure will be a *covered expense* under the *Plan*. It is a voluntary provision, and you are under no obligation to obtain pre-approval of the *surgery*. However, you are encouraged to use this service to avoid incurring *non-covered expenses* for which you will be responsible.

In order to evaluate the proposed treatment, the *Plan* will require detailed medical information from your *physician*, including:

- The identity of the patient (including date of birth and sex);
- The diagnosis code (ICD-9);
- The procedure code (CPT); and
- The amount of the proposed charge.

This information should be submitted to:

Mutual Assurance Administrators, Inc.
4004 Belt Line Rd. Suite 160
Addison, TX 75001
972 774-1100 or 1-800-443-2595

You will receive a written response with the *Plan's* determination, which you may furnish to your *physician* if you so desire.

A pre-approval determination under this section will not be a guarantee of eligibility, coverage or benefits. All benefit determinations will be based upon the provisions of this *Plan* and the decision of the *Plan Administrator* in its sole discretion.

Do not delay seeking medical care for any *covered person* who has a serious condition that may jeopardize his life or health in order to pre-determine benefits. Second *surgical* opinions are not recommended under these circumstances.

Case Management Program

The Plan Administrator may arrange for review and/or case management services from a Professional qualified person to perform such services. Upon the advice of such a Professional, the Plan Administrator shall retain the right to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrifice of the quality of patient care.

The Case Management Program is administered by American Health Holdings. Case managers are medical professionals who will work with your attending *physician* to identify alternate courses of treatment and the best way to use your benefit dollars. They can be of invaluable assistance in locating resources to assist in your recovery.

If you are selected as a candidate for case management, you will be contacted by a case manager who will then work with you and your *physician* throughout the course of treatment. If you have any questions about the Case Management Program, please feel free to contact Mutual Assurance Administrators, Inc. at 972 774-1100 or toll-free 1-800-443-2595.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

Prescription Drugs Drugs integrated with medical plan or Prescription Drug charges purchased outside of the Pharmacy Benefit Card Program	
Prescription Drugs —Medical Plan	80% of <i>usual, customary and reasonable fees</i> , subject to <i>PPO Network Provider deductible</i>
Prescription Drugs purchased outside of the Pharmacy Benefit Card Program will not apply towards the out of pocket maximum.	

Prescription Drug Card Program	
Deductible Per Calendar year <i>(applies to Retail and Mail Order drugs, Preferred and Non Preferred Drugs only)</i>	
• Individual	\$100
• Family	\$200
Retail	
Prescription Drug Card Program — Non Preferred	100% after 50% - maximum 30-day supply
Prescription Drug Card Program — Preferred	100% after 30% - maximum 30-day supply
Prescription Drug Card Program — Generic	100% after \$10 co-payment maximum 30-day supply
CVS - 90 Day Supply <i>(only at CVS Pharmacies)</i>	
Prescription Drug Card Program — Non Preferred	100% after 50% maximum 90-day supply
Prescription Drug Card Program — Preferred	100% after 30% maximum 90-day supply
Prescription Drug Card Program — Generic	100% after \$10 co-payment maximum 90-day supply
Limited to a Maximum of \$500 per month	
OTC (Over the Counter) Generic Covered Drugs – Must present a physician’s written prescription.	
100% - \$0 co-payment maximum 30 day supply for the following drugs	
<ul style="list-style-type: none"> • Alavert, Alavert-D, Zyrtec • Claritin, Claritin-D • Prilosec and any store brand products for these products: Example <i>Wal-Mart – Wal-tin</i> 	
Mail Order – Limited to a Maximum of \$1,000 per month. Prescription drugs over \$1,000 per month must be pre-authorized.	
Prescription Drug Card Program: Mail Service — Non Formulary	100% after 40% maximum 90-day supply
Prescription Drug Card Program: Mail Service — Formulary	100% after 25% maximum 90-day supply
Prescription Drug Card Program: Mail Service — Generic	100% after \$10 co-payment maximum 90-day supply

PRESCRIPTION DRUG BENEFIT LIBRARY OPTIONS (Continued)

Benefits are provided for the purchase of *drugs* through the *Plan's* Prescription Drug Card Program. The *covered person* must purchase the prescription *drugs* through the Prescription Drug Card Program, and use either a participating pharmacy or the "mail order option." If a *covered person*, who is traveling and is at least 100 miles from home, must purchase a prescription *drug* at a non-participating pharmacy due to an *emergency*, the *Plan* will reimburse the cost of the *drug* at the *PPO Network Provider* percentage payable after satisfaction of the *PPO Network Provider deductible*, shown above."

Prescription *drugs* that are not purchased through the *Plan's* Prescription Drug Card Program will be covered as Drugs integrated with medical plan above.

The *Plan's* Prescription Drug Card Program is administered by Caremark. Caremark has a network of pharmacies which can identify *covered persons* and the *Plan's* coverage provisions. To find out which pharmacies participate, contact Caremark at (866) 475-0056.

Covered Prescriptions

Under the Prescription Drug Card Program, *covered expenses* include:

- Federal legend *drugs*.
- State-restricted *drugs*.
- Insulin.
- Syringes and needles used only to inject insulin.
- **Contraceptives including but not limited to devices, implants, injectables, and oral.**
- **Acne/ Skin Disease Medications**
- **Prenatal and Pediatric Vitamins**

Certain *drugs* are not covered, even when prescribed by your *physician*. Please refer to the list of "Excluded Drugs" below.

How the Program Works

There are two ways to purchase drugs through the *Plan's* Prescription Drug Card Program. You may save money by using the "mail order option" if you have prescription *drug(s)* that you must take on an on-going basis.

- To fill a prescription at a participating pharmacy (the "pharmacy option"), simply present your *Plan* ID card and pay your portion of the cost (shown in the "Schedule of Benefits"). The pharmacist will file the claim for you.
- To fill a prescription through the Drug Card Program's "mail order option":
 - Obtain a copy of the mail order form from CVS Caremark.
 - Complete the patient profile questionnaire (for your first order only).
 - Ask your *physician* to prescribe the needed medication for a 90-day supply, plus refills.

PRESCRIPTION DRUG BENEFIT LIBRARY OPTIONS (Continued)

- If you are presently taking medication, you will need a new prescription.
- If you need the medication immediately, **but will be taking it on an on-going basis**, ask your *physician* for two prescriptions: one for a 14-day supply that you can have filled at a local pharmacy, and one for the balance of the prescription, up to a 90-day supply, that you can submit through the “mail order option.”
- Send the completed patient profile questionnaire to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost (shown in the “Schedule of Benefits”).

Once your order is processed, it will be sent to you via First Class Mail and it will include instructions for the re-order of future prescriptions and/or refills.

Copayments for the Prescription Drug Card Program do not accumulate toward the *out-of-pocket expense* limit.

Excluded Drugs

The *Plan* will not cover the following *drugs*, even when prescribed by the *covered person's physician*:

- **Anorexiant**s (weight control *drugs*).
- **Experimental or investigational drugs**, including compounded medications for non-FDA-approved use.
- **Drugs which are not medically necessary for the treatment of an illness, injury or pregnancy.**
- **Fertility medications.**
- **Fluoride.**
- **Growth hormones.**
- **Non-legend drugs**, other than insulin.
- **Provided in or through a Physician's office** (*drugs* intended for use in a setting other than the *physician's office*).
- **Cosmetic for Hair loss including but not limited to Rogaine.**
- **Smoking cessation products.**
- **Therapeutic devices** or appliances, support garments, and other non-medical substances.]
- **Vitamins**, except prenatal and pediatric.
- **Workers' Compensation:** prescriptions which an eligible person is entitled to receive, without charge, under any workers' compensation law, or under any municipal, state or federal program.

GENERAL EXCLUSIONS AND LIMITATIONS

This section applies to all benefits provided under any section of this *summary plan description*. This *Plan* does not cover any charge for services or supplies:

- **Absence of coverage.** That would not have been made in the absence of coverage.
 - This includes charges that are submitted to the *Plan* equal to any amount for which the *provider* has discounted fees or has “written off” amounts due.
- **Civil insurrection or riot.** Resulting from *injuries* incurred or exacerbated while participating in a civil insurrection or riot.
- **Complications.** That result from complications arising from a non-covered *illness* or *injury*, or from a non-covered procedure.
- **Cosmetic.** For *cosmetic surgery* or procedures, or aesthetic services (including complications arising therefrom).
 - This exclusion does not apply to procedures required as the result of an *injury*, or if approved as *medically necessary* for a covered *illness*.
 - This exclusion does not apply to reconstruction of a breast following a *mastectomy*, reconstruction of the other breast to produce a symmetrical appearance, and prosthesis and physical complications from all stages of a *mastectomy*, including lymphadenomas, in a manner determined in consultation with the attending *physician* and the *covered person*.
- **Court-ordered services.** That are ordered by a court, unless determined by the *Plan Administrator*, in its discretion, to otherwise be appropriate and covered.
- **Deductibles, Copayments and Coinsurance.** That are not payable due to the application of any specified deductible, copayment or coinsurance provisions of the *Plan*.
- **Excess.** That are not payable under the *Plan* due to application of any *Plan* maximum or limit or because the charges are in excess of the *Plan Administrator’s* determination of the *usual, customary and reasonable fee* for the particular service or supply.
- **Forms.** For the completion of medical reports, claim forms or itemized billings.
- **Government services.** To the extent paid, or which the *covered person* is entitled to have paid or obtain without cost, by or through any government, or division thereof, except a program for civilian employees of a government.
- **Illegal act.** Related to *injuries* sustained, or an *illness* contracted, during the commission, or attempted commission, of a felony. This exclusion will apply only if the covered person is convicted of the illegal act.
- **Immediate relative.** Provided by an *immediate relative* or an individual residing in your home.
- **Late Claims.** For which the claim is received by the *Plan* after the maximum period allowed under this *Plan* for filing claims has expired.

