PLAN DOCUMENT

HEALTH BENEFIT PLAN

FOR THE EMPLOYEES OF

BAPTIST ST. ANTHONY'S HEALTH SYSTEM, WHICH PLAN IS A PART OF THE ARDENT HEALTH SERVICES WELFARE BENEFIT PLAN

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ESTABLISHMENT OF THE PLAN

ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by Baptist St. Anthony's Health System, which is a part of the Ardent Health Services Welfare Benefit Plan (the "Company" or the "Plan Sponsor") as of January 1, 2014, hereby **amends and restates** the Baptist St. Anthony's Health System Health Benefit Plan (the "Plan"), which was originally adopted by the Company, effective January 1, 2001.

EFFECTIVE DATE - The Plan Document is effective as of the date first set forth above, and each Amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the "Effective Date").

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

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

By:	Witness	By:	Baptist St. Anthony's Health System Signature on File
Name:		Name:	
Title:		Title:	
Date:		Date:	

INTRODUCTION AND GENERAL PLAN INFORMATION

Whereas Baptist St. Anthony's Health System, hereinafter referred to as the "Company", hereby establishes the benefits, rights and privileges which shall pertain to Participating Employees, hereinafter referred to as "Participant", and the eligible Dependents of such Participant, as herein defined, and which benefits are provided through a group medical plan established by the Company and hereinafter referred to as the "Plan". This Plan satisfies the minimum essential coverage requirements as set forth in the Patient Protection and Affordable Care Act.

PURPOSE - The purpose of the Plan Document is to set forth the provisions of the Plan that provide for the payment or reimbursement of all or a portion of "Eligible Medical Expenses", as herein defined.

EFFECTIVE DATE - The effective date of the Plan is January 1, 2001, restated as of January 1, 2014.

General Plan Information

Name of Plan:	Health Benefit Plan for the Employees of Baptist St. Anthony's Health System, which plan is a part of the Ardent Health Services Welfare Benefit Plan
Plan Sponsor:	AHS Management Company, Inc. One Burton Hills Blvd Suite 250 Nashville, TN 37215
Plan Administrator: (Named Fiduciary)	AHS Management Company, Inc. One Burton Hills Blvd Suite 250 Nashville, TN 37215 (615) 296-3000
Plan Sponsor ID No. (EIN):	62 - 1743438
Source of Funding:	Self-Funded
Applicable Law:	ERISA
Plan Year:	January 1 through December 31
Plan Number:	501
Plan Type:	Group Health Plan
Plan Supervisor:	Insurance Management Services P.O. Box 15688 Amarillo, Texas 79105 (806) 373-5944 www.imstpa.com
Participating Employer(s):	Participant and Covered Persons may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if the employer is a plan sponsor, the sponsor's address.
Agent for Service of Process:	AHS Management Company, Inc. One Burton Hills Blvd Suite 250 Nashville, TN 37215

NAMED FIDUCIARY AND PLAN ADMINISTRATOR - The Named Fiduciary and Plan Administrator is:

AHS Management Company, Inc.
One Burton Hills Blvd
Suite 250
Nashville, TN 37215
(615) 296-3000

The Named Fiduciary and Plan Administrator shall have the authority to control and manage the operation and administration of the Plan. The Plan Administrator may delegate responsibilities for the operation and administration of the Plan. The Company shall have the authority to amend the Plan, to determine its policies, to appoint and remove supervisors and agents, fix their compensation (if any), and exercise general administrative authority over them. The Administrator has the sole and discretionary authority to determine eligibility for benefits, to review and make final decisions on all claims for benefits including, without limitation, factual determinations; and to construe the terms of the Plan including without limitation, correcting any defect, supplying any omission and reconciling any inconsistency.

CONTRIBUTIONS TO THE PLAN - The amount of 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 Company and the amount to be contributed (if any) by each covered Participant.

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 terminates the Plan, then as of the effective date of termination, the Company and covered Participant shall have no further obligation to make additional contributions to the Plan.

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 Company shall find that such an attempt has been made with respect to any payment due or to become due to any Covered Person, the Company in its sole discretion may terminate the interest of such Covered Person or former Covered Person in such payment, and in such case shall apply the amount of such payment to or for the benefit of such Covered Person or former Covered Person, his spouse, parent, adult child, guardian of a minor child, brother or sister, or other relative of a dependent of such Covered Person or former Covered Person, as the Company may determine, and any such application shall be a complete discharge of all liability with respect to such benefit payment.

PLAN AMENDMENT - This Document contains all the terms of the Plan and may be amended from time to time by the Company. Any changes so made shall be binding on each covered Participant and on any other Covered Persons referred to in this Plan Document.

TERMINATION OF PLAN - The Company reserves the right at any time to terminate the Plan by a written instrument to that effect. All previous contributions by the Company shall continue to be issued for the purpose of paying benefits under the provisions of this Plan with respect to claims arising before such termination, or shall be used for the purpose of providing similar health benefits to Covered Persons, until all contributions are exhausted.

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 Participant of the Company the right to be retained in the service of the Company or to interfere with the right of the Company to discharge or otherwise terminate the employment of any Participant.

PLAN TYPE - This Plan is a self-insured program of benefits consisting of an "Employee Welfare Benefit Plan" under the Employee Retirement Income Security Act of 1974 (ERISA) and any Amendments thereto. The Plan is funded with employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

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PARTICIPATING EMPLOYERS – A complete list of the employers sponsoring this Plan may be obtained by Participant and Covered Persons upon written request to the Plan Administrator, and is available for examination by Participant and Covered Persons. Participant and Covered Persons may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a sponsor of the Plan and, if the employer is a plan sponsor, the sponsor's address.

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.

DISCRETIONARY AUTHORITY - The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's or Covered Person's rights; and to determine all questions of fact and law arising under the Plan.

BAPTIST ST. ANTHONY'S HEALTH SYSTEM

PLAN 1000 SCHEDULE OF BENEFITS

Effective Date: January 1, 2014

The following is a summary of the benefits, subject to co-payments, deductibles, percentages and limitations, provided to you and any covered dependents. ***Please note the Calendar Year Deductibles are always applicable, unless the schedule states they are waived.*** PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.

Major Medical Expense Benefit	**PPO**	***Non-PPO**
Calendar Year Deductible		
Individual	$1,000	$3,000
Family	$3,000	$9,000
Percentage Payable After Deductible or Co-Payment unless otherwise stated below	80%	50%
Out of Pocket Maximum		
Individual	$3,000	No Limit
Family	$6,000	No Limit
	Including any applicable Deductibles and Co-Payments	
Affordable Care Act mandated maximums		
Individual	$6,350	N/A
Family	$12,700	N/A
	Including any Out-of-Pocket, Deductibles and Co-Payments	
PPO and Non-PPO Deductible and Out of Pocket maximums will <u>NOT</u> be integrated.		
BSA Clinics (Excluding Maternity/OB Care/Pain Management)	$30 Co-Pay, 100%	N/A
For a complete list of BSA Clinics that are subject to the above Co-Pay, please contact IMS Customer Service at 806-373-5944 or 800-687-5944.		
Pediatricians (In Office) (Including Physician's Assistant or Nurse Practitioner)	$30 Co-Pay, 100%	50%
Physician Services (In office)	80%	50%
Office Visits/ X-Ray/ Lab/ Injections/ Diagnostic Medical Procedures/ Office Surgery and Related Expenses/ Medical Supplies / Allergy Testing		
Allergy Injection & Serum	80%	Not Covered
Other Miscellaneous Physician Services	80%	50%
Preventive Care		
Grade A & B (Based on U.S. Preventive Services Task Force)	100%, Waive Deductible	Not Covered
All Other Services		
BSA Clinics (Excluding Maternity/ OB Care/Pain Management)	$30 Co-Pay	N/A
Office Visits	80%, Waive Deductible	Not Covered
Other Outpatient Facilities	80%, Waive Deductible	Not Covered
Chiropractic Care	80%	50%
Calendar Year Maximum	$1,500	
Outpatient Laboratory/Radiology Services	80%	50%
Emergency Services		
Emergency Room Facility	80%	50%
Emergency Room Physicians	80%	50%
Ambulance Services	80%	
Covered Expenses will be considered PPO and will accumulate towards PPO Deductible and Out of Pocket Maximum amounts.		
Outpatient Rehabilitation, Speech, & Occupational Therapy	80%	50%

PLAN 1000 SCHEDULE OF BENEFITS (Cont'd)

Major Medical Expense Benefit	**PPO**	***Non-PPO**
Hospital Services	80%	50%
Non Pre-certified IP Hospital Penalty Deductible	$250	
	Charges will never apply toward satisfying any Out of Pocket maximums.	
Hospital Room & Board Limitation	N/A	Average Semi-Private, Average Private
Intensive Care Unit Limitation	N/A	Average Intensive Care
Inpatient and Outpatient charges for emergency room, radiology, anesthesiology and pathology services rendered by a Non-PPO Physician will be paid the same as Covered Expenses for a PPO Physician if such services are performed at a PPO facility **This does not apply to physician services within the BSA Provider Network Area.**		
Bariatric Surgery	$2,500 Co-Pay, 100%, Waive Deductible	Not Covered
The Bariatric Surgery must be performed at Baptist St. Anthony's Hospital ("BSA") by a physician with privileges at the Baptist St. Anthony's Facility.		
Bariatric Surgery is limited to one (1) surgery per lifetime.		
Physical Therapy	80%	50%
Daily Benefit Maximum per condition	Five (5) modalities, procedures, units	
Maximum Number of Treatments Per Condition	12 Visits	
The Maximum Number of Treatments is waived for any additional treatments, which are due to medical necessity.		
Chemotherapy, Radiation Therapy & Dialysis	80%	50%
Extended Care Services		
Home Health Care	80%	50%
Calendar Year Maximum	60 Visits	
Skilled Nursing Facility	80%	50%
Calendar Year Maximum	30 Days	
Hospice Services	80%	50%
Routine Nursery Care / Newborn Care	80%, Waive Deductible	50%, Waive Deductible
Mental Health Disorders / Substance Use Disorders	Paid as for Illness or Injury. Refer to applicable Major Medical Expense Benefit section in this Schedule of Benefits.	
Prosthetic/Orthotic Appliances	80%	50%
Durable Medical Equipment	80%	50%
Hearing Aids	80%	
Hearing Aids are limited to one (1) set every five (5) years.		
Covered Expenses will be considered PPO and will accumulate towards PPO Deductible and Out of Pocket Maximum amounts.		
Medical Supplies	80%	50%
Diabetic Supplies	80%	50%
Diabetic Education	80%	
Covered Expenses will be considered PPO and will accumulate towards PPO Deductible and Out of Pocket Maximum amounts.		

PLAN 1000 SCHEDULE OF BENEFITS (Cont'd)

Major Medical Expense Benefit	**PPO**	***Non-PPO**
Wigs After Chemotherapy	100%, Waive Deductible	
Wigs are limited to one (1) wig every three (3) years.		
Calendar Year Benefit Maximum	Unlimited	

***** PPO Benefits will apply for:

1. Procedures that cannot be performed by a PPO Provider.
2. Hospital Admission or treatment in a Non-PPO Facility or by a Non-PPO Provider due to an Emergency.

NON-PPO SERVICES PROVIDED INSIDE THE BSA PROVIDER NETWORK AREA *WILL NOT* BE COVERED.

* Non-PPO charges will be reimbursed by the Plan based on Usual & Customary.

BAPTIST ST. ANTHONY'S HEALTH SYSTEM

PLAN 2000 SCHEDULE OF BENEFITS

Effective Date: January 1, 2014

The following is a summary of the benefits, subject to co-payments, deductibles, percentages and limitations, provided to you and any covered dependents. ***Please note the Calendar Year Deductibles are always applicable, unless the schedule states they are waived.*** PLEASE REFER TO THE LIMITATIONS AND EXCLUSIONS FOR ADDITIONAL EXPLANATIONS.

Major Medical Expense Benefit	**PPO**	***Non-PPO**
Calendar Year Deductible		
Individual	$2,000	$6,000
Family	$4,000	$18,000
Percentage Payable After Deductible or Co-Payment unless otherwise stated below	80%	50%
Out of Pocket Maximum		
Individual	$4,000	No Limit
Family	$8,000	No Limit
	Excluding any applicable Deductibles and Co-Payments	
Affordable Care Act mandated maximums		
Individual	$6,350	N/A
Family	$12,700	N/A
	Including any applicable Out-of-Pocket, Deductibles and Co-Payments	
PPO and Non-PPO Deductible and Out of Pocket maximums will NOT be integrated.		
BSA Clinics (Excluding Maternity/OB Care/Pain Management)	$30 Co-Pay, 100%	N/A
For a complete list of BSA Clinics that are subject to the above Co-Pay, please contact IMS Customer Service at 806-373-5944 or 800-687-5944.		
Pediatricians (In Office) (Including Physicians Assistant or Nurse Practitioner)	$30 Co-Pay, 100%	50%
Physician Services (In office)	80%	50%
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Allergy Injection & Serum	80%	Not Covered
Other Miscellaneous Physician Services	80%	50%
Preventive Care		
Grade A & B (Based on U.S. Preventive Services Task Force)	100%, Waive Deductible	Not Covered
All Other Services		
BSA Clinics (Excluding Maternity/ OB Care/Pain Management)	$30 Co-Pay	N/A
Office Visits	80%, Waive Deductible	Not Covered
Other Outpatient Facilities	80%, Waive Deductible	Not Covered
Chiropractic Care	80%	50%
Calendar Year Maximum	$1,500	
Outpatient Laboratory/Radiology Services	80%	50%
Emergency Services		
Emergency Room Facility	80%	50%
Emergency Room Physicians	80%	50%
Ambulance Services	80%	
Covered Expenses will be considered PPO and will accumulate towards PPO Deductible and Out of Pocket Maximum amounts.		

PLAN 2000 SCHEDULE OF BENEFITS (Cont'd)

Major Medical Expense Benefit	**PPO**	***Non-PPO**
Outpatient Rehabilitation, Speech, & Occupational Therapy	80%	50%
Hospital Services	80%	50%
Non Pre-certified IP Hospital Penalty Deductible	$250	
	Charges will never apply toward satisfying any Out of Pocket maximums.	
Hospital Room & Board Limitation	N/A	Average Semi-Private, Average Private
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Inpatient and Outpatient charges for emergency room, radiology, anesthesiology and pathology services rendered by a Non-PPO Physician will be paid the same as Covered Expenses for a PPO Physician if such services are performed at a PPO facility **This does not apply to physician services within the BSA Provider Network Area.**		
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Bariatric Surgery is limited to one (1) surgery every ten (10) years.		
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Daily Benefit Maximum per condition	Five (5) modalities, procedures, units	
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Extended Care Services		
Home Health Care	80%	50%
Calendar Year Maximum	60 Visits	
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Calendar Year Maximum	30 Days	
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Routine Nursery Care / Newborn Care	80%, Waive Deductible	50%, Waive Deductible
Mental Health Disorders / Substance Use Disorders	Paid as for Illness or Injury. Refer to applicable Major Medical Expense Benefit section in this Schedule of Benefits.	
Prosthetic/Orthotic Appliances	80%	50%
Durable Medical Equipment	80%	50%
Hearing Aids	80%	
Hearing Aids are limited to one (1) set every five (5) years.		
Covered Expenses will be considered PPO and will accumulate towards PPO Deductible and Out of Pocket Maximum amounts.		
Medical Supplies	80%	50%
Diabetic Supplies	80%	50%
Diabetic Education	80%	
Covered Expenses will be considered PPO and will accumulate towards PPO Deductible and Out of Pocket Maximum amounts.		

PLAN 2000 SCHEDULE OF BENEFITS (Cont'd)

Major Medical Expense Benefit	**PPO**	***Non-PPO**
Wigs After Chemotherapy	100%, Waive Deductible	
Wigs are limited to one (1) wig every three (3) years.		
Calendar Year Benefit Maximum	Unlimited	

***** PPO Benefits will apply for:

1. Procedures that cannot be performed by a PPO Provider.
2. Hospital Admission or treatment in a Non-PPO Facility or by a Non-PPO Provider due to an Emergency.

NON-PPO SERVICES PROVIDED INSIDE THE BSA PROVIDER NETWORK AREA *WILL NOT* BE COVERED.

* Non-PPO charges will be reimbursed by the Plan based on Usual & Customary.

DEFINITIONS

Certain words and phrases used in this Plan Document are listed below, along with the definition or explanation of the manner in which the term is used for the purposes of this Plan.

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.

ADVERSE BENEFIT DETERMINATION – The term "Adverse Benefit Determination" means a denial, reduction or termination of, or a failure to provide or make payment (in whole or part), for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a Participant's or beneficiary's eligibility to participate in a Plan.

ALCOHOL AND DRUG DEPENDENCY TREATMENT CENTER - The term "Alcohol and Drug Dependency Treatment Center" means a facility that provides a program for the treatment of Alcoholism and Drug Abuse by means of a written treatment plan that is approved and monitored by a Physician. This facility must be affiliated with a Hospital under a contractual agreement with an established system for patient referral, and/or licensed, certified or approved as an Alcohol and Drug Abuse Treatment Program or Center by any state agency that has the legal authority to do so.

ALCOHOLISM, DRUG ADDICTION OR SUBSTANCE ABUSE - The term "Alcoholism, Drug Addiction or Substance Abuse" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces an impairment in personal, social or occupational functions and which constitutes alcohol or drug dependency.

ALLOWABLE EXPENSE - The term "Allowable Expense" means any Medically Necessary, Usual & Customary item or expense for health care that is covered (without regard to any applicable Deductible or Out of Pocket limit) at least in part by this Plan covering the person for whom the claim is made.

