PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

FOR

TIGER LINES, LLC

MEC PLAN

EFFECTIVE JANUARY 1, 2016

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TIGER LINES, LLC MAJOR MEDICAL PLAN – MEC OPTION

AMENDMENT AND RESTATMENT OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

It is the intention of the Plan Sponsor, Tiger Lines, LLC to hereby amend and restate the Tiger Lines, LLC Major Medical Plan – MEC Option, a part of the Tiger Lines, LLC Major Medical Plan, a program of benefits constituting a self-funded "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any amendments thereto.

Effective Date

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

Adoption of the Plan Document

The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document as the written description of the MEC Option Plan. This Plan Document represents both the Plan Document and the Summary Plan Description for the MEC Option, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. ("ERISA"). This Plan Document amends, restates and replaces any prior statement of the MEC Option health care coverage contained in the MEC Option Plan or any predecessor to the MEC Option Plan.

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

Effective date of the Tiger Lines, LLC Major Medical Plan: January 1, 2012
Effective date of the Tiger Lines, LLC Major Medical Plan – MEC Option: January 1, 2016

Tiger Lines, LLC

Date: _____ By: _____

Name: _____

Title: _____

GENERAL INFORMATION AND PURPOSE

This Plan Document describes the benefits for the Employees of **Tiger Lines, LLC**. This statement is required by the Employee Retirement Income Security Act of 1974 (ERISA) and provides important information regarding your rights under this law.

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

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

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

Name of Plan
Tiger Lines, LLC Major Medical Plan – MEC Option
(part of the Tiger Lines, LLC Major Medical Plan)

Plan Sponsor
Tiger Lines, LLC
927 Black Diamond Way
Lodi, California 95241
209-334-4100

Plan Administrator
Tiger Lines, LLC
927 Black Diamond Way
Lodi, California 95241
209-334-4100

Type of Plan
Self-Funded Employee Welfare Benefit Plan

Agent for Service of Legal Process Legal Process may also be served on the Plan Administrator
James D. Musgrave, Executive Vice President/Chief Operating Officer

Tiger Lines, LLC
927 Black Diamond Way
Lodi, California 95241
209-334-4100

Claims Administrator
BCA, LLC
100 SW Albany Ave, Suite 200
Stuart, FL 34994
Toll free 855-228-6583
772-577-7600
Secure fax: 888-974-1264
The Plan Administrator has retained the services of the Claims Administrator to administer Claims under the Plan.

Regional Office of Employee Benefits Security Administration
Employee Benefits Security Administration (EBSA)
Department of Labor
Dallas Regional Office
525 South Griffin Street, Rm 900
Dallas, Texas 75202-5025
972-850-4500 ◆ 866-444-EBSA (3272) www.askebsa.dol.gov for
electronic inquiries ◆ www.dol.gov/ebsa

Plan Year
The twelve (12) month period beginning January 1 and ending December 31 of each Calendar Year

Employer Tax ID Number
71-0873207

ERISA Plan Number
501

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

INTRODUCTION

Tiger Lines, LLC, hereafter referred to as "Company," hereby amends and restates the Tiger Lines, LLC Major Medical Plan, a self-funded Employee Welfare Benefit Plan coming within the purview of the Employee Retirement Income Security Act of 1974 (ERISA), hereafter referred to as the "Plan." The Plan's benefits and administration expenses are paid directly from the Employer's general assets, and the rights and privileges of which shall pertain to Employees and their Dependents with respect to such Plan. The Plan is not insured. Contributions received from Covered Persons are used to cover Plan costs and are expended immediately. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

GENERAL AUTHORITY OF THE PLAN ADMINISTRATOR

Subject to the Claims administration duties delegated to the Claim Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including, without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

The Plan will be interpreted by the Plan Administrator in accordance with the terms of the Plan and their intended meanings. However, the Plan Administrator shall have the discretion to interpret or construe ambiguous, unclear or implied (but omitted) terms in any fashion it deems to be appropriate in its sole judgment. The validity of any such finding of fact, interpretation, construction or decision shall be upheld in any legal action and shall be binding and conclusive on all interested parties unless clearly arbitrary and capricious.

To the extent the Plan Administrator has been granted discretionary authority under the Plan, the prior exercise of such authority by the Plan Administrator shall not obligate it to exercise its authority in a like fashion thereafter.

If due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by the Plan Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Plan Administrator in a fashion consistent with its intent, as determined by the Plan Administrator. The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The foregoing provisions of this Plan may not be invoked by any person to require the Plan to be interpreted in a manner which is inconsistent with its interpretations by the Plan Administrator. All actions taken and all determinations by the Plan Administrator shall be final and binding upon all persons claiming any interest under the Plan subject only to the Claims appeal procedures of the Plan.

ADMINISTRATION OF THE PLAN

The Plan Administrator has full charge of the operation and management of the Plan. The Plan Administrator has retained the services of the Claims Administrator, an independent Claims processor experienced in Claims review.

The Plan Administrator is the named Fiduciary of the Plan except as noted herein. The Plan Administrator maintains discretionary authority to interpret the terms of the Plan, including but not limited to,

determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect and shall be binding on all persons, unless it can be shown that the interpretation or determination was arbitrary and capricious.

PHYSICIAN-PATIENT RELATIONSHIP

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

FREE CHOICE OF PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to make a free choice of the attending Physician or professional provider.

EFFECTIVE DATE

Effective date of the Tiger Lines, LLC Major Medical Plan: **January 1, 2012**
Effective date of the Tiger Lines, LLC Major Medical Plan - MEC Option: **January 1, 2016**

CLAIMS ADMINISTRATOR

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

NAMED FIDUCIARY

The named Fiduciary for purposes of applying the provisions of ERISA to the Plan is **Tiger Lines, LLC**, who, as Plan Administrator, shall have the authority to control and manage the operation and administration of the Plan. The Company may delegate responsibilities for the operation and administration of the Plan. The Company or Board of Directors of the Company, if applicable, shall have the authority to amend or terminate the Plan, to determine its policies, to appoint and remove service providers, adjust their compensation (if any), and exercise general administrative authority over them. The Company has the sole authority and responsibility to review and make final decisions on all Claims to benefits hereunder.

CONTRIBUTIONS TO THE PLAN

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

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

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

In the event that the Company or Board of Directors of the Company, if applicable, terminates the Plan, then as of the effective date of termination, the Employer and Covered Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay Claims incurred after the termination date of the Plan.

CLAIMS PROCEDURE

In accordance with Section 503 of ERISA, the Plan Administrator shall provide adequate notice in writing to any covered Plan Participant whose Claim for benefits under this Plan has been denied, setting forth the specific reasons for such denial and written in a manner calculated to be understood by the Plan Participant. Further, the Plan Administrator shall afford a Reasonable opportunity to any Plan Participant, whose Claim for benefits has been denied, for a fair review of the decision denying the Claim by the person designated by the Plan Administrator for that purpose. Details of the Claims procedure, which are in compliance with ERISA regulations, are found in this Plan Document under the section entitled "Procedures for Claims and Appeals."

PROTECTION AGAINST CREDITORS

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

SUMMARY OF MATERIAL REDUCTION (SMR)

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

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

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

SUMMARY OF MATERIAL MODIFICATIONS (SMM)

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

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

PLAN AMENDMENTS

This Document contains all the terms of the Plan and may be amended from time to time, if the Plan Sponsor is a corporation, by a written resolution of the Plan Sponsor's Board of 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, this Document may be amended 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. Any such Plan Amendment shall become effective as of the date specified in the enabling resolution or applicable governing documents, or by the sole proprietor. A copy of any Plan Amendment shall be furnished to the Plan Administrator, the Trustees (if any) and any outside provider of plan administrative services.

TERMINATION OF PLAN

The Plan Sponsor reserves the right at any time to terminate the Plan or any benefit under the Plan, if the Plan Sponsor is a corporation, by a written resolution of the Plan Sponsor's Board of 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, the Plan or any benefit under the Plan may be terminated 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. Previous contributions by the Employer and Employees shall continue to be used for the purpose of paying benefits under the provisions of this Plan with respect to Claims arising before such termination.

PLAN IS NOT A CONTRACT

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

STATEMENT OF ERISA RIGHTS

As a Plan Participant in the Employee Welfare Benefit Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, 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.

To the extent required by ERISA to be prepared by the Plan, receive a summary of the Plan's annual financial report. Plan Administrators are required by law to furnish Participants in certain plans with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

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

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

(30) days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a Claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should 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 or suit is frivolous.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the 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.

FEDERAL LAWS

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

To the extent applicable to the benefits offered under this Plan, the coverage will comply with the Pregnancy Discrimination Act of 1978, the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Rights Act of 1998. Please see below for a brief summary of each regulation:

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (H.R. 3103, 1996)
The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage.

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

PREGNANCY DISCRIMINATION ACT OF 1978
The Pregnancy Discrimination Act of 1978 forbids discrimination based on pregnancy when it comes to any aspect of employment, including fringe benefits, such as leave and health insurance. When applicable to this Plan, Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness.

FAMILY AND MEDICAL LEAVE ACT OF 1993 (P.L. 103-3)
If a Covered Employee ceases active employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of Public Law 103, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in active employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

OMNIBUS BUDGET RECONCILIATION ACT OF 1993 (OBRA 1993: PL 103-66)
OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)).

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996
The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn Children following delivery, as follows:

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

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

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

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

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

1. Reconstruction of the breast(s) on which a covered mastectomy has been performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prostheses and physical complications related to all stages of covered mastectomy, including lymphedema.

If coverage for this benefit is applicable under your Plan, all applicable benefit provisions still apply, including existing Deductibles, Copays and/or Coinsurance.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008 ("GINA")
GINA prohibits the group health Plan from:

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

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

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

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

What is "Genetic Information" under GINA?

Under GINA, the term "Genetic Information" includes:

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

2. The manifestation of a Disease or disorder in the Family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

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

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP) OFFER FREE OR LOW-COST HEALTH COVERAGE TO CHILDREN AND FAMILIES

If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

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

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

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

If you live in one of the following States, you may be eligible for assistance to pay your Employer health premiums. The following list of States is current as of January 31, 2015. You should contact your State for further information on eligibility:

ALABAMA - Medicaid
Website: http://www.myallhipp.com
Phone: 1-855-692-5447

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

COLORADO - Medicaid
Medicaid Website: http://www.colorado.gov/
Medicaid Customer Contact Center: 1-800-221-3943

FLORIDA - Medicaid
Website: https://www.flmedicaidtplrecovery.com/
Phone: 1-877-357-3268

GEORGIA - Medicaid
Website: http://dch.georgia.gov/
Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone:
1-800-869-1150

INDIANA - Medicaid
Website: http://www.in.gov/fssa
Phone: 1-800-889-9949
IOWA - Medicaid
Website: www.dhs.state.ia.us/hipp/
Phone: 1-888-346-9562

KANSAS - Medicaid
Website: http://www.kdheks.gov/hcf/
Phone: 1-800-792-4884

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

LOUISIANA - Medicaid
Website: http://www.lahipp.dhh.louisiana.gov
Phone: 1-888-695-2447

MAINE - Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html
Phone: 1-800-977-6740 TTY:
1-800-977-6741

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

MINNESOTA - Medicaid
Website: http://www.dhs.state.mn.us/
Click on Health Care, then Medical Assistance
Phone: 1-800-657-3739

MISSOURI - Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm
Phone: 1-573-751-2005

MONTANA - Medicaid
Website: http://medicaid.mt.gov/member
Phone: 1-800-694-3084

NEBRASKA - Medicaid
Website: www.ACCESSNebraska.ne.gov
Phone: 1-855-632-7633

NEVADA - Medicaid
Website: http://dwss.nv.gov/
Phone: 1-800-992-0900

NEW HAMPSHIRE - Medicaid
Website: www.dhhs.nh.gov/oii/documents/hippapp.pdf
Phone: 1-603-271-5218

NEW JERSEY - Medicaid and CHIP
Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/
Medicaid Phone: 1-609-631-2392
CHIP Website: http://www.njfamilycare.org/index.html
CHIP Phone: 1-800-701-0710

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

NORTH CAROLINA - Medicaid
Website: http://www.ncdhhs.gov/dma
Phone: 1-919-855-4100

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

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

OREGON - Medicaid
Website: http://www.oregonhealthykids.gov
Website: http://www.hijossaludablesoregon.gov
Phone: 1-800-699-9075

PENNSYLVANIA - Medicaid
Website: http://www.dpw.state.pa.us/hipp
Phone: 1-800-692-7462

RHODE ISLAND - Medicaid
Website: www.ohhs.ri.gov
Phone: 1-401-462-5300

SOUTH CAROLINA - Medicaid
Website: http://www.scdhhs.gov

Phone: 1-888-549-0820

SOUTH DAKOTA - Medicaid
Website: http://dss.sd.gov
Phone: 1-888-828-0059

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

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

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

VIRGINIA - Medicaid and CHIP
Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm
Medicaid Phone: 1-800-432-5924
CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm
CHIP Phone: 1-855-242-8282

WASHINGTON - Medicaid
Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx
Phone: 1-800-562-3022 ext. 15473
WEST VIRGINIA - Medicaid
Website: www.dhhr.wv.gov/bms/
Phone: 1-877-598-5820, HMS Third Party Liability

WISCONSIN - Medicaid and CHIP
Website: http://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm
Phone: 1-800-362-3002

WYOMING - Medicaid
Website: http://health.wyo.gov/healthcarefin/equalitycare
Phone: 1-307-777-7531

To see if any more States have added a premium assistance program since January 31, 2015, or for more information on special enrollment rights, you can contact either:

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

Or

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

PRIVACY OF PROTECTED HEALTH INFORMATION (PHI)

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

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

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

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

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

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

4. The Plan Sponsor must ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with regard to the PHI.
5. The Plan Sponsor may not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or other Employee Benefit Plan of the Plan Sponsor.

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

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

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

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

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

11. The Plan Sponsor must, if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed

for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor must limit further uses and disclosures to those purposes that make the return or destruction not feasible.

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

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

14. The Plan Sponsor shall not directly or indirectly receive remuneration in exchange for any PHI without valid authorization that includes a specification of whether the PHI can be further exchanged for remuneration by the entity receiving PHI of the individual making authorization, except as otherwise allowed under the American Recovery and Reinvestment Act.

SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION (ePHI)

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

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

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

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

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

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

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

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

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

BREACH AND SECURITY INCIDENTS

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

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

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

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

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

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

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

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

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

FAIR LABOR STANDARDS ACT (FLSA §18B)

FLSA §18B, as added by the Affordable Care Act §1512, provides that, beginning October 1, 2013, an applicable Employer must provide each Employee, regardless of plan enrollment status or of part-time or full-time status, at the time of hiring, a written notice:

1. Informing the Employee of the existence of the Marketplace (referred to in the statute as the Exchange) including a description of the services provided by the Marketplace, and the manner in which the Employee may contact the Marketplace to request assistance;

2. If the Employer Plan's share of the total allowed costs of benefits provided under the Plan is less than sixty (60) percent of such costs, that the Employee may be eligible for a premium tax credit under section 36B of the Internal Revenue Code (the Code) if the Employee purchases a qualified health plan through the Marketplace; and

3. If the Employee purchases a qualified health plan through the Marketplace, the Employee may lose the Employer contribution (if any) to any health benefits plan offered by the Employer and that all or a portion of such contribution may be excludable from income for Federal income tax purposes.

For 2014, the Department of Labor will consider a notice to be provided at the time of hiring if the notice is provided within fourteen (14) days of an Employee's start date. With respect to Employees who are current Employees before October 1, 2013, Employers are required to provide the notice not later than October 1, 2013.

The notice must be provided in writing in a manner calculated to be understood by the average employee, free of charge. Alternatively, it may be provided electronically if the requirements of the Department of Labor's electronic disclosure safe harbor at 29 CFR 2520.104b-1(c) are met.

For more information, please visit: http://www.dol.gov/ebsa/newsroom/tr13-02.html.

SCHEDULE OF BENEFITS

BENEFITS FOR COVERED PERSONS

	Benefit
Lifetime Maximum Dollar Benefit	Unlimited
Annual Maximum Dollar Benefit	Unlimited
Allowable Fee Schedule for All Applicable Providers	135% of Medicare
Annual Out-of-Pocket Maximum (Includes Medical Copays and Prescription Drug Copays) Per Covered Person	$6,600
Family Limit* *Applies collectively to all Covered Persons in the same Family.	$13,200
Urgent Care Facility** (Minor Emergency Medical Clinic) Office Visit (examination/consultation only)	$25 Copay
Retail Limited Service Clinic** (Includes MinuteClinics, Redi Clinics and Take Care Clinics) Office Visit (examination/consultation only)	$25 Copay
Physician Office Services** Office Visit (examination/consultation only)	$25 Copay
** Limited to six (6) visits per Calendar Year for combined Physician Office, Retail Limited Service Clinics and Urgent Care	
Preventive and Wellness Care Benefits	100%
This benefit is payable for Covered Procedures incurred as part of a Preventive and Wellness Care Program and is not payable for treatment of a diagnosed Illness or Injury. Services must be identified and billed as routine or part of a routine physical exam or as specified below.	Copay waived

Examples of Covered Wellness Procedures to include but are not limited to:

1. Routine Physical Exam
2. Annual Well Woman Exam
3. Annual Pap Smear and Other Routine Lab
4. Annual Mammogram (routine) (limited to age 40 and older or Family history of breast cancer)

5. Bone Density Test (routine) (limited to age 60 and older or risk factors for osteoporosis) 6. Annual PSA Test (routine)
7. Well Baby Care Exam/Well Child Care Exam (includes vision and hearing screenings)
8. Routine Immunizations
9. Flu Vaccine/Pneumonia Vaccine
10. Routine Lab, X-ray, Diagnostic Testing and Other Medical Screenings
11. Routine Vision Screening for Children (limited to under age 19)
12. Routine Hearing Screening (limited to newborns)
13. Routine Colonoscopy (including polyp removal; limited to age 50 and older or Family history of colon cancer and once every 10 years)
14. Tobacco Use Screening/Cessation Intervention (limited to two (2) Office Visits per lifetime)
15. All FDA approved Women's Contraceptive methods and Women's elective Sterilization Procedures

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists additional services that may be covered for preventive treatment.

PRESCRIPTION DRUG PLAN BENEFITS

Prescription Drug Copays apply to satisfy the Annual Out-of-Pocket Maximum. After the Annual Out-of-Pocket Maximum has been met, covered Generic non-Specialty Prescription Drugs are payable at 100% for the remainder of the Calendar Year.

Prescription Card Service	
Supply Limit	30 days
Generic Drugs	$2 Copay or 20% of cost; whichever is greater $0 Copay for ACA Preventive Generic Drugs**
Brand Name Drugs	Discounted pricing (except $0 Copay for ACA Preventive Brand Drugs** but only if Generic Drug is unavailable)
Supply Limit	90 days
Generic Drugs	$2 Copay or 20% of cost; whichever is greater $0 Copay for ACA Preventive Generic Drugs**
Brand Name Drugs	Discounted pricing (except $0 Copay for ACA Preventive Brand Drugs** but only if Generic Drug is unavailable)
Specialty Drugs*	
Supply Limit	30 days
Generic and Brand Name Drugs	Discounted pricing

* Patient pays 100% of the discounted price for Generic Drugs/supplies/equipment in the following categories (this list may not be all inclusive):

1. Abortifacients;
2. Acne medications (Cosmetic related), age twenty-six (26) and older;
3. Allergy serums;
4. Blood glucose monitors (one (1) free blood glucose monitor is available through the Prescription Drug Plan);
5. Blood or blood plasma;
6. Cosmetic Drugs;
7. Fertility Drugs;
8. Growth hormones;
9. Impotency/sexual dysfunction Drugs;
10. Miscellaneous Injectables (non-Specialty);
11. Miscellaneous medical supplies (i.e., bandages, splints);
12. Multivitamins (prescription, pre-natal, pediatric);
13. OTC Products;
14. Tobacco deterrent medications or any other tobacco use OTC cessation aids, all dosage forms beyond a 3-month supply limit per Lifetime; and
15. Weight loss medications.

** ACA (Affordable Care Act) requires for certain Preventive Drugs to be covered. Such Drugs must be covered at $0 Copay for Generic or Brand until a Generic becomes available.

NOTE: All FDA approved women's contraceptives - $0 Copay Generic only; if no Generic is available, $0 Copay for Brand name. Tobacco deterrent medications or tobacco use OTC cessation aids - $0 Copay Generic only; if no Generic available, $0 Copay for Brand Name; 3-month supply limit per Lifetime.

If the pharmacy charge is less than the Generic Copay, then the actual charge will become the Copay. Generic copayments apply separately to each prescription and refill.

To be covered, Prescription Drugs must be:

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

DEFINITIONS

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

Generic Drugs
Drugs or substances which:

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

Over the Counter (OTC) Drugs
Drugs which do not require a prescription from a Qualified Prescriber, unless otherwise specified.

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

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

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

Product Selection
The pharmacist substitutes more economically priced Generic equivalent Drugs whenever possible unless there is a specific request for a Brand Name by the prescribing Physician or when State law requires no substitution for the Brand Name Drug.

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

Drug Review
The Plan includes a Drug Review program which is automatically administered by the pharmacist through a nationwide computer network that verifies the eligibility of each Covered Person's card and protects the

Covered Person from conflicting prescriptions which might prove harmful if taken at the same time. This program also guards against duplication of medications and incorrect dosage levels.

Prescription Drug Plan - Exclusions

1. Mental Health, Chemical Dependency and Substance Abuse Prescription Drugs;
2. Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one (1) year from the Physician's original order;
3. Charges for the administration or injection of any Drug;
4. Drugs labeled "Caution-limited by Federal law to Investigational use," or Experimental Drugs, even though a charge is made to the individual;
5. Medication which is to be taken by or administered to an individual, in whole or in part, while he/she is a patient in a licensed Hospital, Extended Care Facility, nursing home or similar institution which operates on its premises, or allows to be operated on its premises, a Facility for dispensing pharmaceuticals; and
6. Prescriptions which a Covered Person is entitled to receive without charge from any Workers' Compensation laws.

NOTE: Refer to the definition of "Preventive Care" for a link to a website that lists Drugs that may be covered for preventive treatment.

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

PLAN MEDICAL BENEFITS

COVERED MEDICAL EXPENSES (COVERED EXPENSES)

Covered Medical Expenses mean the Reasonable and Usual and Customary charges incurred by or on behalf of a Covered Person for medical services listed below which are:

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

COVERED CHARGES

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

ANNUAL OUT-OF-POCKET MAXIMUM

The Annual Out-of-Pocket Maximum is the maximum dollar amount a Covered Person will pay for Covered Medical Expenses each Calendar Year including Medical Copays and Prescription Drug Copays. Upon reaching the Annual Out-of-Pocket Maximum, Covered Medical Expenses and covered Generic nonSpecialty Prescription Drug Expenses are payable at 100% for the remainder of the Calendar Year, excluding:

- Any Covered Charges already paid at 100% in any one (1) Calendar Year period, unless otherwise specified in the Schedule of Benefits; and
- Charges in excess of Usual and Customary or charges for services that do not meet the Plan's definition of Reasonable.

ANNUAL OUT-OF-POCKET MAXIMUM FAMILY LIMIT

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

OFFICE VISIT COPAY (PER VISIT)

The Office Visit Copay is the portion of Covered Medical Expenses, a flat dollar amount, payable by the Covered Person at the time of each visit to a Physician's Office, Urgent Care Facility or Retail Limited Service Clinic. The Office Visit Copay covers professional fees for the examination and/or consultation only and does not cover lab, x-ray, Surgery and supplies provided at the time of the Office Visit.

MEDICAL EXPENSE BENEFITS

The following are Covered Medical Expenses under this Plan, unless specifically excluded under the Medical Plan Exclusions and Limitations. Benefits for these Covered Expenses will be payable as shown in the Schedule of Benefits. Charges are subject to the Reasonable and Usual and Customary amount, which is the usual amount accepted as payment for the same service within a geographic area.

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

Clinical Trials (Routine Patient Costs). Benefits are provided to Qualified Individuals for the Routine Patient Costs of services furnished in connection with participation in an Approved Clinical Trial for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities. Routine Patient Costs include all services consistent with the coverage provided under this Plan that are typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include:

1. The Investigational item, device, or service, itself;
2. Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; or
3. A service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

If one or more Participating Providers is participating in a clinical trial, the Plan may require that a Qualified Individual participate in the trial through such a Participating Provider if the Provider will accept the individual as a participant in the trial.

Approved Clinical Trial is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and that is described in any of the following:

1. Federally funded trials. The study or investigation is approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    a. The National Institutes of Health.
    b. The Centers for Disease Control and Prevention.
    c. The Agency for Health Care Research and Quality.
    d. The Centers for Medicare & Medicaid Services.
    e. A cooperative group or center of any of the entities described in (a) through (d) above or the Department of Defense or the Department of Veterans Affairs.
    f. A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.
    g. The Department of Veterans Affairs, the Department of Defense, or the Department of Energy, if the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines:

        i. to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and ii. assures unbiased review of the highest scientific standards by Qualified Individuals who have no interest in the outcome of the review; or

2. The study or investigation is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration; or

3. The study or investigation is a Drug trial that is exempt from having such an Investigational new Drug application.

A Qualified Individual must meet the following conditions:

1. The individual must be eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition; and

2. Either:

    a. The referring health care professional is a Participating Provider and has concluded that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1); or
    b. The individual provides medical and scientific information establishing that the individual's participation in such trial would be appropriate based upon the individual meeting the conditions described in paragraph (1).

A *life-threatening condition* means any Disease or condition from which the likelihood of death is probable unless the course of the Disease or condition is interrupted.

Contraceptives. The charges for all FDA approved women's contraceptive methods.

Diabetic Supplies. The charges for insulin, insulin syringes, test strips, lancets and glucometers on prescription are covered by the Prescription Drug Card.

Diabetic Training. The charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities for diabetic self-management medical and nutritional training.

Drugs. The charges for Drugs requiring the written prescription of a licensed Physician. See Prescription Drug Plan section. Prescription Drugs are covered by the Prescription Drug Card and not payable under Medical Expense Benefits.

Hearing Screening. The charges for hearing screening for newborns.

Immunizations. The charges for Immunizations and vaccinations under covered Wellness Benefits.

Infertility. The charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities but only when related to the initial diagnosis of infertility.

Maternity Care. The charges for maternity care for Covered Employees and covered Dependents for the examination/consultation only during the initial maternity office visit to a Physician's office, Retail Limited Service Clinic or Urgent Care Facility.

Physician. The charges for the services of a legally qualified Physician for medical care and/or treatment including Office Visits, clinic care, second/third opinion consultations and, when related to covered wellness procedures only, surgical treatment, Hospital Inpatient care and Hospital Outpatient visits/exams.

Retail Limited Service Clinic. The charges for services at a Retail Limited Service Clinic.

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

Second or Third Opinion. The charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities for a second or third opinion when Surgery or other non-surgical treatment has been recommended.

Sleep Disorders. The charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities for the treatment of Sleep Disorders.

Sterilization. The charges for all FDA approved women's elective sterilization procedures, including all related charges.

Temporomandibular Joint (TMJ) Disorders. The charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities for services related to Temporomandibular Joint (TMJ) Syndrome.

Tobacco Use Screening/Cessation Intervention. The charges for tobacco use screening/cessation intervention.

Urgent Care Facility (Minor Emergency Medical Clinic). The charges for services at an Urgent Care Facility.

Vision Screening. The charges for a routine vision screening for Children under age nineteen (19).

Wellness Procedures. The charges for covered wellness procedures listed as Preventive and Wellness Care Benefits, including all related charges.

MEDICAL PLAN EXCLUSIONS AND LIMITATIONS

GENERAL EXCLUSIONS AND LIMITATIONS

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

Abortion. Charges for services or supplies rendered to any Covered Employee or Dependent in connection with an elective abortion.

Admit Kits. Charges for Hospital "admit kits."

Adoption Fees. Charges for adoption fees.

Allergy Testing, Allergy Injections and Allergy Serums. Charges for allergy testing, allergy injections, allergy serums and treatment.

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

Ambulance Services. Charges for ambulance services.

Ambulatory Surgery Center. Charges for treatment in an Ambulatory Surgery Center, including surgical or medical services, except when related to a covered wellness procedure.

Anesthesia. Charges for the cost and administration of an Anesthesia and/or anesthetic, except when related to a covered wellness procedure.

Assistant Surgeon. Charges for services of an assistant surgeon and/or Licensed Surgical Assistant, except when related to a covered wellness procedure.

Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD). Charges for the diagnosis and treatment of Attention Deficit Disorder (ADD) and Attention Deficit Hyperactivity Disorder (ADHD).

Audiologist. Charges of an Audiologist for treatment of a hearing loss or an impaired hearing function.