GENERAL EXCLUSIONS AND LIMITATIONS (Continued)

- **Malpractice.** That are required as a result of malpractice, malfeasance or misfeasance or that are to treat *injuries* that are sustained or an *illness* that is contracted, including infections and complications, while the *covered person* was under the care of a provider for a condition wherein such *illness, injury, infection* or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the *Plan Administrator* in its sole discretion, gave rise to the expense.
- **Military service.** Resulting from, or prolonged as a result of, performing a duty as a member of the military service of any state or country.
- **Missed appointments.** Related to missed appointments.
- **No legal obligation.** That are provided to a *covered person* for which the *provider* customarily makes no direct charge or for which the *covered person* is not legally obligated to pay.
- **Not actually rendered.** That are not actually rendered.
- **Not eligible.** That were rendered or received prior to or after any period of coverage under this *Plan*, except as specifically provided for in this *summary plan description*.
- **Not specifically covered.** That are not specifically covered under the *Plan*.
- **Outside of the U.S.A.** For any care, services, *drugs* or supplies *incurred* outside of the U.S.A. if the *covered person* traveled to such a location for the purpose of obtaining the care, services, *drugs* or supplies.
- **Penalties.** That are related to failure to comply with any requirements for coverage under this *Plan*, or for any copayment amounts identified as a “penalty” in this *summary plan description*.
- **Prohibited by law.** For which the *Plan* is prohibited by law or regulation from providing benefits.
- **Self-inflicted.** Resulting from any intentionally self-inflicted *illness* or *injury*.
- **Subrogation.** That are not payable under the *Plan* by virtue of its subrogation provisions.
- **Tax and shipping.** For taxes and shipping charges levied on *medically necessary* items and services. This exclusion does not apply to surcharges required by law to be paid by the *Plan* in applicable states.
- **Telephone consultations.** For telephone consultations.
- **War.** Resulting from war or an act of war, whether declared or undeclared, or any act of aggression, and any complication therefrom.
- **Work-related illness or injury.** Related to an *illness* or *injury* arising out of, or in the course of, any employment for wage or profit, including that of previous employers or while self-employed, without regard to whether such *illness* or *injury* entitles the *covered person* to workers’ compensation or similar benefits.

With respect to any *injury* which is otherwise covered by the *Plan*, the *Plan* will not deny benefits provided for treatment of the *injury* if the *injury* results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

TERMINATION OF COVERAGE

When does my participation end?

Your participation will end at 12:01 A.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The last day of the month for which you request that your coverage be terminated, provided your request is made on or before that date;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution;
- The last day of the month in which you cease to be eligible for coverage under the *Plan*;
- The last day of the month in which you terminate employment; or
- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.

When does participation end for my dependents?

The coverage for your *dependents* will end at 12:01 A.M. on the earliest of the following dates:

- The date the *Plan* terminates;
- The last date of the month in which the *Plan* discontinues coverage for *dependents*;
- The date your *dependent* becomes covered as an *employee* under the *Plan*;
- The last date of the month in which your coverage terminates;
- If you fail to make any contribution when it is due, the last date of the period for which you made a contribution for your *dependents*;
- In the case of a *child* for whom coverage is being continued due to mental or physical inability to earn his own living, the last day of the month in which earliest of the following events occurs:
 - Cessation of the inability;
 - Failure to furnish any required proof of the uninterrupted continuance of the inability or to submit to any required examination; or
 - Upon the *child's* no longer being *dependent* on you for his support;
- On the last date of the month in which a *dependent child* marries;
- In the case of a *child* other than a *child* for whom coverage is continued due to mental or physical inability to earn his own living, the last date of the month on which the *child* reaches age 19, or age 26 in the case of a *child* who is regularly attending an accredited high school, junior college, college, university or licensed trade school;
- The last date of the month in which person ceases to be a *dependent*; or

TERMINATION OF COVERAGE (Continued)

- The date on which an *employee* or his *dependent* submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the *Plan*, including enrollment information.]

Will the *Plan* provide evidence of coverage?

The *Plan* generally will automatically provide a *certificate of coverage* to anyone who loses coverage in the *Plan*. In addition, a *certificate of coverage* will be provided upon request at any time while the individual is covered under a plan and up to 24 months after the individual loses coverage under the *Plan*.

The *Plan* will make reasonable efforts to collect information applicable to any *dependents* and to include that information on the *certificate of coverage*, but the *Plan* will not issue an automatic *certificate of coverage* for *dependents* until the *Plan* has reason to know that a *dependent* has lost coverage under the *Plan*.

Will my *participating employer* continue our coverage?

Coverage will be continued for you and your *dependents* should the following occur:

- In the event of a layoff, coverage will continue for 90 days following the date of layoff provided that the required Employee contributions are made by the Covered Person
- In the event of *total disability*, coverage will continue for 90 days following termination of *active employment* provided that the required Employee contributions are made by the Covered Person; or
- In the event you take a *leave of absence* which does not meet the requirements of *FMLA*, your coverage will not continue.

The period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA.

May I continue participation during *FMLA* leave?

The *Plan* will at all times comply with *FMLA*. During any leave taken under *FMLA*, you may maintain coverage under this *Plan* on the same conditions as if you had been continuously employed during the entire leave period. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions, if any. Contact your *participating employer* for information concerning your eligibility for *FMLA* and any requirements of the *Plan*.

May I continue participation while I am absent under *USERRA*? Will my coverage be reinstated on return from *USERRA* leave?

If you are absent from employment because you are in the *uniformed services*, you elect to continue your coverage under this *Plan* for up to 24 months. If you elected to continue coverage under *USERRA* before December 10, 2004, the maximum period for continuing coverage is 18 months. To continue your coverage, you must comply with the terms of the *Plan*, including election during the *Plan's annual enrollment period*, and pay your contributions, if any. In addition, *USERRA* also requires that, regardless of whether you elected to continue your coverage under the *Plan*, your coverage and your *dependents'* coverage be reinstated immediately upon your return to employment, so long as you meet certain requirements contained in *USERRA*. Contact your *participating employer* for information concerning your eligibility for *USERRA* and any requirements of the *Plan*.

COBRA Continuation Coverage

The right to *COBRA continuation coverage* was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("*COBRA*"). *COBRA continuation coverage* can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the *Plan* when they otherwise would lose their group health coverage.

TERMINATION OF COVERAGE (Continued)

The entire cost (plus a reasonable administration fee) must be paid by the person. Coverage will end in certain instances, including if you or your *dependents* fail to make timely payment of premiums. You should check with your *participating employer* to see if *COBRA* applies to you and your *dependents*.

What is COBRA continuation coverage?

“*COBRA continuation coverage*” is a continuation of *Plan* coverage when coverage otherwise would end because of a life event known as a “*qualifying event*.” Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your *participating employer’s* plan) are not considered for continuation under *COBRA*.

What is a Qualifying Event?

Specific *qualifying events* are listed below. After a *qualifying event*, *COBRA continuation coverage* must be offered to each person who is a “*qualified beneficiary*.” You, your spouse, and your *dependent children* could become *qualified beneficiaries* if coverage under the *Plan* is lost because of the *qualifying event*.

If you are a *covered employee* (meaning that you are an employee and are covered under the *Plan*), you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because either one of the following *qualifying events* happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of a *covered employee*, you will become a *qualified beneficiary* if you lose your coverage under the *Plan* because any of the following *qualifying events* happens:

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

Your *dependent children* will become *qualified beneficiaries* if they lose coverage under the *Plan* because any of the following *qualifying events* happens:

- The parent-*covered employee* dies;
- The parent-*covered employee*’s hours of employment are reduced;
- The parent-*covered employee*’s employment ends for any reason other than his or her gross misconduct;
- The parent-*covered employee* becomes entitled to *Medicare* benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the plan as a “*dependent child*.”

TERMINATION OF COVERAGE (Continued)

[If the Plan provides retiree health coverage, include the following paragraph:]

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a *qualifying event*. If a proceeding in bankruptcy is filed with respect to *East Texas Baptist University*, and that bankruptcy results in the loss of coverage of any retired employee covered under the *Plan*, the retired employee will become a *qualified beneficiary* with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children also will become *qualified beneficiaries* if bankruptcy results in the loss of their coverage under the *Plan*.

The participating employer must give notice of some qualifying events

When the *qualifying event* is the end of employment, reduction of hours of employment, death of the *covered employee*, or the *covered employee's* becoming entitled to *Medicare* benefits (under Part A, Part B, or both), the *participating employer* must notify the *Plan Administrator* of the *qualifying event*.