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

ALTERNATE CARE - The term "Alternate Care" means medical treatment or care that is provided in lieu of the benefits specified in this Plan, because it may be provided in a less comprehensive setting or because it is less expensive. Alternate Care must be (a) recommended by the Case Manager for a Covered Person; (b) Medically Necessary and (c) approved by the Plan Administrator.

If the Plan Administrator determines that medical treatment or care is Alternate Care for a Covered Person in one instance, it shall not be obligated to determine that the same medical treatment or care is Alternate Care for other Covered Persons under this Plan in any other instance.

ALTERNATE RECIPIENT - The term "Alternate Recipient" shall mean 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.

AMBULATORY SURGICAL CENTER - The term "Ambulatory Surgical Center" means an institution or facility, 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 to and discharged from 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 to be an Ambulatory Surgical Center.

AMENDMENT - The term "Amendment" means a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

ANTIGEN DOSE – The term "Antigen Dose" means the amount of antigen administered in a single injection, whether drawn from single or multiple vials. The number of doses shall be equal to the number of "units" reported by the provider of service.

APPROPRIATE HEALTH CARE PROFESSIONAL – The term "Appropriate Health Care Professional" means a person who meets all of the following requirements:

1. Must be a Physician or other health care professional that is licensed, accredited or certified to perform specified health services under state law;

2. Must have appropriate training and experience in the field of medicine involved in the decision; and

3. Was not consulted in connection with the benefit determination that is the subject of the appeal, nor is a subordinate of the person who was consulted.

ASSIGNMENT OF BENEFITS - The term "Assignment of Benefits" means an arrangement whereby the Plan Participant assigns their right to seek and receive payment of eligible Plan benefits, in strict accordance with the terms of this Plan Document, to a provider. If a provider accepts said arrangement, the 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.

ATTENDING PROVIDER – The term "Attending provider" is an individual, licensed under state law, who is directly responsible for providing maternity or pediatric care to a mother or newborn child. Therefore, a plan, hospital, insurance company or HMO would not be an Attending provider. However, a nurse midwife or physician assistant may be an Attending provider if licensed in the state to provide maternity or pediatric care in connection with childbirth.

AUTHORIZED REPRESENTATIVE – The term "Authorized Representative" means the person who the Claimant appoints to act on his behalf with respect to a benefit claim or appeal of a denial.

AUDIOLOGIST - The term "Audiologist" means a person who: (1) has a master's or doctorate degree in Audiology from an accredited College or University; and (2) is certified by the American Speech-Language and Hearing Association.

BENEFIT PERCENTAGE - The term "Benefit Percentage" means that portion of Eligible Medical Expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any Out-of-Pocket expenses in excess of the annual Deductible that are to be paid by the Participant.

BENEFIT PERIOD - The term "Benefit Period" refers to a time period of one year, as shown on the Schedule of Benefits. Such Benefit Period will terminate on the earliest of the following dates:

1. The last day of the one year period so established; or

2. The day the Plan Benefit Maximum applicable to the Covered Person becomes payable; or

3. The day the Covered Person ceases to be covered for Major Medical Expense Benefits.

BIRTHING CENTER - A facility, duly licensed by the political jurisdiction where located and operating pursuant to that license, which:

1. Is operated primarily as a facility for the delivery of children following a normal, uncomplicated Pregnancy;

2. Is operated under the direct, full-time supervision of a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), or a Registered Nurse (R.N.);

3. Is equipped to perform routine diagnostic laboratory tests, and to handle medical emergencies;

4. Maintains adequate, written medical records for each patient; and

5. Has a written agreement with at least one local Hospital for immediate acceptance of patients who develop complications or require Hospital Confinement.

CALENDAR YEAR - The term "Calendar Year" means a period of time commencing on January 1 and ending on December 31 of the same given year.

CALENDAR YEAR BENEFIT MAXIMUM - The term "Calendar Year Benefit Maximum" means the maximum Plan benefit (as set forth in the Schedule of Benefits) payable under this Plan

CASE MANAGER - The term "Case Manager" means an entity or person that reviews the cost effectiveness or prescribed courses of treatment for the Covered Person and includes assessing, planning, implementing, coordinating and evaluating health related service options, under the terms of an agreement with Employer.

CERTIFICATE OF COVERAGE - The term "Certificate of Coverage" means a document that provides evidence of prior health coverage for a Covered Person, as required by HIPAA.

CHILD(REN) – The term "Child(ren)" means, in addition to the Participant's own blood descendant of the first degree or lawfully adopted Child; a Child placed with the Participant in anticipation of adoption; a Child who is an alternate recipient under a QMCSO as required by the federal Omnibus Budget Reconciliation Act of 1993; any stepchild; or any other Child for whom the Participant has obtained legal guardianship.

CHIP - The term "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 - The term "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, provision or section may be amended from time to time.

CHIROPRACTIC CARE - Any services, supplies, diagnostic procedures and/or treatment provided by a Doctor of Chiropractic.

CLAIMANT - See Covered Person

CLAIM DETERMINATION PERIOD - The term "Claim Determination Period" means a Calendar Year; provided, however, that a Claim Determination Period shall not include any part of a Calendar Year during which such person has no coverage under this Plan or any part of a Calendar Year before the date these COB Rules or a similar coordination of benefits provision is effective with respect to such person.

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

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

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

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

CLINICAL TRIALS – The term "Clinical Trials" means an approved clinical trial includes 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 is either federally funded; conducted under an investigational new drug application reviewed by the FDA; or is a drug trial that is exempt from the requirement of an investigational new drug application.

If you are a participant in a clinical trial, this Plan will provide related care as follows, so long as it is not provided and/or available by the clinical trial:

- Routine care costs – costs for routine services such as doctor visits, lab tests, x-rays and scans, and hospitalizations related to treating the patient's condition, whether the patient is in a clinical trial or is receiving standard therapy. These costs are covered by this Plan.
- Extra care costs – costs related to taking part in a clinical trial such as additional tests that a patient may need as part of a trial, but not as part of the patient's routine care. This plan may cover some of these costs so long as they are Reasonable, providing the plan determined the services are Medically Necessary.
- Research costs – costs related to conducting the clinical trial such as research physician and nurse time, analysis of results, and clinical tests performed only for research purposes. These costs are generally covered by the clinical trial; this Plan does not cover these costs.

CLOSE RELATIVE - The term "Close Relative" means the spouse, parent, brother, sister, child, or spouse's parent of the Covered Person.

COBRA - The term "COBRA" refers to the Consolidated Omnibus Budget Reconciliation Act of 1985 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.

COBRA CONTINUEE - The term "COBRA Continuee" means a person who is receiving continuation coverage under a group health care plan maintained by the Company. A person shall cease to be a COBRA Continuee on the date that the "maximum required period" ends for the "qualifying event" giving rise to his continuation coverage or if earlier, when COBRA coverage terminates hereunder.

COLLEGE - See definition of University.

COMPANY - The term "Company" means Baptist St. Anthony's Health System and any other affiliates that adopt the Plan.

CONCURRENT CLAIM – The term "Concurrent Claim" means a claim that arises when the Plan has approved an on-going course of treatment to be provided over a period of time that involves a reduction or termination by the Plan of such course of treatment (other than by plan Amendment or termination) or number of treatments.

CONFINEMENT - The term "Confinement" means a period of time when an individual becomes confined in a Hospital or Skilled Nursing Facility due to an Illness or Injury.

CONVALESCENT PERIOD - The term "Convalescent Period" means a period of time commencing with the date of Confinement by a Covered Person to a Skilled Nursing Facility. Such Confinement must meet all of the following conditions:

1. Such Confinement must commence within fourteen (14) days of being discharged from a Hospital; and

2. Said Hospital Confinement must have been for a period of not less than three (3) consecutive days; and

3. Both the Hospital and skilled confinements must have been for the care and treatment of the same Illness or Injury.

A Convalescent Period will terminate when the Covered Person has been free of Confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has terminated.

CO-PAYMENT - The term "Co-Payment" means the amount of payment shown in the Schedule of Benefits that is due and payable by a Covered Person to a provider at point of service.

COSMETIC PROCEDURE - The term "Cosmetic Procedure" means any plastic or reconstructive surgery done primarily to improve the appearance of any portion of the body, and for which there is no Medical Necessity and from which no improvement in physiological function could be reasonably expected. Examples of Cosmetic Procedures are as follows: surgery for sagging or extra skin; any augmentation or reduction procedures, rhinoplasty and associated surgery; and any procedures utilizing an implant.

COVERED EXPENSE – The term "Covered Expense" means a Usual and Customary fee for a Reasonable, Medically Necessary service, treatment, or supply, meant to improve a condition of Participant's health that is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions.

All treatment is subject to benefit payment maximums shown in the Schedule of Benefits and as determined elsewhere in this document.

COVERED PERSON - The term "Covered Person" means any Participant or Dependent of a Participant meeting the eligibility requirements for coverage as specified in this Plan, and properly enrolled in the Plan.

CREDITABLE COVERAGE - The term "Creditable Coverage" means health coverage under a group health plan, HMO, an individual health insurance policy, COBRA, Medicaid or Medicare that is not followed by a Significant Break in Coverage and excludes coverage for liability, limited scope dental or vision benefits, specified disease and/or other supplemental-type benefits as defined by the final regulations of HIPAA Portability Act.

CUSTODIAL CARE - The term "Custodial Care" means 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 getting in and out of bed, and supervision over medication that can normally be self-administered.

DEDUCTIBLE - The term "Deductible" means a specified dollar amount of Covered Expenses that must be incurred during a Benefit Period before any other Covered Expenses can be considered for payment according to the applicable Benefit Percentage.

DEPENDENT - The term "Dependent" means:

1. The Participant's legal spouse who is a resident of the same country in which the Participant resides. Such spouse must have met all requirements of a valid marriage contract in the State of marriage of such parties. A marriage license or common law certificate may be required.

DEPENDENT (Cont'd)

2. The Participant's Domestic Partner who is a resident of the same country in which the Participant resides. A Domestic Partner must meet all of the requirements of a Domestic Partner and must provide proof of the same by submitting a Domestic Partnership Affidavit, Municipal Registration documentation and/or a License to document the existence of the relationship.

   Please Note: If a Domestic Partner is not recognized as a legal Spouse, the benefits received will be taxable.

3. The Participant's child who meets all of the following conditions:

a) Is a resident of the same country in which the Participant resides;

b) Is married or unmarried;

c) Is a Natural Child, stepchild, legally adopted child, child for whom legal adoption proceedings have been initiated if such child has been placed in your home, or a child who has been placed under the legal guardianship of the Participant. A Natural Child qualifies as a Dependent at the time of birth. A Natural Child means a child that is related by birth and is not an adopted child, a stepchild, a foster child, niece, nephew, or grandchild. A Domestic Partner's Child who resides with the Participant qualifies as a "Natural Child" Dependent if the child is chiefly dependent on the Participant for financial support and meets all other eligibility requirements of a Dependent child.

d) Is less than twenty-six (26) years of age. The age requirement is waived for any mentally retarded or physically handicapped child, provided that the child is incapable of self-sustaining employment and is chiefly dependent upon the Participant for support and maintenance. Proof of incapacity must be furnished to the Company, and additional proof may be requested from time to time.

3. As required by the federal Omnibus Budget Reconciliation Act of 1993, any child of a Plan Participant who is an Alternate Recipient under a Qualified Medical Child Support Order (QMCSO) and has a right to enroll in the Plan as a Dependent of a Participant.

Those situations specifically excluded from the definition of a Dependent are:

1. A spouse who is legally separated or divorced from the Participant. Such spouse must have met all requirements of a valid separation or divorce contract in the State granting such separation or divorce;

2. Any person on active military duty;

3. Any person eligible for coverage under this Plan as an individual Participant;

4. Any person who is covered as a Dependent by more than one Participant of the same Company.

DEPENDENT COVERAGE - The term "Dependent Coverage" means eligibility under the terms of the Plan for benefits payable as a consequence of Eligible Medical Expenses incurred for an Illness or Injury of a Dependent.

DOMESTIC PARTNER

Benefits are available to same-sex and opposite-sex Domestic Partners of Ardent Health Services benefits-eligible employees. Ardent Health Services defines Domestic Partners as two people who have met all of the following criteria:

- For at least 12 months have shared the same principal residence in an intimate, committed relationship of mutual caring and intend to do so indefinitely.

- Agree to be responsible for each other's basic living expenses during the Domestic Partnership, and agree that anyone who is owed these expenses can collect from either of them.
- Are both 18 years of age or older and of sufficient mental competence to enter binding legal contracts.
- Are not married to anyone, and are not so closely related by blood that a legal marriage between them would be prohibited for that reason in their state of residence.
- Do not presently have a different Domestic Partner.
- Did not have a different Domestic Partner in the last 12 months.

If you have an opposite-sex Domestic Partner and the two of you generally represent yourselves as married, you may have a common law marriage if it is recognized by the state in which you reside. A common law husband or wife is considered a "spouse" rather than a "Domestic Partner." You should enroll him or her through the regular enrollment process.

Eligible Dependents of Your Domestic Partner
You may cover the children of your Domestic Partner if they meet Ardent Health Services' definition of an eligible dependent. Eligible dependents include your natural, adopted, and step children and the children of your Domestic Partner as long as they are under the age of 26.

DOMESTIC PARTNER BENEFITS

Legal Tax Dependents
Your Domestic Partner and/or his or her children may qualify as our dependents for federal income tax purposes for any year in which that individual meets all of the following criteria for the entire calendar year (as specified in Section 152 of the Internal Revenue Code):

- Citizen or resident of the U.S.,
- Lives with you as a member of your household.
- In a relationship with you that does not violate local laws, and
- Receives over half of his or her support from you.

You must maintain, and you and your dependent must occupy, the household in which the dependent resides for the year. A person lives with you as a member of your household even if either (or both) of you are temporarily absent due to special circumstance, including absences of illness, education, business, vacation and military service.

To determine whether you have met the support test (you contribute more than 50% of the money going to support the Domestic Partner or Domestic Partner's dependents), compare the amount you contributed to the person's support with the entire amount of the support the person received from all sources, including support the person provided from his or her own funds. Support includes amounts spent to provide food, lodging, clothing, education, medical and dental care and similar items. If an item of support is in the form of property or lodging, it must be measured in terms of its fair market value. Expenses that aren't directly related to one member of a household must be divided among the members of the household.

For more information about the criteria for tax dependence, see IRS Publication 152, *"Exemptions, Standard Deduction and Filing Information*."

DOMESTIC PARTNER BENEFITS (Cont'd)

Affidavit

An affidavit is a sworn statement in writing, signed in the presence of a notary public.

Imputed Income
Under current law, Ardent Health Services' subsidy for providing medical and dental coverage to a Domestic Partner and that person's children is considered taxable income unless the person is your legal tax Dependent. This means you'll pay federal, FICA, state, local and other applicable payroll taxes on that amount (which will be shown on your paychecks) throughout the year and it will be included on your W-2 Form at the end of each year. The calculation of this additional taxable income is described in the Effect on Your Pay later in this guide. However, this additional taxable income is not included when calculating benefits or contributions under any plan based on compensation (e.g. life insurance).

DURABLE MEDICAL EQUIPMENT - The term "Durable Medical Equipment" means equipment that is:

1. Able to withstand repeated use;

2. Primarily and customarily used to serve a medical purpose;

3. Not generally useful to a person in the absence of Illness or Injury;

4. Appropriate for use in the home.

EFFECTIVE TREATMENT - The term "Effective Treatment" means a program of Alcoholism or Drug Abuse therapy that is prescribed and supervised by a Physician and meets either of the following:

1. The Physician certifies that a follow-up program has been established which includes therapy by a Physician, or a group therapy under a Physician's direction, at least once per month.

2. It includes attendance at least twice a month at meetings of organizations devoted to the therapeutic treatment of Alcoholism or Drug Abuse, whichever condition is being treated.

Treatment solely for detoxification or primarily for maintenance care is not considered Effective Treatment. Detoxification is care aimed primarily at overcoming the aftereffects of a specific episode of drinking or Drug Abuse. Maintenance care consists of the providing of an environment without access to alcohol or drugs.

ELIGIBLE MEDICAL EXPENSES - See Covered Expenses.

EMERGENCY - The term "Emergency" means an Illness or Injury, which if not immediately treated, would jeopardize the person's life or cause serious health impairment.

EMERGENCY ADMISSION – The term "Emergency Admission" means admission to a Hospital for an Illness or Injury, which, unless immediately treated on an Inpatient basis, would jeopardize the person's life or cause serious health impairment.

EMPLOYEE - The term "Employee" means an individual that the Employer classifies as a common-law employee and who is on the Employer's W-2 payroll, but does not include the following: (a) any leased employee (including but not limited to those individuals defined as leased employees in Code § 414(n)) or an individual classified by the Employer as a contract worker, independent contractor, temporary employee, relief employee, PRN, or casual employee for the period during which such individual is so classified, whether or not any such individual is on the Employer's W-2 payroll or is determined by the IRS or others to be a common-law employee of the Employer; (b) any individual who performs services for the Employer but who is paid by a temporary or other employment or staffing agency for the period during which such individual is paid

EMPLOYEE (Cont'd)
by such agency, whether or not such individual is determined by the IRS or others to be a common-law employee of the Employer; (c) any employee covered under a collective bargaining agreement; (d) any self-employed individual; (e) any partner in a partnership; and (f) any more-than-2% shareholder in a Subchapter S corporation. The term "Employee" does include "former Employees" for the limited purpose of allowing continued eligibility for benefits under the Plan for the remainder of the Plan Year in which an Employee ceases to be employed by the Employer, but only to the extent specifically provided elsewhere under this Plan.

ENROLLMENT DATE -The "Enrollment Date" means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

ERISA - The term "ERISA" refers to the Employee Retirement Income Security Act of 1974 as amended, 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.