Birthing Centers. Charges for Birthing Centers.

Blood or Blood Components. Charges for the processing and administration of blood or blood components, except when related to a covered wellness procedure.

Blood Procurement. Charges incurred for procurement and storage of one's own blood.

Botox. Charges for Botox injections.

Breast Reduction (Reduction Mammoplasty). Charges for reduction mammoplasty.

Cardiac Rehabilitation. Charges for cardiac rehabilitation.

Chemical Dependency. Charges for the treatment of Chemical Dependency, Drug and Substance Abuse.

Chemotherapy. Charges for chemotherapy.

Chiropractic Services. Charges for Chiropractic Services and/or services for maintenance therapy.

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

Clinical and Pathological Laboratory Tests. Charges for clinical and pathological laboratory tests and examinations including fees for professional interpretation of their results, except when related to a covered wellness procedure.

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

Coinsurance. Any portion of the billed charges for services or supplies which the provider offers to waive.

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

Continuous Passive Motion Equipment. Charges for purchase or rental of Continuous Passive Motion (CPM) equipment.

Cornea Transplants. Charges for services and supplies in connection with cornea transplants.

Cosmetic. Charges incurred in connection with the care or treatment of, or operations which are performed for, Cosmetic purposes of any kind, including treatment or Surgery for complications or correction of Cosmetic Surgery or treatment.

Counseling. Charges for bereavement counseling, marriage counseling, Family counseling and group therapy.

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

Custom Bras for Prostheses. Charges for custom bras for prostheses following a mastectomy.

Dental. Charges for Dental expenses and Oral Surgery procedures incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes.

Diabetic Supplies. Charges for insulin pumps/supplies.

Diagnostic Tests. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well established diagnostic tests, except when related to a covered wellness procedure.

Diagnostic X-Rays. Charges for radiation services including diagnostic x-rays and interpretation, except when related to a covered wellness procedure.

Dialysis. Charges for dialysis.

Dietitian. Charges for services of a licensed Dietitian.

Durable Medical Equipment. Charges for rental or purchase of a wheelchair, Hospital bed and other Durable Medical Equipment or for repair, adjustment or replacement of rented Durable Medical Equipment or components.

Education. Charges for education or training of any type including those for learning disabilities, except examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities for diabetic self-management medical training for diagnosed cases of diabetes.

Elastic/Surgical Stockings. Charges for elastic/surgical stockings.

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

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

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

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

Foot Care. Charges for callus or corn paring or excision, toenail trimming, any manipulative procedure for weak or fallen arches, flat or pronated foot, foot strain, Orthopedic Shoes, orthotic insoles or other devices for support of the feet.

Genetic Testing. Charges for genetic testing.

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

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

Hearing Exams and Hearing Aids/Devices. Charges incurred in connection with routine hearing exams and charges for the purchase or fitting of hearing aids/devices or such similar aid devices. This exclusion does not apply to routine newborn hearing screenings for Well Baby/Well Child Care.

Heart Valve Replacements. Charges for heart valve replacements.

Home Health Care. Charges by a Home Health Care Agency for care for a Homebound patient.

Home Infusion Therapy. Charges for Home Infusion Therapy.

Hospice Care. Charges for Hospice care.

Hospital. Charges for services in a Hospital, including but not limited to Inpatient expenses, Outpatient Hospital expenses and/or Emergency Room expenses, except when related to a covered wellness procedure.

Illegal Acts. Charges for Injury or Illness resulting from or sustained during the commission, or attempted commission, of an assault or a crime punishable as a felony, whether or not the Covered Person was charged, convicted or received any type of fine, penalty, imprisonment or other sentence or punishment, unless such Injury is the result of a medical condition (either physical or mental) or is the result of the Covered Person being the victim of an act of domestic violence.

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

Immunization Complications. Charges for complications incurred as a result of Immunizations.

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

Infertility. Charges related to or in connection with the diagnosis of, testing and treatment of infertility to include fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination or invitro fertilization or other similar procedures, except charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities but only when related to the initial diagnosis of infertility.

Infusion Therapy. Charges for infusion therapy.

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

Massage Therapy. Charges for massage therapy.

Medical Services Outside the United States. Charges for medical services incurred while traveling or while working for the Company outside the United States.

Medical Supplies. Charges for dressings, sutures, casts, splints, trusses, crutches, braces, Corrective Shoes and other necessary medical supplies, except when related to a covered wellness procedure.

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

Mental Disorders. Charges for the treatment of Mental Disorders.

Midwives. Charges for Midwives.

Multiple Surgical Procedures. Charges for multiple Surgical Procedures when two (2) or more procedures are performed during the same operation.

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

Nerve Stimulators. Charges for nerve stimulators and TENS units.

Newborns of Dependent Children. Charges related to or in connection with newborns of Dependent Children.

Not Acceptable. Charges that are not accepted as standard practice by the AMA, ADA or the FDA.

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

Not Connected with Active Illness. Charges for hospitalization primarily for x-rays, laboratory tests, diagnostic study, physiotherapy, hydrotherapy, medical observation, convalescent or rest care, or any medical examination or test not connected with an active Illness or Injury, unless otherwise specified for Preventive and Wellness Care Benefits or otherwise specified as covered in this Plan.

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

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

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

Nutritional Supplements. Charges for nutritional supplements and related supplies, whether or not prescribed by a Physician.

Obesity. Charges for the treatment of Obesity or Morbid Obesity and charges related to weight control, including Surgery (i.e., gastric by-pass and similar Surgical Procedures) and complications incurred as a result of such Surgery for Obesity.

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

Occupational Therapy. Charges for Occupational Therapy.

Organ Donor Expenses. Charges related to or in connection with Organ Donor expenses.

Organ, Tissue and Bone Marrow Transplants. Charges related to or in connection with Organ, Tissue and Bone Marrow Transplants.

Orthotic Devices. Charges for Orthotic Devices.

Orthotic Insoles. Charges for orthotic insoles.

Oxygen. Charges for oxygen and other gases and their administration, except when related to a covered wellness procedure.

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

Phenylketonuria. Charges for formulas necessary for the treatment of phenylketonuria or other heritable Diseases.

Physical Therapy. Charges for Physical Therapy.

Portable Uterine Monitors. Charges for portable uterine monitors.

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

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

Private Duty Nursing. Charges for Private Duty Nursing.

Prosthetics. Charges for Prosthetics.

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

Psychological Testing. Charges for psychological testing.

Radiation Therapy. Charges for radiation therapy.

Rehabilitation Facility. Charges incurred for rehabilitative and habilitative services and devices and/or confinement in a Rehabilitation Facility.

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

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

Routine Newborn Care. Charges for Routine Newborn Care for a well newborn Child for Nursery Room and Board and routine Inpatient services required for the healthy newborn following birth to include charges for pediatric services and circumcision.

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

Serious Mental Illness. Charges for treatment of Serious Mental Illness.

Sex Change. Charges related to or in connection with sex change procedures and charges for treatment of sexual dysfunctions or inadequacies.

Skilled Nursing Facility/Extended Care Facility. Charges incurred for confinement in a Skilled Nursing Facility/Extended Care Facility.

Speech Language Pathologist. Charges of a Speech Language Pathologist.

Speech Therapy. Charges for Speech Therapy.

Sterilization/Sterilization Reversal. Charges for an elective vasectomy and the charges resulting from or in connection with the reversal of a sterilization procedure.

Surgical Lens Implants. Charges for surgical lens implants for cataracts and other Diseases of the eye.

Surgical Procedure. Charges incurred for a Surgical Procedure, except when related to a covered wellness procedure.

Surrogate Fees. Charges for surrogate fees.

Total Parenteral Nutrition (TPN). Charges for hyperalimentation or total parenteral nutrition (TPN).

Travel for Organ Transplants. Charges related to or in connection with travel and lodging expenses associated with an Organ Transplant.

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

Vision Correction Surgery. Charges for any Surgical Procedure for the correction of a visual refractive problem including radial keratotomy, lasik or similar Surgical Procedures.

Vision Exam and Eyewear. Charges incurred in connection with routine vision exams or eye refractions, and the purchase or fitting of eyeglasses and contact lenses. This exclusion/limitation shall not apply to routine vision screenings for Children under age nineteen (19).

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

Weight Loss Programs. Charges for weight loss programs even when recommended by a Physician, except charges for examinations/consultations only during visits to Physicians' offices, Retail Limited Service Clinics or Urgent Care Facilities.

COORDINATION OF BENEFITS

Coordination of benefits sets out rules for the order of payment of Covered Expenses when two (2) or more plans – including Medicare – are paying. However, when a Participant is covered by this Plan and another plan, or the Employee's spouse is covered by this Plan and by another plan or the couple's covered Children are covered under two (2) or more plans, this Plan will always pay as primary and will ***not*** coordinate benefits with any other plan.

PROCEDURES FOR CLAIMS AND APPEALS

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

NOTICE AND PROOF OF CLAIM

Written notice and proof of an incurred Claim should always be filed with the Claims Administrator as soon as possible. **Claims must be filed within twelve (12) months from the date of service to be covered by the Plan.** If an individual's coverage under the Plan ceases, all Claims incurred prior to termination of coverage **must** be filed within twelve (12) months from the date of service, or the Claims will not be covered by the Plan.

Claims **must** be filed sooner in certain circumstances:

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

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

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

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

- A “Concurrent Claim” arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either: (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests an extension of the course of treatment beyond that which the Plan has approved. The Plan does not require Claimants to obtain approval of medical services prior to getting treatment. The Claimant simply follows the Plan's procedures with respect to notice that is required after receipt of treatment, and files the Claim as a Post-service Claim.

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

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

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

8. The name of the patient.

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

CLAIMS DETERMINATION

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination within the following timeframes:

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

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

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

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

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

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

1. A determination of an individual's eligibility to participate in a plan or health insurance coverage;
2. A determination that a benefit is not a covered benefit;
3. The imposition of a source-of-Injury exclusion or other limitation on otherwise covered benefits; or
4. A determination that a benefit is Experimental, Investigational, or not Medically Necessary or appropriate.

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

NOTICE OF ADVERSE BENEFIT DETERMINATION

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

1. Information sufficient to identify the Claim involved, including the date of the service, the health care provider, the Claim amount (if applicable), and, upon request, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;
2. The reason or reasons for the Adverse Benefit Determination or final internal Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, used in denying the Claim. In the case of a final internal Adverse Benefit Determination, this description must also include a discussion of the decision;

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

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

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

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

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

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

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

PHYSICAL EXAMINATION

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

CLAIMS AUDIT

Once a written Claim for benefits is received, the Claims Administrator, acting on the discretionary authority of the Plan Administrator, may elect to have such Claim reviewed or audited for accuracy and reasonableness of charges as part of the adjudication process. This process may include, but may not be limited to, identifying: (a) charges for items/services that may not be covered or may not have been delivered, (b) duplicate charges and (c) charges beyond the Reasonable, necessary and Usual and Customary guidelines as determined by the Plan.

PAYMENT OF CLAIMS

Plan benefits are payable to the Covered Employee, unless the Claimant gives written direction, at the time of filing proof of such loss, to pay directly the health care provider rendering such services. Such payment to a health care provider is subject to the approval of the Plan Administrator. If any such benefit remains unpaid at the death of the Covered Employee, if the Claimant is a minor, or if the Claimant is (in the opinion of the Plan Administrator) legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Claimant: wife, husband, mother, father, Child or Children, brother or brothers, sister or sisters. Such payment will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Plan Administrator will not be required to follow-up and determine how such paid money was used.

APPEAL PROCESS

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

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

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

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

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

5. The Claimant will be provided, on request and free of charge: (a) Reasonable access to, and copies of all documents, records, and other information relevant to the Claimant’s Claim in possession of the Plan Administrator or the Claims Administrator; (b) information regarding any rule, guideline, protocol, or other similar criterion relied upon in making the Adverse Benefit Determination; (c) information

regarding any voluntary appeals procedures offered by the Plan; (d) information regarding the Claimant's right to an external review process; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances.

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

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

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

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

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

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

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

FIRST APPEAL LEVEL

Requirements for First Appeal

The Claimant must file the first appeal, in writing, within one hundred eighty (180) days following receipt of the notice of an Adverse Benefit Determination. The Claimant's appeal must be addressed as follows:

BCA, LLC
100 SW Albany Ave, Suite 200
Stuart, FL 34994
Toll free 855-228-6583
772-577-7600
Secure fax: 888-974-1264

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

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

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

Timing of Notification of Benefit Determination on First Appeal

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

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

Notice of Benefit Determination on First Appeal

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

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

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

3. A description of any additional material or information necessary for the Claimant to perfect the Claim, and an explanation of why such material or information is necessary;
4. A statement that the Claimant is entitled to receive, upon request and free of charge, Reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's Claim;

5. A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;

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

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

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

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

10. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your 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 the section relating to Notice of Benefit Determination on First Appeal, as appropriate.

SECOND APPEAL LEVEL

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

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

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

Manner and Content of Notification of Adverse Benefit Determination on Second Appeal
The same information must be included in the Plan's response to a second appeal as a first appeal, except for: (a) a description of any additional information necessary for the Claimant to perfect the Claim and an explanation of why such information is needed; and (b) a description of the Plan's review procedures and the time limits applicable to the procedures. See the section entitled "Notice of Benefit Determination on First Appeal."

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

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

Appointment of Authorized Representative

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

EXTERNAL REVIEW OF ADVERSE BENEFIT DETERMINATIONS

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

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

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

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

EXPEDITED EXTERNAL REVIEW FOR URGENT OR EMERGENCY CARE

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

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

PROCEDURES FOR INITIATION OF AN EXTERNAL REVIEW

Standard External Review

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Expedited External Review

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

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

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

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

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

- The IRO must provide notice of the final external review decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO received the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to the Claimant and the Plan within forty-eight (48) hours following the notice.

DECISION FOLLOWING AN EXTERNAL REVIEW

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

RECOVERY OF PAYMENTS

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

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

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a 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 or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit Claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on Claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within thirty (30) days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, Provider or other person or entity to enforce the provisions of this section, then that Covered Person, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

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

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person; or
5. Pursuant to a Claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or Disease to the extent that such benefits are recovered. This

provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

GENERAL PROVISIONS

RIGHT OF RECOVERY

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

MISSTATEMENT OF AGE

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

WAIVER OR ESTOPPEL

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

WORKERS' COMPENSATION NOT AFFECTED

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

CONFORMITY WITH LAW

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

CONFORMITY WITH STATUTE(S)

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

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

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

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

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

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

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

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

ASSIGNMENT

The benefits provided under this Plan shall not be assignable without the consent of the Plan Administrator. The Employee may authorize the Plan Administrator to pay benefits directly to the Hospital, Physician or other party providing medical treatment. Any such payment will discharge the Plan to the extent of payment made. Unless permitted by law, payments may not be attached, nor be subject to the Employee's debts.