You must give notice of some qualifying events

Each *covered employee* or *qualified beneficiary* is responsible for providing the *Plan Administrator* with the following notices, in writing, either by U.S. First Class Mail or hand delivery:

- Notice of the occurrence of a *qualifying event* that is a divorce or legal separation of a *covered employee* (or former employee) from his or her spouse;
- Notice of the occurrence of a *qualifying event* that is an individual's ceasing to be eligible as a *dependent* under the terms of the *Plan*;
- Notice of the occurrence of a second *qualifying event* after a *qualified beneficiary* has become entitled to *COBRA continuation coverage* with a maximum duration of 18 (or 29) months;
- Notice that a *qualified beneficiary* entitled to receive *COBRA continuation coverage* with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of *COBRA continuation coverage*; and
- Notice that a *qualified beneficiary*, with respect to whom a notice described in the bulleted item above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The *Plan Administrator* is:

*East Texas Baptist University
Plan Administrator
1209 N. Grove
Marshall, TX 75670
903 923-2120*

A form of notice is available, free of charge, from the *Plan Administrator* and must be used when providing the notice.

Deadline for providing the notice

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

- The date on which the relevant *qualifying event* occurs;

TERMINATION OF COVERAGE (Continued)

- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan's summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

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

- The date of the disability determination by the SSA;
- The date on which a *qualifying event* occurs;
- The date on which the *qualified beneficiary* loses (or would lose) coverage under the *Plan* as a result of the *qualifying event*; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan's summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

In any event, this notice must be furnished before the end of the first 18 months of *COBRA continuation coverage*.

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

- The date of the final determination by the SSA that the *qualified beneficiary* is no longer disabled; or
- The date on which the *qualified beneficiary* is informed, through the furnishing of the *Plan's summary plan description* or the general notice, of both the responsibility to provide the notice and the *Plan's* procedures for providing such notice to the *Plan Administrator*.

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

Who can provide the notice

Any individual who is the *covered employee* (or former employee), a *qualified beneficiary* with respect to the *qualifying event*, or any representative acting on behalf of the *covered employee* (or former employee) or *qualified beneficiary*, may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related *qualified beneficiaries* with respect to the *qualifying event*.

Required contents of the notice

The notice must contain the following information:

- Name and address of the *covered employee* or former employee;

TERMINATION OF COVERAGE (Continued)

- If you already are receiving *COBRA continuation coverage* and wish to extend the maximum coverage period, identification of the initial *qualifying event* and its date of occurrence;
- A description of the *qualifying event* (for example, divorce, legal separation, cessation of dependent status, entitlement to *Medicare* by the *covered employee* or former employee, death of the *covered employee* or former employee, disability of a *qualified beneficiary* or loss of disability status);
- In the case of a *qualifying event* that is divorce or legal separation, name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;
- In the case of a *qualifying event* that is *Medicare* entitlement of the *covered employee* or former employee, date of entitlement, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;
- In the case of a *qualifying event* that is a dependent child's cessation of dependent status under the *Plan*, name and address of the child, reason the child ceased to be an eligible *dependent* (for example, attained limiting age, lost student status, married or other);
- In the case of a *qualifying event* that is the death of the *covered employee* or former employee, the date of death, and name(s) and address(es) of spouse and *dependent child(ren)* covered under the *Plan*;
- In the case of a *qualifying event* that is disability of a *qualified beneficiary*, name and address of the disabled *qualified beneficiary*, name(s) and address(es) of other family members covered under the *Plan*, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
- In the case of a *qualifying event* that is loss of disability status, name and address of the *qualified beneficiary* who is no longer disabled, name(s) and address(es) of other family members covered under the *Plan*, the date the disability ended and the date of the SSA's determination; and
- A certification that the information is true and correct, a signature and date.

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

If the notice does not contain all of the required information, the *Plan Administrator* may request additional information. If the individual fails to provide such information within the time period specified by the *Plan Administrator* in the request, the *Plan Administrator* may reject the notice if it does not contain enough information for the *Plan Administrator* to identify the plan, the *covered employee* (or former employee), the *qualified beneficiaries*, the *qualifying event* or disability, and the date on which the *qualifying event*, if any, occurred.

Electing COBRA continuation coverage

Complete instructions on how to elect *COBRA continuation coverage* will be provided by the *Plan Administrator* within 14 days of receiving the notice of your *qualifying event*. You then have 60 days in which to elect *COBRA continuation coverage*. The 60-day period is measured from the later of the date coverage

TERMINATION OF COVERAGE (Continued)

terminates and the date of the notice containing the instructions. If *COBRA continuation coverage* is not elected in that 60-day period, then the right to elect it ceases.

Each *qualified beneficiary* will have an independent right to elect *COBRA continuation coverage*. *Covered employees* may elect *COBRA continuation coverage* on behalf of their spouses, and parents may elect *COBRA continuation coverage* on behalf of their *children*.

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

How long does *COBRA continuation coverage* last?

COBRA continuation coverage will be available up to the maximum time period shown below. Multiple *qualifying events* which may be combined under *COBRA* will not continue coverage for more than 36 months beyond the date of the original *qualifying event*. When the *qualifying event* is “entitlement to *Medicare*,” the 36-month continuation period is measured from the date of the original *qualifying event*. For all other *qualifying events*, the continuation period is measured from the date of the *qualifying event*, not the date of loss of coverage.

When the *qualifying event* is the death of the *covered employee* (or former employee), the *covered employee’s* (or former employee’s) becoming entitled to *Medicare* benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child’s losing eligibility as a *dependent child*, *COBRA continuation coverage* lasts for up to a total of 36 months.

When the *qualifying event* is the end of employment or reduction of the *covered employee’s* hours of employment, and the *covered employee* became entitled to *Medicare* benefits less than 18 months before the *qualifying event*, *COBRA continuation coverage* for *qualified beneficiaries* other than the *covered employee* lasts until 36 months after the date of *Medicare* entitlement. For example, if a *covered employee* becomes entitled to *Medicare* 8 months before the date on which his employment terminates, *COBRA continuation coverage* for his spouse and children can last up to 36 months after the date of *Medicare* entitlement, which is equal to 28 months after the date of the *qualifying event* (36 months minus 8 months).

Otherwise, when the *qualifying event* is the end of employment (for reasons other than gross misconduct) or reduction of the *covered employee’s* hours of employment, *COBRA continuation coverage* generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of *COBRA continuation coverage* can be extended.

Disability extension of 18-month period of *COBRA continuation coverage*

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

Second qualifying event extension of 18-month period of *COBRA continuation coverage*

If your family experiences another *qualifying event* while receiving 18 months of *COBRA continuation coverage*, the spouse and *dependent children* in your family can get up to 18 additional months of *COBRA continuation coverage*, for a maximum of 36 months, if notice of the second *qualifying event* properly is given to the *Plan* as set forth above. This extension may be available to the spouse and any *dependent children* receiving *COBRA continuation coverage* if the *covered employee* or former employee dies, becomes entitled to *Medicare* benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the *Plan* as a *dependent child*, but only if the event would have caused the spouse or

TERMINATION OF COVERAGE (Continued)

dependent child to lose coverage under the *Plan* had the first *qualifying event* not occurred. An extra fee will be charged for this extended *COBRA continuation coverage*.

Does COBRA continuation coverage ever end earlier than the maximum periods above?

COBRA continuation coverage also may end before the end of the maximum period on the earliest of the following dates:

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

Payment for COBRA continuation coverage

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

Two provisions under the *Trade Act* affect the benefits received under *COBRA*. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 65% tax credit for premiums paid for certain types of health insurance, including *COBRA* premiums. Second, eligible individuals under the *Trade Act* who do not elect *COBRA continuation coverage* within the election period will be allowed an additional 60-day period to elect *COBRA continuation coverage*. If the *qualified beneficiary* elects *COBRA continuation coverage* during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the *Plan Administrator* if you believe the *Trade Act* applies to you.

Additional Information

Additional information about the *Plan* and *COBRA continuation coverage* is available from the *Plan Administrator*, who is:

*East Texas Baptist University
Plan Administrator
1209 N. Grove
Marshall, TX 75670
903 923-2120*

Current Addresses

In order to protect your family's rights, you should keep the *Plan Administrator* (who is identified above) informed of any changes in the addresses of family members.

CLAIM PROCEDURES

You will receive a *Plan* identification (ID) card which will contain important information, including claim filing directions and contact information. Your ID card will show your *PPO network*, and your Cost Containment Program administrator.

At the time you receive treatment, show your ID card to your *provider* of service. In most cases, your *provider* will file your claim for you. You may file the claim yourself by submitting the required information to:

Mutual Assurance Administrators, Inc.
4004 Belt Line Rd. Suite 160
Addison, TX 75001
972 774-1100

Most claims under the *Plan* will be “*post service claims.*” A “*post service claim*” is a claim for a benefit under the *Plan* after the services have been rendered. *Post service claims* must include the following information in order to be considered filed with the *Plan*:

A Form HCFA or Form UB92 completed by the *provider* of service, or a form approved for use by the ADA, completed by the *dentist*, including:

- The date of service;
- The name, address, telephone number and tax identification number of the *provider* of the services or supplies;
- The place where the services were rendered;
- The diagnosis and procedure codes;
- The amount of charges (including *PPO network* repricing information);
- The name of the *Plan*;
- The name of the covered *employee*; and
- The name of the patient.

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.

Procedures For All Claims

The procedures outlined below must be followed by *covered persons* to obtain payment of health benefits under this *Plan*.

Health Claims

All claims and questions regarding health claims should be directed to the *third party administrator*. The *Plan Administrator* shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with *ERISA*. Benefits under the *Plan* will be paid only if the *Plan Administrator* decides in its discretion that the *covered person* is entitled to them. The responsibility to process claims in accordance with the *summary plan description* may be delegated to

CLAIM PROCEDURES (Continued)

the *third party administrator*; provided, however, that the *third party administrator* is not a fiduciary of the *Plan* and does not have the authority to make decisions involving the use of discretion.