ERROR - The term "Error" means procedures required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Participant was under, and due to, the care of a provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the sole discretion of the Plan Administrator, unreasonably gave rise to the expense.

EXPERIMENTAL AND/OR INVESTIGATIONAL - The term "Experimental" and/or "Investigational" shall mean 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 treatment, 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/or Drug Administration and the AMA's Council on Medical Specialty Societies.

3. A drug, device, or medical treatment or procedure is Experimental 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.

4. The Plan Administrator retains maximum legal authority and discretion to determine what is Experimental.

5. The service, procedure, treatment, drug or supply is under study or in a "clinical trial" to evaluate its toxicity, safety or efficacy for a particular diagnosis or set of indications. "Clinical trials" includes but is not limited to Phase I, II, III and IV clinical trials.

6. A recognized national medical or dental society or regulatory agency has determined, in writing, that it is Experimental, Investigational or for research purpose; or

7. The written protocol used by the treating facility or the protocol or protocols of any other facility studying substantially the same drug, device, procedure or treatment or the written informed consent used by the treating facility or by another facility studying the same drug, device, procedure or treatment states that it is Experimental, Investigational or for research purposes.

For purposes of this definition, a drug or device being used for an indication or dosage that reliable evidence shows is an accepted off label use, will not be considered Experimental or Investigational

FAMILY - The term "Family" means a Covered Person and his eligible dependents.

FMLA – The term "FMLA" refers to the Family Medical and Leave Act of 1993, 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.

FULL-TIME EMPLOYEE - The term "Full-Time Employee" means a basis whereby a Participant is employed, and is compensated for services, by the Company for at least the number of hours per week stated in the eligibility requirements. The work may occur either at the usual place of business of the Company or at a location to which the business of the Company requires the Participant to travel.

GENETIC INFORMATION - The term "Genetic Information" means information about genes, gene products, and inherited characteristics that may be derived from an individual or a Family member. This includes information regarding carrier status, information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, Family histories, and direct analysis of genes or chromosomes.

HIPAA - The term "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996, as amended, or any provision or section thereof or regulation hereunder, which is herein specifically referred to, as such act, provision or section may be amended from time to time.

HOME HEALTH CARE AGENCY - The term "Home Health Care Agency" means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions:

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

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

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

4. It has a full-time administrator.

HOME HEALTH CARE PLAN - The term "Home Health Care Plan" means a program for continued care and treatment of the Covered Person established and approved in writing by the Covered Person's attending Physician.

HOSPICE - The term "Hospice" means 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 prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and one 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.

HOSPICE BENEFIT PERIOD - The term "Hospice Benefit Period" means a specified amount of time during which the Covered Person undergoes treatment by a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminally ill, and the Covered Person is accepted into a Hospice program. The period shall end the earliest of six (6) months from this date or at the death of the Covered Person. A new Benefit Period may begin if the attending Physician certifies that the patient is still terminally ill; however, additional proof may be required by the Plan Administrator before such a new Benefit Period can begin.

HOSPITAL - The term "Hospital" means an institution which: is licensed and operated in accordance with the laws which pertain to Hospitals where it is located; is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense; maintains on its premises all the facilities necessary to provide for diagnosis and medical and surgical treatment of an Illness or an Injury; such treatment is provided by or under the supervision of Physicians with continuous twenty-four (24) hour nursing services by Registered Nurses; and is a provider of services under Medicare.

Under no circumstances will a Hospital be other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for Alcoholics, or a nursing home.

HOSPITAL MISCELLANEOUS EXPENSES - The term "Hospital Miscellaneous Expenses" means the actual charges made by a Hospital in its own behalf for services and supplies rendered to the Covered Person that 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 - The term "Illness" means a bodily disorder, disease, physical sickness, mental infirmity, Functional Nervous Disorder, (refer to definition of Mental Illness or Disorder and Functional Nervous Disorder) or Pregnancy of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders that exist simultaneously which are due to the same or related causes shall be considered one Illness.

INCURRED EXPENSES - The term "Incurred Expenses" means that a Covered Expense is incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, Covered Expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not incurred upon commencement of the first stage of the procedure or course of treatment.

INJURY - The term "Injury" means a condition caused by accidental means that result in damage to the Covered Person's body from an external force. Any loss that is caused by or contributed to by a hernia of any kind will be considered a loss under the definition of Illness, and not as a loss resulting from accidental Injury.

INPATIENT - The term "Inpatient" refers to the classification of a Covered Person when that person is admitted to a Hospital, Hospice, or Skilled Nursing Facility for treatment, and charges are made for Room and Board to the Covered Person as a result of such treatment.

INTENSIVE CARE UNIT - The term "Intensive Care Unit" means a section, ward, or wing within the Hospital which is separated from other facilities and:

1. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use;

3. Provides constant observation and treatment by Registered Nurses (R.N.'s) or other highly trained Hospital personnel.

LATE ENROLLEE - The term "Late Enrollee" means a Participant or eligible Dependent who enrolls under the Plan other than during:

1. On the earliest date on which coverage can become effective for the individual under the terms of the Plan; or

2. A special enrollment period.

LEASED EMPLOYEE - The term "Leased Employee" means an individual who is not paid through an Employer's payroll and who is typically compensated by a company (e.g., an employee leasing company or temporary agency) other than an Employer.

LICENSED PRACTICAL NURSE - The term "Licensed Practical Nurse" means 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.

MEDICAL CHILD SUPPORT ORDER - The term "Medical Child Support Order" shall mean 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.

MEDICALLY NECESSARY - The term "Medically Necessary" means health care services, supplies or treatment which is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

To be appropriate, the service or supply must:

1. Be care or treatment, as likely to produce a significant positive outcome as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or Injury involved and the person's overall health condition;

2. Be a diagnostic procedure, indicated by the health status of the person and be as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both as to the disease or Injury involved and the person's overall health condition; and

3. As to diagnosis, care and treatment be no more costly (taking into account all health expenses incurred in connection with the service or supply) than any alternative service or supply to meet the above tests.

In determining if a service or supply is appropriate under the circumstances, the Plan Administrator will take into consideration:

1. Information provided on the affected person's health status;

2. Reports in peer reviewed medical literature;

3. Reports and guidelines published by nationally recognized health care organizations that include supporting scientific data;

4. Generally recognized professional standards of safety and effectiveness in the United States for diagnosis, care or treatment;

5. The opinion of health professionals in the generally recognized health specialty involved; and

6. Any other relevant information brought to the Plan Administrator's attention.

MEDICALLY NECESSARY (Cont'd)
In no event will the following services or supplies be considered to be Medically Necessary:

1. Experimental or Investigational services or supplies;

2. Those that do not require the technical skills of a medical, a mental health or dental professional; or

3. Those furnished mainly for the personal comfort or convenience of the person, any person who cares for him or her, any person who is part of his or her Family, any healthcare provider or healthcare facility; or

4. Those furnished solely because the person is an Inpatient on any day on which the person's disease or Injury could safely and adequately be diagnosed or treated while not confined; or

5. Those furnished solely because of the setting if the service or supply could safely and adequately be furnished in a Physician's or a dentist's office or other less costly setting.

MEDICAL RECORD REVIEW - The term "Medical Record Review" is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a drug or supply was provided that is not supported in the billing. The Plan Administrator may determine the Covered Expense according to the Medical Record Review and audit results.

MEDICARE - The term "Medicare" means the programs established by Title I of Public Law 88-98 (79 Statutes 291) as amended entitled "Health Insurance for the Aged Act", and which includes Parts A & B and Title XVIII of the Social Security Act (as amended by Public Law 89-97, 79) as amended from time to time.

MENTAL OR NERVOUS DISORDER – The term "Mental or Nervous Disorder" shall mean any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

MHPAEA – The term "MHPAEA" refers to the Mental Health Parity and Addiction Equity Act of 2008, that requires a group health plan of 51 or more employees that provides both medical and surgical benefits and mental health or substance use benefits, ensure that financial requirements and treatment limitations applicable to mental health/substance use disorder benefits are no more restrictive than the predominant requirements and limitations placed on substantially all medical/surgical benefits.

MICHELLE'S LAW – The term "Michelle's Law" shall mean H.R. 2851. Dependent students under the terms of the plan who take a Physician certified Medically Necessary leave of absence from a postsecondary educational institution (college, university, or vocational school) due to a serious illness or injury will have coverage the earlier of one year from the first day of the medical leave of absence or the date on which the coverage otherwise would terminate.

MINOR EMERGENCY MEDICAL CLINIC - The term "Minor Emergency Medical Clinic" means a freestanding facility that is engaged primarily in providing minor Emergency and episodic medical care to a Covered Person. A board-certified Physician, a Registered Nurse, and a Registered X-Ray Technician must be in attendance at all times that the clinic is open. The clinic's facilities must include x-ray and laboratory equipment and a life support system. For the purposes of this Plan, a clinic meeting these requirements will be considered to be a Minor Emergency Medical Clinic, by whatever actual name it may be called; however, a clinic located on or in conjunction with or in any way made a part of a regular Hospital shall be excluded from the terms of this definition.

MORBID OBESITY - The term "Morbid Obesity" means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person.

NAMED FIDUCIARY - The term "Named Fiduciary" means Baptist St. Anthony's Health System, which has the authority to control and manage the operation and administration of the Plan.

NATIONAL MEDICAL SUPPORT NOTICE- The term "National Medical Support Notice" or "NMSN" shall mean 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 a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients); and

4. Identity of an underlying child support order.

NATURAL CHILD – The term "Natural Child " means a child that is related by birth and is not an adopted child, a stepchild, a foster child, niece, nephew, or grandchild.

NEWBORN - The term "Newborn" refers to an infant from the date of his birth until the initial Hospital discharge or until the infant is seven (7) days old, whichever occurs first.

NMHPA - The term "NMHPA" refers to the Newborns' and Mothers' Health Protection Act of 1996 and all Amendments and revisions. This includes a provision for Pregnancy-related care whereby group health plans and health insurance issuers generally may not under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother or newborn Attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NURSE PRACTITIONER - The term "Nurse Practitioner" means a Registered Nurse with at least a master's degree in nursing and advanced education in the primary care of particular groups of clients. Capable of independent practice in a variety of settings, and is licensed and registered in the state where he/she practices.

OPEN ENROLLMENT PERIOD - The term "Open Enrollment Period" means the period of time established by the Plan Administrator during which Participants will be allowed to make plan changes and eligible Late Enrollees who have not previously enrolled in the Health Plan may do so. The Open Enrollment Period will be determined by the Plan Administrator each year, with the requested changes being effective on January 1 of the following year.

ORTHOTIC APPLIANCE - The term "Orthotic Appliance" means a casted external device intended to correct any defect in form or function of the human body.

OTHER PLAN - The term "Other Plan" as used herein will mean any plan providing benefits or services for or by reason of medical or dental treatment, and such benefits or services are provided by:

Group insurance or any other arrangement for coverage for Covered Persons in a group whether on an insured or uninsured basis, including but not limited to:

1. Hospital indemnity benefits; and

2. Hospital reimbursement-type plans;

3. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;

OTHER PLAN (Cont'd)

4. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

5. A licensed Health Maintenance Organizations (HMO);

6. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;

7. Any coverage under a government program (other than Medicaid), and any coverage required or provided by any statute;

8. Group automobile insurance;

9. Individual automobile insurance coverage on an automobile leased or owned by the Company;

10. Any plans or polices funded in whole or in part by an employer or deductions made by an employer from a person's compensation or retirement benefits;

11. Labor/management trustee, union welfare, employer organization or employee benefit organization plans; or

OUT-OF-POCKET - The term "Out-of-Pocket" means all expenses paid by the Participant for Covered Expenses under the Plan, but not paid by the Plan, including any applicable Deductibles and Co-Payments.

OUTPATIENT - The term "Outpatient" refers to the classification of a Covered Person when that Covered Person received medical care, treatment, services or supplies at a clinic, a Physician's office, or at a Hospital if not a registered bed-patient at that Hospital, an Outpatient Psychiatric Facility or an Outpatient Alcoholism Treatment Facility.

OUTPATIENT ALCOHOLISM TREATMENT FACILITY - The term "Outpatient Alcoholism Treatment Facility" means an institution which provides a program for diagnosis, evaluation, and Effective Treatment of Alcoholism; provides detoxification services needed with its Effective Treatment program; provides infirmary-level medical services or arranges with 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 licensing standards.

OUTPATIENT PSYCHIATRIC FACILITY - The term "Outpatient Psychiatric Facility" means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient Mental Health services and which 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.

PARTICIPANT - The term "Participant" means an Employee who meets the eligibility requirements and who is properly enrolled in the Plan.

PARTICIPANT COVERAGE - The term "Participant Coverage" means coverage hereunder providing benefits payable as a consequence of an Injury or Illness of a Participant.

PHYSICIAN - The term "Physician" means a legally licensed medical or dental doctor or surgeon, chiropractor, osteopath, chiropodist, podiatrist, optometrist, or certified consulting Psychologist, licensed social worker and licensed professional counselor to the extent that same, within the scope of their license, are permitted to perform services provided in this Plan. A Physician shall not include the Covered Person or any Close Relative of the Covered Person.

PHYSICIAN ASSISTANT – The term "Physician Assistant" means a specially trained and licensed individual who performs tasks usually done by physicians and works under the direction of a supervising physician.

PLACEMENT FOR ADOPTION – The term "Placement for Adoption" means that a child has been placed in the home and is living with the Participant after the formal legal adoption proceedings have been initiated.

PLAN - The term "Plan" means without qualification, this Plan Document.

PLAN ADMINISTRATOR - The term "Plan Administrator" means the Company, which is responsible for the day-to-day functions and management of the Plan. The Plan Administrator, in its sole discretion, may employ persons or firms to process claims and perform other Plan connected services.

PLAN SPONSOR – The term "Plan Sponsor" means Baptist St. Anthony's Health System.

PLAN SUPERVISOR - The term "Plan Supervisor" means a person or firm hired by the Plan Administrator to perform claims processing and other specified administrative services in relation to the Plan. The Plan Supervisor is not an insurer of health benefits under this Plan or a fiduciary of the Plan and does not exercise any of the discretionary authority and responsibility granted to the Plan Administrator. The Plan Supervisor is not responsible for the Plan financing and does not guarantee the availability of benefits under the Plan.

PLAN YEAR – The term "Plan Year" means a period of time commencing on January 1 and ending on December 31 of the next year.

POST-SERVICE CLAIM – The term "Post-Service Claim" is any claim for a benefit under a group health plan that is not a Pre-Service Non-Urgent Claim. It is further defined as any claim with respect to which plan approval is not a prerequisite to obtaining medical services and payment is being requested for medical care already rendered to the Claimant.

PRE-ADMISSION CERTIFICATION – The term "Pre-Admission Certification" means a determination of the number of days of Hospital Confinement that are Medically Necessary for the care or treatment of a person's Illness or Injury.

PRE-ADMISSION CERTIFICATION COMPANY – The term "Pre-Admission Certification Company" means IMS Managed Care, Inc., a company employed by the Plan Administrator to review all hospitalizations, and establish Medical Necessity and length of stay of Hospital Confinements.

PRE-EXISTING CONDITION - The term "Pre-existing Condition" means any Sickness, Illness, Disease or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the six (6) months immediately prior to the Enrollment Date.

Effective January 1, 2014, this Plan will not refuse to cover the treatment of a Pre-existing Condition that you had before you enrolled in this Plan solely because you had the condition prior to enrolling in this Plan.

PRE-SERVICE NON-URGENT CLAIM – The term "Pre-Service Non-Urgent Claim" means a request for review or approval that a Plan requires as part of the process of receiving a benefit in advance of obtaining medical care, even if such review or approval does not guarantee that the Plan will ultimately grant the benefit (i.e. pre-certification or prior authorization).

PREFERRED PROVIDER ORGANIZATION (PPO) - The term "Preferred provider Organization (PPO)" is a network of medical providers that the Plan uses to obtain discounts for the Plan and Plan Participant. A current list of PPO providers may be obtained from the Plan Administrator or the Plan Supervisor.

PREGNANCY - The term "Pregnancy" means that physical state which results in childbirth, abortion, or miscarriage, and medical complications arising out of or resulting from such state.

PSYCHIATRIC CARE - The term "Psychiatric Care", also known as psychoanalytic care, means treatment for a Mental Illness or Disorder, a Functional Nervous Disorder, Alcoholism or Drug Addiction.

PSYCHOLOGIST - The term "Psychologist" means an individual holding the degree of Ph. D. and acting within the scope of his license.

QUALIFIED MEDICAL CHILD SUPPORT ORDER- The term "Qualified Medical Child Support Order" or "QMCSO" is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth in the definition of "National Medical Support Notice";

2. Identifies either the specific type of coverage or all available group health coverage. If the Company receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Company and the Plan Administrator will assume that all are designated; or

3. Informs the Plan Administrator that, if a group health plan has multiple options and the Participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

4. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated Dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participant and Eligible Beneficiaries without regard to this provision, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

REASONABLE - The term "Reasonable" and/or "Reasonableness" means in the Plan Administrator's discretion, services or supplies, or fees for services or supplies that 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. Services, supplies, care and/or treatment that results from Errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients, are not Reasonable. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator. A finding of provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

REASONABLE (Cont'd)
Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment 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 - The term "Registered Nurse" means 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.

REGISTERED NURSE FIRST ASSISTANT – The term "Registered Nurse First Assistant" (RNFA) means an advanced practice nurse who is a perioperative nurse and is a specialist in the operating room environment. The RNFA is a nurse who meets certain criteria and who through training, classroom study and internship achieves a certification as a Registered Nurse First Assistant 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.