APPORTIONMENT OF BENEFITS

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

FACILITY OF PAYMENT

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

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

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

ELIGIBILITY FOR COVERAGE

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

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

EMPLOYEE ELIGIBILITY

An Employee will be considered eligible for coverage on the first day of the month concurrent with or following the date that he/she:

1. Completes a sixty (60) day Waiting Period as described below; and
2. Is regularly scheduled to work for the Employer on a Full-time Employment basis for an average of at least thirty (30) hours per week per month.

WAITING PERIOD

A Waiting Period is the period of time that must pass before coverage can become effective for an otherwise Eligible Employee or Dependent. The Plan's Waiting Period for all new Employees is at least thirty (30) days. The Waiting Period ends on the first day of the month concurrent with or following thirty (30) days of employment.

DEPENDENT ELIGIBILITY

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

1. **For Employees with coverage for Dependent Children in effect:** A newborn Child of a Covered Employee will be considered eligible and will be covered from the moment of birth. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an Eligible Dependent.

For Employees with no coverage for Dependent Children in effect: A newborn Child of a Covered Employee will be considered eligible and will be covered from the moment of birth **if written notification to add the Child is received by the Plan Administrator within sixty (60) days following the Child's date of birth**. If written notification to add a newborn Child is received by the Plan Administrator AFTER the sixty (60) day period immediately following the Child's date of birth, the Child is considered a Late Enrollee and not eligible for the Plan until the next Annual Open Enrollment Period. A newborn Child of a Dependent Child is not eligible for this Plan unless the newborn Child meets the definition of an Eligible Dependent.

2. A new spouse of a Covered Employee and any Dependent Children of a new spouse who meet the Plan's definition of Dependent will be considered eligible and will be covered on the date of the

Covered Employee's marriage, provided the spouse and/or his/her Children are enrolled as Dependents of the Covered Employee within thirty-one (31) days after the date of marriage.

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

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

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

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

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

If a Dependent has a change in eligibility while covered under this Plan from Dependent to Employee and no interruption in coverage has occurred, the Plan will consider that coverage has been continuous with respect to the Eligibility Waiting Period.

A person cannot be covered as a Dependent of more than one (1) Employee under this Plan.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS / PLACEMENT FOR ADOPTION

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

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

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

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

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

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

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

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

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

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

EFFECTIVE DATE OF COVERAGE

EMPLOYEE EFFECTIVE DATE

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

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

DEPENDENT EFFECTIVE DATE

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

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

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

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

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

LATE ENROLLEE

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

EMPLOYEE AND DEPENDENT SPECIAL ENROLLMENT PERIODS

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

SPECIAL ENROLLMENT PERIOD FOR LOSS OF ELIGIBILITY FOR OTHER COVERAGE

Eligible Employees and Eligible Dependents who do not enroll in the Plan at their initial opportunity because of other health coverage and subsequently lose eligibility for that other coverage (except for cause or nonpayment of premium) have Special Enrollment rights. Special Enrollment in this Plan must be requested within thirty-one (31) days after the date eligibility for other coverage ends. If an individual enrolls during a Special Enrollment Period, he/she is considered a Special Enrollee; he/she will not be considered a Late Enrollee.

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

1. Legal separation, divorce, death, termination of employment or reduction in the number of hours worked;
2. Loss of Dependent status;
3. The plan no longer offers any benefits to a class of similarly situated individuals;
4. Moving out of an HMO service area with no other coverage option available;
5. Termination of a benefit package option, unless a substitute is offered;
6. Employer contributions were terminated; or
7. COBRA Continuation Coverage was exhausted.

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

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

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

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

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

SPECIAL ENROLLMENT PERIOD FOR NEW DEPENDENT

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

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

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

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

Length of Special Enrollment Period for New Dependents

A request for a Special Enrollment due to acquiring new Dependents must be made no later than thirty-one (31) days after the date of marriage, adoption or Placement for Adoption or sixty (60) days after the date of birth.

Effective Date of Coverage Following New Dependent Special Enrollment

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

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

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

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

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

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

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

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

ANNUAL OPEN ENROLLMENT PERIOD FOR THE MAJOR MEDICAL PLAN

The Annual Open Enrollment Period for the Plan is a period of time designated by the Employer each year for coverage to become effective January 1, provided written or electronic application for coverage is made on or before the end of the Open Enrollment Period or within thirty-one (31) days after the Annual Open Enrollment Period. All Eligible Employees and Dependents not currently enrolled in the Plan may do so during the Annual Open Enrollment Period. All Covered Employees are required to re-enroll in the Plan. If application to enroll is made more than thirty-one (31) days after the Annual Open Enrollment Period ends, the Employee and/or Dependent must wait until the Plan's next Open Enrollment Period to enroll.

The Plan allows a choice of Plan Options: Cost Plus and MEC. An Eligible Employee can elect one (1) Plan Option for himself/herself and the same option for his/her Eligible Dependents.

LATE ENROLLEE

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

EMPLOYEE LATE ENROLLEE

An Employee is considered a Late Enrollee if:

1. He/she makes written or electronic application for coverage under the Plan more than thirty-one (31) days after the date of his/her initial eligibility;
2. He/she is not eligible for a Special Enrollment or enrollment as a result of a Status Change; or
3. He/she failed to enroll by the end of a Special Enrollment Period or enrollment period for a Status Change.

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

DEPENDENT LATE ENROLLEE

A Dependent is considered a Late Enrollee if:

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

2. The Covered Employee makes a written or electronic request to add a Dependent after the thirty-one (31) day period immediately following the date of marriage, date of adoption or date of Placement for Adoption, or after the sixty (60) day period immediately following the date of birth; or

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

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

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

COVERAGE CHANGES

FOR EMPLOYEES PARTICIPATING IN THE SECTION 125 PLAN

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

The Annual Election Period for the Section 125 Plan is the same as the Annual Open Enrollment Period for the Major Medical Plan. It is a period of time designated by the Employer each year for an effective date of January 1. Once an election is made to participate, this election can only be changed during the next year's Annual Open Enrollment Period for the Plan.

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

Status Changes

- Marriage
- Divorce or legal separation (in those States recognizing legal separation)
- Birth or adoption of a Child
- Death of spouse or Child
- Commencement of spouse's or Dependent's employment
- Termination of spouse's or Dependent's employment
- Open enrollment for spouse's/Dependent's Employer plan
- Significant cost or coverage changes for Employee, spouse or Dependent
- Change from part-time to Full-time Employment (or vice-versa)/reduction or increase in hours
- Unpaid Leave of Absence
- Change in the residence or worksite
- Dependent satisfies or ceases to satisfy the eligibility requirements for coverage
- Qualified Medical Child Support Order (QMCSO)
- Entitlement to or loss of eligibility for Medicare or Medicaid
- Entitlement to or loss of eligibility for a State Children's Health Insurance Program (CHIP)

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

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

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

Effective Date of Coverage Following Status Change

Most Status Changes qualify for Special Enrollment. See the Employee and Dependent Special Enrollment Periods section.

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

PLAN OPTION CHANGES

The Plan allows a choice of Plan Options. Plan Option changes can only be made once a year during the Annual Open Enrollment Period for the Plan unless there is a Status Change or a Special Enrollment. See section entitled Employee and Dependent Special Enrollment Periods.

TERMINATION OF COVERAGE

EMPLOYEE COVERAGE TERMINATION

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

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

DEPENDENT COVERAGE TERMINATION

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

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

9. The last day of the month in which the Dependent Child reaches age twenty-six (26);
10. The last day of the month in which the unmarried adult Dependent Child age twenty-six (26) or older for whom coverage is being continued due to the Child being Physically Handicapped or Intellectually Disabled and incapable of earning his/her own living, upon the earliest to occur of: a. cessation of such inability; b. failure to furnish any required proof of the uninterrupted continuance of such inability or to submit to any required examination; c. the Child no longer being dependent on the Employee for his/her support; or d. the Child's marriage; or
11. The last day of the month following the date the Employee dies.

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

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

COVERAGE DURING LEAVE OF ABSENCE

If active work ceases due to an Employer approved Pregnancy Disability Leave, an Employer approved Workers' Compensation Disability Leave, an approved Leave of Absence subject to the Family and Medical Leave Act (FMLA) or approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave), the Plan Administrator may, while the Plan is in force, continue the Employee's coverage (Employee and Dependent) during the period after cessation of active work due to:

1. Employer approved Pregnancy Disability Leave (disabled due to pregnancy, childbirth or related medical condition) for up to four (4) months, provided any required Employee contributions are made; or

2. Employer approved Workers' Compensation Disability Leave up to the maximum amount of time allowed under FMLA or approved leave required by applicable state law, provided any required Employee contributions are made; or

3. Approved Family and Medical Leave (FMLA), but not to exceed a period of twelve (12) weeks (or twenty-six (26) weeks in the case of a Family service member medical leave) provided any required Employee contributions are made; or

4. Approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave) for up to the minimum amount of time required by such State law provided any required Employee contributions are made.

The Employer approved Disability Leaves may be concurrent with the twelve (12) week (or twenty-six (26) weeks in the case of a Family service member medical leave) approved Family and Medical Leave (FMLA) or the minimum amount of time required by an approved leave required by applicable State law (Family, Medical, Disability and/or other temporary leave).

NOTE: Pregnancy Disability Leave is concurrent with FMLA (Federal law), but not with applicable State law. Workers' Compensation Disability Leave is concurrent with both FMLA and applicable State law.

NOTE: If applicable State law requires a longer Leave of Absence than FMLA or any other approved Leave of Absence, then State law will prevail.

If the Employee has not returned to Employment that meets the eligibility requirements after completion of an approved Leave of Absence, or if the Employee notifies the Employer that he/she will not be returning to Employment that meets the eligibility requirements following the Leave of Absence, coverage terminates and COBRA continuation becomes available on the basis of reduction in hours. See Continuation of Group Health Coverage (COBRA) section. Failure of the Employee to make any required Employee contributions during an approved Leave of Absence will also result in termination of coverage.

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

ACTIVE DUTY IN THE ARMED FORCES

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

REHIRES / REINSTATEMENT OF COVERAGE

An Employee, whose employment/coverage was terminated and who resumes employment with the Company within a six (6) month period immediately following the date of such termination, shall become eligible for reinstatement of coverage on the first day of the month following a thirty (30) day Waiting Period following the date he/she resumes employment, and his/her Dependents shall also become eligible for reinstatement on that date. Otherwise, the reinstated Employee and his/her Dependents are treated as new Covered Persons.

NOTE: An exception applies for a terminated Employee on COBRA who is rehired and returns to work after expiration of the six (6) month reinstatement period. Coverage will be continuous from the date he/she resumes employment with no Waiting Period applied.

An Employee whose coverage would terminate due to active duty in the Uniformed Services of the United States, and who qualifies for military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), will be reinstated on the date he/she resumes employment with the Company provided that such resumption of employment is within the time period specified in USERRA.

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

REPLACEMENT OF GROUP MEDICAL COVERAGE DUE TO THE ACQUISITION OF AN EMPLOYER BY THE COMPANY

The following provisions apply only to persons who were covered for medical expense benefits under a prior plan on the date of its discontinuance and who are included in a class of persons who are eligible for coverage under this Plan on the effective date of the acquisition of the Employer. Each person for whom the required contributions, if any, are paid shall become covered on the later of:

1. The effective date of the acquisition; or

2. The date the prior plan is discontinued.

If such person has not met the Employee Eligibility or other applicable Effective Date requirements of this Plan, but has satisfied all or a portion of the waiting periods of the prior plan, that time will be counted together with time employed at the Company to satisfy the Eligibility requirements of this Plan.

The following conditions apply:

1. No benefits will be paid for expenses incurred prior to the effective date of the acquisition.

2. No benefits will be paid for expenses incurred under the Plan if such expenses are payable under the terms of the prior plan.

FAMILY AND MEDICAL LEAVE (FMLA)

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

1. The birth or adoption of a Child;

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

3. The Employee's own disabling serious Illness;

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

5. The serious Illness or Injury of the Employee's spouse, Child, parent or next of kin service member whose Illness or Injury was incurred in the line of duty that may render the member unfit to perform the duties of the service member's office, grade, rank or rating.

ELIGIBLE EMPLOYEES: Employees who have been employed by the Employer for at least twelve (12) months and who have worked at least 1,250 hours for the Employer during the previous twelve (12) months are eligible for Family and Medical Leave.

BENEFIT REQUIREMENT: The Employer must provide the same group health plan during the leave under the same level of contribution required during active employment.

RETURN TO EMPLOYMENT: Although the leave is unpaid, the Employee must be guaranteed return to the same or equivalent position with equivalent Employee benefits, pay, and other terms of employment. (Note: An Employer may deny job restoration under the leave law to Employees who are in the highest paid 10% of Employees.)

Employee benefits may include:

- group life
- educational benefits
- sick leave
- medical
- annual leave
- disability
- dental
- pensions

If an Employee chooses not to retain Plan coverage during Family and Medical Leave, Plan coverage may be restored upon return to active service as an Eligible Employee. Employees must be treated as though no service interruption had occurred. This means that new Waiting Periods will not be applied. Any period of coverage provided for disability may run concurrently with Family and Medical Leave.

The above listing of Employee benefits may or may not be applicable to every company's plan of benefits. This section is intended as a summary of the Family and Medical Leave Act of 1993 (FMLA), effective August 5, 1993, as amended, not as a complete interpretation of the law.

NOTE: An Eligible Employee must refer to the Company's policy for complete information.

CONTINUATION OF GROUP HEALTH COVERAGE (COBRA)

CONTINUATION OF COVERAGE

(Applies to Medical and Prescription Drug Coverage)

When Plan coverage terminates due to a Qualifying Event, a Covered Employee or covered Dependent is a Qualified Beneficiary and eligible to elect continued group health coverage ("COBRA coverage"). COBRA coverage is the same health coverage that applies to Covered Employees and covered Dependents under the Plan. However, the individual electing COBRA coverage must pay the full cost of the coverage plus an administrative fee of 2%.

The length of time COBRA coverage can be continued is based upon the date of and the applicable Qualifying Event as described below:

Qualified Beneficiary	**Qualifying Event**	**Maximum Coverage Period**
Covered Employee and/or Covered Dependent	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	18 months
Disabled Covered Employee and/or Disabled Covered Dependent and each Qualified Beneficiary who is not disabled*	Loss of coverage due to termination of employment (other than for gross misconduct) or reduction in hours	29 months*
Covered Dependent	Loss of coverage due to divorce, legal separation or death of Employee	36 months
Covered Dependent	Loss of coverage due to Dependent Child losing eligibility as a Dependent Child	36 months
Covered Dependent	Loss of coverage due to Covered Employee's entitlement to Medicare (See Special Medicare Entitlement Rule section.)	36 months

QUALIFIED BENEFICIARY

A Qualified Beneficiary also includes a Child born to or placed for adoption with a former Covered Employee/Qualified Beneficiary during the period of COBRA coverage. Newborns and adopted Children of former Covered Employees/Qualified Beneficiaries have independent COBRA rights and can remain on the Plan even if the former Covered Employee/Qualified Beneficiary drops coverage.

***SOCIAL SECURITY DISABILITY**

If a Covered Employee or a covered Dependent is determined to be disabled, as defined in the Social Security Act, on the date of the termination of employment or reduction in hours, or at any time during the first sixty (60) days of COBRA Continuation Coverage, the disabled person may be entitled to continue COBRA coverage for up to twenty-nine (29) months from the date of termination of employment or reduction in hours, provided the Social Security Administration determines, during the initial eighteen (18) month coverage period, that the individual is disabled. To qualify for the eleven (11) month extension of the maximum coverage period, the disabled person must provide the Plan Administrator with a copy of the Social Security Administration determination letter within sixty (60) days of receipt of same, and not later than the expiration of the original eighteen (18) month initial coverage period.

The cost of COBRA coverage for an individual entitled to extended coverage due to Social Security Disability for the period after the end of the eighteen (18) month COBRA coverage period will increase to 150% of the full cost for active participants.

SECONDARY QUALIFYING EVENTS

If COBRA coverage is elected by a covered Dependent based on the Covered Employee's loss of coverage due to termination of employment or reduction in hours and a second Qualifying Event (divorce, legal separation, death or a Dependent Child losing eligibility as a Dependent Child) occurs during the eighteen (18) month COBRA coverage period, the covered Dependent's maximum COBRA coverage period will begin on the date of the first Qualifying Event and continue for a thirty-six (36) month period. For example: If a Covered Employee terminates employment on December 31, 2012, the Employee's covered Dependent elects COBRA coverage, and the former Employee dies before July 1, 2014 (that is prior to the end of the original eighteen (18) month COBRA coverage period), the maximum COBRA coverage period for the Dependent who elected COBRA coverage is extended until December 31, 2015.

SPECIAL MEDICARE ENTITLEMENT RULE

Entitlement to Medicare is not considered a traditional secondary Qualifying Event for a covered Dependent; however, Medicare entitlement does provide potentially longer periods of continuation coverage to certain Qualified Beneficiaries based on the sequence of events. If a Covered Employee becomes entitled to Medicare, but the Employee is still a full-time active Employee, this event is not a COBRA Qualifying Event since Medicare entitlement alone does not cause a loss of coverage. If the Covered Employee voluntarily terminates employment after the Medicare entitlement date, the loss of coverage triggers a potential eighteen (18) month COBRA continuation period for all Qualified Beneficiaries. While the Covered Employee is only entitled to eighteen (18) months of COBRA Continuation Coverage, the other Qualified Beneficiaries (spouse and/or Dependent Children) are entitled to eighteen (18) months or thirty-six (36) months, measured from the date of the Employee's Medicare entitlement, whichever is greater.

EMPLOYEE RESPONSIBILITIES

COBRA coverage <u>is not automatic</u> upon the occurrence of a Qualifying Event. COBRA coverage must be elected as described below. In addition, a Covered Employee or a covered Dependent is responsible for notifying the Plan Administrator within sixty (60) days after the date of the Qualifying Event if the Qualifying Event is the loss of coverage due to divorce, legal separation, or a Dependent Child losing eligibility as a Dependent Child. A change form may be obtained from the Employer. Failure to provide such notice will result in loss of eligibility to elect COBRA coverage.

A Qualified Beneficiary must elect COBRA coverage no later than sixty (60) days after the date the eligible individual is sent an election form describing his/her right to elect continuation coverage (COBRA Election Period). If a Qualified Beneficiary elects coverage during the sixty (60) day COBRA Election Period, coverage is continuous from the time coverage would otherwise have been lost. A properly completed election form must be returned to the Plan Administrator, signed and dated, by the end of the COBRA Election Period.

If premium payment is not sent with the election form, initial premium payment for COBRA coverage must be received no later than forty-five (45) days after the date COBRA coverage was elected. Initial payment must cover the retroactive monthly coverage period beginning with the date of loss of coverage. **Coverage will not become effective until initial premium payment is received.**

Coverage will remain in effect if subsequent premiums are paid no later than thirty (30) days after the due dates of such payments. **Failure to pay premiums within the time periods specified will result in termination of COBRA coverage. Once continuation is terminated, the coverage cannot be reinstated.** If timely payments of the premium are made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for continuation coverage, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a Reasonable period of time (30 days) for payment of the deficiency to be made. For purposes of this section an amount not significantly less than the amount the Plan requires to be paid shall be defined as not more than the lesser of $50 or 10% of the required payment amount.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA coverage, for a Qualified Beneficiary who elects such coverage, will terminate prior to the completion of the eighteen (18) month, twenty-nine (29) month, or thirty-six (36) month period previously described upon one of the following occurrences:

1. The Qualified Beneficiary becomes covered by another group health plan **after** the date of COBRA election;
2. Required contributions are not paid by or on behalf of the Qualified Beneficiary in a timely manner;
3. The Qualified Beneficiary becomes entitled to benefits under Medicare **after** the date of COBRA election;
4. The Qualified Beneficiary makes a request, in writing, to terminate coverage; or
5. The Plan Sponsor ceases to provide any group health plan to any similarly situated Employee.

NEW DEPENDENTS

If during the eighteen (18) months, twenty-nine (29) months or thirty-six (36) months, if applicable, of COBRA coverage, a Qualified Beneficiary acquires new Dependents (such as through marriage), the new Dependent(s) may be added to the coverage according to the provisions of the Plan. However, the new Dependents do not gain the status of a Qualified Beneficiary and will lose coverage if the Qualified Beneficiary who added them to the Plan loses coverage.

An exception to this is a Child who is born to, or a Child who is placed for adoption with, the Covered Employee Qualified Beneficiary. If the newborn or adopted Child is added to the Covered Employee's COBRA Continuation Coverage, then, unlike a new spouse, the newborn or adopted Child will gain the rights of all other Qualified Beneficiaries. The addition of a newborn or adopted Child does not extend the eighteen (18) or twenty-nine (29) month coverage period. Plan procedures for adding new Dependents can be found in the Eligibility and Effective Date sections of this Plan. Premium rates will be adjusted at that time to the applicable rate.

OPEN ENROLLMENTS

Should an Open Enrollment Period occur during the COBRA continuation period, the Plan Administrator will notify the COBRA Participant of that right as well. If an Open Enrollment Period occurs, the Qualified Beneficiary will have the same rights to select the coverage and any of the options or plans that are available for similarly situated non-COBRA Participants.

TIMING OF THE ELECTION NOTICE

If a Qualifying Event is the Covered Employee's loss of coverage due to termination of employment, reduction in hours, death or Medicare entitlement, the Plan Administrator has forty-four (44) days to notify the Qualified Beneficiary of the right to elect COBRA coverage.

CONTINUATION OF COVERAGE UNDER USERRA

This section summarizes continuation of coverage under this Plan for Employees absent from work due to military service. The Plan intends to provide benefits as a result of military Leave of Absence as mandated by USERRA, as it may be amended from time to time.

As an Employee you have a right to choose this continuation of coverage if you are absent from work due to service in one of the uniformed services of the United States. "Service" means: active duty, active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty and absence from work to determine the Employee's fitness for any of the designated types of duty.
Employees who are dishonorably discharged from the military are not eligible for continuation of coverage under USERRA.

Under the law, the Employee must give the Employer written or verbal advance notice of the military leave, if it is practical to do so, and failure to do so may result in the departing Employee's coverage being cancelled, unless the Employee is excused from giving advance notice of service under USERRA's provisions because it was impossible, unreasonable, or precluded by military necessity. A designated, authorized officer of the branch of the military in which the Employee will be serving may also provide such notice directly to the Employer.

Coverage also may be cancelled if a departing Employee leaves for a period of service that exceeds thirty (30) days and gives advance notice of service, but fails to elect continuation coverage. However, should the Employee pay all unpaid amounts due within sixty (60) days from the date the Employee left for such service, then the Employee will be retroactively reinstated with uninterrupted coverage to the Employee's date of departure.

If the Employee chooses Continuation of Coverage under USERRA, the Employer is required to offer coverage identical to that provided under the Plan prior to the Employee's military leave. If the Employee takes military leave on or after December 10, 2004, and the Employee lost coverage due to that military service, the Employee has the right to elect to extend coverage for the Employee, the Employee's spouse and the Employee's Dependents who are covered by the Plan for up to twenty-four (24) months while the Employee remains on active duty, or during the period that the Employee's reemployment rights are protected. During the first thirty (30) days of leave, the cost of the coverage the Employee elects is the same as the rate that the Employee paid as an Employee. After that time, the rate is the same rate that the Plan charges for COBRA Continuation Coverage. If the Employee or another member of the Employee's Family covered by the Plan becomes disabled during the first sixty (60) days of such coverage, and the Employee provides to the Plan a copy of the Social Security Administration determination of disability before the end of the twenty-four (24) months of coverage, the coverage by the

Plan for the Employee, as well as the Employee's spouse and other Family members, can be extended to twenty-nine (29) months. The Employee will have to pay a higher rate for this additional five (5) months of coverage. In addition, if there is an event that would allow the Employee's spouse or Dependent to receive thirty-six (36) months of COBRA coverage, as described above under the COBRA Continuation Coverage provisions, then the Employee's spouse or Dependent will be entitled to elect such coverage if they notify the Plan within sixty (60) days after the event occurs.

If the Employee does not make timely premium payments, then the Plan will provide the Employee with thirty (30) days written notice to pay the premiums. If the Employee fails to pay the requested premium(s) within the thirty (30) days, the Plan has the right to cancel the Employee's continuation of coverage.

If an Employee's or a Dependent of an Employee's health plan coverage was terminated by reason of service in the uniformed services, that coverage must be reinstated upon reemployment, unless the Plan imposes an exclusion or Waiting Period as to Illnesses or Injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of service.

If you feel you might have continuation rights under USERRA, please contact Human Resources as soon as possible.

DEFINITIONS

Terminology listed below, along with the definition or explanation of the manner in which the term is used, will be recognized for the purpose of this Plan, only if used in this Plan. Terms defined, but not used in this Plan, are to be considered general in nature and are in no way to be used to define or limit benefits or provisions of the Plan. Words or phrases used in this Plan that are capitalized or set forth in bold type but not defined in the Plan are contained in that form as section headings or for ease of review and are intended to have the general meanings associated with such words or phrases based on the context in which they are used.

Masculine pronouns used in this Plan Document shall include masculine or feminine gender unless the context indicates otherwise.

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

Accident: A sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

Accidental Injury: See definition of "Injury."

Actively at Work: As applied to an Employee: the Employee will be considered "Actively at Work" on any day the Employee performs in the customary manner all of the regular duties of employment; an Employee will be deemed "Actively at Work" on each day of a regular paid vacation or on a regular non-working day on which the Covered Employee is not totally disabled, provided the Covered Employee was "Actively at Work" on the last preceding regular work day. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor, subject to the Plan's Leave of Absence provisions.

ADA: The American Dental Association.

Adverse Benefit Determination: Any denial, reduction or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit.

Adverse Benefit Determination on Appeal: The upholding or affirmation of an appealed Adverse Benefit Determination.

Allowable Expense: The Usual and Customary charge for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some other plan provides benefits in the form of services rather than cash payments, the Reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any other plan include the benefits that would have been payable had claim been duly made.

Alternate Recipient: Any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

Alternative Care Plan: In circumstances where there is a Reasonable expectation of savings for standard of care medical treatment, medication, or other services and this alternative care can be substituted for more costly care while remaining the treatment of choice, an Alternative Care Plan will be

developed to optimize the savings obtained by the services substituted. Example: Substituting Home Health Private Duty Nursing for care in an Inpatient Skilled Nursing Facility.

AMA: The American Medical Association.

Ambulatory Surgery Center: An institution or Facility, either free-standing or as a part of a Hospital with permanent Facilities, equipped and operated for the primary purpose of performing Surgical Procedures and to which a patient is admitted and from which a patient is discharged within a twenty-four (24) hour period. An office maintained by a Physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of Pregnancy, shall not be considered as an Ambulatory Surgery Center.

Ancillary Services: Incidental services that assist a medical procedure, but are not essential to the accomplishment of the medical procedure (i.e., laboratory testing).

Annual: Yearly; occurring once each Calendar Year.

Annual Out-of-Pocket Maximum: The Maximum dollar amount a Covered Person will pay for Covered Medical Expenses, including Medical Copays and Prescription Drug Copays, but excluding any Covered Charges already paid at 100% in any one Calendar Year period, unless otherwise specified in the Schedule of Benefits.

Approved Clinical Trial: A phase I, II, III or IV trial that is federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, CMS, Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the FDA (if such application is required).

Assignment of Benefits: An arrangement whereby the Plan Participant assigns his/her right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a Provider. If a provider accepts said arrangement, Provider's rights to receive Plan benefits are equal to those of a Plan Participant, and are limited by the terms of this Plan Document. A Provider that accepts this arrangement indicates acceptance of an "Assignment of Benefits" as consideration in full for services, supplies, and/or treatment rendered.

Authorized Representative: Person authorized to act on behalf of a Claimant for a benefit Claim or appeal of an Adverse Benefit Determination.

Benefit Determination: A determination by the Plan Administrator or Claims Administrator on a Claim for benefits, including an Adverse Benefit Determination.

Benefit Percentage: The portion of Covered Expenses to be paid by the Plan in accordance with the coverage provisions as shown on the Schedule of Benefits. It is the basis used to determine any out-ofpocket expenses, including Medical Copays and Prescription Drug Copays, which are to be paid by the Covered Person.

Birthing Center: A Facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Breach: A Breach is, generally, an impermissible use or disclosure under the Privacy Rule that compromises the security or privacy of the Protected Health Information such that the use or disclosure poses a significant risk of financial, reputational, or other harm to the affected individual.

Calendar Year: A period of time commencing on January 1 and ending on December 31 of the same given year.

Chemical Dependency: The abuse of, or psychological or physical dependency on, or addiction to, alcohol or a controlled substance. A "controlled substance" means a toxic inhalant or a substance designated as a controlled substance in Chapter 481 of the Texas Health and Safety Code or equivalent State code where applicable.

Chemical Dependency Treatment Center: A Facility which provides a program for the treatment of Chemical Dependency pursuant to a written treatment plan approved and monitored by a Physician and is also:

1. Accredited as such a Facility by the Council on Accreditation (COA) or Joint Commission on Accreditation of Health Care Organizations or sponsored by the A.M.A. or A.H.A.;
2. Affiliated with a Hospital under contractual agreement with an established system for patient referral;
3. Licensed as a Chemical Dependency treatment program by the applicable State Commission on Alcohol and Drug Abuse; and
4. Licensed, certified or approved as a Chemical Dependency treatment program or center by any other State agency having legal authority to so license, certify or approve.

Child(ren): In addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a Covered Employee in anticipation of adoption, a Covered Employee's Child who is an Alternate Recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, or any other Child for whom the Employee has been legally appointed guardian or conservator. See definition of "Dependent" for any other eligibility provisions for a Child.

CHIP: Refers to the Children's Health Insurance Program or any provision or section thereof, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

CHIPRA: Refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

Chiropractic Services: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Claim: A request for a Plan benefit or benefits made by a Claimant in accordance with the Plan's Reasonable procedure for filing benefit Claims.

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

Claimant: Individual for whom a Claim is filed.

Claims Administrator: The third party or parties with whom the Plan Administrator has contracted to process the Claims for the benefits under this Plan.

Clean Claim: A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a Claim which has no defect or impropriety. A defect or impropriety shall include a lack of required substantiating documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include Claims under investigation for fraud and abuse or Claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard Claim forms, along with any attachments and additional elements or revisions to data elements of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to Claim submittal) to ensure charges constitute covered expenses as defined by and in accordance with the terms of this document. The paper Claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A Claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

Close Relative: Includes the spouse, mother, father, sister, brother, Child, or in-laws of the Covered Person.

COBRA: Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Coverage: Coverage under this Plan that satisfies an applicable COBRA continuation provision.

COBRA Election Period: The sixty (60) day period during which a COBRA Qualified Beneficiary, who would lose coverage as a result of a Qualifying Event, may elect continuation coverage under COBRA. This sixty (60) day period begins the later of:

1. The date of termination of coverage as a result of a Qualifying Event; or
2. The date of the notice of the right to elect COBRA Continuation Coverage under this Plan.

COBRA Qualified Beneficiary: A former Employee or Dependent covered under this Plan on the day before the Qualifying Event who is eligible for continuing coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) and its amendments. A COBRA Qualified Beneficiary has independent election rights.

Coinsurance: The portion of Covered Expenses that is shared by the Plan and the Covered Person in a specific ratio (i.e., 80%/20%).

Company: Tiger Lines, LLC (Plan Sponsor).

Concurrent Review: The review of a Hospital stay, periodically evaluating the need for continued hospitalization.

Copay: The portion of Covered Expenses which is payable by the Covered Person.

Corrective Shoes: Shoes with a prescription correction which is a permanent and integral part of the shoe.

Cosmetic Procedure/Cosmetic Surgery: A procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of bodily function.

Covered Employee: An Employee meeting the eligibility requirements for coverage as specified in this Plan and who is properly enrolled in the Plan.

Covered Medical Expenses (Covered Expenses): The Reasonable and Usual and Customary charges incurred by or on behalf of a Covered Person for the Hospital or other medical services listed below which are:

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

Covered Person: An Employee, a Dependent, a COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent meeting the eligibility requirements for coverage as specified in this Plan, and who is properly enrolled in the Plan.

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

Date of Hire: The Employee's first day of Full-time Employment with the Employer.

Dependent:

1. The Covered Employee's legal licensed spouse of the opposite sex who is a resident of the same country in which the Covered Employee resides. Such spouse must have met all requirements of a valid marriage contract in accordance with the laws of the State of such parties. However, the Plan does not recognize a common-law marriage. **NOTE:** Proof of legal status may be required by the Plan Administrator.

2. The Covered Employee's Child who meets all of the following conditions:

   a. Is less than **twenty-six (26) years of age**; and

   b. Is either a:

      i. Natural (biological) Child; or
      ii. Child who has been legally adopted or placed for adoption with the Covered Employee; or
      iii. Stepchild; or
      iv. Child who has been placed under the legal guardianship or conservatorship of the Covered Employee; or
      v. Grandchild who has been placed under the legal guardianship of the Covered Employee or the Employee's spouse.

   The age requirement above is waived for any unmarried Child who is Physically Handicapped or Intellectually Disabled and incapable of sustaining his/her own living, who has the same legal residence as the Employee for more than one-half of the Calendar Year, and who does not provide more than one-half of his/her own support for the Calendar Year in which the Child is enrolled for coverage under the Plan. Such Child must have been mentally or physically incapable of earning his/her own living prior to attaining the limiting age stated above. Proof of incapacity must be furnished to the Plan Administrator at the time of initial enrollment or within thirty-one (31) days of the date such Dependent's coverage would have otherwise terminated due to the age requirement. In addition, the Claims Administrator reserves the right to request proof of continued incapacity at any time.

   NOTE: Proof of Dependent eligibility may be required.

Diagnostic Service: A test or procedure performed for specified symptoms to detect or to monitor a Disease or condition. It must be ordered by a Physician or other professional Provider.

Disease: Any disorder which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit; however, if evidence satisfactory to the Plan is furnished showing that the individual concerned is covered as an Employee under any Workers' Compensation law, occupational Disease law or any other legislation of similar purpose, or under the maritime doctrine of maintenance, wages, and cure, but that the disorder involved is one not covered under the applicable law or doctrine, then such disorder shall, for the purposes of the Plan, be regarded as a sickness, Illness or Disease.

Domestic Partners: Applies to two (2) individuals either of the same sex or opposite sex who live together in a long-term relationship of indefinite duration with an exclusive mutual commitment in which the Domestic Partners agree to be jointly responsible for each other's common welfare and share financial obligations.

Donor: One who furnishes blood, tissue, or an organ to be used in another person.

Drug: Insulin and prescription legend Drugs. A prescription legend Drug is a Federal legend Drug (any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a Prescription") or a State restricted Drug (any medicinal substance which may be dispensed only by Prescription, according to State law) and which, in either case, is legally obtained from a licensed Drug dispenser only upon a prescription of a currently licensed Physician.

Durable Medical Equipment: Equipment which is:

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

Elective Surgical Procedure/Elective Surgery: A non-Emergency Surgical Procedure which is scheduled at the Covered Person's convenience without endangering the Covered Person's life or without causing serious impairment to the Covered Person's bodily functions.

Electronic Protected Health Information (ePHI): "Electronic Protected Health Information (ePHI)" has the meaning set forth in 45 C.F.R. Section 160.103, as amended from time to time, and generally means Protected Health Information that is transmitted or maintained in any electronic media.

Eligible Dependent: An Employee's Dependent who meets the Plan's eligibility requirements to enroll for coverage while the Employee is covered under the Plan.

Eligible Employee: An Employee who has satisfied the applicable Waiting Period and who is employed by the Employer on a full-time basis for at least thirty (30) hours per week, not to include seasonal, temporary, contract or leased Employees.

Emergency/Medical Emergency: A situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist. Some examples of an Emergency are: apparent heart attack, severe bleeding, sudden loss of consciousness, severe or multiple Injuries, convulsions, respiratory distress including asthma attacks, apparent poisoning or severe pain from the sudden onset of an Illness. Some examples of conditions that are not generally considered an Emergency are: colds, influenza, ear infections, nausea or headaches.

Emergency Services: With respect to an Emergency medical condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the Emergency department of a Hospital, including Ancillary Services routinely available to the Emergency department to evaluate such Emergency medical condition; and
2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employee: A person who is regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Employer: The Company and any affiliates adopting the Plan with the consent of the Company by approval of the affiliate entity's governing body.

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

ERISA: Employee Retirement Income Security Act of 1974 as amended. "ERISA" also refers to a provision or section thereof to which a specific reference is made herein.

Essential Health Benefits: "Essential Health Benefits" shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA), those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; Prescription Drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

Experimental/Investigational: Services or treatments that are not widely used or accepted by most Practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments, and that are not the subject of, or in some manner related to, the conduct of an Approved Clinical Trial, as such term is defined herein; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

1. Do not constitute accepted medical practice under the standards of the case and by the standards of a Reasonable segment of the medical community or government oversight agencies at the time rendered; or
2. Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

Non-approved Phase I and II clinical trials shall be considered Experimental. Non-approved clinical trials include anything that is not listed in the Approved Clinical Trial definition.

A Drug, device, or medical treatment or procedure is Experimental:

1. If the Drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the Drug or device is furnished;

2. If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or (unless identified as a covered service elsewhere) under study to determine its:

    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or

3. Reliable evidence shows that the opinion among experts regarding the treatment, procedure, device, Drug, or medicine is that the preponderance of current evidence does not support its efficacy, safety, or its efficacy as compared with the standard means of treatment or with regard to medication, has not determined its maximum tolerated dose.

Reliable evidence shall mean:

1. Only published reports and articles in the authoritative medical and scientific literature;
2. The written protocol or protocols used by the treating Facility or the protocol(s) of another Facility studying substantially the same Drug, device, or medical treatment or procedure; or
3. The written informed consent used by the treating Facility or by another Facility studying substantially the same Drug, device, or medical treatment or procedure.

Subject to a medical opinion, if no other FDA approved treatment is feasible and as a result the Participant faces a life or death medical condition, the Plan Administrator retains discretionary authority to cover the services or treatment.

Medical care and treatment, including prescriptions/diagnostics/labs that are not related directly to a clinical trial are considered for coverage under the Plan for those patients participating in a clinical trial.

Facility/Free-standing Facility: An independent Facility which provides medical services on an Outpatient basis, usually not affiliated with a Hospital (i.e., Ambulatory Surgery Center).

Family: A Covered Employee and his/her Eligible Dependents.

Family and Medical Leave: A Leave of Absence pursuant to the provisions of the Family and Medical Leave Act of 1993 (FMLA), as amended.

Fiduciary: The Plan Administrator, but only with respect to the specific responsibilities relating to the administration of the Plan.

Foster Child: A Child for whom an Employee has assumed a legal obligation to support and care, provided:

1. Such Child normally lives with the Employee in a parent-Child relationship; and
2. The Employee has a legal right to claim such Child as a Dependent on his federal income tax return if the Child resides with the Employee for a period of six (6) months or longer.

Full-time Employment: A basis whereby an Employee is regularly expected to be employed by the Employer for the minimum number of hours shown in the Employee Eligibility section of this Plan Document. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

Genetic Information: Information about genes, gene products and inherited characteristics that may derive from an individual or a Family member. This includes information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories and direct analyses of genes or chromosomes.

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

Habilitation Services: Services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

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

Health Insurance Portability and Accountability Act of 1996 (HIPAA): With regard to health care plans, it should be noted that this Act implemented the portability of health insurance, amended ERISA disclosure requirements and changed health status eligibility provisions for Employee health plans.

Health Maintenance Organization (HMO): An organized system of health care delivery available to individuals residing in a specific geographic area providing comprehensive medical care to enrollees for a predetermined periodic payment.

HIPAA Privacy Standards: The Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, as they may be amended from time to time.

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

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

2. It has policies established by a professional group associated with the agency or organization. This professional group must include at least one (1) Physician and at least one (1) Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or Registered Nurse (R.N.);

3. It maintains a complete medical record on each individual; and

4. It has a full-time administrator.

Home Health Care Plan: A program for care and treatment of a Homebound Covered Person, established and approved by the Covered Person's attending Physician, which is in lieu of confinement as an Inpatient in a Hospital or other Inpatient Facility in the absence of the services and supplies provided for under the Home Health Care Plan.

Home Infusion Therapy: The administration of fluids, nutrition or medication (including all additives and chemotherapy) by intravenous or gastrointestinal (enteral) infusion or by intravenous injection in the home setting. Home Infusion Therapy shall include:

1. Drugs and IV solutions;
2. Pharmacy compounding and dispensing services;
3. All equipment and ancillary supplies necessitated by the defined therapy;
4. Delivery services;
5. Patient and Family education; and 6. Nursing services.

Over-the-counter products which do not require a Physician's or other provider's prescription, including but not limited to standard nutritional formulations used for enteral nutrition therapy, are not included within this definition.

Homebound: A patient's medical condition is such that it significantly restricts the ability to leave the home, and the patient is unable to drive a motor vehicle by himself/herself.

Hospice: A health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings for Covered Persons suffering from a condition that has a terminal diagnosis. A Hospice must have an interdisciplinary group of personnel which includes at least one (1) Physician and one (1) Registered Nurse (R.N.), and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable State licensing requirements.

Hospital: An accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations or the American Osteopathic Association, and which meets all of the following criteria:

1. It is primarily engaged in providing, for compensation from its patients and on an Inpatient basis, diagnostic and therapeutic Facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians;

2. It continuously provides twenty-four (24) hours per day nursing services by registered professional Nurses under the supervision of Physicians; and

3. It is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Hospital Expenses: Charges by a Hospital for Room and Board (including Private room accommodations) and/or for care in an Intensive Care Unit provided that such care is furnished at the direction of a Physician.

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

Illness: A bodily disorder, Disease or physical sickness of a Covered Person.

Immunization: The protection of individuals or groups from specific Diseases by vaccination or the injection of immune globulins.

Incurred Date: The date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for

the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Individual Treatment Plan: A treatment plan with specific attainable goals and objectives appropriate to both the patient and the treatment modality of the program.

Injury: A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

Inpatient: Refers to a patient admitted as a bed patient to a Hospital, Hospice, Rehabilitation Facility or Skilled Nursing Facility for treatment or observation; charges must be incurred for Room and Board or observation for a period of at least twenty-four (24) hours.

Intensive Care Unit (ICU): A separate, clearly designated service which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has Facilities for special nursing care not available in regular rooms and wards of the Hospital, special life saving equipment which is immediately available at all times, at least two (2) beds for the accommodation of the critically ill and at least one (1) Registered Nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

Late Enrollee: An Employee or Dependent who gave up his/her initial opportunity to enroll in the Plan and who enrolls in the Plan more than thirty-one (31) days after the date of his/her initial eligibility and who is not eligible for a Special Enrollment or enrollment as a result of a Status Change, or who has failed to enroll by the end of a Special Enrollment Period or enrollment period for a Status Change. Late Enrollees can only enroll once a year during the Annual Open Enrollment Period for the Plan.

Leave of Absence: A Leave of Absence of an Employee that has been approved by his/her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

Licensed Practical Nurse/Licensed Vocational Nurse: An individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the State or regulatory agency responsible for such licensing in the State in which that individual performs such services.

Material Reduction: Material Reduction in covered services or benefits is any modification to the Plan or change in the information required to be included in the Summary Plan Description (SPD) that, independently or in conjunction with other contemporaneous modifications or changes, would be considered by the average Plan Participant to be an important reduction in covered services or benefits.

Maximum Allowable Charge: The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed. Maximum Allowable Charge(s) shall be calculated by the Plan Administrator taking into account and after having analyzed the following:

1. The Usual and Customary amount;
2. The allowable charge specified under the terms of the Plan;
3. The Reasonable charge specified under the terms of the Plan;
4. The negotiated rate established in a contractual arrangement with a Provider; or
5. The actual billed charges for the covered services.

The Plan will reimburse according to the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

Maximum Amount: Any Calendar Year or Lifetime benefit limit, or any limits on benefits otherwise specified, that are payable under the Plan.

Maximum Benefit: The Maximum Amount that may be payable for each Covered Person for expenses incurred. The applicable Maximum Benefit is shown in the Schedule of Benefits. No further benefits are payable once the Maximum Benefit is reached.

Medical Care Benefits: Amounts paid for the diagnosis, cure, mitigation, treatment or prevention of Disease or amounts paid for the purpose of affecting any structure or function of the body.

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

1. Provides for Child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to Medical Child Support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

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

Medical Review Specialist: An organization under contract to the Plan Administrator to provide the services required under the Cost Containment Features of Hospital Admission Notification/Continued Stay Review/Case Management. The Plan Administrator will furnish the name, address and phone number of the Medical Review Specialist.

Medically or Dentally Necessary/Medical or Dental Necessity: Refers to health care services ordered by a Physician or Dentist exercising prudent clinical judgment provided to a Plan Participant for the purposes of evaluation, diagnosis or treatment of that Plan Participant's Illness or Injury. Such services, to be considered Medically/Dentally Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of the Plan Participant's Illness or Injury. The Medically/Dentally Necessary setting and level of service is that setting and level of service which, considering the Plan Participant's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically/Dentally Necessary must be no more costly than alternative interventions and are at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of the Plan Participant's Illness or Injury without adversely affecting the Plan Participant's medical condition.

1. It must not be maintenance therapy or maintenance treatment;
2. Its purpose must be to restore health;
3. It must not be primarily custodial in nature;
4. It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and
5. The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical or Dental Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition and that safe and adequate care cannot be received as an Outpatient or in a less intensive medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician or Dentist does not mean that it is "Medically or Dentally Necessary." In addition, the fact that certain services are excluded from coverage under this Plan

because they are not "Medically or Dentally Necessary" does not mean that any other services are deemed to be "Medically or Dentally Necessary."

To be Medically or Dentally Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically or Dentally Necessary. The determination of whether a service, supply, or treatment is or is not Medically or Dentally Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors.

Medicare Benefits: All benefits under Parts A, B and/or D of Title XVIII of the Social Security Act of 1965, as amended from time to time.

Mental Disorder: Any Disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of *International Classification of Diseases*, published by the U.S. Department of Health and Human Services, or is listed in the current edition of *Diagnostic and Statistical Manual of Mental Disorders*, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA): In the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

1. The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

2. The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits, if these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Midwife: A Practitioner who is certified as a Nurse Midwife (C.N.M.) by the American College of NurseMidwives and who is authorized to practice as a Nurse Midwife under State regulations.

Morbid Obesity: A diagnosed condition in which the body weight of an individual is the greater of 100 pounds or 100% over the medically recommended weight for a person of the same height, age and mobility and by a BMI (body mass index) greater than 40.

National Medical Support Notice or NMSN: A notice that contains the following information:

1. Name of an issuing State agency;
2. Name and mailing address (if any) of an Employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the Child or Children of the Participant or the name and address of an official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying Child support order.

Newborns' and Mothers' Health Protection Act of 1996 (NMHPA): A regulation that amended ERISA by adding a new section restricting the extent to which group health plans may limit Hospital lengths of stays for mothers and newborn Children following delivery. NMHPA regulations apply as of the first day of the first Plan Year beginning on or after January 1, 1998.

No-Fault Automobile Insurance: Automobile insurance that pays for medical expenses for Injuries sustained during the operation of an automobile, regardless of who may have been responsible for causing the Accident.

Nurse: An individual who has received specialized nursing training and is authorized to use the designation Registered Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.), and who is duly licensed by the State or regulatory agency responsible for such license in the State in which the individual performs the nursing services.

Obesity: A diagnosed condition in which the BMI (body mass index) is at least 30 (ranging from 30-39).

OBRA: The coverage provided under the provisions of the Omnibus Budget Reconciliation Act of 1993 (OBRA 1993), effective August 10, 1993.

Occupational Therapy: Treatment which is rendered for reasons other than restoration of bodily functions and the prevention of disability. Such treatment is usually rendered by the use of work-related skills and leisure tasks for the evaluation of an individual's behavior and/or abilities of self-care, work or play.

Oral Surgery: Maxillofacial Surgical Procedures include, but are not limited to:

1. Excision of non-dental related neoplasms, including benign tumors and cysts and all malignant and premalignant lesions and growths;
2. Incision and drainage of facial abscess;
3. Surgical Procedures involving salivary glands and ducts and non-dental related procedures of the accessory sinuses; and
4. Surgical and diagnostic treatment of conditions affecting the temporomandibular joint (including the jaw and the craniomandibular joint) as a result of an Accident, a trauma, a congenital defect, a developmental defect or a pathology.

Orthopedic Shoes: Special shoes designed for support of the feet or the prevention or correction of deformities of the feet.

Orthotic Devices: External devices used to support, align, prevent or correct deformities or to improve the function of movable parts of the body. An orthotic insole is a foot supporting device prescribed by a Physician or licensed Practitioner.

Outpatient: A patient who receives medical services at a Hospital but is not admitted as a registered overnight bed patient; this must be for a period of less than twenty-four (24) hours. This term can also be applicable to services rendered in a free-standing independent Facility, such as an Ambulatory Surgery Center.

Outpatient Chemical Dependency/Drug Treatment Facility: An institution which provides a program for a diagnosis, evaluation and effective treatment of Chemical Dependency, and/or Drug use or abuse; provides Detoxification services needed with its effective treatment program; provides infirmary level medical services or arranges at a Hospital in the area for any other medical services that may be required; is at all times supervised by a staff of Physicians; provides at all times skilled nursing care by licensed Nurses who are directed by a full-time Registered Nurse (R.N.); prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs, which is supervised by a Physician; and meets applicable State and Federal, if any, licensing standards.

Outpatient Psychiatric Day Treatment Facility: An administratively distinct governmental, public, private or independent unit or part of such unit that provides for a psychiatrist who has regularly scheduled hours in the Facility, and who assumes the overall responsibility for coordinating the care of all patients.

Part-time Employee: An Employee who is not regularly scheduled to work for the Employer for at least the minimum number of hours shown in the Eligibility section of this Plan Document.

Physical Therapy: Management of the patient's movement system. This includes conducting an examination; alleviating impairments and functional limitation; preventing Injury, impairment, functional limitation and disability; and engaging in consultation, education and research. Direct interventions include the appropriate use of patient education, therapeutic exercise and physical agents such as massage, thermal modalities, hydrotherapy and electricity.

Physically Handicapped or Intellectually Disabled: The inability of a person to be self-sufficient as the result of a condition such as intellectual disability, cerebral palsy, epilepsy or another neurological disorder and diagnosed by a Physician as a permanent and continuing condition.

Physician: A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the State or jurisdiction where the services are rendered.

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

Plan: Without qualification, this Plan Document/Summary Plan Description, including any Plan Amendments thereto.

Plan Administrator: Tiger Lines, LLC, who is responsible for the day-to-day functions and arrangements of the Plan. The Plan Administrator may employ persons or firms to process Claims and perform other Plan connected services.

Plan Amendment: A formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Sponsor.

Plan Participant: Eligible Employee, Eligible Dependent, eligible COBRA Qualified Beneficiary or a COBRA Qualified Beneficiary's Dependent properly enrolled in the Plan.

Plan Sponsor: Tiger Lines, LLC.

Plan Year: The twelve (12) month period beginning on January 1 and ending December 31 of each Calendar Year. The Plan Year is the year on which Plan records are kept.

Practitioner: A Physician or person acting within the scope of applicable State licensure/certification requirements including the following:

1. Advanced Practice Nurse (A.P.N.)
2. Audiologist
3. Certified Diabetic Educator and Dietitian
4. Certified Nurse Midwife (C.N.M.)
5. Certified Operating Room Technician (C.O.R.T.)

6. Certified Registered Nurse Anesthetist (C.R.N.A.)
7. Certified Surgical Technician (C.S.T.)
8. Doctor of Chiropractic (D.C.)
9. Doctor of Dental Medicine (D.M.D.)
10. Doctor of Dental Surgery (D.D.S.)
11. Doctor of Medicine (M.D.)
12. Doctor of Optometry (O.D.)
13. Doctor of Osteopathy (D.O.)
14. Doctor of Podiatric Medicine (D.P.M.)
15. Licensed Acupuncturist (L.AC.)
16. Licensed Clinical Social Worker (L.C.S.W.)
17. Licensed Marriage and Family Therapist (L.M.F.T.)
18. Licensed Occupational Therapist
19. Licensed or Registered Physical Therapist
20. Licensed Practical Nurse (L.P.N.)
21. Licensed Professional Counselor (L.P.C.)
22. Licensed Surgical Assistant (L.S.A.)
23. Licensed Vocational Nurse (L.V.N.)
24. Master of Social Work (M.S.W.)
25. Physician Assistant (P.A.)
26. Psychologist (Ph.D., Ed.D., Psy.D.)
27. Registered Nurse (R.N.)
28. Registered Nurse First Assistant (R.N.F.A.)
29. Registered Nurse Practitioner (R.N.-N.P.)
30. Speech Language Pathologist

Pregnancy: The physical state which results in childbirth, life-threatening abortion, or miscarriage, and any medical complications arising out of, or resulting from, such state.

Prescription Drugs: Licensed medicine that is government regulated which must be prescribed by a Qualified Prescriber before it can be obtained.

Preventive Care: This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for:

- Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
- Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
- Comprehensive guidelines for infants, Children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
- Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html. For more information, you may contact the Plan Administrator / Employer at 209-334-4100.

Privacy Regulation: The regulations issued under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as amended.

Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other Facility providing services on an Inpatient basis in which one (1) patient bed is available per room.

Private Duty Nursing: Continuous skilled care or intermittent care by a Registered Nurse (R.N.), Licensed Practical Nurse or Licensed Vocational Nurse while a patient is not confined in a Hospital.

Protected Health Information (PHI): Individually identifiable health information that is created or received by a Covered Entity (the Plan) and relates to: (a) a person's past, present or future physical or mental health or condition; (b) provision of health care to that person; or (c) past, present or future payment for that person's health care. This term shall be construed in accordance with the Privacy Regulation.

Provider: A Physician, Practitioner, health care professional or health care Facility licensed, certified or accredited as required by state law.

Psychiatric Treatment Facility: A mental health Facility which:

1. Provides treatment for individuals who suffer from acute Mental Disorders;
2. Uses a structured psychiatric program with Individual Treatment Plans that have specified goals and appropriate objectives for the patient and treatment modality of the program; and
3. Is clinically supervised by a Physician of medicine who is certified in psychiatry by the American Board of Psychiatry and Neurology.

Qualified Individual: Someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the participant provides medical and scientific information establishing that their participation is appropriate.

Qualified Medical Child Support Order (QMCSO): As originally enacted in OBRA 1993, as amended, a Medical Child Support Order that satisfies the following requirements to be a Qualified Medical Child Support Order under ERISA Section 609 (a)(2):

1. The name and last known mailing address of the Plan Participant;
2. The name and address of each Alternate Recipient. "Alternate Recipient" means any Child of a Plan Participant who is recognized under a Medical Child Support Order as having a right to enrollment under a group health plan with respect to such Plan Participant;
3. A Reasonable description of the type of coverage to be provided by the group health plan or the manner in which coverage will be determined;
4. The period for which coverage must be provided; and
5. Each plan to which the order applies.

Qualified Medical Child Support Orders include not only court orders, but also administrative processes established under State law.

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

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

determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.
Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or Facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration, but not limited to, CMS guidelines.

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

Registered Nurse (R.N.): An individual who has received specialized nursing training and is authorized to use the designation of "R.N.," and who is duly licensed by the State or regulatory agency responsible for such licensing in the State in which the individual performs such nursing services.

Rehabilitation Facility: A legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative Inpatient care, and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, Custodial Care, ambulatory, or part-time care services, or an institution which primarily provides treatment of Mental Disorders or Chemical Dependency.

Residential Treatment Center: Facility that provides twenty-four (24) hour treatment for Chemical Dependency, Drug and Substance Abuse or mental health problems on an Inpatient basis. It must provide at least the following: Room and Board; medical services; nursing and dietary services; patient diagnosis, assessment and treatment; individual, Family and group counseling; and educational and support services. A Residential Treatment Center is recognized if it is accredited for its stated purpose by the Joint Commission on Accreditation of Hospitals and carries out its stated purpose in compliance with all relevant State and local laws.

Retrospective Review: A determination that medical services performed either Inpatient or Outpatient met criteria for Medical Necessity.

Room and Board: All charges, by whatever name called, which are made by a Hospital, Hospice, Skilled Nursing Facility, Rehabilitation Facility or other covered Facilities as a condition of Inpatient confinement as a bed patient. Such charges do not include the professional services of Physicians nor intensive nursing care, by whatever name called.

Routine Newborn Care: Inpatient charges for a well newborn Child for nursery Room and Board, related expenses following birth, including newborn hearing exams and Physician's pediatric services including circumcision. This term does not apply to a newborn Child's diagnosed Illness.

Routine Patient Cost(s): All items and services consistent with the coverage provided in the Plan that is typically covered for a Qualified Individual who is not enrolled in a clinical trial. Routine Patient Costs do not include: 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan's network area unless out-of network benefits are otherwise provided under the Plan.

Security Incidents: "Security Incidents" has the meaning set forth in 45 C.F.R. Section 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use,

disclosure, modification, or destruction of information or interference with systems operations in an information system.

Semi-Private: A class of accommodations in a Hospital or Skilled Nursing Facility or other Facility providing services on an Inpatient basis in which at least two (2) patient beds are available per room.

Serious Mental Illness: Defined as any one of the following eight (8) categories:

1. Schizophrenia;
2. Paranoid and other psychotic disorders;
3. Bipolar disorders (mixed, manic and depressive);
4. Major depressive disorders (single episode or recurrent);
5. Schizo-affective disorders (bipolar or depressive);
6. Pervasive developmental disorders;
7. Obsessive compulsive disorder; and 8. Depression in childhood and adolescence.

Skilled Nursing Facility/Extended Care Facility: An institution that:

1. Primarily provides skilled, as opposed to custodial, nursing services to patients; and
2. Is approved by the Joint Commission on the Accreditation of Health Care Organizations and/or Medicare.

Sleep Disorder: Medical/psychological condition that disrupts the patient's sleep on a chronic basis.

Special Enrollee: An Eligible Employee and his/her Eligible Dependents who have Special Enrollment rights and who enroll in the Plan during a Special Enrollment Period.

Special Enrollment Period: The period of thirty-one (31) days in which an Eligible Employee or Dependent who previously declined enrollment in the Plan by signing a waiver of coverage can enroll in the Plan. The Special Enrollment Period for both Employees and Dependents can be activated by:

1. Loss of eligibility for other coverage (except for cause or non-payment of premium);
2. A new Dependent acquired by an Employee through marriage, birth, adoption or Placement for Adoption;
3. Loss of eligibility under Medicaid or a State Children's Health Insurance Program (CHIP) (in which case the Special Enrollment Period is sixty (60) days); or
4. Gain of eligibility for a premium assistance subsidy under Medicaid or CHIP (in which case the Special Enrollment Period is sixty (60) days).

Speech Therapy: A program which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his/her social interaction skills, such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills and higher-level cognitive skills, such as understanding abstract thought, making decisions, sequencing, etc. Therapy must be considered medically appropriate even for patients who do not have apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic Disease process.

Status Change: Cafeteria plans (under Section 125 of the Internal Revenue Code) permit coverage changes during a Plan Year when a change in status occurs that affects gain or loss of eligibility for coverage for the Employee, the Employee's spouse or Dependent. Some examples of a Status Change are: change in Employee's legal marital status, change in number of Employee's Dependents, change in employment status of Employee, spouse or Dependent and loss of other coverage.

Substance Abuse: The excessive use of a substance, especially alcohol or a Drug. The current edition of *Diagnostic and Statistical Manual of Mental Disorders* definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a twelve (12) month period:

    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (i.e., repeated absences or poor work performance related to substance use; substancerelated absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (i.e., driving an automobile or operating a machine when impaired by substance use);
    c. Recurrent substance-related legal problems (i.e., arrests for substance-related disorderly conduct); and
    d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (i.e., arguments with spouse about consequences of intoxication, physical fights).

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

Substance Abuse Treatment Center: An Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a Facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

Substance Dependence: Substance use history which includes the following:

1. Substance Abuse (see above);
2. Continuation of use despite related problems;
3. Development of tolerance (more of the Drug is needed to achieve the same effect); and
4. Withdrawal symptoms.

Surgery: Any of the following:

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

Surgical Procedure: Surgical Procedures will include all CPT (Current Procedural Terminology) codes from 10000 to 69999.

TEFRA: Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Temporomandibular Joint (TMJ) Disorders: Disorders that affect the temporomandibular joints at either side of the jaw also known as myofascial pain-dysfunction syndrome.

Total Disability (Totally Disabled): A physical state of a Covered Person resulting from an Illness or Injury which wholly prevents:

1. An Employee from engaging in any and every business or occupation and from performing any and all work for compensation or profit; or
2. A Dependent or a COBRA Qualified Beneficiary from performing the normal activities of a person of that age and sex in good health.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA): A Federal law which applies to persons who have been absent from work because of "service in the uniformed services." "Uniformed services" consists of the United States Army, Navy, Marine Corps, Air Force or Coast Guard; Army Reserve, Naval Reserve, Marine Corps Reserve, Air Force Reserve or Coast Guard Reserve; Army National Guard or Air National Guard; Commissioned Corps of the Public Health Service; any other category of persons designated by the President in time of war or Emergency. "Service" in the uniformed services means: active duty, active duty for training, initial active duty for training, inactive duty training, fulltime National Guard duty and absence from work for an examination to determine a person's fitness for any of the designated types of duty.

Urgent Care Facility (Minor Emergency Medical Clinic): A Free-standing Facility which is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse (R.N.), and a registered x-ray technician must be in attendance at all times that the clinic is open. The clinic's Facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be an Urgent Care Facility (Minor Emergency Medical Clinic), by whatever actual name it may be called; however, a clinic located on the premises of, or in conjunction with, or in any way made a part of, a regular Hospital shall be excluded from the terms of this definition.

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

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care Facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was incurred.

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual

charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

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

Waiting Period: The period of time that must pass before Plan coverage can become effective for an otherwise Eligible Employee or Dependent. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor.

Well Baby Care or Well Child Care: Medical treatment, services or supplies rendered to a Child, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury, to include medical screenings for vision and hearing.

APPENDIX I

STATES WITH CONSUMER ASSISTANCE PROGRAMS UNDER PHS ACT SECTION 2793

** Current as of October 21, 2015**

(Periodic updates will be posted at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html)

In addition to the State information provided in the chart below, the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) may also be a helpful resource to participants and beneficiaries in need of assistance. Plans and issuers are encouraged to include EBSA's contact information in their notices as well. (EBSA contact information is also included in the Department's model notices.)

EBSA may be contacted at: 1-866-444-EBSA (3272) or www.askebsa.dol.gov.

State	Contact Information
Alabama	No program
Alaska	No program
American Samoa	No program
Arizona	No program
Arkansas	Arkansas Insurance Department, Consumer Services Division 1200 West Third St. Little Rock, AR 72201 (855) 332-2227 Insurance.consumers@arkansas.gov
California	California Consumer Assistance Program Operated by the California Department of Managed Health Care and Department of Insurance 980 9th St, Suite #500 Sacramento, CA 95814 (888) 466-2219 http://www.HealthHelp.ca.gov
Colorado	No program
Commonwealth of Northern Mariana Islands	No program

Connecticut	Connecticut Office of the Healthcare Advocate P.O. Box 1543 Hartford, CT 06144 (866) 466-4446 www.ct.gov/oha healthcare.advocate@ct.gov
Delaware	Delaware Department of Insurance 841 Silver Lake Blvd Dover, DE 19904 (800) 282-8611 consumer@state.de.us
District of Columbia	DC Office of the Health Care Ombudsman and Bill of Rights 899 North Capitol Street, NE, 6th Floor, Room 6037 Washington, DC 20002 (877) 685-6391 healthcareombudsman@dc.gov
Florida	No program
Georgia	Georgia Office of Insurance and Safety Fire Commissioner

	Consumer Services Division 2 Martin Luther King, Jr. Drive West Tower, Suite 716 Atlanta, Georgia 30334 (800) 656-2298 http://www.oci.ga.gov/ConsumerService/Home.aspx
Guam	Guam Department of Revenue and Taxation 1240 Army Drive Barrigada, Guam 96921 (671) 635-1846
Hawaii	No program
Idaho	No program
Illinois	Illinois Department of Insurance 320 W. Washington St, 4th Floor Springfield, IL 62767 (877) 527-9431 http://www.insurance.illinois.gov DOI.Director@illinois.gov
Indiana	No program
Iowa	No program
Kansas	Kansas Insurance Department Consumer Assistance Division 420 SW 9th Street Topeka, KS 66612 (800) 432-2484 (in state) 785-296- 7829 (all others) http://www.ksinsurance.org CAP@ksinsurance.org

Kentucky	Kentucky Department of Insurance, Consumer Protection Division P.O. Box 517 Frankfort, KY 40602 (877) 587-7222 http://healthinsurancehelp.ky.gov DOI.CAPOmbudsman@ky.gov
Louisiana	No program
Maine	Consumers for Affordable Health Care 12 Church Street, PO Box 2490 Augusta, ME 04338-2490 (800) 965-7476 www.mainecahc.org consumerhealth@mainecahc.org
Maryland	Maryland Office of the Attorney General Health Education and Advocacy Unit 200 St. Paul Place, 16th Floor Baltimore, MD 21202 (877) 261-8807 http://www.oag.state.md.us/Consumer/HEAU.htm heau@oag.state.md.us
Massachusetts	Massachusetts Consumer Assistance 30 Winter Street, Suite 1004 Boston, MA 02108 (888)-211- 6168 www.massconsumerassistance.org
Michigan	Michigan Health Insurance Consumer Assistance Program (HICAP) Michigan Office of Financial and Insurance Regulation P.O. Box 30220
	Lansing, MI 48909 (877) 999-6442 http://michigan.gov/ofir Ofir-hicap@michigan.gov
Minnesota	No program
Mississippi	Health Help Mississippi 800 North President Street Jackson, MS 39202 (877) 314-3843 http://www.healthhelpms.org healthhelpms@mhap.org
Missouri	Missouri Department of Insurance 301 W. High Street, Room 830 Harry S. Truman State Office Building Jefferson City, MO 65101 (800) 726-7390 www.insurance.mo.gov consumeraffairs@insurance.mo.gov

Montana	Office of the Commissioner of Securities & Insurance Commissioner Monica J. Linden Montana State Auditor's Office Attn: Policyholder Services 840 Helena Ave Helena, MT 59601 (800) 332-6148 (in-state only) http://www.csi.mt.gov
Nebraska	No program
Nevada	Office of Consumer Health Assistance Governor's Consumer Health Advocate 555 East Washington Ave #4800 Las Vegas, NV 89101 (702) 486-3587 (888) 333-1597 http://www.govcha.nv.gov cha@govcha.nv.gov
New Hampshire	New Hampshire Department of Insurance 21 South Fruit Street, Suite 14 Concord, NH 03301 (800) 852-3416 www.nh.gov/insurance consumerservices@ins.nh.gov
New Jersey	New Jersey Department of Banking and Insurance 20 West State Street, PO Box 329 Trenton, NJ 08625 (800) 446-7467 (888) 393-1062 (appeals) http://www.state.nj.us/dobi/consumer.htm ombudsman@dobi.state.nj.us
New Mexico	NMPRC Insurance Division Health Insurance Consumer Assistance Program 1120 Paseo De Peralta Santa Fe, NM 87504 (855) 857-0972 or (888) 427-5772 (505) 476-0326 (fax)

State	Contact Information
	http://nmprc.state.nm.us/id.htm (website) mchb.grievance@state.nm.us (email)
New York	Community Service Society of New York, Community Health Advocates 105 East 22nd Street, 8th floor New York, NY 10010 (888) 614-5400 http://www.communityhealthadvocates.org/ cha@cssny.org
North Carolina	Mailing Address:

	North Carolina Department of Insurance Health Insurance Smart NC 1201 Mail Service Center Raleigh, NC 27699-1201 (877)885-0231 http://ncdoi.com/Smart/ Delivery Service/Physical Address: North Carolina Department of Insurance Health Insurance Smart NC 430 N. Salisbury Street Raleigh, NC 27603
North Dakota	No program
Northern Marianas Islands	No program
Ohio	No program
Oklahoma	Oklahoma Insurance Department Five Corporate Plaza 3625 Northwest 56th Street, Suite 100 Oklahoma City, OK 73112 (800) 522-0071 (in-state only) (405) 521-2991 http://www.ok.gov/oid/Consumers/Consumer_Assistance/index.html
Oregon	Oregon Health Connect 1435 NE 81st Ave. Suite 500 Portland, OR 97213-6759 855-999-3210 oregonhealthconnect.org healthconnect@211info.org
Pennsylvania	Pennsylvania Department of Insurance 1209 Strawberry Square Harrisburg, PA 17111 (877) 881-6388 http://www.pahealthoptions.com
Puerto Rico	Puerto Rico Oficina de la Procuradora del Paciente Calle Recinto Sur #303 San Juan, PR 00910 (787) 979-0909 http://www.pr.gov/ (website) querellas@opp.gobierno.pr (email)
Rhode Island	Rhode Island Consumer Assistance Program Rhode Island Parent Information Network, Inc. 1210 Pontiac Avenue Cranston, RI 02920 (855) 747-3224 www.RIREACH.org
South Carolina	South Carolina Department of Insurance Consumer and Individual Licensing Services P.O. Box 100105 Columbia, SC 29202
State	**Contact Information**

	(800) 768-3467 http://www.doi.sc.gov consumers@doi.sc.gov
South Dakota	No program
Tennessee	Tennessee Department of Commerce and Insurance 500 James Robertson Pkwy Davy Crockett Tower, 4th floor Nashville, TN 37243-0574 (615) 741-2218 (800) 342-4029 (615) 532-7389 (Fax) www.tn.gov/commerce/insurance
Texas	Texas Consumer Health Assistance Program Texas Department of Insurance Mail Code 111-1A 333 Guadalupe P.O. Box 149091 Austin, TX 78714 (855) 839-2427 (855-TEX-CHAP) www.texashealthoptions.com chap@tdi.state.tx.us
Utah	No program
Vermont	Vermont Legal Aid 264 North Winooski Ave. Burlington, VT 05402 (800) 917-7787 www.vtlegalaid.org
Virginia	Virginia State Corporation Commission Life & Health Division, Bureau of Insurance P.O. Box 1157 Richmond, VA 23218 (877) 310-6560 http://www.scc.virginia.gov/boi bureauofinsurance@scc.virginia.gov
Virgin Islands	U.S. Virgin Islands Division of Banking and Insurance 1131 King Street Suite 101 Christiansted St. Croix, VI 00820 (340) 773-6459
Washington	Washington Consumer Assistance Program 5000 Capitol Blvd Tumwater, WA 98501 (800) 562-6900 http://www.insurance.wa.gov cap@oic.wa.gov

West Virginia	West Virginia Office of the Insurance Commissioner Consumer Service Division P.O. Box 50540 Charleston, WV 25305 (888) 879-9842 http://www.wvinsurance.gov
Wisconsin	No program
Wyoming	No program