Each *covered person* claiming benefits under the *Plan* shall be responsible for supplying, at such times and in such manner as the *Plan Administrator* in its sole discretion may require, written proof that the expenses were *incurred* or that the benefit is covered under the *Plan*. If the *Plan Administrator* in its sole discretion shall determine that the *covered person* has not *incurred* a *covered expense* or that the benefit is not covered under the *Plan*, or if the *covered person* shall fail to furnish such proof as is requested, no benefits shall be payable under the *Plan*.

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

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

A “*pre-service urgent care claim*” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the *covered person* or the *covered person’s* ability to regain maximum function, or, in the opinion of a physician with knowledge of the *covered person’s* medical condition, would subject the *covered person* to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

Further, if the *Plan* does not require the *covered person* to obtain approval of a specific medical service prior to getting treatment, then there is no *pre-service claim*. The *covered person* simply follows the *Plan’s* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim*.

- **Concurrent Claims.** A “*concurrent claim*” arises when the *Plan* has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - The *Plan Administrator* determines that the course of treatment should be reduced or terminated; or
 - The *covered person* requests extension of the course of treatment beyond that which the *Plan Administrator* has approved.

Since the *Plan* does not require the *covered person* to obtain approval of a medical service in an emergency or urgent care situation prior to getting treatment, then there is no need to contact the *Plan Administrator* to request an extension of a course of treatment in an urgent care situation. The *covered person* simply follows the *Plan’s* procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a *post-service claim*.

- **Post-service Claims.** A “*post-service claim*” is a claim for a benefit under the *Plan* after the services have been rendered.

When Health Claims Must Be Filed

Post-service health claims must be filed with the *third party administrator* within 30 days of the date charges for the service were *incurred*. Failure to file a claim within this time limit will not invalidate the claim provided

CLAIM PROCEDURES (Continued)

that the *covered person* submits evidence satisfactory to the *Plan Administrator* that it was not reasonably possible to file the claim within the time limit. In no event will the time limit be extended beyond one year from the date the charges were *incurred* except in the case of legal incapacity of the *covered person*. Benefits are based upon the *Plan's* provisions at the time the charges were *incurred*. **Claims filed later than that date shall be denied.**

A *pre-service claim* (including a *concurrent claim* that also is a *pre-service claim*) is considered to be filed when the request for approval of treatment or services is made and received by the *third party administrator* in accordance with the *Plan's* procedures.

Upon receipt of the required information, the claim will be deemed to be filed with the *Plan*. The *third party administrator* will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the *third party administrator* within 45 days from receipt by the *covered person* of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The *Plan Administrator* shall notify the *covered person*, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of *pre-service claims* and *concurrent claims*, of decisions that a claim is payable in full) within the following timeframes:

- *Pre-service Non-urgent Care Claims:*
 - If the *covered person* has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - If the *covered person* has not provided all of the information needed to process the claim, then the *covered person* will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The *covered person* will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the *Plan Administrator* and the *covered person* (if additional information was requested during the extension period).
- *Concurrent Claims:*
 - *Plan Notice of Reduction or Termination.* If the *Plan Administrator* is notifying the *covered person* of a reduction or termination of a course of treatment (other than by *Plan* amendment or termination), before the end of such period of time or number of treatments. The *covered person* will be notified sufficiently in advance of the reduction or termination to allow the *covered person* to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
 - *Request by Covered Person Involving Non-urgent Care.* If the *Plan Administrator* receives a request from the *covered person* to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a *pre-service non-urgent claim* or a *post-service claim*).
- *Post-service Claims:*

CLAIM PROCEDURES (Continued)

- If the *covered person* has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
- If the *covered person* has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the *covered person* will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the *covered person* will be notified of the determination by a date agreed to by the *Plan Administrator* and the *covered person*.
- Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *covered person*, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.
- Extensions – Post-service Claims. This period may be extended by the *Plan* for up to 15 days, provided that the *Plan Administrator* both determines that such an extension is necessary due to matters beyond the control of the *Plan* and notifies the *covered person*, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the *Plan* expects to render a decision.
- Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the *Plan*.

Notification of an Adverse Benefit Determination

The *Plan Administrator* shall provide a *covered person* with a notice, either in writing or electronically, containing the following information:

- A reference to the specific portion(s) of the *summary plan description* upon which a denial is based;
- Specific reason(s) for a denial;
- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures and the time limits applicable to the procedures, including a statement of the *covered person's* right to bring a civil action under section 502(a) of *ERISA* following an adverse benefit determination on final review;
- A statement that the *covered person* 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 *covered person's* claim for benefits;
- 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);
- Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the *covered person*, free of charge, upon request); and

CLAIM PROCEDURES (Continued)

- In the case of denials based upon a medical judgment (such as whether the treatment is *medically necessary* or *experimental*), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances, or a statement that such explanation will be provided to the *covered person*, free of charge, upon request.

Appeals of Adverse Benefit Determinations

Full and Fair Review of All Claims

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

- *Covered persons* at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination and 30 days to appeal a second adverse benefit determination;
- *Covered persons* the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
- For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the *Plan*, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- For a review that takes into account all comments, documents, records, and other information submitted by the *covered person* relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;
- That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the *Plan* fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
- For the identification of medical or vocational experts whose advice was obtained on behalf of the *Plan* in connection with a claim, even if the *Plan* did not rely upon their advice; and
- That a *covered person* will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the *covered person's* claim for benefits in possession of the *Plan Administrator* or the *third party administrator*; information regarding any voluntary appeals procedures offered by the *Plan*; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances.

First Appeal Level

Requirements for First Appeal

The *covered person* must file the first appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the *covered person's* appeal must be addressed as follows and mailed or faxed as follows:

CLAIM PROCEDURES (Continued)

Mutual Assurance Administrators, Inc.
Attn: Claims Department
4004 Belt Line Rd. #160
Addison, TX 75001-5846
972-774-1220 (fax)

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

- The name of the *employee/covered person*;
- The *employee/covered person's* social security number;
- The group name or identification number;
- All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the *covered person* will lose the right to raise factual arguments and theories which support this claim if the *covered person* fails to include them in the appeal;**
- A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
- Any material or information that the *covered person* has which indicates that the *covered person* is entitled to benefits under the *Plan*.

If the *covered person* 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 Administrator* shall notify the *covered person* of the *Plan's* benefit determination on review within the following timeframes:

- *Pre-service Non-urgent Care Claims*: Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the appeal.
- *Concurrent Claims*: The response will be made in the appropriate time period based upon the type of claim – *pre-service non-urgent* or *post-service*.
- *Post-service Claims*: Within a reasonable period of time, but not later than 30 days after receipt of the appeal.
- *Calculating Time Periods*. 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.

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

The *Plan Administrator* shall provide a *covered person* with notification, in writing or electronically, of a *Plan's* adverse benefit determination on review, setting forth:

- The specific reason or reasons for the denial;

CLAIM PROCEDURES (Continued)

**Reference to the specific portion(s) of the *summary plan description* on which the denial is based;
The identity of any medical or vocational experts consulted in connection with the claim, even if the *Plan* did not rely upon their advice;**

- A statement that the *covered person* 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 *covered person's* claim for benefits;
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the *covered person* upon request;
- If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the *Plan* to the *covered person's* medical circumstances, will be provided free of charge upon request;
- A description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is necessary;
- A description of the *Plan's* review procedures (including instructions that all second appeals must be sent to both the *third party administrator* and the *DDM*) and the time limits applicable to the procedures;
- A statement of the *covered person's* right to bring an action under section 502(a) of *ERISA*, following an adverse benefit determination on final review; and
- The following statement: "You and your *Plan* may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

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

Second Appeal Level

Adverse Decision on First Appeal; Requirements for Second Appeal

Upon receipt of notice of the *Plan's* adverse decision regarding the first appeal, the *covered person* has 60 days to file a second appeal of the denial of benefits. The *covered person* again is entitled to a "full and fair review" of any denial made at the first appeal, which means the *covered person* has the same rights during the second appeal as he or she had during the first appeal. As with the first appeal, the *covered person's* second appeal must be in writing and must include all of the items set forth in the section entitled "Requirements for First Appeal." Second appeals must be sent to both the *third party administrator* and the *DDM*.

Timing of Notification of Benefit Determination on Second Appeal

The *Plan Administrator* shall notify the *covered person* of the *Plan's* benefit determination on review within the following timeframes:

- *Pre-service Non-urgent Care Claims:* Within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the second appeal.

CLAIM PROCEDURES (Continued)

- ***Concurrent Claims:*** The response will be made in the appropriate time period based upon the type of claim – *pre-service non-urgent* or *post-service*.
- ***Post-service Claims:*** Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.
- ***Calculating Time Periods:*** 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 description of any additional information necessary for the *covered person* to perfect the claim and an explanation of why such information is needed; and
- A description of the *Plan's* review procedures and the time limits applicable to the procedures. See the section entitled "Manner and Content of Notification of Adverse Benefit Determination on First Appeal."