RELEVANT INFORMATION – The term "Relevant Information" includes documents, records and information if:

1. It was relied upon in making the benefit determination;

2. It was submitted, considered or generated in the course of the benefit determination, whether or not it was relied upon;

3. It demonstrates compliance with the requirements of the new regulations that claim determinations are made in accordance with plan documents and that, where appropriate, the plan provisions have been applied consistently with similarly situated Claimants; or

4. It constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit for the Claimant's diagnosis, whether or not it was relied upon.

RELIABLE EVIDENCE – The term "Reliable Evidence" means only published reports and articles in the authoritative medical and scientific literature.

RESIDENTIAL TREATMENT - The term "Residential Treatment" means a program which is organized and staffed to provide both general and specialized non-hospital based interdisplinary services twenty-four (24) hours a day, seven (7) days a week for persons with behavioral health disabilities or disorders; victims or perpetrators of domestic violence or other abuse; or persons needing treatment because of eating or sexual disorders; gambling or Internet addictions. Residential treatment services are organized to provide environments in which the person resides and receives services from personnel who are trained in the delivery of services for persons with behavioral health disorders or related problems.

ROOM AND BOARD - The term "Room and Board" refers to all charges by whatever name called which are made by a Hospital, Hospice or Skilled Nursing Facility as a condition or occupancy. Such charges do not include the professional services of Physicians nor intensive nursing care by whatever name called.

SCHOOL - See definition of University.

SEMI-PRIVATE - The term "Semi-Private" refers to a class accommodation in a Hospital, or Skilled Nursing Facility in which at least two (2) patients' beds are available per room.

SIGNIFICANT BREAK IN COVERAGE - The term "Significant Break in Coverage" means a period of sixty-three (63) consecutive days or longer during each of which the Covered Person did not have Creditable Coverage. Periods of no coverage during an HMO affiliation period or Waiting Period shall not be taken into account for purposes of determining whether Significant Break in Coverage has occurred. For this purpose, an HMO affiliation period or Waiting Period means a period of time that must expire before health insurance coverage provided by an HMO or Waiting Period becomes effective.

SKILLED NURSING FACILITY - The term "Skilled Nursing Facility" means an institution, or distinct part thereof, operated pursuant to law and which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Injury or Illness, professional nursing services rendered by a Registered Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;

2. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse; and

3. It provides twenty-four (24) hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; and

4. It maintains a complete medical record on each patient; and

5. It has an effective utilization review plan; and

6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, custodial or educational care, or care of Mental Disorders; and

7. It is approved and licensed by Medicare.

This term shall also apply to expenses incurred in an institution referring to itself as a Sub-acute Nursing Facility, Extended Care Facility or any such other similar nomenclature.

SPECIAL ENROLLEE - The term "Special Enrollee" means an Employee or Dependent who is entitled to and who requests Special Enrollment:

1. Within thirty (30) days of losing other health coverage; or

2. For a newly acquired Dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption.

SPEECH-LANGUAGE PATHOLOGIST - The term "Speech-Language Pathologist" means a person who: (1) has a master's or doctorate degree in speech pathology or speech-language pathology from an accredited College or University; and (2) is certified by the American Speech-Language and Hearing Association.

SUBSTANCE USE DISORDER - The term "Substance Use Disorder" means the pathological use or abuse of alcohol or other drugs in a manner or to a degree that produces impairment in personal, social or occupational functions and which constitutes alcohol or drug dependency.

TOTAL DISABILITY (TOTALLY DISABLED) - The term "Total Disability" means a physical state of a Covered Person resulting from an Illness or Injury that wholly prevents:

1. In the case of a Participant, from engaging in any and every business or occupation and from performing any and all work for compensation or profit; and

2. In the case of a Dependent from performing the normal activities of a person of like age and sex in good health.

UNIVERSITY - The term "University" means an institution accredited as a College, School or University by the State in which the institution is located.

URGENT – See Emergency.

USERRA LEAVE – The term "USERRA Leave" refers to a leave of absence taken by an Employee Participant for a call to military duty that is protected by the Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time.

USUAL AND CUSTOMARY - The term "Usual and Customary" (U&C) shall mean 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 where the charge is 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 that is appropriate for the care or treatment of the same sex, comparable age and those receiving such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge, 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 what the Usual and Customary charge is for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and 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.

The Plan uses the Usual & Customary allowance for medical procedures performed by providers that do not participate in the PPO Network. Usual & Customary allowances may not apply to an Emergency in a Non-PPO facility or when a PPO facility is not available.

WAITING PERIOD - The term "Waiting Period" means the time that must pass before an Employee or Dependent is eligible to enroll in the Plan. Notwithstanding the foregoing, the time between the date a Late Enrollee or Special Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage shall not be treated as a Waiting Period.

WELL-BABY CARE - The term "Well-Baby Care" means medical treatment, services or supplies rendered to a child or Newborn solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

ELIGIBILITY FOR COVERAGE

Coverage provided under this Plan for Participant and their Dependents shall be in accordance with the Eligibility for Coverage, Effective Date of Coverage, Termination of Coverage and Continuation of Coverage under the COBRA provisions as stated in this Plan Document,

Any change in the amount of coverage available to a Covered Person occasioned by a change in the Participant's classification shall become effective automatically on the classification change date.

PARTICIPANT ELIGIBILITY - A Participant eligible for coverage under this Plan shall include employees who meet all of the following conditions:

1. Is employed as a Full-time Employee and works for at least twenty (20) hours per week; or

2. Is a regular part-time Employee and works for at least twenty (20) hours per week; and

3. Has been continuously employed for a period of 30 days, which is the Waiting Period.

An Employee's prior time worked will be counted towards the Waiting Period if a Full-time or regular part-time Employee transfers from one affiliated company of Ardent Health Services to another.

For purposes of the above requirements only, an Employee shall be deemed continuously employed if the Employee is absent from work due to a health factor. It is important to note that, as set forth in the section entitled "Participant Effective Date," the Employee must actually report for and begin work in order for his coverage to become effective.

Independent contractors, Leased Employees and temporary employees shall not be deemed to meet the definition of "Employee" or "Full-Time Employee."

A Participant eligible for Dependent Coverage shall be any Participant whose Dependents meet the definition of a Dependent as stated earlier in the Plan. Each Participant will become eligible for Dependent Coverage on the latest of the following:

1. The date he becomes eligible for Participant Coverage; or

2. The date on which he first acquires a Dependent; or

If both the husband and wife are employed by the Company, and both have Dependent children eligible for Dependent Coverage, either the husband or wife but not both, may elect Dependent Coverage for their eligible Dependent children.

DEPENDENT ELIGIBILITY - A Dependent will be considered eligible for coverage on the date the Participant becomes eligible for Dependent Coverage, subject to all limitations and requirements of this Plan, and in accordance with the following:

1. A spouse will be considered an eligible Dependent from the date of marriage, provided the spouse is properly enrolled as a Dependent of the Participant within thirty (30) days of the date of marriage. A Domestic Partner will be considered an eligible Dependent provided the Domestic Partner is properly enrolled as a Dependent of the Participant within thirty (30) days of satisfying the requirements of a recognized Domestic partner as set forth herein.

   Please Note: If a Domestic Partner is not recognized as a legal Spouse, the benefits received will be taxable.

2. A Newborn Natural Child will be eligible from the moment of birth for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or prematurity, provided the child is properly enrolled as a Dependent of the Participant within thirty (30) days of the child's date of birth. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.

3. If a Dependent is acquired, other than at the time of birth for a Natural Child, due to a court order, decree, marriage, adoption or Placement for Adoption or Domestic Partnership, that Dependent will be eligible from the date of such court order, decree, marriage, adoption or Placement for Adoption or proof of Domestic Partnership, for Injury or Illness, including the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or conditions related to prematurity, provided that this new Dependent is properly enrolled as a Dependent of the Participant within thirty (30) days of the court order, decree, marriage, adoption or Placement of Adoption.

4. A child may become eligible for Dependent Coverage as set forth in a qualified medical child support order (QMCSO). The Plan Administrator shall have sole discretion to determine whether a medical child support order is qualified and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency that issued the order.

A Dependent spouse of a Participant who is employed and eligible for group health coverage as an active employee through their employer must be enrolled on their employer's health plan to be eligible under this Plan.

No Dependent shall be denied enrollment in the Plan due to his confinement in a hospital or other health care institution or inability to engage in normal life activities.

EFFECTIVE DATE OF COVERAGE

PARTICIPANT EFFECTIVE DATE – Participant Coverage under the Plan shall become effective on the first of the month coinciding with or next following the date the Participant becomes eligible, provided written application for such coverage is made within thirty (30) days of eligibility. If application is made after the initial date of eligibility (other than during a special enrollment period available to Special Enrollees), the Participant shall be a Late Enrollee and, coverage for the eligible Employee shall become effective on January 1 following the Open Enrollment Period.

In order for an Employee's coverage to become effective, an Employee must actually report for and begin work. If the Employee is unable to report for and begin work as scheduled (even if such inability is due to a health factor), then his coverage will become effective on such later date when the Employee reports for and begins work.

DEPENDENT EFFECTIVE DATE - A Dependent of a Participant who makes written request for Dependent Coverage hereunder, on a form approved by the Plan Administrator, shall be subject to the provisions of this article, becomes covered as follows:

1. If the Participant makes such written request on or before the date he becomes eligible for Dependent Coverage he shall become covered, with respect to those persons who are then his Dependents, on the date he becomes eligible for Participant Coverage.

2. As provided under "Dependent Eligibility" (i.e., for Newborn, adopted, and newly acquired Dependents) or as provided under the "Special Enrollment Effective Date", "Dependent Special Enrollment Effective Date", or "Addition Of Pre-existing Dependents In Conjunction With Dependent Special Enrollment" below. If the Participant makes such written request after the date on which he is eligible for Dependent Coverage, those persons who are then his Dependents shall be Late Enrollees, and coverage for the eligible Dependent shall become effective on January 1 following the Open Enrollment Period.

3. Newborn children and newly adopted children of the Participant will be covered from the moment of birth or placement for adoption for the first 30 days. The child must be properly enrolled as a Dependent of the Participant within 30 days of the child's date of birth or placement of adoption to be covered after 30 days.

SPECIAL ENROLLMENT EFFECTIVE DATE - Eligible Employees and Dependents are permitted to enroll in this Plan upon loss of other group health coverage if enrollment is requested by the Employees within thirty (30) days of loss of coverage. The Special Enrollee must meet the following conditions:

1. The Employee or Dependent had other health coverage or was under a COBRA continuation provision at the time coverage was offered by this Plan and the Employee stated in writing that coverage under another plan was the reason for declining enrollment; and

2. The Employee or Dependent lost such coverage due to divorce, legal separation, death, termination of employment, reduction of hours, termination of employer contribution, or established COBRA coverage exhausted. Loss of coverage because of non-payment of premium is not a condition to qualify for Special Enrollment.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if a Dependent of that Employee has a special enrollment right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment in the new benefit option within 30 days of the date the other health coverage was lost.

The effective date for the above Special Enrollee shall be the day following the loss of other group health coverage provided proper enrollment is completed within thirty (30) days of loss of coverage.

CHIPRA SPECIAL ENROLLMENT EFFECTIVE DATE - This Plan will permit Employees and Dependents who are eligible, but not enrolled for coverage, to enroll in two additional circumstances:

1. The employee's or Dependent's Medicaid or CHIP coverage is terminated as a result of loss of eligibility and the employee requests coverage under the Plan within sixty (60) days after the termination or,

2. The employee or Dependent become eligible for a premium assistance subsidy under Medicaid or CHIP, and the employee requests coverage under the Plan within sixty (60) days after eligibility is determined.

The Employee must make written application for CHIPRA Special Enrollment within sixty (60) days of the date that Medicaid or CHIP coverage was lost, or within sixty (60) days of the determination that the employee or Dependent is eligible for a premium assistance subsidy. The effective date for the CHIPRA Special Enrollee shall be the first of the month following loss of coverage, or following determination of eligibility for premium assistance, provided proper enrollment is completed within sixty (60) days of loss of coverage.

DEPENDENT SPECIAL ENROLLMENT EFFECTIVE DATE - Newly acquired Dependents of eligible Participant shall be Special Enrollees and eligible to enroll without a Waiting Period if enrollment is requested within thirty (30) days of the following:

1. A Natural Child's date of birth; or

2. Date of final legal adoption; or

3. Date of Placement for Adoption; or

4. Date of marriage.

The effective date of coverage for the above Special Enrollee shall be the Natural Child's date of birth, date of final legal adoption, date of Placement for Adoption, or date of marriage provided proper enrollment is received within thirty (30) days.

The eligible Employee and/or Employee's Spouse of the newly acquired Dependent that are not covered by the Plan shall also be a Special Enrollee eligible to enroll with the newly acquired Dependent. The effective date of coverage will be same as that of one Dependent being added as explained above.

ADDITION OF PREEXISTING DEPENDENTS IN CONJUNCTION WITH DEPENDENT SPECIAL ENROLLMENT – An Eligible Dependent not previously enrolled in this Plan may enroll in the Plan in conjunction with a Dependent Special Enrollment. An Eligible Dependent enrolling under this paragraph will be eligible to enroll without a Waiting Period if enrollment is requested within the time period allowed under the Dependent Special Enrollment Effective Date.

TERMINATION OF COVERAGE

PARTICIPANT TERMINATION - Participant Coverage shall automatically terminate immediately upon the earliest of the following dates:

1. At the end of the month in which Participant's employment terminates; or
2. Date the Participant ceases to be in a class of Participant eligible for coverage; or
3. Date the Participant fails to make any required contribution for coverage; or
4. Date the Plan is terminated; or with respect to any Participant benefits of the Plan, the date of termination of such benefit; or
5. Date the Participant dies.

PARTICIPANT REINSTATEMENT - A Participant whose coverage terminates by reason of termination of employment and who resumes employment with the Company within a thirty (30) day period immediately following the date of such termination shall become eligible for reinstatement of coverage on the date he resumes employment.

DEPENDENT TERMINATION - The Dependent Coverage of a Participant shall automatically terminate immediately upon the earliest of the following dates:

1. Date the Dependent ceases to be an eligible Dependent as defined in Plan; or
2. Date of termination of the Participant's coverage under the Plan; or
3. Date the Participant ceases to be in a class of Participant eligible for Dependent Coverage; or
4. Date the Participant fails to make any required contribution for Dependent Coverage; or
5. Date the Plan terminated; or with respect to any Dependent's benefit of the Plan, the date of termination of such benefit; or
6. Date the Participant dies.

The Dependent Termination subsection of the Plan applies to Domestic Partner coverage and coverage shall automatically terminate immediately upon the earliest dates as defined by this Dependent Termination subsection.

In addition, the Participant will be responsible to complete and to file a Declaration of Termination of Domestic Partnership within thirty-one (31) days of termination of the Domestic Partnership.

FAMILY AND MEDICAL LEAVE ACT OF 1993 - All previous provisions including Eligibility For Coverage, Effective Date of Coverage, and Termination of Coverage are intended to be in compliance with the Family and Medical Leave Act of 1993 (FMLA). To the extent the FMLA applies to the Company, group health benefits may be maintained during certain leaves of absence at the level and under the conditions that would have been present as if employment had not been interrupted. Employee eligibility requirements, the obligations of the employer and Employee concerning conditions of leave, and notification and reporting requirements are specified by the FMLA. Any Plan provision which conflicts with the FMLA are superseded by the FMLA to the extent such provisions conflict with the FMLA. A Participant with questions concerning any rights and/or obligations should contact the Plan Administrator or his employer.

MEDICAL LEAVE OF ABSENCE - A Participant whose active work ceases because of Illness or Injury and whose employment has not terminated shall be considered employed by the Company for the purposes of his coverage under the Plan, and such coverage may continue until the Company, acting in accordance with a policy which precludes individual selection, terminates such coverage, but not beyond the period ending twelve (12) months after the date that active work ceases because of Illness or Injury. This continuation provision neither expands nor limits the requirement of the FMLA.

LEAVE OF ABSENCE - Coverage on a Participant whose active work ceases due to an approved leave of absence granted for reasons other than Injury or Illness and whose employment has not terminated may be continued until the Company, acting in accordance with a policy which precludes individual selection, terminates such coverage, but not beyond the period ending twelve (12) months after such leave of absence began. This continuation during a leave of absence neither expands nor limits the requirement of the FMLA.

TEMPORARY LAYOFF - A Participant whose active work ceases due to a temporary layoff shall be considered employed by the Company for the purpose of his coverage under the Plan, and such coverage may continue until the end of the month in which the layoff began.

MILITARY LEAVE ACT - Notwithstanding anything in this Plan to the contrary, with respect to any Employee Participant or Dependent who loses coverage under this Plan during the Employee's Participant's absence from employment by reason due to a USERRA Leave, no Waiting Period may be imposed upon the reinstatement of such Employee's Participant's or Dependent's coverage upon re-employment of the Employee unless the Waiting Period would have otherwise applied to such Employee Participant or Dependent had the Employee Participant not been on a USERRA Leave.

PRE-EXISTING CONDITIONS LIMITATIONS

Effective January 1, 2014, this Plan will not refuse to cover the treatment of a Pre-Existing Condition you had before you enrolled in this Plan solely because you had the condition prior to enrolling in this Plan. If you incur claims prior to the effective date set forth above, the following shall apply to you and your claims.

A Pre-existing Condition limitation will apply for all Employees and Dependents entering or reentering the Plan after the Effective Date, except as set forth in the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Coverage will be available for such condition on the day immediately following the expiration of twelve (12) months or, in the case of a Late Enrollee, eighteen (18) months after the Enrollment Date. A Participant has the right to demonstrate any Creditable Coverage, and the applicable period shall be reduced by any Creditable Coverage unless that Creditable Coverage occurred before a Significant Break in Coverage.