Furnishing Documents in the Event of an Adverse Determination

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

Decision on Second Appeal to be Final

If, for any reason, the *covered person* does not receive a written response to the appeal within the appropriate time period set forth above, the *covered person* may assume that the appeal has been denied. The decision by the *Plan Administrator* or other appropriate named fiduciary of the *Plan* on review will be final, binding and conclusive 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 90 days after the *Plan's* claim review procedures have been exhausted.**

Appointment of Authorized Representative

A *covered person* is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a *covered person* to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the *covered person* must complete a form which can be obtained from the *Plan Administrator* or the *third party administrator*. However, in connection with a claim involving urgent care, the *Plan* will permit a health care professional with knowledge of the *covered person's* medical condition to act as the *covered person's* authorized representative without completion of this form. In the event a *covered person* designates an authorized representative, all future communications from the *Plan* will be with the representative, rather than the *covered person*, unless the *covered person* directs the *Plan Administrator*, in writing, to the contrary.

Physical Examinations

The *Plan* reserves the right to have a *physician* of its own choosing examine any *covered person* whose *illness* or *injury* is the basis of a claim. All such examinations shall be at the expense of the *Plan*. This right may be exercised when and as often as the *Plan Administrator* may reasonably require during the pendency of a claim. The *covered person* must comply with this requirement as a necessary condition to coverage.

CLAIM PROCEDURES (Continued)

Autopsy

The *Plan* reserves the right to have an autopsy performed upon any deceased *covered person* whose *illness* or *injury* is the basis of a claim. This right may be exercised only where not prohibited by law.

Payment of Benefits

All benefits under this *Plan* are payable, in U.S. Dollars, to the covered *employee* whose *illness* or *injury*, or whose covered *dependent's illness* or *injury*, is the basis of a claim. In the event of the death or incapacity of a covered *employee* and in the absence of written evidence to this *Plan* of the qualification of a guardian for his estate, the *Plan Administrator* may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of the *Plan Administrator*, is or was providing the care and support of such *employee*.

Assignments

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

Non-U.S. Providers

Medical expenses for care, supplies or services which are rendered by a *provider* whose principal place of business or address for payment is located outside the United States (a "*non-U.S. provider*") are payable under the *Plan*, subject to all *Plan* exclusions, limitations, maximums and other provisions, under the following conditions:

- Benefits may not be assigned to a *non-U.S. provider*;
- The *covered person* is responsible for making all payments to *non-U.S. providers*, and submitting receipts to the *Plan* for reimbursement;
- Benefit payments will be determined by the *Plan* based upon the exchange rate in effect on the *incurred* date;
- The *non-U.S. provider* shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
- Claims for benefits must be submitted to the *Plan* in English.

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, or are not paid according to the *Plan's* terms, conditions, limitations or exclusions. Whenever the *Plan* pays benefits exceeding the amount of benefits payable under the terms of the *Plan*, the *Plan Administrator* has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from 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 the amount of such erroneous payment to the *Plan* within 30 days of discovery or demand. The *Plan Administrator* shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

CLAIM PROCEDURES (Continued)

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

Providers and any other person or entity accepting payment from the *Plan*, in consideration of such payments, 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 *Plan Administrator*. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the *Plan* within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the *Plan* must bring an action against a *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.

Medicaid Coverage

A *covered person's* eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such *covered person*. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the *covered person*, as required by the state Medicaid program; and the *Plan* will honor any subrogation rights the state may have with respect to benefits which are payable under the *Plan*.

COORDINATION OF BENEFITS

Benefits Subject to This Provision

This provision applies to all benefits provided under any section of this *Plan*.

“Other Plan”

“*Other plan*” means any of the following plans, other than this *Plan*, providing benefits or services for medical or dental care or treatment:

- Group, blanket, or franchise insurance coverage;
- Blue Cross, Blue Shield, group practice, and other group prepayment coverage;
- Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance, or employee benefit organization plans;
- Any coverage under governmental programs, and any coverage required or provided by statute; and
- Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle *accident*, and any other medical and liability benefits received under any automobile policy.

“Allowable Expenses”

“*Allowable expenses*” shall mean any *medically necessary, usual, reasonable and customary* 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 will be deemed to be the benefit.

It is important that you fulfill any requirements of *other plan(s)* for payment of benefits. If you fail to properly file for, and receive payment by, any *other plan(s)*, this *Plan* will estimate the benefits that would otherwise have been payable and apply that amount, as though actually paid, to the “Application to Benefit Determination” calculation explained in this section.

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 charge that would have been covered by the HMO had the *covered person* used the services of an HMO provider.

Effect on Benefits

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. If this *Plan* is a secondary or subsequent plan, this *Plan* will pay the balance due up to 100% of the total cumulative *allowable expenses* for that calendar year; however, in no event will this *Plan* pay more than it would have in the absence of any *other plan(s)*. When there is a conflict in the order of benefit determination, this *Plan* will never pay more than 50% of *allowable expenses*.

When medical payments are available under automobile insurance, this *Plan* will always be considered the secondary carrier regardless of the individual’s election under personal injury protection (PIP) coverage with the automobile insurance carrier.

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

COORDINATION OF BENEFITS (Continued)

- The *other plan* would, according to its rules, determine its benefits after the benefits of this *Plan* have been determined; and
- The rules in the section entitled “Order of Benefit Determination” would require this *Plan* to determine its benefits before the *other plan*.

Order of Benefit Determination

For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The *Plan* will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim.

- A plan without a coordinating provision will always be the primary plan;
- The benefits of a plan which covers the person on whose expenses claim is based, other than as a dependent, will be determined before the benefits of a plan which covers such person as a dependent. If the person on whose expenses the claim is based is an inactive employee (e.g. retired or on layoff) or the dependent of an inactive employee, the benefits of the plan covering the person in an active status will be determined before the benefits of a plan covering the person in an inactive status;
- If the person for whom claim is made is a dependent child covered under both parents’ plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:
 - When the parents are separated (whether or not ever legally married) or divorced, and the parent with the custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of a plan which covers the child as a dependent of the parent without custody; or
 - When the parents are separated (whether or not ever legally married) or divorced and, the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers that child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

Notwithstanding the above provisions, if there is a court decree which would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any *other plan* which covers the child as a dependent child; and

- When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

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

COORDINATION OF BENEFITS (Continued)

Facility of Payment

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

Right of Recovery

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 provision, the *Plan* shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this *Plan*.

Coordination of Benefits with Medicare

If you are eligible for *Medicare*, and you are eligible for coverage under this *Plan*, you may choose to continue coverage under this *Plan*, and any *Medicare* benefits to which you are entitled may be used to supplement the benefits of this *Plan*. If, however, you choose to make *Medicare* your primary plan, you may not supplement your *Medicare* coverage with the benefits of this *Plan*.

In all cases, coordination of benefits with *Medicare* will conform with Federal law. When coordination of benefits with *Medicare* is permitted, each individual who is eligible for *Medicare* will be assumed to have full *Medicare* coverage whether or not the individual has enrolled for full coverage. Your benefits under this *Plan* will be secondary to *Medicare* to the extent allowed by Federal law.

Coordination of Benefits with Medicaid

In all cases, benefits available through a state or Federal Medicaid program will be secondary or subsequent to the benefits of this *Plan*.

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of medical 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 dependants, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").
2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
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.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to 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.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation 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 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) worker's 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 coverage;

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

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (Continued)

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.

C. 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 subrogation lien. The obligation 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, expressed 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.

D. Excess Insurance

1. 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 provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:
 - 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) worker's 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 coverage;

E. Separation of Funds

1. 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.

F. Wrongful Death

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (Continued)

1. In the event that the Covered Person(s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

G. Obligations

1. It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b) to provide the Plan with pertinent information regarding the sickness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
 - e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way dependant upon the Covered Person(s)' cooperation or adherence to these terms.

H. Offset

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

I. 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 or 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.

J. Language Interpretation

1. 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.

K. Severability

1. 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

SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT (Continued)

severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

DEFINITIONS

In this section you will find the definitions for the italicized words found throughout this *summary plan description*. There may be additional words or terms that have a meaning that pertains to a specific section, and those definitions will be found in that section. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this summary plan description for that information.**

“Accident” means a sudden and unforeseen event, definite as to time and place, or a deliberate act resulting in unforeseen consequences.

“Actively at work” or **“Active employment”** means performance by the *employee* of all the regular duties of his occupation at an established business location of the *participating employer*, or at another location to which he may be required to travel to perform the duties of his employment. An *employee* will be deemed *actively at work* if the *employee* is absent from work due to a health factor. In no event will an *employee* be considered *actively at work* if employment has been terminated.

“ADA” means the American Dental Association.

“AHA” means the American Hospital Association.

“AMA” means the American Medical Association.

“Ambulatory surgical center” means any public or private state licensed and approved (whenever required by law) establishment with an organized medical staff of *physicians*, with permanent facilities that are equipped and operated primarily for the purpose of performing *surgical procedures*, with continuous *physician* services and registered professional nursing service whenever a patient is in the *institution*, and which does not provide service or other accommodations for patients to stay overnight.

“Annual enrollment period” means the period from December 1 through December 31 each year during which *employees* may make new coverage elections.

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

“Cardiac care unit” means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

DEFINITIONS (Continued)

“Certificate of coverage” means a written certification provided by any source that offers medical care coverage, including the *Plan*, for the purpose of confirming the duration and type of an individual’s previous coverage.

“Child(ren)” means, in addition to the *employee’s* own blood descendant of the first degree or lawfully adopted child, a child placed with the *employee* in anticipation of adoption, a child who is an *alternate recipient* under a QMCSO 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. In order for a child to meet the *Plan’s* definition of a *dependent*, the child must have the same principal place of abode for more than one-half of the calendar year and receive more than one-half of his or her support for the calendar year in which the child is enrolled for coverage under the *Plan* from the *employee*. However; a child whose parents are divorced, legally separated, separated under a written separation agreement, or who have lived apart at all times during the last six months of the calendar year, who receives over one half of his or her support from his or her parents, and who is in the custody of one or both parents for more than one half of the calendar year, may be the *dependent child* of both parents.