WAIVERS OF THE PRE-EXISTING CONDITION LIMITATION - Pregnancy is not considered a Pre-Existing Condition. The Pre-Existing Condition does not apply to your Child or to any Covered Person that has not yet reached age nineteen (19). Genetic Information shall not be treated as a Pre-Existing Condition in the absence of a diagnosis of the condition related to the Genetic Information.

PROOF OF CREDITABLE COVERAGE - A Participant may prove Creditable Coverage by either of two methods:

1. For prior coverage effective on or after July 1, 1996, the Participant may present a written Certificate of Coverage from the source or entity that provided the coverage showing:

a) The date the Certificate was issued;

b) The name of the group health plan that provided the coverage;

c) The name of the Participant or Dependent to whom the Certificate applies, and any other information necessary for the Plan providing the coverage specified in the certificate to identify the individual, such as the individual's identification number under the plan and the name of the Participant if the certificate is for (or includes) a Dependent;

d) The name, address, and telephone number of the plan administrator or issuer providing the Certificate;

e) A telephone number for further information (if different);

f) Either:

i. A statement that the Participant or Dependent has at least twelve (12) months (365 days) of Creditable Coverage or at least eighteen (18) months (546 days) if a Late Enrollee, not counting days of coverage before a Significant Break in Coverage; or

ii. The date any waiting period (and affiliation period, if applicable) began and the date Creditable Coverage began; and

g) The date Creditable Coverage ended, unless the Certificate indicates that coverage is continuing as of the date of the Certificate; or

2. If the Participant for any reason is unable to obtain a Certificate from another plan (including because the prior coverage was effective prior to July 1, 1996), he may demonstrate Creditable Coverage by other evidence, including but not limited to documents, records, third party statements, or telephone calls by this Plan to a third party provider of medical services. This Plan will treat a Participant as having provided a Certificate if that individual:

a) Attests to the period of Creditable Coverage;

b) Presents relevant corroborating evidence of some Creditable Coverage during the period; and

c) Cooperates with the Plan Administrator's efforts to verify his status.

A Participant has the right to request a Certificate from his prior health plan, and the Plan Administrator will help the Participant in obtaining the Certificate.

NOTICE OF THE PRE-EXISTING CONDITION LIMITATION EXCLUSION

If, within a reasonable time after receiving the information about Creditable Coverage described above, the Plan Administrator determines that exclusion for Pre-existing Conditions applies, it will notify the Participant of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification will also explain the Plan's appeals procedures and give the Participant a reasonable opportunity to present additional evidence.

If the Plan Administrator later determines that an individual did not have the claimed Creditable Coverage, the Plan Administrator may modify its initial determination to the contrary. In that case, the individual will be notified of the reconsideration; however, until a final determination is reached, the Plan Administrator will act in accordance with its initial determination in favor of the Participant for the purpose of approving medical services.

PRE-ADMISSION CERTIFICATION

PRE-ADMISSION CERTIFICATION PROCEDURES - When a Physician says that a Covered Person must go into the Hospital, the Covered Person or his Physician must call the Pre-Admission Certification Company at the toll free number assigned to the Plan. It is the Covered Person's responsibility to advise his doctor of the Pre-Admission Certification requirement and to provide him with a copy of the signed Physician Information/Consent Form. For pre-scheduled admissions, the Covered Person or Physician should secure certification from the Pre-Admission Certification Company prior to the Covered Person or his Dependent actually entering the Hospital. It is the Covered Person's responsibility to see that the Pre-Admission Certification Company is notified.

For Emergency Admissions, the Hospital, a Physician or a Family member must telephone the Pre-Admission Certification Company within 48 hours or on the first business day following weekend/holiday admissions. For detailed information regarding admissions for childbirth, see the section entitled "Hospital Admissions for Childbirth" below.

To contact IMS Managed Care, Inc., call or write to the following address:

IMS Managed Care, Inc.
P.O. Box 15688
Amarillo, Texas 79105

(800) 687-3020 or (806) 373-6666

EFFECT OF PRE-ADMISSION CERTIFICATION PROCEDURES - Covered charges shall not include any charges that are Incurred on any day of Confinement that is in excess of the number of days deemed by the Preadmission Certification Company to be Medically Necessary; and no benefits will be paid for such charges.

Failure to notify the Pre-Admission Certification Company of a pre-scheduled admission or an Emergency Admission will result in a reduction of benefits, if any, as stated in the Schedule of Benefits, on charges related to that admission, except as required by applicable law with respect to childbirth.

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

WHEN HEALTH CLAIMS MUST BE FILED - A Pre-Service Non-Urgent Claim (including a Concurrent Claim that also is a Pre-Service Non-Urgent Claim) is considered filed when the request for approval of treatment or services is made and received by the Pre-Admission Certification Company in accordance with the Plan's procedures.

Upon receipt of this information, the claim will be deemed filed with the Plan. The Pre-Admission Certification Company will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Pre-Admission Certification Company within 45 days from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

TIMING OF CLAIM DECISIONS - The Pre-Admission Certification Company shall notify the Claimant, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-Service Non-Urgent Claims and Concurrent Claims, of decisions of claims) within the following timeframes:

PRE-SERVICE NON-URGENT CLAIMS - If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Pre-Admission Certification Company and the Claimant (if additional information was requested during the extension period).

CONCURRENT CLAIMS -

1. **Plan Notice of Reduction or Termination** - If the Pre-Admission Certification Company is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan Amendment or termination), before the end of such period of time or number of treatments, the Claimant will be notified sufficiently in advance of the reduction or termination. This will allow the Claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. **Request by Claimant Involving Non-Urgent Care** - If the Pre-Admission Certification Company receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-Service Non-Urgent Claim or a Post-Service Claim).

3. **Calculating Time Periods** - The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION - The Pre-Admission Certification Company shall provide a Claimant with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;

2. Specific reason(s) for a denial;

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

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

5. 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 for benefits;

6. 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);

7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request);

8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided to the Claimant, free of charge, upon request.

GENETIC INFORMATION NONDISCRIMINATION ACT OF 2008

The Genetic Information Nondiscrimination Act of 2008 (GINA) amends ERISA to prevent discrimination based on Genetic Information for a group health plan or a health insurance issuer offering group health insurance coverage in connection with a group health plan.

A group health plan and a health insurance issuer offering health insurance coverage in connection with a group health plan shall not request or require an individual or a Family Member of such individual to undergo a Genetic Test.

DEFINITIONS

FAMILY MEMBER – The term" Family Member" means, with respect to any individual:

1. A Dependent of such individual; and

2. Any other individual who is a first-degree, second-degree, third-degree or fourth-degree relative of such individual or of an individual who is a pregnant woman, including her fetus; and

3. Any embryo legally held by a Family Member or individual.

GENETIC INFORMATION - The term "Genetic Information" means, with respect to any individual:

1. Such individual's Genetic Tests;

2. The Genetic Tests of Family Members of such individual; and,

3. The manifestation of a disease or disorder in Family Members of such individual.

Genetic Information includes, with respect to any individual, any request for, or receipt of, Genetic Services or participation in clinical research that includes Genetic Services, by such individual or any Family Member of such individual.

Genetic Information shall not include information about the sex or age of any individual.

GENETIC TEST – The term "Genetic Test" means an analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes.

Genetic Test does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations or chromosomal changes, or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

GENETIC SERVICES – The term "Genetic Services" means a Genetic Test, genetic counseling or genetic education.

WELLNESS PROGRAM RIDER TO GROUP HEALTH PLAN

The Plan includes a wellness incentive program (the "Wellness Program"). The Wellness Program includes incentives that potentially reduce Plan premium contributions if Participants qualify for certain pre-determined healthy lifestyle rewards. The Wellness Program is separately administered by Bravo Wellness, LLC ("Bravo"), which acts as the claims administrator for the Wellness Program. The contact information for Bravo is as follows: Bravo Wellness, LLC, One International Place, 20445 Emerald Parkway Dr. SW, Suite 400, Cleveland, OH 44135, 877-662-7286.

By qualifying for healthy lifestyle rewards under the Wellness Program, Participants are eligible to pay reduced premiums. The Wellness Program generally provides for on-site exams at no cost to Participants. Generally, the value of the rewards under the Wellness Program is determined by the results of a health screening exam. However, Participants may be eligible to qualify for the full reward upon completion of an alternative program (sometimes referred to as a "reasonable alternative standard"). Information on the alternative program may be obtained from Bravo and recommendations of a Participant's personal physician will be accommodated.

Participants will be provided with the opportunity to qualify for the reward at least once each year. Additionally, an annual calculation is performed in order to determine the maximum amount of results-based reward available to Participants by law. If the amount available under the Wellness Program exceeds the annual maximum permitted, Participants can earn an alternative minimum reward based on participation in the Wellness Program.

The tests, goals, and points are as follows:

Wellness Screening Tests	Goals	Alternative Goal^	Employee Points Earned if Goal Met	Spouse Points Earned if Goal Met
Body Mass Index (BMI)*	≤ 27.5	If you are unable to meet a goal, you may qualify for an alternative goal. Contact Bravo Wellness	4	4
Tobacco / Nicotine	Negative		1	1
Participants must complete a full screening to receive points.				

*If you fail the BMI goal, you may still earn points based on secondary measures of body fat percentage or waist measurement.

^If you have results from a prior Bravo screening, your improvement will be automatically considered. If Bravo does not have prior results, you will be provided the information you need to request an alternative goal in your results letter.

WELLNESS PROGRAM RIDER TO GROUP HEALTH PLAN (Cont'd)

The monthly or bi-weekly premium discounts are as follows:

Monthly or Bi-Weekly Participation Discounts on Premiums				
	Employee Points		Spouse Points	
Participation	Monthly	Per Pay Period	Monthly	Per Pay Period
	$120	$55.38	$120	$55.38
Additional Monthly or Bi-Weekly Discounts for Points Earned:				
0 points	$0	$0	$0	$0
1 point	$10	$4.62	$10	$4.62
4 points	$40	$18.46	$40	$18.46
5 points	$50	$23.08	$50	$23.08

Participants can dispute the screening results and provide information from their physician certifying corrected results (must include lab report, if applicable). Claims and appeals will be determined in accordance with required reasonable claims and appeal procedures. A determination on an appeal shall in any case be made within 30 days after receipt of the request for review by Bravo. Approved appeals will result in the full point(s) being issued.

The results of a health assessment do not necessarily preclude a Participant from obtaining points under this Wellness Program. If results are correct but the Participant can demonstrate that achieving the stated goal is unreasonably difficult to achieve due to a medical condition or inadvisable to attempt due to a medical condition, they must provide supporting documentation from their physician. Participants who cannot achieve the original goal or the alternative goal provided because of this exception may be given a waiver or a different option to qualify. The other method will be determined on a case-by-case basis by Bravo, the Participant and, in some cases, their physician. Participants qualifying for the alternative award may earn the full point(s) available.

PREVENTIVE CARE BENEFIT

All charges incurred by a Covered Person in connection with routine Tests, X-Ray and Lab will be eligible for reimbursement, as stated in the Schedule of Benefits. This benefit includes but is not limited to Office Visits, Routine Eye Exams (including eye refractions), Routine Hearing Exams, Routine Tests, Immunizations, Well Baby Care, Pap Smears, Blood Pressure Tests, Cholesterol Screening, Inoculations, and Prostate Screening. This benefit includes Grade A & B Preventive Care based on the U. S. Preventive Services Task Force.

For further information on Grade A & B benefits, please go to http://www.USPreventiveServicesTaskForce.org for a complete and current listing of all recommended Preventive Services.

This benefit does not include charges for eyeglasses or hearing aids nor does it include nursery charges or miscellaneous services and supplies for a healthy Newborn child.

PREFERRED PROVIDER ORGANIZATION (PPO)

The Company has entered into a Preferred Provider Organization (PPO) agreement to give Plan Participant access to providers that have agreed by contract to charge rates that in most cases are below the prevailing rates of Non-PPO providers.

The Plan has agreed, as an incentive for Plan Participant to use these PPO providers, to reimburse charges at a higher level than those incurred at Non-PPO providers. The different levels of benefits are as stated in the Schedule of Benefits.

It is the ultimate responsibility of the covered Person to confirm that the provider being utilized is a PPO provider in order to obtain the best reimbursement on charges by the Plan. A listing of Participating PPO providers can be obtained by contacting the Plan Administrator.

In the event of an Emergency medical condition that makes it impossible to obtain treatment by a PPO provider, the Plan will reimburse charges at the PPO level. The Plan Supervisor will review all circumstances related to the Emergency, including Physician notes if necessary, in determining whether or not the charges qualify as an Emergency and qualify for reimbursement at the PPO level.

MAJOR MEDICAL EXPENSE BENEFITS

BENEFIT PERCENTAGE AND DEDUCTIBLE - Upon receipt of Proof of Loss, Eligible Medical Expenses as defined by the Plan, which are in excess of any applicable Deductible and Co-Payments will be paid as stated in the Schedule of Benefits. All Eligible Medical Expenses incurred in the Benefit Period in excess of the Out-of-Pocket maximum will be paid at 100%, unless otherwise stated in the Plan.

The Deductible applies to the eligible charges of each Benefit Period, but it applies only once for each Covered Person within a Benefit Period regardless of the number of Illnesses. However, if the individual Deductibles of the Family members reach a maximum as stated in the Schedule of Benefits during the same Benefit Period, no further Deductible applies to any member of that Family during that Benefit Period. Any expenses incurred during the last 3 months of such Benefit Period and accumulated towards the Deductible will be applied toward the following Benefit Period Deductible requirement.

If two or more members of the same Family receive injuries in the same accident, and as a result of those injuries, incur Covered Expenses during the same Benefit Period in which the accident occurs, only one Major Medical Deductible Amount will be deducted from the total Eligible Medical Expenses incurred.

ALLOCATION AND APPORTIONMENT OF BENEFITS - The Company reserves the right to allocate the Deductible amount to any eligible charges and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment shall be conclusive and shall be binding upon the Covered Person and all assignees.

CHANGES IN COVERAGE CLASSIFICATION - If a change in the coverage classification of a Covered Person which would otherwise decrease the Plan Benefit Maximum applicable to the Dependent becomes effective in accordance with the terms of the Plan, such decrease shall apply immediately with respect to the Major Medical Expense Benefits applicable to the Covered Person, except that if the Covered Person is Totally Disabled on the date of change, the decrease shall not apply to the benefits payable for eligible charges incurred during the subsequent period of continuous Total Disability within the Benefit Period in which the change occurs and due solely to the Illness or Injury which caused the Total Disability.

COVERED EXPENSES - In order to be eligible for benefits under this provision, expenses actually incurred by a Covered Person must meet all the following requirements:

1. They are administered or ordered by a Physician; and

2. They are Medically Necessary for the diagnosis and treatment of an Illness or Injury unless otherwise specifically included as a Covered Expense; and

3. They are not excluded under any provision or section of this Plan.

Covered Expenses include, but are not limited to, the following:

1. Charges made by a Hospital for:

    a. Daily Room and Board and general nursing services, or Confinement in an Intensive Care Unit, not to exceed the applicable maximum limits shown in the Schedule of Benefits. However, nursery charges for a healthy Newborn Dependent child will be considered Covered Expenses. If the Hospital offers both semi-private and private rooms, the room allowance will be the daily Room and Board rate most commonly charged by the facility for a semi-private room with two or more beds. If the Hospital offers only private rooms, the room allowance will be the daily Room and Board rate most commonly charged by the facility for a private room. The Intensive Care Unit room allowance will be the daily rate most commonly charged for an Intensive Care Unit room at the facility that the patient is receiving care.

b. Necessary service and supplies other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and Emergency room use, physical therapy treatments, hemodialysis, and x-ray and linear therapy. Charges incurred for such miscellaneous services and supplies by a healthy Newborn Dependent child will be considered Covered Expenses.

2. Charges made by a Skilled Nursing Facility for the following services and supplies furnished by the facility. Only charges incurred in connection with convalescence from the Illness or Injury for which the Covered Person is confined will be eligible for benefits. These expenses include:

   a. Room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily Room and Board charge allowed will not exceed the facility's average semi-private charges or an average semi-private rate made by a representative cross section of similar institutions in the area;

   b. Medical services customarily provided by the Skilled Nursing Facility, with the exception of private duty or special nursing services and Physician's fees;

   c. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

3. Charges made by a Hospice for:

   a. Nursing care by a Registered Nurse, a Licensed Practical Nurse, a vocational nurse or a public health nurse who is under the direct supervision of a Registered Nurse;

   b. Physical therapy and speech therapy when rendered by a licensed therapist;

   c. Medical supplies, including drugs and biologicals and the use of medical appliances;

   d. Physician's services; or

   e. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

4. The services of a legally qualified Physician for medical care and/or surgical treatments including office, home visits, Hospital Inpatient care, Hospital Outpatient visits/exams, clinic care, and surgical opinion consultations. Also included are services of a resident or intern of a Hospital or a Physician Assistant under the direct supervision of a Licensed Physician.

5. Fees of Registered Nurses (R.N.'s) graduate nurses, or Licensed Practical Nurses (L.P.N.'s) for private duty nursing acting within the scope of their license.

6. Treatment or services rendered by a licensed physical therapist or licensed occupational therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

7. Benefits will be paid for care and treatment of loss or impairment of speech or hearing provided by an Audiologist (Master's or Doctorate Degree in Audiology) or Speech-Language Pathologist (Master's or Doctorate Degree in speech pathology or speech-language pathology). Benefits will be paid as for Illness.

8. Charges for professional ambulance service to the nearest facility where Emergency care or treatment is rendered.

MAJOR MEDICAL EXPENSE BENEFITS (Cont'd)

9. Charges for drugs requiring the written prescription of a licensed Physician; such drugs must be necessary for the treatment of an Illness or Injury. Prescription Drugs are limited to a thirty (30) day supply. Most charges are only eligible under your MAXORPLUS Supplemental Prescription Drug Program sponsored through your employer. For more information, please contact MAXORPLUS Customer Service at (806) 324-5430 or (800) 687-0707.

10. Charges for x-rays, microscopic tests, and laboratory tests. This benefit includes professional and technical components for automated lab charges.

11. Charges for radiation therapy or treatment.

12. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

13. Charges for oxygen and other gasses and their administration.

14. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

15. Charges for the cost and administration of an anesthetic.

16. Charges for ostomy supplies, sterile dressing change kits, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces or corrective shoes.

17. Initial charges for the rental of a wheelchair, Hospital bed or other Durable Medical Equipment required for temporary therapeutic use or the purchase of this equipment, if economically justified, whichever is less. Prior rental amounts will reduce the purchase price. Durable Medical Equipment may be replaced after five (5) years if Medically Necessary.

18. Charges for artificial limbs, eyes or larynx, but not the replacement thereof. Initial charges for prosthetic/Orthotic Appliances and replacement, or repair, only if necessitated by skeletal growth. Orthotic Appliances must be custom molded. If replacement of a prosthetic/Orthotic Appliance is due to a medical necessity other than skeletal growth, a replacement will be covered under this Plan once every three (3) years only.

19. Services for voluntary sterilization for Participant and Dependent Spouses.

20. Charges made by a licensed Ambulatory Surgical Center or Minor Emergency Medical Clinic when treatment has been rendered.

21. Services and supplies in connection with transplant procedures, subject to the following conditions:

    a. The transplant must be recognized as a non-Experimental procedure by the American Medical Association.

    b. A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending Physician's findings regarding the medical necessity of such procedure. The Physician rendering this second opinion must be qualified to render such a service either through experience, specialist training or education, or such similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

    c. If the donor is covered under this Plan, Eligible Medical Expenses incurred by the donor will be considered for benefits to the extent that such expenses are not payable by the recipient's plan.

d. If the recipient is covered under this Plan, Eligible Medical Expenses incurred by the recipient will be considered for benefits. Expenses incurred by the donor who is not ordinarily covered under this Plan according to Participant eligibility requirements, will be considered Eligible Medical Expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the Maximum Plan Benefit still available to the recipient.

e. If both the donor and the recipient are covered under this Plan, Eligible Medical Expenses incurred by each person will be treated separately for each person.

f. The Usual and Customary cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a Hospital's charge for storage or transportation of the organ will be considered a Covered Expense.

22. Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan. Such expenses include:

    a. Provided or supervised by a Registered Nurse in the patient's home on a part-time, intermittent schedule when skilled care is required. Skilled care includes skilled nursing, skilled teaching and skilled rehab services that must be delivered or supervised by licensed technical or professional medical personnel to obtain a specified medical outcome.

    b. Certified home health aides under the direct supervision of a Registered Nurse; or

    c. Medical supplies, drugs and medicines prescribed by a Physician, and laboratory services provided by a Physician, and laboratory services provided by or on behalf of a Hospital.

    Medical Necessity of home health services should be determined by the IMS Managed Care, Inc when home health services are ordered. **Failure to do so may result in claims being declined or reduced.**

    Specifically excluded from coverage under this benefit are the following:

    a. Custodial or delivered to assist with activities of daily living

    b. Services and supplies not included in the Home Health Care Plan.

    c. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person.

    d. Services of any social worker.

    e. Transportation services.

23. Physician's charges for obstetrical service are paid on the same basis as for an Illness, including the mother's prenatal care. Benefits are **not** provided for a Pregnancy of a Dependent child.

24. Newborn care following a delivery, charges for circumcision and routine physician office visits and immunizations for the first 30 days.

25. Charges for Psychiatric Care rendered by a Physician or certified and licensed social worker under the direct supervision of a Physician, subject to the percentages and amounts listed in the Schedule of Benefits.

26. Treatment, care, and services for expenses in connection with medical complications and Effective Treatment of Drug Abuse will be treated the same as any other Illness or Injury if Confined as an Inpatient in a Hospital which does not have a section which is a Drug Dependency Center.

If an individual is confined as a full-time Inpatient in a Drug Dependency Center for Effective Treatment of Drug Abuse, Room and Board expenses and expenses for other necessary services and supplies furnished by the center will be considered as any other Illness or Injury, as shown on the Schedule of Benefits.

27. Treatment, care, and services in connection with alcoholism are covered as any other Illness or Injury, and will be subject to the same Exceptions, Limitations, and other provisions of this Plan.

    In addition to a Hospital, care, treatment and services in connection with alcoholism will be covered in an Alcohol Dependency Treatment Center and will be considered as any other Illness or Injury, as shown on the Schedule of Benefits.

28. Charges made by a licensed Birthing Center and incurred while coverage is in force. This benefit is paid for charges made by the center, and not for charges made separately by any Physician for services provided at the center.

29. Any services, supplies, diagnostic procedures, and/or treatment provided by a Doctor of Chiropractic

30. Charges for reconstruction of the breast on which a mastectomy has been performed; surgery and reconstruction of the other breast to produce symmetrical appearance; and charges for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the patient, as required by the Women's Health and Cancer Rights Act.

31. Charges for surgery to correct a functional defect that results from a congenital and/or acquired disease or anomaly.

32. Charges for surgery to correct a seriously disfiguring condition resulting from an accidental injury.

33. Charges for thirteen (13) Antigen Doses per quarter, not to exceed a thirteen (13) week supply. The Plan shall not be responsible for the re-mixing of vials or for replacement due to an instance of breakage or misplacement, within the above timeframe.

34. Any services and/or treatment provided by a licensed Physical Therapist, subject to the percentages and amounts listed in the Schedule of Benefits.

35. Charges for acupuncture performed by a Physician when Medically Necessary.

36. Charges for Residential Treatment when Medically Necessary.

37. Charges for Nurse Practitioners, Registered Nurse First Assistants and Physician's Assistants acting within the scope of their license.

38. Charges for the treatment of Diabetes and Diabetic Education.

39. Charges for Cardiac Rehabilitation.

40. Charges for routine costs including any medically necessary health service, such as a doctor's visit, hospital stay, tests, and/or x-rays, for which benefits are already provided under the Plan, without regard to whether the Participant is participating in a clinical trial (Phase I, II, III or IV Clinical Trial).

    Routine costs WILL NOT include:

    a. The cost of an investigational drug or device that is not approved for indication by the FDA, unless considered Medically Necessary by the Plan.

b. The cost of a service that is not a healthcare service, regardless of whether the service is required in connection with the participation in the clinical trial.

c. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

d. A cost associated with managing a clinical trial.

e. The cost of a health care service that is specifically excluded from coverage under a health benefit plan.

f. The cost for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

41. Charges incurred for the treatment of Morbid Obesity including bariatric surgery if medically necessary, provided the following criteria is met:

a. The treatment of Morbid Obesity must be performed by a BSA Provider.

b. The surgery must be performed at Baptist St. Anthony's Hospital ("BSA") by a BSA Physician.

c. The surgery must be performed at Baptist St. Anthony's Hospital ("BSA") by a BSA Physician in order for complications that arise from bariatric surgery to be considered for payment.

d. Bariatric surgery is limited to one (1) surgery per lifetime.

e. The Participant must be a Covered Person under the BSA Health Benefit Plan for at least two years in order for the Participant or any Covered Person to be eligible for this benefit.

f. The Participant must complete three (3) months of supervised weight loss administered by a Registered Dietician, in addition to three (3) months of supervised exercise regimen immediately prior to surgery.

Supervised Exercise Regimen shall be defined as documented (written) supervision (oversight provided by a qualified professional i.e., a gym, personal trainer, or BSA Fit Quest) for a period of three (3) calendar months. Self-supervision shall not be included in this definition.

g. The Covered Person must be at least eighteen (18) years of age.

h. This benefit does not include treatment of Morbid Obesity, including bariatric surgery, for Dependent Children under the age of twenty-six (26).

Medical Necessity should be determined by IMS Managed Care, Inc., when bariatric surgery is requested. **Failure to do so may result in claims being denied.**

BSA reserves the right to amend or remove coverage for this benefit at any time and for any reason.

CASE MANAGEMENT

The Case Manager will assess the continuing care needs in catastrophic and chronic high cost medical care cases and discuss with the attending Physician less costly Alternate Care. Coverage may be provided for less costly medical services and supplies, even though such alternatives are not specifically covered by the Plan. However, this does not cover expenses that are considered Experimental or Investigational as set forth in the Plan or are provided only as a convenience to the Covered Person, the Covered Person's Family or the health care provider. Coverage for Alternate Care is subject to the same overall Plan Benefit Maximum, Co-Payment, Deductible and/or Out-of-Pocket requirements that apply to the medical care being replaced.

Although the Case Manager may suggest to the Physician less costly Alternate Care, the final decision on patient care and treatment is the responsibility of the Covered Person, the Family, and the attending Physician. If the Case Manager suggests less costly Alternate Care, the Plan will reimburse at that lesser rate, even if the Covered Person elects more costly care.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS

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

1. Charges incurred prior to the effective date of coverage under the Plan or after coverage is terminated.

2. 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.

3. Charges for any services or supplies provided in connection with an occupational sickness or an injury sustained in the scope of and in the course of any employment whether or not benefits are or could be provided under Workers' Compensation.

4. Charges incurred while confined in a Hospital owned or operated by the United States Government or any Agency thereof, or charges for services, treatments or supplies furnished by the United States Government or any Agency thereof except those charges in connection with an Illness or Injury that are unrelated to a military or U. S. Government activity.

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

6. Charges for care, supplies, treatment, and/or services that are not specifically covered under this Plan.

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

8. Charges resulting from or occurring during the commission of a crime, illegal act, felonious act, or while engaging in an illegal occupation or act, or aggravated assault by the Covered Person, including, without limitation, illegally driving by the Covered Person while under the influence of alcohol or drugs, but excluding minor traffic violations. It is not necessary that an arrest occur, criminal charges be filed or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act.

9. Charges incurred in connection with a self-inflicted Injury, Illness, or overdose as well as, injuries or Illnesses that are a result of an attempted suicide. This exclusion does not apply (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

10. Charges incurred for routine medical examinations, preventive treatment or routine health check-ups, nutritional supplements, or immunizations not necessary for the treatment of an Injury or Illness unless specified as a Covered Expense in the Plan.

11. Charges incurred in connection with services and supplies which are not necessary for treatment of the Injury or Illness, are in excess of Usual and Customary charges, are not recommended and approved by a Physician, or treatment or tests not related to the diagnosis given, unless specifically shown as a Covered Expense elsewhere in the Plan.

12. Charges incurred for services or supplies that constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, education or training or expenses actually incurred by other persons.

13. Charges incurred for Cosmetic Procedures, unless specifically shown as a Covered Expense elsewhere in this Plan.

14. Charges for services, supplies or treatments not recognized by the American Medical Association as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Illness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by the American Medical Association as having no medical value, unless specified as a Covered Expense elsewhere in the Plan.

15. Charges for services rendered by a Physician, nurse or licensed therapist if such Physician, nurse or licensed therapist is a Close Relative of the Covered Person or resides in the same household of the Covered Person.

16. Charges for elective abortions.

17. Charges incurred outside the United States if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs, or supplies.

18. Charges for hospitalization when such Confinement occurs primarily for physiotherapy, hydrotherapy or rest care, or any routine physical examinations or tests not connected with the actual Illness or Injury.

19. Charges for Physicians' fees for any treatment that is not rendered by or in the physical presence of a Physician or charges for Physicians working outside the scope of their license, unless otherwise stated in the Plan.

20. Charges incurred in connection with radial keratotomy, orthoptics, vision training, vision therapy, automated lamellar keratoplasty (ALK or LK), astigmatic keratotomy (AK), photorefractive keratotomy (PRK-laser), or other yet named procedures for vision correction, the purchase or fitting of eyeglasses, contact lenses, or such similar aid devices unless otherwise specified elsewhere in this Plan. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery.

21. Charges incurred in connection with cochlear implants.

22. Charges incurred for dental care and treatment, dental surgery, dental appliances, treatment of overbite or under bite and any malocclusion associated thereto, including those deemed congenital or developmental anomalies, general correction of malocclusion, however, benefits will be payable for charges incurred (1) for excision of neoplasm, including benign, malignant and pre-malignant lesions, tumors and cysts; incision and drainage of cellulites or surgical procedures including accessory sinuses, salivary glands and ducts and (2) for treatment required because of accidental injury to sound natural teeth effected solely through external means. An injury incurred as a result of biting or chewing shall not be considered an accidental injury. Such expenses must be incurred within 6 months of the date of accident. Section (2) of this exception shall not in any event be deemed to include charges for treatment for the repair or replacement of a denture.

23. Charges related to or in connection with fertility studies, sterility studies, procedure to restore or enhance fertility, artificial insemination, or in-vitro fertilization, including but not limited to, gamete intrafallopian transfer (GIFT) and zygote intrafallopian transfer (ZIFT), donor sperm, surrogate parenting fees, or premature removal of subdermal implants for purpose of conception.

24. Charges for professional services on an Outpatient basis in connection with Mental Illness, Alcoholism, Drug Addiction, Functional Nervous Disorders, Mental or Nervous Disorders of any type or cause, or for psychiatric or psychoanalytic care for any reason, unless such services are rendered by a Physician. Such charges are payable as defined in the Schedule of Benefits.

GENERAL PLAN EXCLUSIONS AND LIMITATIONS (Cont'd)

25. Charges for professional nursing services if rendered by other than a Registered Nurse (R.N.) or Licensed Practical Nurse (L.P.N.), unless such care was vital as a safeguard of the Covered Person's life, and unless such care is specifically listed as a Covered Expense elsewhere in the Plan.

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

27. Charges as a result of or in connection with the pregnancy of a Dependent child.

28. Charges for Experimental or Investigational procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States, unless considered Medically Necessary by the Plan.

29. Charges for Well-Baby Care, including the usual, ordinary and routine care of a Newborn unless otherwise stated in the Schedule of Benefits.

30. Charges for services, treatment or care of any kind of Chemical Dependency if the Participant is convicted in any court of Law and is required by the court, or arranges in lieu of conviction, to undergo care or treatment as an alternative to, or in addition to, fine or imprisonment.

31. Chiropractic treatment for children up to age sixteen (16) will be excluded unless Medically Necessary.

32. Charges for Durable Medical Equipment for: (1) special features or supplies for Durable Medical Equipment, which are not part of the basic equipment, including but not limited to, electric beds or electric wheelchairs; (2) maintenance, repairs or replacement, unless otherwise specifically shown as a Covered Expense elsewhere in this Plan.

33. Charges in connections with the treatment for obesity, including but not limited to, gastric intestinal bypass surgery, unless specifically shown as a Medically Necessary Covered Expense elsewhere in this Plan.

34. Charges for surgical procedures for snoring.

35. Charges for corrective shoes and shoe inserts including charges for diabetic shoes, unless Medically Necessary.

36. Charges for wigs or prosthetic hair, unless otherwise specifically shown as a Covered Expense elsewhere in this Plan.

37. Charges in connection with Temporomandibular Joint Syndrome (TMJ) or any related services.

38. Charges for the repair or replacement of hearing aids due to normal wear and tear and loss or damage.

39. Charges for equipment considered dispensable or convenient for use in the home, including but not limited to, over the counter bandages and dressings; foam cervical collars, air conditioners, humidifiers, dehumidifiers, and other personal comfort items.

40. Charges incurred for massage therapy, unless otherwise specifically shown as a Covered Expense elsewhere in this Plan.

41. Charges for postage and handling.

42. Charges for compounding and delivery fees for drugs and/or medications.

43. Charges for Hospice Bereavement Counseling for individuals or family, unless specifically shown as a Covered Expense elsewhere in this Plan.

44. Charges by a Physician for contacting a Covered Person by phone, fax or e-mail or charges for ordering a prescription.

45. Charges for Prescription Drugs or medicines, which are only eligible under your MAXORPLUS Supplemental Prescription Drug Program, sponsored through your employer, which has its own Exclusions and limitations. For more information, please contact MAXORPLUS Customer Service at (806) 324-5430 or (800) 687-0707.

46. Charges that have been previously processed (duplicate charges).

47. Charges for sleep studies or related expenses performed in the home.

48. Charges for the care, services or treatment for non-congenital transexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

49. Charges disallowed based on Medical Record Review and determination.

50. Charges for care, supplies, treatment, and/or services that are not actually rendered.

51. Charges for care, supplies, treatment, and/or services for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any licensed Physician.

52. Charges in connection with Morbid Obesity, including bariatric surgery, for a Dependent child.

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

APPEALS OF ADVERSE BENEFIT DETERMINATIONS

HEALTH CLAIM PROCEDURES

All claims and questions regarding health claims should be directed to the Third Party Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

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

A call from a Provider who wants to know if an individual is covered under the Plan or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and **any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions**. Once treatment is rendered, a Clean Claim must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

A Participant has the right to request a review of an Adverse Benefit Determination. If the claim is denied at the end of the appeal process, as described below, the Plan's final decision is known as a final adverse benefit determination. If the Participant receives notice of a final adverse benefit determination, or if the Plan does not follow the claims procedures properly, the Participant then has the right to request an independent external review. The external review procedures are described below.

The claims procedures are intended to provide a full and fair review. This means, among other things, that claims and appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

Benefits will be payable to a Plan Participant, or to a Provider that has accepted an assignment of benefits as consideration in full for services rendered.

According to Federal regulations that apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

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

  If the Plan does not require the Participant to obtain approval of a specific medical service prior to getting treatment, then there is no Pre-service Claim. The Participant simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

- **Concurrent Claims**. A "concurrent claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:

- The Plan Administrator determines that the course of treatment should be reduced or terminated; or

- The Participant requests extension of the course of treatment beyond that which the Plan Administrator has approved.