“Chiropractic care” means all services related to a chiropractic visit.

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

“Company” means *East Texas Baptist University*.

“Complications of pregnancy” means:

- Conditions whose diagnoses are distinct from *pregnancy*, but adversely affected by *pregnancy* or caused by *pregnancy*. Such conditions include acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, and eclampsia;
- A non-elective cesarean section *surgical procedure*; or
- A terminated ectopic *pregnancy*.

Complications of pregnancy does not mean:

- False labor;
- Occasional spotting;
- Prescribed rest during the period of *pregnancy*; or
- Similar conditions associated with the management of a difficult *pregnancy*, but not constituting a distinct complication of *pregnancy*.]

“Cosmetic” or “cosmetic surgery” means any *surgery*, service, *drug* or supply designed to improve the appearance of an individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except when necessitated by an *injury*.

“Covered expense” means a *medically necessary* service or supply which is *usual, customary and reasonable*, and which is listed for coverage in this *Plan*.

“Covered person” means a covered *employee* and his covered *dependents* who are eligible for benefits under the *Plan*.

DEFINITIONS (Continued)

“Creditable coverage” shall mean coverage of an individual under any of the following: a group health plan, health insurance coverage, Medicare, Medicaid (other than coverage consisting solely of benefits under the program for distribution of pediatric vaccines), medical and dental care for members and certain former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, a health benefit plan under Section 5(e) of the Peace Corps Act, or Title XXI of the Social Security Act (State Children’s Health Insurance Program). To the extent that further clarification is needed with respect to the sources of Creditable Coverage listed in the prior sentence, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

“Custodial care” means care or confinement provided primarily for the maintenance of the *covered person*, essentially designed to assist the *covered person*, whether or not *totally disabled*, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

“Deductible” means an amount of money that must be paid by a *covered person* for *covered expenses* before the *Plan* will reimburse additional *covered expenses incurred* during that *plan year*.

“Dentally necessary” means services or supplies, which are determined by the *Plan Administrator* to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the dental condition, *injury or illness*;
- Provided for the diagnosis or direct care and treatment of the dental condition, *injury or illness*;
- Within standards of good dental practice within the organized dental community;
- Not primarily for the convenience of the *covered person*, the *covered person’s dentist* or another *provider*; and
- The most appropriate supply or level of service which can safely be provided.

“Dentist” means an individual holding a D.D.S. or D.M.D. degree, who is licensed to practice dentistry in the jurisdiction where such services are provided.

“Dependent” means one or more of the following person(s):

- An *employee’s* lawfully married spouse possessing a marriage license who is not divorced from the *employee*. For purposes of this section, “marriage or married” means a legal union between one man and one woman as husband and wife;
- An *employee’s* common law spouse, based upon a common law marriage which is legally recognized in the jurisdiction in which the *employee* has his principal residence;
- An *employee’s* unmarried *child* who is less than 19 years of age;
 - An *employee’s* unmarried *child* who is at least 19 years of age but less than 26 years of age, who is dependent upon the *employee* for support and who is a full-time student at an accredited high school, junior

DEFINITIONS (Continued)

college, college, university, or licensed trade school. With respect to a junior college, college or university, full-time attendance requires enrollment for credit of at least twelve hours per semester. With respect to a licensed trade school, full-time attendance requires enrollment in a course of instruction requiring at least six months to complete and attendance of at least twenty hours per week. If a full time student dependent leaves school during a school term due to a “medically necessary leave of absence” the dependent will be able to extend coverage for up to twelve (12) months from the date of the disability with a certification by physician. The requirement to extend coverage during “medically necessary leaves of absence” applies only if the plan receives a written certification by a treating physician of the dependent which states the diagnosis, estimated length of the disability and that the dependent is suffering from a serious illness or injury and that the leave of absence is medically necessary. The Plan may request updated information regarding the illness or injury from the physician throughout the 12 month period. If a *dependent* whose eligibility is based on his continuous attendance in an accredited school as a full-time student becomes ineligible because of his failure to enroll as a full-time student, he will again become eligible to be a *covered person* on the date he enrolls as a full-time student. However, in no event will a *dependent* who has enrolled as a full-time student again become eligible, if such *dependent* has not been a full-time student for 12 months or longer; or

- An *employee’s* unmarried *child*, regardless of age, who was continuously covered prior to attaining the limiting age under the fourth and fifth bullets above, who is mentally or physically incapable of sustaining his own living, who has the same principal place of abode as the employee for more than one-half of the calendar year, and who does not provide more than one half of his or 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 own living prior to attaining the limiting age under the fourth and fifth bullets above. Written proof of such incapacity and dependency satisfactory to the *Plan* must be furnished and approved by the *Plan* within 31 days after the date the *child* attains the limiting age under the fourth and fifth bullets above. The time limit for written proof of incapacity and dependency is 30 days following the original eligibility date for a new or re-enrolling employee. The *Plan* may require, at reasonable intervals, subsequent proof satisfactory to the *Plan* during the next two years after such date. After such two-year period, the *Plan* may require such proof, but not more often than once each year.

“*Dependent*” does not include any person who is a member of the armed forces of any country or who is a resident of a country outside the United States.

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

“**Detoxification**” means 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 to a minimum.

“**Diagnostic service**” means a test or procedure performed for specified symptoms to detect or to monitor an *illness* or *injury*. It must be ordered by a *physician* or other professional *provider*.

“**Drug**” means 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**” means equipment which:

DEFINITIONS (Continued)

- Can withstand repeated use;
- Is primarily and customarily used to serve a medical purpose;
- Generally is not useful to a person in the absence of an *illness* or *injury*; and
- Is appropriate for use in the home.

“**Effective date**” means, January 1, 2000 , the original *effective date* of the *Plan*.

“**Emergency**” means 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, hemorrhage, severe chest pain, difficulty in breathing, sudden onset of weakness or paralysis of a body part, severe burns, unconsciousness, partial or complete severing of a limb, and convulsions.

For purposes of the “Dental Benefits” section of the Plan, emergency means a dental problem requiring immediate treatment for relief of extreme pain, acute infection, bleeding or *injury* to the gums and/or teeth.

Other emergencies and acute conditions may be considered on receipt of proof, satisfactory to the *Plan*, that an *emergency* did exist.

“**Employee**” means a person who is a regular full-time employee of the *participating employer*, regularly scheduled to work for the *participating employer* in an employer-employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered “full-time.” An employee is not a seasonal, temporary or leased employee, or an independent contractor.

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

“**Experimental**” means services, supplies, care, procedures, treatments or courses of treatment, which:

- 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
- 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. All phases of clinical trials shall be considered experimental.

For purposes of the “Dental Benefits” section of the Plan, experimental means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted dental practice under the standards of the case and by the standards of a reasonable segment of the dental community or government oversight agencies at the time rendered; or
- Are rendered on a research basis as determined by the United States Food and Drug Administration or by a recognized national medical or dental society.

Drugs are considered *experimental* if they are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

“**Family unit**” means the *employee*, his spouse and his *dependent children*.

DEFINITIONS (Continued)

“**FMLA**” means the Family and Medical Leave Act of 1993, as amended.

“**FMLA leave**” means a *leave of absence*, which the *company* is required to extend to an *employee* under the provisions of the *FMLA*.

“**Full-time Student “Medically Necessary leave of absence”**” means a leave of absence from a postsecondary education institution that commences while such child is suffering from a serious illness or injury, is medically necessary, and causes such child to lose student status for purposes of coverage under the terms of the plan.

“**Generic drug**” means drugs not protected by a trademark, usually descriptive of drug’s chemical structure.

“**HIPAA**” means the Health Insurance Portability and Accountability Act of 1996, as amended.

“**Home health care**” means certain services and supplies required for treatment of an *illness* or *injury* in the *covered person’s* home as part of a formal treatment plan certified by the attending *physician* and approved by the *Plan Administrator*.

“**Home health care agency**” means an agency or organization which provides a program of *home health care* and which:

- Is approved as a home health agency under *Medicare*;
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements:
 - It is an agency which holds itself forth to the public as having the primary purpose of providing a *home health care* delivery system bringing supportive services to the home;
 - It has a full-time administrator;
 - It maintains written records of services provided to the patient;
 - Its staff includes at least one registered nurse (R.N.) or it has nursing care by a registered nurse (R.N.) available; and
 - Its employees are bonded and it provides malpractice insurance.

“**Hospice Care Agency**” means an agency which has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24 hour a day, seven days a week service, supervised by a qualified practitioner;
- Has a full-time coordinator;
- Keeps written records of services provided to each patient;

DEFINITIONS (Continued)

- Has a nurse coordinator who is a registered nurse (RN) with four years of full-time clinical experience, of which at least two years involved caring for terminally ill patients; and
- Has a licensed social service coordinator.

A Hospice Care Agency will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an on going quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

"Hospital" means an *institution* that meets all of the following requirements:

- It provides medical and *surgical* facilities for the treatment and care of injured or sick persons on an *inpatient* basis;
- It is under the supervision of a staff of *physicians*;
- It provides 24-hour-a-day nursing service by registered nurses;
- It is duly licensed as a *hospital*, except that this requirement will not apply in the case of a state tax-supported *institution*;
- It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution, or an institution which is supported in whole or in part by a federal government fund; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

The requirement of *surgical* facilities shall not apply to a *hospital* specializing in the care and treatment of mentally ill patients, provided such *institution* is accredited as such an *institution* by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the *AMA* and the *AHA*.

"Illness" means a condition, sickness or disease not resulting from trauma.

"Immediate relative" means spouse, child, brother, sister or parent of the *covered person*, whether by birth, adoption or marriage

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

"Incurred" means 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. More specifically, *covered expenses* for the entire procedure or course of treatment are not *incurred* upon commencement of the first stage of the procedure or course of treatment.

"Injury" means physical damage to the body, caused by an external force, and which is due directly and independently of all other causes, to an *accident*.

DEFINITIONS (Continued)

“Inpatient” means any person who, while confined to a *hospital*, is assigned to a bed in any department of the *hospital* other than its outpatient department and for whom a charge for *room and board* is made by the *hospital*.

“Institution” means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a *hospital*, *ambulatory surgical center*, *psychiatric hospital*, community mental health center, residential treatment facility, *psychiatric hospital*, *substance abuse treatment center*, alternative birthing center, *home health care center*, or any other such facility that the *Plan* approves.

“Intensive care unit” means a separate, clearly designated service area which is maintained within a *hospital* and which meets all the following requirements:

- It is solely for the treatment of patients who require special medical attention because of their critical condition;
- It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the *hospital*;
- It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
- It contains at least two beds for the accommodation of critically ill patients; and
- It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

“Leave of absence” means a leave of absence of an *employee* that has been approved by his *participating employer*, as provided for in the *participating employer’s* rules, policies, procedures and practices.

“Mastectomy” means the *surgical* removal of all or part of a breast.

“Medically necessary” means services or supplies which are determined by the *Plan Administrator* to be:

- Appropriate and necessary for the symptoms, diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;
- Provided for the diagnosis or direct care and treatment of the medical condition, *injury* or *illness*;
- Within standards of good medical practice within the organized medical community;
- Not primarily for the convenience of the *covered person*, the *covered person’s physician* or another *provider*; and
- The most appropriate supply or level of service which can safely be provided.

For *hospital* stays, this means that acute care as an *inpatient* is necessary due to the kind of services the *covered person* is receiving or the severity of the *covered person’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* 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*.”

DEFINITIONS (Continued)

“Medicare” means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

“Mental or nervous disorder” means any *illness* or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services; or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

“Morbid obesity” means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the *covered person*.

“Network” means the *Preferred Provider Organization (PPO)* network of *providers* offering discounted fees for services and supplies to *covered persons*. The *network* will be identified on the *covered person’s Plan* Identification Card.

“Out-of-pocket expense” means the cost to the *covered person* for *deductibles*, coinsurance, copayments, penalties and non-covered *expenses*.

“Participating employer(s)” means *East Texas Baptist University*.

“Physician” means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental *Surgery* (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.).

“Plan” means the *East Texas Baptist University Employee Welfare Benefit Plan*.

“Plan Administrator” means *East Texas Baptist University*.

“Plan Document” means this *plan document* and *summary plan description*.

“Plan Sponsor” means *East Texas Baptist University*.

“Plan year” means the period commencing January 1 and continuing until the next succeeding anniversary.

“Pre-admission tests” means those *diagnostic services* done before a scheduled *hospital inpatient* admission, provided that:

- The tests are required by the *hospital* and approved by the *physician*;
- The tests are performed on an outpatient basis prior to *hospital* admission;
- The tests are not duplicated on admission to the *hospital*; and
- The tests are performed at the *hospital* where the confinement is scheduled, or at a qualified facility approved by the *hospital* to perform the tests.

“Preferred Provider Organization” or **“PPO”** means the network of *providers* offering discounted fees for services and supplies to *covered persons*. The *network* will be identified on the *covered person’s Plan* Identification Card.

“Pregnancy” means carrying a child, resulting childbirth, miscarriage and non-elective abortion. The *Plan* considers *pregnancy* as an *illness* for the purpose of determining benefits.

DEFINITIONS (Continued)

“Privacy Standards” means the standards for privacy of individually identifiable health information, as enacted pursuant to *HIPAA*.

“Provider” means a *physician*, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, psychiatrist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, certified midwife, or other practitioner or facility defined or listed herein, or approved by the *Plan Administrator*.

“Psychiatric hospital” means an *institution* constituted, licensed, and operated as set forth in the laws that apply to *hospitals*, which meets all of the following requirements:

- It is primarily engaged in providing psychiatric services for the diagnosis and treatment of mentally ill persons either by, or under the supervision of, a *physician*;
- It maintains clinical records on all patients and keeps records as needed to determine the degree and intensity of treatment provided;
- It is licensed as a *psychiatric hospital*;
- It requires that every patient be under the care of a *physician*; and
- It provides 24-hour-a-day nursing service.

It does not include an *institution*, or that part of an *institution*, used mainly for nursing care, rest care, convalescent care, care of the aged, *custodial care* or educational care.

“Rehabilitation hospital” means an *institution* which mainly provides therapeutic and restorative services to sick or injured people. It is recognized as such if:

- It carries out its stated purpose under all relevant federal, state and local laws;
- It is accredited for its stated purpose by either the Joint Commission on Accreditation of Healthcare Organizations or the Commission on Accreditation for Rehabilitation Facilities; or
- It is approved for its stated purpose by *Medicare*.

“Room and board” means an *institution*'s charge for:

- Room and linen service;
- Dietary service, including meals, special diets and nourishment;
- General nursing service; and
- Other conditions of occupancy which are *medically necessary*.

“Security standards” mean the final rule implementing *HIPAA*'s Security Standards for the Protection of *Electronic PHI*, as amended.

DEFINITIONS (Continued)

“Significant break in coverage” means a period of 63 consecutive days during each of which an individual does not have any *creditable coverage*.

“Substance abuse” means any use of alcohol, any *drug* (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal.

“Substance abuse treatment center” means 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:

- Affiliated with a *hospital* under a contractual agreement with an established system for patient referral;
- Accredited as such a facility by the Joint Commission on Accreditation of Healthcare Organizations; or
- Licensed, certified or approved as an alcohol or *substance abuse* treatment program or center by a state agency having legal authority to do so.

“Summary plan description” means this *plan document* and *summary plan description*.

“Surgery” or “Surgical Procedure” means any of the following:

- The incision, excision, debridement or cauterization of any organ or part of the body, and the suturing of a wound;
- The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;
- The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;
- The induction of artificial pneumothorax and the injection of sclerosing solutions;
- Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;
- Obstetrical delivery and dilation and curettage; or
- Biopsy.

“Third party administrator” means Mutual Assurance Administrators, Inc.

“Total disability” or “totally disabled” means the inability of an employee to perform substantially all of the duties of his occupation due to an illness or injury. The *Plan Administrator* may, in its sole discretion, require satisfactory evidence of total disability.

“Trade Act” means the Trade Act of 2002, as amended.

“Uniformed services” means the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or *emergency*.

DEFINITIONS (Continued)

“USERRA” means the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”).

“Usual, customary and reasonable” or “usual, customary and reasonable fees” (“UCR”) means services and supplies which are *medically necessary* for the care and treatment of *illness* or *injury*, but only to the extent that such fees are reasonable. Determination that a fee is reasonable will be made by the *Plan Administrator*, taking into consideration:

- The fee which the *provider* most frequently charges the majority of patients for the service or supply;
- The prevailing range of fees charged in the same *area* by *providers* of similar training and experience for the service or supply; and
- Unusual circumstances or complications requiring additional time, skill and experience in connection with the particular service or supply.

“Area” means a metropolitan area, county or such greater area as is necessary to obtain a representative cross-section of *providers* rendering such services or furnishing such supplies.

“Waiting period” means an interval of time during which the *employee* is in the continuous, *active employment* of his *participating employer* before he becomes eligible to participate in the *Plan*.

PLAN ADMINISTRATION

Who has the authority to make decisions in connection with the *Plan*?

The *Plan* is administered by the *Plan Administrator* in accordance with *ERISA*. The *Plan Administrator* has retained the services of the *Third Party Administrator* to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the *Plan Sponsor* to be *Plan Administrator* and serve at the convenience of the *Plan Sponsor*. If the *Plan Administrator* resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the *Plan Sponsor* will appoint a new *Plan Administrator* as soon as reasonably possible.

The *Plan Administrator* will administer this *Plan* in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this *Plan* that the *Plan Administrator* will have maximum legal discretionary authority to construe and interpret the terms and provisions of the *Plan*, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are *experimental*), to decide disputes which may arise relative to a *covered person's* rights, and to decide questions of *Plan* interpretation and those of fact relating to the *Plan*. The decisions of the *Plan Administrator* as to the facts related to any claim for benefits and the meaning and intent of any provision of the *Plan*, or its application to any claim, 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* decides, in its discretion, that the *covered person* is entitled to them.

The duties of the *Plan Administrator* include the following:

- To administer the *Plan* in accordance with its terms;
- To determine all questions of eligibility, status and coverage under the *Plan*;
- To interpret the *Plan*, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
- To make factual findings;
- To decide disputes which may arise relative to a *covered person's* rights;
- 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;
- To keep and maintain the *Plan* documents and all other records pertaining to the *Plan*;
- To appoint and supervise a third party administrator to pay claims;
- To perform all necessary reporting as required by *ERISA*;
- To establish and communicate procedures to determine whether *MCSOs and NMSNs* are *QMCSOs*;
- To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
- To perform each and every function necessary for or related to the *Plan's* administration.

PLAN ADMINISTRATION (Continued)

May changes be made to the *Plan*?

The *Plan Sponsor* expects to maintain this *Plan* indefinitely; however, the *Plan Sponsor* 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 as required by *ERISA*. 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 *covered persons* are limited to expenses *incurred* before termination. All amendments to this *Plan* shall become effective as of a date established by the *Plan Sponsor*.

MISCELLANEOUS INFORMATION

Who pays the cost of the *Plan*?

The *Plan Sponsor* is responsible for funding the *Plan* and will do so as required by law. To the extent permitted by law, the *Plan Sponsor* is free to determine the manner and means of funding the *Plan*. The amount of the *covered person's* contribution (if any) will be determined from time to time by the *Plan Sponsor*, in its sole discretion.

Will the *Plan* release my information to anyone?

For the purpose of determining the applicability of and implementing the terms of these benefits, the *Plan Administrator* may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or *covered person* for benefits under this *Plan*. In so acting, the *Plan Administrator* shall be free from any liability that may arise with regard to such action; however, the *Plan Administrator* at all times will comply with the *privacy standards*. Any *covered person* claiming benefits under this *Plan* shall furnish to the *Plan Administrator* such information as may be necessary to implement this provision.

What if the *Plan* makes an error?

Clerical errors made on the records of the *Plan* and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this *Plan* regardless of whether any contributions with respect to *covered persons* have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Will the *Plan* conform to applicable laws?

This *Plan* shall be deemed automatically to 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 that are otherwise limited or excluded under this *Plan*, such payments will be considered as being in accordance with the terms of this *summary plan description*. It is intended that the *Plan* will conform to the requirements of *ERISA*, as it applies to employee welfare plans, as well as any other applicable law.

What constitutes a fraudulent claim?

The following actions by you, or your knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this *Plan* for the entire *family unit* of which you are a member:

- 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*;
- Attempting to file a claim for a *covered person* for services that were not rendered or *drugs* or other items that were not provided;
- Providing false or misleading information in connection with enrollment in the *Plan*; or
- Providing any false or misleading information to the *Plan*.

How will this document be interpreted?

The use of masculine pronouns in this *summary plan description* shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this *summary plan description* are used for convenience of reference only. *Covered persons* are advised not to rely on any provision because of the heading.

The use of the words, "you" and "your" throughout this *summary plan description* applies to eligible or covered *employees* and, where appropriate in context, their covered *dependents*.

MISCELLANEOUS INFORMATION (Continued)

How may a *Plan* provision be waived?

No term, condition or provision of this *Plan* shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this *Plan*, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such 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 the one specifically waived.

Is this *summary plan description* a contract between the *participating employer* and *covered persons*?

This *summary plan description* and any amendments constitute the terms and provisions of coverage under this *Plan*. The *summary plan description* shall not be deemed to constitute a contract of any type between the *employer* and any *covered person* or to be consideration for, or an inducement or condition of, the employment of any *employee*. Nothing in this *summary plan description* shall be deemed to give any *employee* the right to be retained in the service of the *employer* or to interfere with the right of the *employer* to discharge any *employee* at any time.

What if there is coverage through workers' compensation?

This *Plan* excludes coverage for any *injury* or *illness* that is eligible for coverage under any workers' compensation policy or law regardless of the date of onset of such *injury* or *illness*. However, if benefits are paid by the *Plan* and it is later determined that you received or are eligible to receive workers' compensation coverage for the same *injury* or *illness*, the *Plan* is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the *injury* or *illness* regardless of the amount or terms of any settlement you receive from workers' compensation. The *Plan* will exercise its right to recover against you. The *Plan* reserves its right to exercise its rights under this section and the section entitled "Recovery of Payment" even though:

- The workers' compensation benefits are in dispute or are made by means of settlement or compromise;
- No final determination is made that the *injury* or *illness* was sustained in the course of or resulted from your employment;
- The amount of workers' compensation benefits due specifically to health care expense is not agreed upon or defined by you or the workers' compensation carrier; or
- The health care expense is specifically excluded from the workers' compensation settlement or compromise.

You are required to notify the *Plan Administrator* immediately when you file a claim for coverage under workers' compensation if a claim for the same *injury* or *illness* is or has been filed with this *Plan*. Failure to do so, or to reimburse the *Plan* for any expenses it has paid for which coverage is available through workers' compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the *Plan* for recovery and disciplinary action.

Will the *Plan* cover an alternate course of treatment?

The *Plan Administrator* may, in its sole discretion, determine that a service or supply, not otherwise listed for coverage under this *Plan*, be included for coverage, if the service or supply is deemed appropriate and necessary, and is in lieu of a more expensive, listed covered service or supply.

If a *covered person*, in cooperation with his *provider*, elect a course of treatment that is deemed by the *Plan Administrator*, in its sole discretion, to be more extensive or costly than is necessary to satisfactorily treat the *illness* or *injury*, this *Plan* will allow coverage for the *usual, customary and reasonable* value of the less costly or extensive course of treatment.

HIPAA PRIVACY PRACTICES

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information:

Disclosure of Summary Health Information to the Plan Sponsor

In accordance with *HIPAA's* Standards for Privacy of Individually Identifiable Health Information (the "*privacy standards*"), the *Plan* may disclose *summary health information* to the *Plan Sponsor*, if the *Plan Sponsor* requests the *summary health information* for the purpose of:

- Obtaining premium bids from health plans for providing health insurance coverage under this *Plan*; or
- Modifying, amending or terminating the *Plan*.

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

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

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

- Not use or further disclose *PHI* other than as permitted or required by the *Plan* documents or as *required by law* (as defined in the *privacy standards*);
- Ensure that any agents, including a subcontractor, to whom the *Plan Sponsor* provides *PHI* received from the *Plan* agree to the same restrictions and conditions that apply to the *Plan Sponsor* with respect to such *PHI*;
- Not use or disclose *PHI* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *Plan Sponsor*, except pursuant to an authorization which meets the requirements of the *privacy standards*;
- Report to the *Plan* any *PHI* use or disclosure that is inconsistent with the uses or disclosures provided for of which the *Plan Sponsor* becomes aware;
- Make available *PHI* in accordance with section 164.524 of the *privacy standards* (45 CFR 164.524);
- Make available *PHI* for amendment and incorporate any amendments to *PHI* in accordance with section 164.526 of the *privacy standards* (45 CFR 164.526);
- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the *privacy standards* (45 CFR 164.528);
- Make its internal practices, books and records relating to the use and disclosure of *PHI* received from the *Plan* available to the Secretary of the U.S. Department of Health and Human Services ("*HHS*"), or any other officer or employee of *HHS* to whom the authority involved has been delegated, for purposes of determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);

HIPAA PRIVACY PRACTICES (Continued)

- If feasible, return or destroy all *PHI* received from the *Plan* that the *Plan Sponsor* still maintains in any form and retain no copies of such *PHI* when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the *PHI* infeasible; and
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in section 164.504(f)(2)(iii) of the *privacy standards* (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - The following employees, or classes of employees, or other persons under control of the *Plan Sponsor*, shall be given access to the *PHI* to be disclosed: HIPAA Privacy Officer, HIPAA Privacy Staff designated by HIPAA Privacy Officer and Plan Auditor.
 - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan*.
 - In the event any of the individuals described in above do not comply with the provisions of the *Plan* documents relating to use and disclosure of *PHI*, the *Plan Administrator* shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

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

The *Plan* shall disclose *PHI* to the *Plan Sponsor* only upon receipt of a certification by the *Plan Sponsor* that:

- The *Plan* documents have been amended to incorporate the above provisions; and
- The *Plan Sponsor* agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the *Plan Sponsor*

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

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

The *Plan Sponsor* hereby authorizes and directs the *Plan*, through the *Plan Administrator* or the *third party administrator*, to disclose *PHI* to stop-loss carriers, excess loss carriers or managing general underwriters (“*MGUs*”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the *Plan*. Such disclosures shall be made in accordance with the *privacy standards*.

Other Disclosures and Uses of *PHI*

With respect to all other uses and disclosures of *PHI*, the *Plan* shall comply with the *privacy standards*.

HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information (“Electronic PHI”) to the *Plan Sponsor* for Plan Administration Functions

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

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;
- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;
- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides Electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and
- Report to the *Plan* any Security Incident of which it becomes aware.

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

STATEMENT OF ERISA RIGHTS

As a *covered person* in the *Plan*, you are entitled to certain rights and protections under *ERISA*. *ERISA* provides that all *covered persons* are entitled to:

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for *pre-existing conditions* under the *Plan*, if you have *creditable coverage* from another plan. You should be provided a *certificate of coverage*, free of charge, from your group health plan or health insurance issuer on request or when you lose coverage under the plan, when you become entitled to elect *COBRA* continuation coverage, when your *COBRA* continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of *creditable coverage*, you may be subject to a *pre-existing condition* exclusion or limitation for 12 months (18 months for *late enrollees*) after your *enrollment date* in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under *ERISA*, there are steps you can take to enforce the above rights. For instance, if you request a copy of *Plan* documents or the latest annual report from the *Plan* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *Plan Administrator* to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *Plan Administrator*. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the *Plan's* decision or lack thereof concerning the qualified status of a domestic relations order, a *medical child support order* or a *national medical support notice*, you may file suit in Federal court. If it should happen that *Plan* fiduciaries misuse the *Plan's* money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of

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Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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