If the Plan does not require the Participant to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Participant simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a post-service claim.

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

WHEN HEALTH CLAIMS MUST BE FILED

Post-service health claims must be filed with the Contract Administrator within one hundred eighty (180) days of the date charges for the service were incurred. Benefits are based upon the Plan's provisions at the time the charges were incurred. **Claims filed later than that date shall be denied.**

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

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

TIMING OF CLAIM DECISIONS

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

- **Pre-service Non-urgent Care Claims:**

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim, then the Participant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Participant (if additional information was requested during the extension period).

- **Concurrent Claims:**

  - **Plan Notice of Reduction or Termination**. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

  - **Request by Participant Involving Urgent Care.** If the Plan Administrator receives a request from a Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim, as long as the Participant makes the request at least 72 hours prior to the expiration of the prescribed period of time or number of treatments. If the Participant submits the request with less than 72 hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and decided within the urgent care timeframe.

  - **Request by Participant Involving Non-urgent Care**. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

  - **Request by Participant Involving Rescission**. With respect to rescissions, the following timetable applies:

    - Notification to Participant 30 days

    - Notification of adverse benefit determination on appeal 30 days

- **Post-service Claims:**

  - If the Participant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

  - If the Participant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Participant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

- **Extensions – Pre-service Non-Urgent Care Claims**. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- **Extensions – Post-service Claims**. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

- **Calculating Time Periods.** The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT DETERMINATION

The Plan Administrator shall provide a Participant with a notice, in writing or electronically. The notice will contain the following information:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an adverse benefit determination on final review;

6. A statement that the Participant 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 Participant's claim for benefits;

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. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

9. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and

10. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review processes.

11. In a claim involving urgent care, a description of the Plan's expedited review process.

FULL AND FAIR REVIEW OF ALL CLAIMS

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

1. Participants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

2. Participants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;

3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

4. For a review that takes into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in any prior benefit determination;

5. That, in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual;

6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice;

7. That a Participant will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant's claim for benefits in possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances; and

8. In an urgent care claim, for an expedited review process pursuant to which:

    - A request for an expedited appeal of an Adverse Benefit Determination may be submitted orally or in writing by the Participant; and

    - All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the Participant by telephone, facsimile or other available similarly expeditious method.

REQUIREMENTS FOR FIRST APPEAL

The Participant must file the appeal in writing within 180 days following receipt of the notice of an Adverse Benefit Determination.

To file an appeal in writing, the Participant's appeal must be addressed as follows and mailed or faxed as follows:

To file an appeal in writing, the Claimant's appeal must be addressed as follows or faxed to the following numbers:

For Post Service Claims:

Insurance Management Services
Customer Service Representative
P.O. Box 15688
Amarillo, TX 79105
(806) 373-6646

For Pre-Service Non-Urgent Claims:

IMS Managed Care
UR Nurse
P.O. Box 15688
Amarillo, TX 79105
(806) 373-1458

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

1. The name of the employee/Participant;

2. The employee/Participant'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 their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal**;

5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and

6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

If the Participant 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 REVIEW

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

- **Pre-service Non-urgent Care Claims**: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

- **Concurrent Claims**: The response will be made in the appropriate time period based upon the type of claim – pre-service urgent, pre-service non-urgent or post-service.

- **Post-service Claims**: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

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

MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION ON REVIEW

The Plan Administrator shall provide a Participant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;

5. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant's right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;

6. A statement that the Participant 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 Participant's claim for benefits;

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. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;

9. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; 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 "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

DECISION ON REVIEW

If, for any reason, the Participant does not receive a written response to the appeal within the appropriate time period set forth above, the Participant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the Plan must be exhausted before any legal action is brought.**

SECOND APPEAL LEVEL

ADVERSE DECISION ON FIRST APPEAL; REQUIREMENTS FOR SECOND APPEAL - Upon receipt of notice of the Plan's adverse decision regarding the first appeal, the 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 Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

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

2. **Concurrent Claims** -The response will be made in the appropriate time period based upon the type of claim – Pre-Service Non-Urgent or Post-Service.

3. **Post-Service Claims** - Within a reasonable period of time, but not later than 30 days after receipt of the second appeal.

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

MANNER AND CONTENT OF NOTIFICATION OF ADVERSE BENEFIT DETERMINATION ON SECOND APPEAL - The Plan Administrator shall provide Claimant with notification, in writing or electronically, of a Plan's Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);

2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;

3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;

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

5. A description of the Plan's review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and 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 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 for benefits;

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. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Claimant, free of charge, upon request;

9. In the case of denials based upon a medical judgment (such as whether the treatment is medically necessary or experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Claimant, free of charge, upon request; 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 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 "Manner and Content of Notification of Adverse Benefit Determination on First Appeal" as is appropriate.

DECISION ON SECOND APPEAL TO BE FINAL - If, for any reason, the 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 by the Plan Administrator or other appropriate Named Fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one (1) year after the Plan's claim review procedures have been exhausted.

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 a denial. 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 Plan Supervisor. In the event a Claimant designates an Authorized Representative, all future communications from the Plan will be with the representative rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

EXTERNAL REVIEW PROCESS

A. STANDARD EXTERNAL REVIEW

Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

1. **Request for external review.** The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be

filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review.** Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:

   (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;

   (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);\

   (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and

   (d) The claimant has provided all the information and forms required to process an external review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

3. **Referral to Independent Review Organization**. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. **Reversal of Plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan immediately will provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

B. EXPEDITED EXTERNAL REVIEW

1. **Request for expedited external review**. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:

   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or

(b) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review 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 been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.

3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will 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 or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

4. **Notice of final external review decision.** The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

Before filing a lawsuit, the Participant must exhaust all available levels of review as described in this section, unless an exception under applicable law applies. A legal action to obtain benefits must be commenced within one (1) year of the date of the Notice of Determination on the final level of internal or external review, whichever is applicable

INTERNAL RULES, GUIDELINES OR PROTOCOL

Below are the administrative processes that are used in operating the Plan to satisfy basic fiduciary standards of conduct under ERISA. These procedures are utilized for consistent decision-making that may or may not result in documents or information that can be disclosed pertaining to an individual claims decision. To receive more information concerning these concepts free of charge, please make a written request to the Plan Supervisor.

UTILIZATION REVIEW - The plan utilizes InterQual Criteria which is an industry standard for guiding healthcare insurers, plans, and providers toward medical best practices and care settings.

Criteria are clinical statements that help determine the appropriateness of a proposed medical intervention. They are used to determine if the intervention is indicated, based on the clinical data, or requires further review. Criteria are an objective tool used to support a clinical rationale for decision-making and are an integral component of the utilization management program.

The Criteria reflect clinical interpretations analyses and cannot alone resolve medical ambiguities of particular situations or provide the sole basis for definitive decisions. The Criteria is intended solely for use as screening guidelines with respect to the medical appropriateness of healthcare services and not for final clinical or payment determinations concerning the type or level of medical care provided, or proposed to be provided, to a patient. Specifically, InterQual Criteria allows for the efficient screening of cases with the goal of referring only those cases truly needing medical review.

InterQual Criteria allow the non-physician reviewer and the provider to identify the majority of cases where an intervention is warranted, in both the inpatient and outpatient settings. The Criteria does not replace provider judgment; rather it serves as a tool to promote sound and efficient utilization management.

CLAIMS EDIT SYSTEM - The Claims Edit System Knowledgebase (referred to as CES) helps identify inappropriate coding relationships and the line item information on provider medical bills. Application of the CES Knowledgebase allows claims processors and adjudicators to identify potentially incorrect or inappropriate coding relationships by a single provider, for a single patient and/or for a single date of service.

CES shows coding relationships for CPT, HCPCS and ICD-9 codes. These three nomenclature and classification systems are the healthcare industry standards used to report procedures, professional/ancillary services, supplies, drugs, anesthesia services, and diagnosis.

Because the practice of medicine is not an exact science, the billing and reimbursement of medical services is a process with many complexities. To construct the multiple edits that are found in the CES Knowledgebase, clinical staff found it necessary to formulate a set of rules in the form of clinical concepts. The clinical concepts are guidelines established specifically and only for the CES Knowledgebase.

PPO FEE SCHEDULES AND PPO PROVIDERS - The Plan utilizes a Preferred provider Organization (PPO) fee schedule for medical procedures performed by providers that participate in the PPO Network. The Participating providers and the PPO Fee Schedule are subject to change at any time with written notice from the Preferred provider Organization (PPO).

CPT CODE MODIFIER - The CPT coding system includes two-digit modifier codes, which are used to report that a service or procedure has been “altered or modified by some specific circumstance” without altering or modifying the basic definition or CPT code. Certain modifiers may affect the Usual and Customary fee for that procedure.

INTERNAL RULES, GUIDELINES OR PROTOCOL (Cont'd)

USUAL & CUSTOMARY - The Plan uses medical pricing data, a pricing approach which combines the use of a relative value scale along with charge data by geozip (geographical area), in calculating Usual & Customary allowances. Relationships between procedures are also used in determining potential allowable charge amounts.

The Plan uses the Usual & Customary allowance for medical procedures performed by providers that do not participate in the PPO Network. Usual & Customary allowances may not apply to an Emergency in a Non-PPO facility or when a PPO facility is not available.

NON-PPO AMBULATORY SURGICAL FACILITY - Ambulatory surgical facility allowables are subject to local PPO allowables, and are at the discretion of the Plan Administrator.

HIPAA PRIVACY

Commitment to Protecting Health Information

The Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") set forth by the U.S. Department of Health and Human Services ("HHS") pursuant to the Health Insurance Portability and Accountability Act ("HIPAA"). Such standards control the dissemination of "protected health information" ("PHI") of Plan Participant. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entity that may assist in the operation of the Plan.

The Plan is required by law to take reasonable steps to ensure the privacy of the Plan Participant's PHI, and inform him/her about:

1. The Plan's disclosures and uses of PHI;
2. The Plan Participant's privacy rights with respect to his/her PHI;
3. The Plan's duties with respect to his/her PHI;
4. The Plan Participant's right to file a complaint with the Plan and with the Secretary of HHS; and
5. The person or office to contact for further information about the Plan's privacy practices.

Within this provision capitalized terms may be used, but not otherwise defined. These terms shall have the same meaning as those terms set forth in 45 CFR §160.103 and §164.501. Any HIPAA regulation modifications altering a defined HIPAA term or regulatory citation shall be deemed incorporated into this provision.

How Health Information May be Used and Disclosed

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining authorization, only if the use or disclosure is:

1. To carry out Payment of benefits;
2. For Health Care Operations;
3. For Treatment purposes; or
4. If the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities).

Disclosure of PHI to the Plan Sponsor for Plan Administration Purposes

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

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the privacy standards);

2. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;

5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;

6. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the privacy standards;

7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

8. Make available PHI in accordance with § 164.524 of the privacy standards (45 CFR 164.524);

9. Make available PHI for Amendment and incorporate any Amendments to PHI in accordance with § 164.526 of the privacy standards (45 CFR 164.526);

10. Make available the information required to provide an accounting of disclosures in accordance with § 164.528 of the privacy standards (45 CFR 164.528);

11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards (45 CFR 164.500 et seq);

12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;

13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;

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

15. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in § 164.504(f)(2)(iii) of the privacy standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

    (a) The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

        (i) Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Sponsor performs for the Plan.

In the event any of the individuals described in above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan, and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Sponsor

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Plan Participant. The Plan may use or disclose "summary health information" to the Plan Sponsor for obtaining premium bids or modifying, amending, or terminating the group health plan.

Disclosure of Certain Enrollment Information to the Plan Sponsor

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

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

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

Other Disclosures and Uses of PHI:

1. Primary Uses and Disclosures of PHI

2. Treatment, Payment and Health Care Operations: The Plan has the right to use and disclose a Plan Participant's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule.

3. Business Associates: The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Plan Participant's information.

4. Other Covered Entities: The Plan may disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Plan Participant, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Plan Participant has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. Required by Law: The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.

2. Public Health and Safety: The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:

   (a) a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;

   (b) report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;

   (c) locate and notify persons of recalls of products they may be using; and (d) a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.

3. The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect permitted by (1) above, when required or authorized by law, or with the Plan Participant's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Plan Participant that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.

4. Health Oversight Activities: The Plan may disclose PHI to a health oversight agency for oversight of a health care system, government health care program, and compliance with certain laws.

5. Lawsuits and Disputes: The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Plan Participant's PHI may be disclosed in response to a subpoena, discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Plan Participant of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. Law activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of enforcement: The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Plan Participant's PHI in response to a law enforcement official's request if he/she is, or are suspected to be a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Sponsor's or Plan's premises.

7. Decedents: The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law.

8. Research: The Plan may use or disclose PHI for research, subject to certain limited conditions.

9. To Avert a Serious Threat to Health or Safety: The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.

10. Workers' Compensation: The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

11. Military and National Security: The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

Disclosures to Plan Participant: The Plan is required to disclose to a Plan Participant most of the PHI in a Designated Record Set when the Plan Participant requests access to this information. The Plan will disclose a Plan Participant's PHI to an individual who has been assigned as his/her representative and who has qualified for such designation in accordance with the relevant State law. Before disclosure to an individual qualified as a personal representative, the Plan must be given written supporting documentation establishing the basis of the personal representation.

The Plan may elect not to treat the person as the Plan Participant's personal representative if it has a reasonable belief that the Plan Participant has been, or may be subjected to domestic violence, abuse or neglect by such person. It is not in the Plan Participant's best interest to treat the person as his/her personal representative, or treating such person as his/her personal representative could endanger the Plan Participant.

Disclosures to the Secretary of the U.S. Department of Health and Human Services: The Plan is required to disclose the Plan Participant's PHI to the Secretary of the U.S. Department of Health and Human Resources when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

Rights to Individuals

The Plan Participant has the following rights regarding PHI about him/her:

1. Request Restrictions: The Plan Participant has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Plan Participant may request the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.

2. Right to Receive Confidential Communication: The Plan Participant has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and state the method in which the Plan Participant would like to be contacted. The Plan will accommodate all reasonable requests.

3. Copy of this Notice: The Plan Participant is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.

4. Accounting of Disclosures: The Plan Participant has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Plan Participant is entitled to such an accounting for the six (6) years prior to his/her request, though not earlier than April 14, 2003. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Plan Participant of the basis of the disclosure, and certain other information. If the Plan Participant wishes to make a request, please contact the Privacy Compliance Coordinator.

5. Access: The Plan Participant has the right to request the opportunity to view or obtain copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Plan Participant requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Plan Participant's request. If the Plan denies the request, the Plan Participant may be entitled to a review of that denial.

6. Amendment: The Plan Participant has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. The request must be submitted to the Privacy Compliance Coordinator. The Plan may deny the Plan Participant's request in certain cases, including if it is not writing or if he/she does not provide a reason for the request.

Questions or Complaints

If the Plan Participant wants more information about the Plan's privacy practices, has questions or concerns, or believes that the Plan may have violated his/her privacy rights, please contact the Plan using the following information. The Plan Participant may submit a written complaint to the U.S. Department of Health and Human Services or with the Plan. The Plan will provide the Plan Participant with the address to file his/her complaint with the U.S. Department of Health and Human Services upon request.

The Plan will not retaliate against the Plan Participant for filing a complaint with the Plan or the U.S. Department of Health and Human Services.

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

Director of Employee Benefits
Human Resources Director
Plan Auditor
Chief Financial Officer
Any staff designated by one of the above positions.

A complete list may be obtained free of charge from your Plan Sponsor, upon written request.

HIPAA SECURITY

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

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION ("SECURITY RULE")

The Security Rule imposes regulations for maintaining the integrity, confidentiality and availability of protected health information that it creates, receives, maintains, or maintains electronically that is kept in electronic format (ePHI) as required under the Health Insurance Portability and Accountability Act (HIPAA).

Definitions;

1. *"Electronic Protected Health Information"* (ePHI) is defined in § 160.103 of the Security Standards (45 C.F.R. 160.103) and means individually identifiable health information transmitted or maintained in any electronic media.

2. *"Security Incidents"* is defined within § 164.304 of the Security Standards (45 C.F.R. §164.304) and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operation in an information system.

Plan Sponsor Obligations

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

2. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan.

3. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate security measures.

4. Ensure that any agent, including a subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate report to the Plan any security incident of which it becomes aware.

5. Report to the Plan any security incident of which it becomes aware.

Notification Requirements in the Event of a Breach of Unsecured PHI

The required breach notifications are triggered upon the discovery of a breach of unsecured PHI. A breach is discovered as of the first day the breach is known, or reasonably should have been known.

When a breach of unsecured PHI is discovered, the Plan will:

1. Notify the individual whose PHI has been or is reasonably believed to have been, accessed, acquired, used, or disclosed as a result of the breach. The individual will be notified in writing, without unreasonable delay, and in no case later than sixty (60) calendar days after discovery of the breach.

2. Notify the media if the breach affects more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than sixty (60) calendar days after the date the breach was discovered.

3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.

4. When a business associate that provides services for the Plan comes in contact with PHI, and in connection with those services, discovers a breach has occurred, that business associate will notify the Plan without unreasonable delay and in no case later than sixty (60) calendar days after discovery of a breach so that the affected individuals may be notified. To the extent possible, the business associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

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

PARTICIPANT'S RIGHTS

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

Receive Information About Your Plan and Benefits

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

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

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

Continue Group Health Plan Coverage

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

Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 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 that 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 would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

COORDINATION OF BENEFITS (COB)

The following COB Rules shall govern entitlement to benefits notwithstanding any contrary provision in the Plan.

INTRODUCTION - The COB Rules provide a claim-payment procedure that may enable a Covered Person to receive, from all health plans (including government plans) under which the Covered Person is covered, total payments up to but not more than, the full amount of a Covered Expense. Generally, when this Plan is the Primary Plan with respect to a Participant or Dependent, it pays full Plan benefits for the claim. When this Plan is the Secondary Plan with respect to a Participant or Dependent, it will pay the amount set forth in the section entitled "Effect On The Benefits Of This Plan" below.

CASES WHERE THIS PLAN IS SECONDARY PLAN - When there is a basis for a claim under this Plan and under another plan, this Plan is a "Secondary Plan" which has its benefits determined after benefits of the Other Plan, unless:

The other plan has rules coordinating its benefits with Benefits under this Plan; and

Both the rules of the other plan and the rules in the section entitled "Ordering Rules" below, require that Benefits under this Plan be determined before benefits under the other plan.

Otherwise, this Plan is "Primary Plan." If this Plan is the Secondary Plan, the Other Plan will be the Primary Plan. If this Plan is the Primary Plan, the Other Plan will be the Secondary Plan.

EXCESS INSURANCE - If at the time of injury, sickness, disease or disability there is available, or potentially available, any Coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage. Whenever possible, the Plan's benefits will be excess to:

1. any primary payer besides the Plan;

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

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

4. worker's compensation or other liability insurance company, or

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

ORDERING RULES - This Plan determines its order of benefits using the first (in numeric sequence) of the following rules that is applicable:

1. Participant/Dependent - The benefits of the plan that covers the recipient of Covered Services as a Participant are determined before those of the plan that covers the recipient of Covered Services as a Dependent.

2. Child of Parents Not Separated or Divorced - Except as stated in the section entitled "Ordering Rules" subsection (3), below, when this Plan and another plan cover the same child as a Dependent of different persons, called "parents":

a) The benefits of the plan of the parent whose birthday falls earlier in a Calendar Year (month and day) are determined before those of the plan of the parent whose birthday falls later in that year; but

b) If both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the other plan that covered the other parent for a shorter period of time.

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

3. Child of Separated or Divorced Parents - If two (2) or more plans cover a recipient of Covered Services as a child of divorced or separated parents, benefits for the child are determined in this order:

a) First, the plan of the parent with custody of the child;

b) Then, the plan of the Spouse of the parent with custody of the child; and

c) Finally, the plan of the parent not having custody of the child.

However, if the terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the plan of that parent has actual knowledge of those terms, the benefits of that plan are determined first. The section (C) above, does not apply with respect to any Claim Determination Period or plan year during which any benefits are actually paid or provided before the entity has such actual knowledge.

4. Active/Inactive Employee - The benefits of a plan which covers the recipient of Covered Services as an Employee who is neither laid off nor retired (or as that Employee's Dependent) are determined before those of a plan which covers such person as a laid off or retired Employee (or as that Employee's Dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, the rule of this subsection (4) is ignored.

5. For a Qualified Beneficiary who has elected Continuation of Coverage under this Plan and is covered under another group insurance arrangement, this Plan will always be considered secondary payor to the other group insurance arrangement.

6. Longer/Shorter Length of Coverage - If none of the above rules determines the order of benefits, the benefits of the plan that covered the recipient of Covered Services longer are determined before those of the plan that covered such person for the shorter time.

SUBMISSION OF CLAIMS - Claims should be submitted to the Primary Plan first. Any balance remaining after payment by the Primary Plan should then be submitted to the Secondary Plan. Claims for Covered Services not covered under this Plan will not be considered Covered Expenses even though they are covered under another plan that covers a Participant or a Dependent.

EXCHANGES OF INFORMATION - In order to administer the COB Rules, the Plan Supervisor may exchange information about any Claim with the carrier of any other plan that covers a Participant or a Dependent. As part of this process, the Plan Supervisor may require a Participant to provide relevant information.

EFFECT ON THE BENEFITS OF THIS PLAN - If this Plan is a Secondary Plan with respect to (and its benefits are determined after those of) one or more other plans, the amount of Covered Expenses for which a Covered Person shall be reimbursed in a Claim Determination Period shall be the lessor of: (a) the Covered Expenses that would otherwise be payable under this Plan in the absence of these COB Rules with respect to an Allowable Expense incurred by the Covered Person during the Claim Determination Period; or (b) the

Covered Expenses minus the actual benefits payable by the other plan. When another plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit payable. Amounts payable by this Plan will never exceed the total liability of this Plan. When Covered Expenses of this Plan are reduced in accordance with these COB Rules, each separate Covered Expense shall be reduced in the same proportion and then charged against any applicable benefit limit of this Plan.

OTHER RULES - If payment made under another plan includes an amount that should have been paid under this Plan, the Plan Administrator may pay that amount directly to that other plan. Any amount paid under the preceding sentence shall be treated as a Covered Expense paid under this Plan, and such amount shall not be paid again. With respect to benefits provided in the form of services, the amount of a "payable made" shall equal the reasonable cash value of the benefits provided in the form of services.

If the amount of any payment made by this Plan is more than should have been paid under these COB Rules, the Plan may recover the excess from:

1. The Covered Person to whom, or on whose behalf, payment was made;

2. Any insurance company that should have made such payment;

3. Any other plan that should have made such payment;

4. Any service provider to whom such payment was erroneously made; or

5. Any other individual or entity which should have made such payment or which received the benefit of such erroneous payments.

6. With respect to benefits provided in the form of services, the amount of payments made shall equal the reasonable cash value of any benefits provided in the form of services.

7. Individual automobile insurance coverage on an automobile leased or owned by the Company;

8. Individual automobile insurance coverage based upon the principles of "NO-Fault" coverage. This does not apply to Personal Injury Protection (PIP) coverage in the state of Texas;

9. Any plans or polices funded in whole or in part by an employer or deductions made by an employer from a person's compensation or retirement benefits; or

10. Labor/management trustee, union welfare, employer organization or employee benefit organization plans.

COORDINATION WITH MEDICARE - A Participant and his spouse (ages 65 and over) may, at the option of such Employee, elect or reject coverage under this Plan. If such Employee elects coverage under this Plan, the benefits of this Plan shall be determined before any benefits provided by Medicare. If coverage under this Plan is rejected by such Employee, benefits listed herein will not be payable even as secondary coverage to Medicare.

To the extent required by federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor. The Participant and his Dependents will be assumed to have full Medicare coverage (that is, both Part A & B) whether or not the Participant has enrolled for the full coverage. If the provider accepts assignment with Medicare, Covered Expenses will not exceed the Medicare-approved expenses.

If any Participant is eligible for Medicare benefits because of End Stage Renal Disease, the benefits of the Plan will be determined before Medicare benefits for the first 18 months of Medicare entitlement (with respect to charges incurred on or after February 1, 1991 and before August 5, 1997), and for the first 30 months of Medicare entitlement (with respect to charges incurred on or after August 5, 1997), unless applicable federal law provides to the contrary, in which event the benefits of the Plan will be determined in accordance with such law.

SUBROGATION, REIMBURSEMENT, AND THIRD PARTY RECOVERY PROVISION

Payment Condition

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

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

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

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

Subrogation

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

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

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

4. If the Plan Participant(s) fails to file a claim or pursue damages against:

   a) the responsible party, its insurer, or any other source on behalf of that party;

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

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

d) worker's compensation or other liability insurance company; or,

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

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

Right of Reimbursement

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

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

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

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

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

Excess Insurance

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

The Plan's benefits shall be excess to:

a) the responsible party, its insurer, or any other source on behalf of that party;

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

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

d) worker's compensation or other liability insurance company; or

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

Separation of Funds

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

Wrongful Death

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

Obligations

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

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

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

   c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

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

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

   f) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Participant may have against any responsible party or coverage.

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

3. The Plan's right to reimbursement and/or subrogation is in no way dependent upon the Plan Participant(s)' cooperation or adherence to these terms.

Offset

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

The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Participant's rights; and to determine all questions of fact and law arising under the Plan.

Minor Status

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

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

Language Interpretation

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

Severability

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

CONTINUATION OF COVERAGE

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus a reasonable administration fee) must be paid by the continuing person. Coverage will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of forty-five (45) days during initial premium/contribution and thirty (30) days thereafter). **Failure to do so will result in claims being denied.** This law is referred to as "COBRA", which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985. Generally, COBRA applies to employers with twenty (20) or more full/or part-time Employees. Employees should check with their Employers to see if COBRA applies to them.

BENEFITS AFFECTED BY COBRA

There are two (2) categories of benefits that may be continued under COBRA.

"Core benefits" are Medical Benefits. Any COBRA continuance option must include core benefits for which the person was covered just prior to the COBRA "qualifying event" (an event that qualifies a person for continued coverage under COBRA).

"Non-core benefits" include Dental Benefits, Vision Care Benefits and Flexible Spending Accounts under Section 125 (Cafeteria-type) plans.

If the "qualified beneficiary" (a person eligible for COBRA continuance) was covered by these non-core benefits prior to termination, the individual may, but is not required to, continue them under COBRA. Which non-core benefits, if any, are to be continued will be indicated by the qualified beneficiary at the time of COBRA enrollment.

Life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits (if a part of the Employer's plan) are not considered for continuance under COBRA.

MAXIMUM TIME PERIODS - Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's coverage for more than thirty-six (36) months beyond the date of the original qualifying event, or when the qualifying event is "entitlement to Medicare", the thirty-six (36) month continuation period is measured from the date of Medicare entitlement.

1. Up to eighteen (18) months for an Employee and his covered Dependent(s) when coverage terminates due to reduction of hours worked, or termination of employment for reasons other than gross misconduct.

Note: An individual who is disabled and his covered Dependent(s) may have COBRA coverage extended (and an extra fee charged) from eighteen (18) months to twenty-nine (29) months, furthermore, even if the disabled individual is a covered minor Dependent, his entire Family can extend their COBRA coverage for an additional eleven (11) months provided that:

   a) The individual is determined as being disabled for Social Security purposes and the disability occurs at any time during the first sixty (60) days of COBRA coverage.

   b) The individual notifies the Plan Administrator within sixty (60) days of the Social Security Administration's determination of disability and within the original eighteen (18) month COBRA period that applies to the person.

2. Up to thirty-six (36) months for:

   a) A covered child who ceases to be an eligible Dependent;

   b) A covered Dependent of a deceased Employee;

c) A former covered Spouse whose coverage ceases due to divorce or legal separation; or

d) A covered Dependent when the Employee's coverage ceases due to eligibility for Medicare.

3. There is a special continuation period for Retired Employees and their Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the Retired Employees and their Dependents lose substantial coverage within one year before or after the date the bankruptcy proceedings commenced. Coverage will be continued for each person until the date of that person's death. However, the surviving Spouse or children of a deceased Retired Employee may continue coverage for up to a maximum of thirty-six (36) months following the Retired Employee's death. For this item 3, coverage does not terminate when the person becomes eligible for Medicare.

Continued coverage may also cease before the end of the maximum period on the earliest of:

a) The date that the Employer ceases to provide a group health plan to any Employee; or

b) The date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health plan (as an Employee or otherwise), or (b) entitled to benefits under Medicare (except as stated in item 3 above). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Conditions limit must be allowed to continue COBRA coverage for the length of a Pre-Existing Condition or to the COBRA maximum time period, if less. Effective January 1, 1997 the COBRA law has been amended which provides that if a person has COBRA coverage and becomes covered under another plan that has a Pre-Existing Condition provision that is offset by prior coverage credits, then COBRA coverage can be terminated because the person is covered under another group plan and has satisfied the Pre-Existing Condition provision with prior coverage credits.

NOTICE REQUIREMENTS

When coverage terminates due to an Employee's death, termination or eligibility for Medicare, the Employer has thirty (30) days in which to notify the Plan Administrator of the qualifying event.

When coverage terminates due to divorce, legal separation or change of Dependent status, the qualified beneficiary has sixty (60) days from the qualifying event or from the date coverage terminates in which to notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within fourteen (14) days of receiving notice of the qualifying event. Covered Persons then have sixty (60) days in which to elect continuation. The sixty (60) day period is measured from the later of the date coverage terminates or the date notice of the right to continue is sent. If continuation is not elected in that sixty (60) day period, then the right to elect continuation ceases.

PERSONS ON USERRA LEAVE - Any Participant who is absent from active employment on a USERRA Leave (and any covered Dependent of such Participant) may elect to continue coverage under this Plan for up to twenty-four (24) months. If the Covered Person elected to continue coverage under USERRA before December 10, 2004, the maximum period for continuing coverage is eighteen (18) months. To continue coverage, the Participant must comply with the terms of the Plan, and pay any required contributions. USERRA also requires, regardless of whether continuation of coverage was elected, that coverage be reinstated immediately upon return to employment, so long as the Covered Person complies with the requirements set forth under USERRA.

The cost of continuing coverage will be:

1. For leaves of thirty (30) days or less, the same as the contribution required from similarly situated Participant;

2. For leaves of thirty-one (31) days or more, up to 102% of the contribution required from similarly situated Participant and the Participating Employer.

Note: For complete information regarding your rights under USERRA, contact your Participating Employer.

DOMESTIC PARTNER – For Domestic Partners that are not considered legal Spouses, COBRA coverage will still be available so long as the Domestic Partner satisfies all of the requirements as set forth herein. **However, the benefits will be taxable.**

GENERAL PROVISIONS

EXAMINATION - The Company shall have the right and opportunity to have the Covered Person examined whose Injury or Illness is the basis of a claim hereunder when and so often as it may reasonably require during pendency of claim hereunder.

PAYMENT OF CLAIMS - All Plan benefits are payable to the Participant, or subject to any written direction of the Participant. All or a portion of any indemnities provided by the Plan on account of Hospital, nursing, medical or surgical services may, at the Participant's option and unless the Participant requests otherwise in writing not later than the time of filing proofs of such loss, be paid directly to the Hospital or person rendering such services; however, if any such benefit remains unpaid at the death of the Participant or if the Participant is a minor or is, in the opinion of the Company, legally incapable of giving a valid receipt and discharge for any payment, the Company may, at its option, pay such benefits to any one or more of the following relatives of the Participant: wife, husband, mother, father, child, or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the Company's obligation to the extent of such payment and the Company will not be required to see the application of the money so paid.

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. 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 Plan Participant or dependent on whose behalf such payment was made.

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

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

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9, ICD-10 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 Plan Participant, provider or other person or entity to enforce the provisions of this section, then that Plan Participant, provider or other person or entity agrees to pay the Plan's attorney fees and costs, regardless of the outcome of the action.

Further, Plan Participant and/or their Dependants, Covered Persons, estate, heirs, guardian, personal representative, or assigns 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 Plan Participant(s) are entitled, for or in relation to facility acquired condition(s), provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits payable under this Plan the amount of any payment that 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 years after the date such coverage commences;

4. With respect to an ineligible person;

5. In anticipation of obtaining a recovery if a Plan Participant fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or

6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

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

FREE CHOICE OF PHYSICIAN - The Covered Person or Covered Dependents shall have free choice of any legally qualified Physician or surgeon and the Physician-patient relationship shall be maintained.

WORKERS' COMPENSATION NOT AFFECTED - This Plan does not take the place of, and does not affect any requirement for coverage by Workers' Compensation Insurance.

CONFORMITY WITH LAW - If any provision of this Plan is contrary to any law to which it is subject, including but not limited to ERISA or HIPAA, such provision is hereby amended to conform thereto.

STATEMENTS - In the absence of fraud, all statements made by a Covered Person will be deemed representations and not warranties. No such representations will void the Plan benefits or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS - Section titles are for conveniences 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.

PLAN ADMINISTRATOR'S DUTY TO ISSUE CERTIFICATES OF CREDITABLE COVERAGE – The Plan Administrator shall issue certificates of Creditable Coverage to a Covered Person whose coverage terminates (and to such individuals upon their written request within twenty-four (24) months of the date of coverage termination). In addition, a Certificate of Coverage will be provided upon request at any time while the individual is covered under a plan. A plan is required to use reasonable efforts to determine any information needed for a certificate relating to dependent coverage. In any case in which an automatic certificate is required to be furnished with respect to a Dependent, no individual certificate is required to be furnished until the plan knows (or making reasonable efforts should know) of the Dependent's cessation of coverage under the plan. A certificate may provide information with respect to both a Participant and the Participant's Dependents if the information is identical for each individual. If the information is not identical, certificates may be provided on one form if the form provides all the required information for each individual and separately states the information that is not identical.

All certificates of Creditable Coverage that must be issued as the result of the occurrence of a Qualifying Event as such term is defined in the section of this Plan entitled "Continuation of Coverage" shall be issued to the Covered Participant no later than the time the Plan Administrator provides the notice of COBRA to the Qualified Beneficiary under the section of this Plan entitled "Continuation of Coverage." All certificates of Creditable Coverage that must be issued upon termination of coverage (including termination of COBRA coverage) when no COBRA Qualifying Event has occurred at such time, shall be issued by the Plan Administrator as soon as possible after the coverage has terminated.

The Plan Administrator shall respond in a reasonably prompt manner to any request for certification of Creditable Coverage by categories of coverage and may charge the party requesting such certification by categories of coverage a reasonable amount for the preparation of such certification.

PLAN ADMINISTRATOR'S DUTY TO ISSUE NOTICES UNDER THE WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998 - The Plan Administrator shall provide each eligible employee a notice at enrollment and to each covered employee and covered dependent annually thereafter describing the Plan's benefits for a person who has a mastectomy with respect to:

Reconstruction of the breast on which the mastectomy was performed;

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

Prosthesis and physical complications in all stages of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

NOTICE OF ENROLLMENT RIGHTS

If an Employee declines enrollment for himself or his Dependents (including his spouse) because of other health insurance coverage, he may in the future be able to enroll himself or his Dependents in this Plan, provided that he request enrollment within thirty (30) days after the other coverage ends. In addition, if an Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Employee may be able to enroll himself and his Dependents, provided that he requests enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption.