COOPER-BOOTH WHOLESALE COMPANY LP

HEALTH AND MEDICAL BENEFITS PLAN
PREFERRED PROVIDER ORGANIZATION

Plan Document and Summary Plan Description
Effective: October 15, 1980
Restated: July 1, 2015

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ARTICLE I
ESTABLISHMENT OF THE PLAN: ADOPTION OF THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION ("Plan Document"), made by **Cooper-Booth Wholesale Company LP** (the "Company" or the "Plan Sponsor") as of July 1, 2014, hereby **amends and restates** the Cooper-Booth Wholesale Company LP Health and Medical Benefits Plan Preferred Provider Organization (the "Plan"), which was originally adopted by the Company, October 15, 1980. Any wording which may be contrary to Federal Laws or Statutes is hereby understood to meet the standards set forth in such. Also, any changes in Federal Laws or Statutes which could affect the Plan are also automatically a part of the Plan, if required.

1.01 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 (the "Effective Date").

1.02 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.

Cooper-Booth Wholesale Company LP

By: Eileen Valentine

Name: Eileen Valentine

Title: VP, Human Resources

Date: Nov. 17, 2015

ARTICLE II
INTRODUCTION AND PURPOSE

2.01 Introduction and Purpose

The Plan Sponsor has established the Plan for the benefit of eligible Employees and their eligible Dependents, in accordance with the terms and conditions described herein. Plan benefits are self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or are funded solely from the general assets of the Plan Sponsor. The Plan's benefits and administration expenses are paid directly from the Employer's general assets. Participants in the Plan may be required to contribute toward their benefits. Contributions received from Participants are used to cover Plan costs and are expended immediately.

The Plan Sponsor's purpose in establishing the Plan is to protect eligible Employees and their Dependents against certain catastrophic health expenses and to help defray the financial effects arising from Injury or Sickness. To accomplish this purpose, the Plan Sponsor must be mindful of the need to control and minimize health care costs through innovative and efficient plan design and cost containment provisions, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to effectively assign the resources available to help Participants in the Plan to the maximum feasible extent.

The Plan Sponsor is required under ERISA to provide to Participants a Plan Document and a Summary Plan Description; a combined Plan Document and Summary Plan Description, such as this document, is an acceptable structure for ERISA compliance. The Plan Sponsor has adopted this Plan Document as the written description of the Plan to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for eligible benefits. The Plan Document is maintained by the **Cooper-Booth Wholesale Company LP** and may be reviewed at any time during normal working hours by any Participant.

The Plan shall take effect for each Participating Employer on the Effective Date, unless a different date is set forth above opposite such Participating Employer's name.

2.02 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.

2.03 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

2.04 Mental Health Parity

Pursuant to the Mental Health Parity Act (MHPA) of 1996 and the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), collectively, the mental health parity provisions in Part 7 of ERISA, this Plan applies its terms uniformly and enforces parity between covered health care benefits and covered mental health and substance disorder benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

2.05 Applicable Law

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

2.05A Notice for Mastectomy Patients

If a Participant elects breast reconstruction in connection with a mastectomy, the Participant is entitled to coverage under this Plan for:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. Prosthesis and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

2.05B Notice for Medicare Eligible Participants

Please read this section carefully and keep this document where you can find it. This section has information about your current Prescription Drug coverage under this Plan and about your options under Medicare's Prescription Drug coverage. This information can also help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare Prescription Drug coverage in your area. Information about where you can get help to make decisions about your Prescription Drug coverage is at the end of this section.

There are two important things you need to know about your current coverage and Medicare's Prescription Drug coverage:

1. Medicare Prescription Drug coverage became available in 2006 to everyone with Medicare. you can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers Prescription Drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The Plan has determined that the Prescription Drug coverage offered under this Plan is, on average for all Participants, expected to pay out as much as the standard Medicare Prescription Drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can you Join A Medicare Drug Plan

you can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable Prescription Drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To your Current Coverage If you Decide To Join A Medicare Drug Plan

If you decide to join a Medicare drug plan, your current Plan coverage will not be affected.

If you decide to join a Medicare drug plan and drop your current Plan coverage, be aware that you and your dependents will be able to get this coverage back provided you and your dependents are still eligible under the Plan.

When Will you Pay a Higher Premium (Penalty) To Join a Medicare Drug Plan

you should also know that if you drop or lose your current coverage with the Plan and do not join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 days or longer without creditable Prescription Drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage.

For example, if you go nineteen months without Creditable Coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. you may have to pay this higher premium (a penalty) as long as you have Medicare Prescription Drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Section or your Current Prescription Drug Coverage
Contact the Plan Administrator for further information. you may receive this information at other times in the future such as before the next period you can enroll in Medicare Prescription Drug coverage, and if this coverage through the Plan changes. you also may request a copy of this document at any time.

For More Information About your Options Under Medicare Prescription Drug Coverage
More detailed information about Medicare plans that offer Prescription Drug coverage is in the "Medicare & you" handbook. you will get a copy of the handbook in the mail every year from Medicare. you may also be contacted directly by Medicare drug plans.

For more information about the Medicare Prescription Drug coverage:

1. Visit www.medicare.gov,
2. Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & you" handbook for their telephone number) for personalized help,
3. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Remember: Keep this document. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this section when you join to show whether or not you have maintained Creditable Coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

If you have limited income and resources, extra help paying for Medicare Prescription Drug coverage is available. For information about this extra help, visit Social Security Administration on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

2.06 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 rights; and to determine all questions of fact and law arising under the Plan.

ARTICLE III
ELIGIBILITY FOR COVERAGE

3.01 Eligibility for Individual Coverage

Class I Employees shall become eligible for coverage on his/her first day as an Active Employee working for his/her Participating Employer. Class II Employees shall become eligible for coverage on the first day of the month following completion of a 60 consecutive day Service Waiting Period as an Active Employee, provided the Employee has begun work for his or her Participating Employer.

If the Employee is unable to begin work as scheduled, then his or her coverage will become effective on such later date when the Employee begins work. Each Employee who was covered under the Prior Plan, if any, will be eligible on the Effective Date of this Plan. Any Service Waiting Period or portion thereof satisfied under the Prior Plan, if any, will be applied toward satisfaction of the Service Waiting Period of this Plan.

Pursuant to § 4980H of the Affordable Care Act, eligible employees include *employees* which are determined by the *participating employer* to have met eligibility requirements during any stability and measurement periods.

After you become covered under the Plan, if your employment ends and you return to active employment within 13 weeks, the waiting period will not apply. If you had not satisfied your waiting period before your employment ended and you return to active employment within 13 weeks you will be given credit for the period of time previously credited toward satisfaction of your waiting period on the first day you return to active employment. However, if the Employee is returning to work and continues his or her COBRA coverage until he again becomes eligible for coverage as an Employee, any limitations provision will apply only to the extent it was in effect on the last day of COBRA coverage.

3.02 Eligibility Dates for Dependent Coverage

Each Employee will become eligible for coverage under this Plan for his or her Dependents on the latest of the following dates:

1. His or her date of eligibility for coverage for himself or herself under the Plan;
2. The date coverage for his or her Dependents first becomes available under any amendment to the Plan, if such coverage was not provided under the Plan on the Effective Date of the Plan; and
3. The first date upon which he or she acquires a Dependent.

In no event will any Dependent Child be covered as a Dependent of more than one Employee who is covered under the Plan.

If the Dependent Spouse is eligible to obtain group health coverage through his or her employer, and does not elect to do so, the Dependent Spouse will not be eligible for coverage under this Plan. However, the Dependent Spouse may elect to be covered under his or her employer's group health coverage and also be covered under this Plan. In the latter case, the Dependent Spouse's employer's group health coverage will always be primary and his or her coverage under this Plan will always be secondary.

Any reference in this Plan to an Employee's Dependent being covered means that such Employee is covered for Dependent Coverage.

"Michelle's Law" prohibits a group health plan, or a health insurance issuer that provides health insurance coverage in connection with a group health plan, from terminating coverage of a Dependent Child due to a qualifying "Medically Necessary Leave of Absence" from, or other change in enrollment at, a postsecondary educational Institution prior to the earlier of:

1. The date that is one year after the first day of the Medically Necessary Leave of Absence; or
2. The date on which such coverage would otherwise terminate under the terms of the Plan.

In order to be a Medically Necessary Leave of Absence the student's leave must:

1. Commence while the Dependent Child is suffering from a serious Illness or Injury;
2. Be Medically Necessary; and
3. Cause the Dependent Child to lose student status for purposes of coverage under the terms of the parents' plan or coverage.

A Child is a "Dependent Child" under the law if he or she:

1. Is a Dependent Child, under the terms of the Plan or coverage, is a Dependent of a Participant under the Plan or coverage; and
2. Was enrolled in the Plan or coverage, on the basis of being a student at a postsecondary educational Institution, immediately before the first day of the Medically Necessary Leave of Absence.

A treating Physician of the Dependent Child must certify that the Dependent Child is suffering from a serious Illness or Injury and that the Leave of Absence (or other change of enrollment) described is Medically Necessary.

3.03 Effective Dates of Coverage; Conditions

The coverage for which an individual is eligible under this Plan will become effective on the date specified below, subject to the conditions of this section.

1. Enrollment Form. Employee(s) may seek to obtain coverage for themselves and/or Dependents via a form furnished by the Plan Administrator, in a manner that is satisfactory to the Plan Administrator, and within 31 days following the applicable date of eligibility. If coverage is available and appropriate, coverage will become effective after review of the form, and upon the subsequent date such Employee or Dependents are eligible.

2. Coverage as Both Employee and Dependent. A Participant that may enroll in this Plan as an Employee or a Dependent may enroll as either an Employee or Dependent, but not both.

3. Birth of Dependent Child. If a Dependent Child is born to an Employee on a date subsequent to the date their coverage goes into effect, coverage shall be deemed to be in effect for said Child at and after the moment of birth, and any Plan limitations applicable to congenital defects shall not apply to such Child. The coverage shall continue for 31 days as it applies to the aforementioned Child, but shall subsequently terminate unless Employee submits a written application to the Plan, to enroll the Child. The application must also be accompanied by any required contribution, ongoing, as the case may be. Should an Employee already have secured coverage for Dependents at the date of such Child's birth, the additional application may not be required.

4. Newly Acquired Dependents. If while an Employee is enrolled for coverage, that Employee acquires a Dependent, coverage for the newly acquired Dependent shall be effective on the date the Dependent becomes eligible only if the existing coverage extends to Dependents. If coverage for Dependents has not already been secured by the Employee, a written application must be made to the Plan within 31 days of the date of the newly acquired Dependent's eligibility, and any required contributions are also to be made if enrollment is otherwise approved by the Plan Administrator.

5. Requirement for Employee Coverage. Coverage for Dependents shall only be available to Dependents of Employees eligible for coverage him or herself

6. Dependents of Multiple Employees. If a Dependent may be deemed to be a Dependent of more than one Covered Employee, such Dependent shall be deemed to be a Dependent of one such Employee only.

7. Medicaid Coverage. An individual's eligibility for any State Medicaid benefits will not be taken into account by the Plan in determining that individual's eligibility under the Plan.

8. FMLA Leave. Regardless of any requirements set forth in the Plan, the Plan shall at all times comply with FMLA.

NOTE: It is the responsibility of the enrolled Employee to notify his/her Employer of any changes in the Dependent's status.

3.04 Special and Open Enrollment

Federal law requires and the Plan provides so-called "Special Enrollment Periods," during which Employees may enroll in the Plan, even if they declined to enroll during an initial or subsequent eligibility period. The Special Enrollment rules are described in more detail within this Article.

3.04A Loss of Other Coverage

This Plan will permit an eligible Employee or Dependent (including his or her spouse) who is eligible, but not enrolled, to enroll for coverage under the terms of the Plan if each of the following conditions are met:

1. The eligible Employee or Dependent was covered under another group health plan or had other health insurance coverage at the time coverage under this Plan was offered;
2. The eligible Employee stated in writing at the time this Plan was offered, that the reason for declining enrollment was due to the eligible Employee having coverage under another group health plan or due to the Employee having other health insurance coverage;
3. The eligible Employee or Dependent lost other coverage pursuant to one of the following events:
    a. The eligible Employee or Dependent was under COBRA and the COBRA coverage was exhausted;
    b. The eligible Employee or Dependent was not under COBRA and the other coverage was terminated as a result of loss of eligibility (including as a result of Legal Separation, divorce, loss of Dependent status, death, termination of employment, or reduction in the number of hours worked);
    c. The eligible Employee or Dependent moved out of an HMO service area with no other option available;
    d. The Plan is no longer offering benefits to a class of similarly situated individuals;
    e. The benefit package option is no longer being offered and no substitute is available; or
    f. The Employer contributions were terminated; and
4. Under the terms of this Plan, the eligible Employee requests enrollment into this Plan not later than 30 days after an event, as described in item 3 above.

If an Employee is currently enrolled in a benefit package, the Employee may elect to enroll in another benefit package under the Plan if:

1. Multiple benefit packages are available, and
2. A Dependent of the enrolled Employee has a special enrollment right in the Plan because the Dependent has lost eligibility for other coverage.

The Employee must apply for special enrollment in the new benefit package in writing within 30 days of the date the other health coverage was lost.

Special enrollment rights will not be available to an Employee or Dependent if:

1. The other coverage is/was available via COBRA Continuation Coverage and the Employee or Dependent failed to exhaust the maximum time available to him or her for such COBRA coverage; or
2. The Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the Other Plan).

For an eligible Employee or Dependent(s) who has met the conditions specified above, this Plan will be effective at 12:01 A.M. on the first day of the first calendar month beginning after the date the written request for enrollment is received by the Plan and the request is made within 31 days from loss of coverage. For example, if the Employee loses his or her other health coverage on April 22, he or she must notify the Plan Administrator and apply for coverage by close of business on May 23.

3.04B New Dependent

An Employee or Dependent who is eligible, but not enrolled in this Plan, may be eligible to enroll during a special enrollment period if an Employee acquires a new Dependent as a result of marriage, birth, adoption, or placement for adoption. To be eligible for this special enrollment, the Employee must apply in writing no later than 31 days after he or she acquires the new Dependent. For example, if the Employee or Employee's spouse gives birth to a baby on June 22, he or she must notify the Plan Administrator and apply for coverage by close of business on July 23. The following conditions apply to any eligible Employee and Dependents:

An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll during a special enrollment period if:

1. The eligible Employee is a covered Employee under the terms of this Plan but elected not to enroll during a previous enrollment period; and
2. An individual has become a Dependent of the eligible Employee through marriage, birth, adoption, or placement for adoption.

If the conditions for special enrollment are satisfied, the coverage of the Dependent and/or Employee enrolled during the Special Enrollment Period will be effective at 12:01 A.M.:

1. In the case of marriage, on the date of the marriage;
2. In the case of a Dependent's birth, as of the date of birth; or
3. In the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

3.04C Additional Special Enrollment Rights

Employees and Dependents who are eligible but not enrolled are entitled to enroll under the following circumstances:

1. The Employee's or Dependent's Medicaid or State Child Health Insurance Plan (i.e. CHIP) coverage has terminated as a result of loss of eligibility and the Employee requests coverage under the Plan within 60 days after the termination; or
2. The Employee or Dependent become eligible for a contribution / premium assistance subsidy under Medicaid or a State Child Health Insurance Plan (i.e. CHIP), and the Employee requests coverage under the Plan within 60 days after eligibility is determined.

3.04D Open Enrollment

Prior to the start of a Plan Year, this Plan has an Open Enrollment Period. Eligible Participants who are not covered under this Plan may enroll for coverage during Open Enrollment Periods. Employees who are enrolled will be given an opportunity to change their coverage effective the first day of the upcoming Plan Year. A Participant who fails to make an election during the Open Enrollment Period will automatically retain his or her present coverages. Coverage for Participants enrolling during an Open Enrollment Period will become effective on July 1st, unless the Employee has not satisfied the Service Waiting Period, in which event coverage for the Employee and his or her Dependents will become effective on the day following completion of the Service Waiting Period.

The terms of the Open Enrollment Period, including duration of the election period, shall be determined by the Plan Administrator and communicated prior to the start of an Open Enrollment Period.

The Open Enrollment Period shall occur on an annual basis in each Plan Year.

3.04E Effective Date of Coverage; Conditions

All conditions for effectiveness of coverage under the Plan, which are set forth in the section entitled "Effective Dates of Coverage; Conditions," will apply to Participants enrolling during a special or Open Enrollment Period. Coverage for Participants enrolling during a special enrollment period will become effective on the first day following the enrollment due to loss of coverage or marriage, and on the date of birth, adoption or placement for adoption in the case of such events.

3.05 Qualified Medical Child Support Orders

This Plan will provide for immediate enrollment and benefits to the Child(ren) of a Participant who are the subject of a Qualified Medical Child Support Order (QMCSO), regardless of whether the Child(ren) reside with the Participant, provided the Child or Child(ren) are not already enrolled as an eligible Dependent as described in this Plan. If a QMCSO is issued, then the Child(ren) shall become Alternate Recipient(s) of the benefits under this Plan, subject to the same limitations, restrictions, provisions and procedures as any other Participant. The Plan Administrator will determine if the order properly meets the standards described herein. A properly completed National Medical Support Notice (NMSN) will be treated as a QMCSO and will have the same force and effect.

"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.

"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 of a Participant 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. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. The name of an issuing State child support enforcement agency;
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment;
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which 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 eligible Dependent is entitled under this Plan.

To be considered a Qualified Medical Child Support Order, the medical child support order must contain the following information:

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 this 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 applies; and
4. The name of this Plan.

A National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "National Medical Support Notice";
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated;

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.

An NMSN need not be recognized as a QMSCO if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and eligible Participants without regard to the provisions herein, 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).

In the instance of any Medical Child Support Order received by this Plan, the Plan Administrator shall, as soon as administratively possible:

1. In writing, notify the Participant and each Alternate Recipient covered by such Order (at the address included in the Order) of the receipt of such Order and the Plan's procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

In the instance of any National Medical Support Notice received by this Plan, the Plan Administrator shall:

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

As required by Federal law, the Plan Administrator shall:

1. Establish reasonable procedures to determine whether Medical Child Support Order or National Medical Support Notice are Qualified Medical Child Support Orders; and
2. To administer the provision of benefits under such qualified orders.
3. Such procedures shall
    a. Be in writing;
    b. Provide for the notification of each person specified in a Medical Child Support Order as eligible to receive benefits under the plan (at the address included in the Medical Child Support Order) of such procedures promptly upon receipt by the plan of the Medical Child Support Order; and
    c. Permit an Alternate Recipient to designate a representative for receipt of copies of notices that are sent to the Alternate Recipient with respect to a Medical Child Support Order.

3.06 Late Enrollee

"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

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

3.07 Acquired Companies

Eligible Employees of an acquired company who are Actively at Work and were covered under the Prior Plan of the acquired company will be eligible for the benefits under this Plan on the date of acquisition. Any waiting period previously satisfied under the prior health plan will be applied toward satisfaction of the Service Waiting Period of

this Plan. In the event that an acquired company did not have a health plan, all eligible Employees will be eligible on the date of the acquisition.

3.08 Genetic Information Nondiscrimination Act ("GINA")

"GINA" prohibits group health plans, issuers of individual health care policies, and Employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

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.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detect genotypes, mutations, or chromosomal changes. Genetic information is a form of Protected Health Information (PHI) as defined by and in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and is subject to applicable Privacy and Security Standards.

Family members as it relates to GINA include Dependents, plus all relatives to the fourth degree, without regard to whether they are related by blood, marriage, or adoption. Underwriting as it relates to GINA includes any rules for determining eligibility, computing premiums or contributions, and applying preexisting conditions. Offering reduced premiums or other rewards for providing genetic information would be impermissible underwriting.

GINA will not prohibit a health care Provider who is treating an individual from requesting that the patient undergo genetic testing. The rules permit the Plan to obtain genetic test results and use them to make claims payment determinations when it is necessary to do so to determine whether the treatment provided to the patient was medically advisable and/or necessary.

The Plan may request, but not require, genetic testing in certain very limited circumstances involving research, so long as the results are not used for underwriting, and then only with written notice to the individual that participation is voluntary and will not affect eligibility for benefits, premiums or contributions. In addition, the Plan will notify and describe its activity to the Health and Human Services secretary of its activities falling within this exception.

While the Plan may collect genetic information after initial enrollment, it may not do so in connection with any annual renewal process where the collection of information affects subsequent enrollment. The Plan will not adjust premiums or increase group contributions based upon genetic information, request or require genetic testing or collect genetic information either prior to or in connection with enrollment or for underwriting purposes.

ARTICLE IV
TERMINATION OF COVERAGE

4.01 Termination Dates of Individual Coverage

The coverage of any Employee for himself or herself under this Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated;
2. The date the covered Employee's eligible class is eliminated;
3. The day of the month in, or with respect to which, he or she requests that such coverage be terminated, on the condition that such request is made on or before such date;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for himself or herself to which he or she has agreed in writing;
5. The date of the month in which he or she is no longer eligible for such coverage under the Plan;
6. The date and time of the month in which the termination of employment occurs; or
7. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

4.02 Termination Dates of Dependent Coverage

The coverage for any Dependents of any Employee who are covered under the Plan will terminate on the earliest to occur of the following dates:

1. The date upon which the Plan is terminated;
2. Upon the discontinuance of coverage for Dependents under the Plan;
3. The date of termination of the Employee's coverage for himself or herself under the Plan;
4. The date of the expiration of the last period for which the Employee has made a contribution, in the event of his or her failure to make, when due, any contribution for coverage for Dependents to which he or she has agreed in writing;
5. In the case of a Child age 26 or older for whom coverage is being continued due to mental or physical inability to earn his or her own living, the earliest to occur of:
    a. Cessation of such disability or inability;
    b. Failure to provide any required proof of continuous disability or inability or to submit to any required examination; or
    c. Upon the Child's no longer being dependent on the Employee for his or her support;
6. The day immediately preceding the date such person is no longer a Dependent, as defined herein, except as may be provided for in other areas of this section;
7. For a Dependent Child whose coverage is required pursuant to a QMCSO, the last day of the calendar month as of which coverage is no longer required under the terms of the order or this Plan; or
8. Immediately upon submission of a fraudulent claim or any fraudulent information to the Plan (including enrollment information), by and/or on behalf of an Employee or his or her Dependent, or upon the Employee or his or her Dependent gaining knowledge of the submission, as determined by the Plan Administrator in its discretion, consistent with applicable laws and/or rules regarding such rescission.

ARTICLE V
SUMMARY OF BENEFITS

5.01 General Limits
Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions. All coverage figures are after the out of pocket Deductible has been satisfied. Benefits for Pregnancy expenses, are paid the same as any other Sickness.

Failure to comply with Utilization Management will result in a higher cost to Participants. "Utilization Management" includes Hospital pre-admission certification, continued stay review, length of stay determination and discharge planning. These programs are designed to ensure that Medically Necessary, high quality patient care is provided and enables maximum benefits under the Plan.

5.01A Services that Require Pre-Certification
See Section 7.04A for a list of services that require pre-certification (or reimbursement from the Plan may be reduced).

5.01B Pre-Certification Procedures and Contact Information
See Section 7.04B for Pre-Certification or Notification Procedures and Contact Information.

5.01C Pre-Certification Penalty
See Section 7.04C for Pre-Certification Penalty information.

5.01D Network and Non-Network Provider Arrangement
The Plan contracts with the medical Provider Networks to access discounted fees for service for Participants. Hospitals, Physicians and other Providers who have contracted with the medical Provider Networks are called "Network Providers." Those who have not contracted with the Networks are referred to in this Plan as "Non-Network Providers." This arrangement results in the following benefits to Participants:

1. The Plan provides different levels of benefits based on whether the Provider Participants use is a Network or Non-Network Provider. Unless one of the exceptions shown below applies, if a Participant elects to receive medical care from the Non-Network Provider, the benefits payable are generally lower than those payable when a Network Provider is used. The following exceptions apply:
    a. In the event a Network Provider refers a Participant to a non-Network Provider and is preauthorized by the Third Party Administrator;
    b. In the event a Participant has no choice of Network Providers in the specialty that the Participant is seeking within the PPO service area; and
    c. The Network Provider level of benefits is payable when a Participant receives Emergency care either Out of Area or at a Non-Network Hospital for an Accidental Bodily Injury or Emergency.

2. If the charge billed by a Non-Network Provider for any covered service is higher than the Usual and Customary fees determined by the Plan, Participants are responsible for the excess unless the Provider accepts Assignment of Benefits as consideration in full for services rendered. Since Network Providers have agreed to accept a negotiated discounted fee as full payment for their services, Participants are not responsible for any billed amount that exceeds that fee.

3. To receive benefit consideration, Participants must submit claims for services provided by Non-Network Providers to the Third Party Administrator. Network Providers have agreed to bill the Plan directly, so that Participants do not have to submit claims themselves.

4. Benefits available to Network Providers are limited such that if a Network Provider advances or submits charges which exceed amounts that are eligible for payment in accordance with the terms of the Plan, or are for services or supplies for which Plan coverage is not available, or are otherwise limited or excluded by the Plan, benefits will be paid in accordance with the terms of the Plan.

Please note affirmation that a treatment, service, or supply is of a type compensable by the Plan is not a guarantee that the particular treatment, service, or supply in question, upon receipt of a Clean Claim and review by the Plan Administrator, will be eligible for payment.

5.02 Balance-Billing

In the event that a claim submitted by a Network or non-Network Provider is subject to a medical bill review or medical chart audit and that some or all of the charges in connection with such claim are repriced because of billing errors and/or overcharges, it is the Plan's position that the Participant should not be responsible for payment of any charges denied as a result of the medical bill review or medical chart audit, and should not be balance-billed for the difference between the billed charges and the amount determined to be payable by the Plan Administrator. However, balance-billing is legal in many jurisdictions, and the Plan has no control over non-Network Providers that engage in balance-billing practices.

In addition, with respect to services rendered by a Network Provider being paid in accordance with a discounted rate, it is the Plan's position that the Participant should not be responsible for the difference between the amount charged by the Network Provider and the amount determined to be payable by the Plan Administrator, and should not be balance-billed for such difference. Again, the Plan has no control over any Network Provider that engages in balance-billing practices, except to the extent that such practices are contrary to the contract governing the relationship between the Plan and the Network Provider.

The Participant is responsible for payment of Co-insurances, Deductibles, and Out-of-Pocket Maximums and may be billed for any or all of these.

5.03 Choice of Providers

The Plan is not intended to disturb the Physician-patient relationship. Each Participant has a free choice of any Physician or surgeon, and the Physician-patient relationship shall be maintained. Physicians and other healthcare Providers are not agents or delegates of the Plan Sponsor, Company, Plan Administrator, Employer or Third Party Administrator. The delivery of medical and other healthcare services on behalf of any Participant remains the sole prerogative and responsibility of the attending Physician or other healthcare Provider. The Participant, together with his or her Physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care.

5.04 Preferred Provider Information

This Plan contains provisions under which a Participant may receive more benefits by using certain Providers. These Providers are individuals and entities that have contracted with the Plan to provide services to Participants at pre-negotiated rates. The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

A current list of Network Providers is available, without charge, through the Third Party Administrator's website (located at www.strateben.com). If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, contact the Human Relations Department. The Network Provider list changes frequently; therefore, it is recommended that a Participant verify with the Provider that the Provider is still a Network Provider before receiving services. Please refer to the Participant identification card for the Network website address.

5.05 Claims Audit

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

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

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

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

5.06 Calendar Year Maximum Benefit – Gold Plan

The following Calendar Year maximums apply to each Participant.

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM PLAN YEAR BENEFIT AMOUNT	Unlimited	
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total that may be split between Participating and Non-Participating Providers.		
DEDUCTIBLE, PER PLAN YEAR	Amounts applied to the Deductible for charges from Participating Providers will not be used to satisfy the Deductible for charges from Non-Participating Providers and vice versa.	
	$750 per person	$1,500 per person
	$1,500 per family	$3,000 per family
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Participating Providers will not be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Participating Providers and vice versa. The out of pocket maximum listed below does include the deductible.	
Per Participant	$3,500	$8,500
Per Family Unit	$7,000	$17,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Cost containment penalties Non-Covered Expenses Amounts that exceed the Usual and Customary Charge or benefit maximums		

5.07 Summary of Benefits – Medical – Gold Plan

The following benefits are per Participant per Plan Year:

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Ambulance Service	80% after Deductible	
Attention Deficit Disorder & Attention Deficit Hyperactivity Disorder Treatment		
Office Visit	100% after $20 co-pay, no Deductible	60% after Deductible
Other services	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Cardiac Rehabilitation Therapy	80% after Deductible	60% after Deductible
Chemotherapy Includes services provided in physician's office.	80% after Deductible	60% after Deductible
CT Scan, MRI, PET Scan *Only for outpatient services not performed at a Physician's office*	80% after Deductible	60% after Deductible
Developmental Disorders / Delay (e.g., Autism)	Not Covered	Not Covered
Diabetic Education	80% after Deductible	60% after Deductible
Diabetic Supplies	80% after Deductible	60% after Deductible
Dialysis Treatment	80% after Deductible	60% after Deductible
Durable Medical Equipment Limited to once every 2 years for irreparable damage and/or normal wear.	80% after Deductible	60% after Deductible
Family Planning **Sterilization** *Note: Preventive services required by the Patient Protection and Affordable Care Act to be* ***covered for women*** *(e.g., contraceptive methods approved by the Food and Drug Administration for women) are payable at 100%, Deductible waived, if received from a Network Provider.*	80%, after one time $300 Deductible	60%, after one time $300 Deductible
Genetic Tests that are an item or service required to be covered by 29 CFR Section 2590.715-2713 of the Patient Protection and Affordable Care Act (i.e., a preventive health service included in the recommendations and guidelines listed in that section). **Genetic Tests** that are Medically Necessary and meet the conditions listed in the Medical Benefits section of the Plan.	100%, no Deductible 80% after Deductible	60% after Deductible 60% after Deductible
Home Health Care	80% after Deductible	60%, after Deductible
Hospice Care (Bereavement Counseling)	80% after Deductible	60%, after Deductible
Hospice Care (Inpatient & Outpatient)	80% after Deductible	60%, after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Hospital Services		
Room and Board *Benefits are payable up to the facility's semi-private room rate. Confinement Deductible is waived for newborns.*	80% after Deductible	60% after Deductible
Intensive Care Unit *Benefits are payable at the facility's ICU rate.*	80% after Deductible	60% after Deductible
Emergency Room (Medical Emergency)	100% after $300 copay, Deductible waived	100% after $300 copay, Deductible waived
Non-Emergency Use of Emergency Room	100% after $500 copay, Deductible waived	100% after $500 copay, Deductible waived
The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization management administrator must be notified within 48 hours after the admission, even if the patient is discharged within 48 hours after the admission.		
Routine Well Newborn Care (Inpatient Care)	80% after Deductible	60% after Deductible
Inpatient Private Duty Nursing *See limits in Medical Benefits section*	80% after Deductible	60% after Deductible
Pre-admission Testing	80% after Deductible	60% after Deductible
All other charges from a Hospital for inpatient services; or from a Hospital or Ambulatory Surgical Facility for Outpatient Surgery, including Diagnostic Colonoscopy and Cardiac Catheterization	80% after Deductible	60% after Deductible
Impotence Testing and Treatment	Not Covered unless as the result of an Illness or Injury sustained while covered by the Plan.	Not Covered unless as the result of an Illness or Injury sustained while covered by the Plan.
Independent Laboratory Services *(i.e., not in Physician office or Hospital and non-routine)*	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Independent Laboratory Services provided and billed by Quest or LabCorp	100%, no Deductible	Not Covered
Independent X-ray Services *(i.e., not in Physician office or Hospital and non-routine; also does not include CT scan, MRI, PET scan)*	80% after Deductible	60% after Deductible
Infusion Therapy	80% after Deductible	60% after Deductible
Injectables	80% after Deductible	60% after Deductible
Jaw Joint/TMJ Services	Not Covered	Not Covered
Maternity Services Office Services Inpatient Hospital and all other Charges	100% after $20 co-pay. Co-pay applies to the first office visit only. 80% after Deductible	60% after Deductible 60% after Deductible
Mental Disorders		
Inpatient	80% after Deductible	60% after Deductible
Partial Hospitalization	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Office Visit	100% after $20 co-pay, no Deductible	60% after Deductible
Occupational Therapy, Speech Therapy and Physical Therapy (combined) Inpatient: 45 days per Calendar Year combined Maximum Outpatient: 30 visits per Calendar Year combined Maximum	80% after Deductible	60% after Deductible
Organ Procurement Transplants	80% after Deductible	60% after Deductible
Organ Transplants	80% after Deductible	60% after Deductible
Orthotics	80% after Deductible	60% after Deductible
Outpatient Private Duty Nursing	Not Covered	Not Covered
Pain Management	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Physician		
Inpatient visits *Includes inpatient well newborn care*	80% after Deductible	60% after Deductible
Emergency Room Services	Included in Hospital Emergency Room benefit	Included in Hospital Emergency Room benefit
Office Visit – Primary Care Physician	100% after $20 co-pay, no Deductible	60% after Deductible
Office Visit Services – Primary Care Physician These include laboratory services, x-rays, surgery and diagnostic tests performed in the office on the same day as office visit. Benefits for injections performed in the office are described below.	100%, no Deductible	60% after Deductible
Services performed in office but not associated with office visit (i.e., no office visit charge) Specialist Physician. These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below.	100% after $20 copay, no Deductible	60% after Deductible
Office Visit – Specialist Physician	100% after $40 co-pay, no Deductible	60% after Deductible
Office Visit Services – Specialist Physician These include laboratory services, x-rays, surgery and diagnostic tests performed in the office on the same day as office visit. Benefits for injections performed in the office are described below.	100%, no Deductible	60% after Deductible
Services performed in office but not associated with office visit (i.e., no office visit charge) Specialist Physician. These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below.	100% after $40 co-pay, no Deductible	60% after Deductible
Injections Allergy injections and serum	80% after Deductible	60% after Deductible
Other injections	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Allergy Testing	80% after Deductible	60% after Deductible
PHYSICIAN SERVICES		
Inpatient Surgery	80% after Deductible	60% after Deductible
Outpatient Surgery	80% after Deductible	60% after Deductible
Extraction of Impacted Teeth	80% after Deductible	60% after Deductible
Second Surgical Opinion	100% after $40 co-pay	60% after Deductible
Endoscopic Tests (Non-Routine)	80% after Deductible	60% after Deductible
Contraceptive Management	100%, no Deductible	
Office Visit	100%, no Deductible	60% after Deductible
Injections	100%, no Deductible 100%, no Deductible 100%, no Deductible 100%, no Deductible 100%, no Deductible	60% after Deductible
Implants		60% after Deductible
Intrauterine Device		60% after Deductible
Diaphragm		60% after Deductible
Female condom		60% after Deductible
Over the Counter Contraceptives*(must be approved by the Food and Drug Administration for women and prescribed by a Physician)*		Not Covered
TelaDoc- 1-800-TelaDoc	100% after $10 Co-pay	**Not Covered**

PREVENTIVE CARE

The Plan will cover the following preventive services from Participating Providers:

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force *except* for the recommendations issued in or around November of 2009 for breast cancer screening, mammography, and prevention are not considered to be current.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

	PARTICIPATING PROVIDERS	**NON-PARTICIPATING PROVIDERS**
Routine Well Adult Care		
Physical examination, gynecological exam, pap smear, mammogram (limited to one each year for women ages 40 and over), prostate screening, colonoscopy, and fecal occult screening.	100%	60% after Deductible
Vision Exam	Not Covered	Not Covered
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Hearing Exam	Not Covered	Not Covered
Routine Well Child Care (for individuals from age 0 **through** age 19)		
Physical examination, Immunizations, x-rays and laboratory tests	100%	60% after Deductible
Hearing Screening	80% after Deductible	60% after Deductible
Vision Screening	Not Covered except as required to be covered under the Affordable Care Act	Not Covered
Routine Well Child Care (for individuals from age 0 **through** age 19)		
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Injections Allergy injections and serum	80% after Deductible	60% after Deductible
Allergy Testing	80% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Prosthetics	80% after Deductible	60% after Deductible
Radiation Therapy	80% after Deductible	60% after Deductible
Routine Patient Costs Associated with Approved Clinical Trials	80% after Deductible	60% after Deductible
Skilled Nursing Facility *Benefits payable at the facility's semiprivate room rate.* *Confinement must immediately follow a Hospital stay or home health care utilization.* *Calendar Year Maximum: 100 days*	80% after Deductible	60% after Deductible
Sleep Disorder	80% after Deductible	60% after Deductible
Sleep Study	80% after Deductible	60% after Deductible
Spinal Manipulation Chiropractic Maximum 20 visits per Calendar Year	100% after $40 co-pay	60% after Deductible
Substance Abuse		
Inpatient Services	80% after Deductible	60% after Deductible
Partial Hospitalization	80% after Deductible	60% after Deductible
Outpatient	80% after Deductible	60% after Deductible
Office Visit	100% after $20 co-pay, no Deductible	60% after Deductible
Urgent Care Center	100% after $40 co-pay, no Deductible	100% after $40 co-pay, no Deductible
Wig after Chemotherapy *Limited to one every 24 months*	80% after Deductible	60% after Deductible

5.08 Calendar Year Maximum Benefit – Silver Plan

The following Calendar Year maximums apply to each Participant.

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
MAXIMUM PLAN YEAR BENEFIT AMOUNT	Unlimited	
Note: The maximums listed below are the total for Participating and Non-Participating expenses. For example, if a maximum of 60 days is listed twice under a service, the Plan Year maximum is 60 days total that may be split between Participating and Non-Participating Providers.		
DEDUCTIBLE, PER PLAN YEAR	Amounts applied to the Deductible for charges from Participating Providers will not be used to satisfy the Deductible for charges from Non-Participating Providers and vice versa.	
	$2,000 per person	$4,000 per person
	$4,000 per family	$8,000 per family
MAXIMUM OUT-OF-POCKET AMOUNT, PER PLAN YEAR	Amounts applied to the Maximum Out-Of-Pocket Amount for charges from Participating Providers will not be used to satisfy the Maximum Out-of-Pocket Amount for charges from Non-Participating Providers and vice versa. The out of pocket maximum listed below does include the deductible.	
Per Participant	$5,000	$10,000
Per Family Unit	$10,000	$20,000
The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Plan Year unless stated otherwise.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Cost containment penalties Non-Covered Expenses Amounts that exceed the Usual and Customary Charge or benefit maximums		

5.09 Summary of Benefits – Medical – Silver Plan

The following benefits are per Participant per Plan Year:

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Ambulance Service	70% after Deductible	
Attention Deficit Disorder & Attention Deficit Hyperactivity Disorder Treatment		
Office Visit	100% after $30 co-pay, no Deductible	60% after Deductible
Other services	70% after Deductible	60% after Deductible
Cardiac Rehabilitation Therapy	70% after Deductible	60% after Deductible
Chemotherapy Includes services provided in physician's office.	70% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
CT Scan, MRI, PET Scan *Only for outpatient services not performed at a Physician's office*	70% after Deductible	60% after Deductible
Developmental Disorders / Delay (e.g., Autism)	Not Covered	Not Covered
Diabetic Education	70% after Deductible	60% after Deductible
Diabetic Supplies	70% after Deductible	60% after Deductible
Dialysis Treatment	70% after Deductible	60% after Deductible
Durable Medical Equipment Limited to once every 2 years for irreparable damage and/or normal wear.	70% after Deductible	60% after Deductible
Family Planning **Sterilization** *Note: Preventive services required by the Patient Protection and Affordable Care Act to be* ***covered for women*** *(e.g., contraceptive methods approved by the Food and Drug Administration for women) are payable at 100%, Deductible waived, if received from a Network Provider.*	70%, after one time $300 Deductible	60%, after one time $300 Deductible
Genetic Tests that are an item or service required to be covered by 29 CFR Section 2590.715-2713 of the Patient Protection and Affordable Care Act (i.e., a preventive health service included in the recommendations and guidelines listed in that section). **Genetic Tests** that are Medically Necessary and meet the conditions listed in the Medical Benefits section of the Plan.	100%, no Deductible 70% after Deductible	60% after Deductible 60% after Deductible
Home Health Care	70% after Deductible	60%, after Deductible
Hospice Care (Bereavement Counseling)	70% after Deductible	60%, after Deductible
Hospice Care (Inpatient & Outpatient)	70% after Deductible	60%, after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Hospital Services		
Room and Board *Benefits are payable up to the facility's semi-private room rate. Confinement Deductible is waived for newborns.*	70% after Deductible	60% after Deductible
Intensive Care Unit *Benefits are payable at the facility's ICU rate.*	70% after Deductible	60% after Deductible
Emergency Room (Medical Emergency)	100% after $300 copay, Deductible waived	100% after $300 copay, Deductible waived
Non-Emergency Use of Emergency Room	100% after $500 copay, Deductible waived	100% after $500 copay, Deductible waived
The Emergency room co-payment is waived if the patient is admitted to the Hospital on an emergency basis. The utilization management administrator must be notified within 48 hours after the admission, even if the patient is discharged within 48 hours after the admission.		
Routine Well Newborn Care (Inpatient Care)	70% after Deductible	60% after Deductible
Inpatient Private Duty Nursing *See limits in Medical Benefits section*	70% after Deductible	60% after Deductible
Pre-admission Testing	70% after Deductible	60% after Deductible
All other charges from a Hospital for inpatient services; or from a Hospital or Ambulatory Surgical Facility for Outpatient Surgery, including Diagnostic Colonoscopy and Cardiac Catheterization	70% after Deductible	60% after Deductible
Impotence Testing and Treatment	Not Covered unless as the result of an Illness or Injury sustained while covered by the Plan.	Not Covered unless as the result of an Illness or Injury sustained while covered by the Plan.
Independent Laboratory Services *(i.e., not in Physician office or Hospital and non-routine)*	70% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Independent Laboratory Services provided and billed by Quest or LabCorp	100%, no Deductible	Not Covered
Independent X-ray Services *(i.e., not in Physician office or Hospital and non-routine; also does not include CT scan, MRI, PET scan)*	70% after Deductible	60% after Deductible
Infusion Therapy	70% after Deductible	60% after Deductible
Injectables	70% after Deductible	60% after Deductible
Jaw Joint/TMJ Services	Not Covered	Not Covered
Maternity Services Office Services Inpatient Hospital and all other Charges	100% after $30 co-pay. Co-pay applies to the first office visit only. 70% after Deductible	60% after Deductible 60% after Deductible
Mental Disorders		
Inpatient	70% after Deductible	60% after Deductible
Partial Hospitalization	70% after Deductible	60% after Deductible
Outpatient	70% after Deductible	60% after Deductible
Office Visit	100% after $30 co-pay, no Deductible	60% after Deductible
Occupational Therapy, Speech Therapy and Physical Therapy (combined) Inpatient: 45 days per Calendar Year combined Maximum Outpatient: 30 visits per Calendar Year combined Maximum	70% after Deductible	60% after Deductible
Organ Procurement Transplants	70% after Deductible	60% after Deductible
Organ Transplants	70% after Deductible	60% after Deductible
Orthotics	70% after Deductible	60% after Deductible
Outpatient Private Duty Nursing	Not Covered	Not Covered
Pain Management	70% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Physician		
Inpatient visits *Includes inpatient well newborn care*	70% after Deductible	60% after Deductible
Emergency Room Services	Included in Hospital Emergency Room benefit	Included in Hospital Emergency Room benefit
Office Visit – Primary Care Physician	100% after $30 co-pay, no Deductible	60% after Deductible
Office Visit Services – Primary Care Physician These include laboratory services, x-rays, surgery and diagnostic tests performed in the office on the same day as office visit. Benefits for injections performed in the office are described below.	100%, no Deductible	60% after Deductible
Services performed in office but not associated with office visit (i.e., no office visit charge) Specialist Physician. These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below.	100% after $30 copay, no Deductible	60% after Deductible
Office Visit – Specialist Physician	100% after $60 co-pay, no Deductible	60% after Deductible
Office Visit Services – Specialist Physician These include laboratory services, x-rays, surgery and diagnostic tests performed in the office on the same day as office visit. Benefits for injections performed in the office are described below.	100%, no Deductible	60% after Deductible
Services performed in office but not associated with office visit (i.e., no office visit charge) Specialist Physician. These include laboratory services, x-rays, and diagnostic tests. Benefits for injections performed in the office are described below.	100% after $60 co-pay, no Deductible	60% after Deductible
Injections Allergy injections and serum	70% after Deductible	60% after Deductible
Other injections	70% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Allergy Testing	70% after Deductible	60% after Deductible
PHYSICIAN SERVICES		
Inpatient Surgery	70% after Deductible	60% after Deductible
Outpatient Surgery	70% after Deductible	60% after Deductible
Extraction of Impacted Teeth	70% after Deductible	60% after Deductible
Second Surgical Opinion	100% after $60 co-pay	60% after Deductible
Endoscopic Tests (Non-Routine)	70% after Deductible	60% after Deductible
Contraceptive Management Office Visit	100%, no Deductible 100%, no Deductible	60% after Deductible
Injections	100%, no Deductible 100%, no Deductible 100%, no Deductible 100%, no Deductible 100%, no Deductible	60% after Deductible
Implants		60% after Deductible
Intrauterine Device		60% after Deductible
Diaphragm		60% after Deductible
Female condom		60% after Deductible
Over the Counter		Not Covered
Contraceptives*(must be approved by the Food and Drug Administration for women and prescribed by a Physician)*		
TelaDoc- 1-800-TelaDoc	100% after $10 Co-pay	**Not Covered**

PREVENTIVE CARE

The Plan will cover the following preventive services from Participating Providers:

- Evidence based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force *except* for the recommendations issued in or around November of 2009 for breast cancer screening, mammography, and prevention are not considered to be current.
- Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.
- With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
- With respect to women, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

	PARTICIPATING PROVIDERS	**NON-PARTICIPATING PROVIDERS**
Routine Well Adult Care		
Physical examination, gynecological exam, pap smear, mammogram (limited to one each year for women ages 40 and over), prostate screening, colonoscopy, and fecal occult screening.	100%	60% after Deductible
Vision Exam	Not Covered	Not Covered
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Hearing Exam	Not Covered	Not Covered
Routine Well Child Care (for individuals from age 0 **through** age 19)		
Physical examination, Immunizations, x-rays and laboratory tests	100%	60% after Deductible
Hearing Screening	70% after Deductible	60% after Deductible
Vision Screening	Not Covered except as required to be covered under the Affordable Care Act	Not Covered
Routine Well Child Care (for individuals from age 0 **through** age 19)		
Vision Hardware (frames, lenses, and contacts)	Not Covered	Not Covered
Injections Allergy injections and serum	70% after Deductible	60% after Deductible
Allergy Testing	70% after Deductible	60% after Deductible

	PARTICIPATING PROVIDERS	NON-PARTICIPATING PROVIDERS
Prosthetics	70% after Deductible	60% after Deductible
Radiation Therapy	70% after Deductible	60% after Deductible
Routine Patient Costs Associated with Approved Clinical Trials	70% after Deductible	60% after Deductible
Skilled Nursing Facility *Benefits payable at the facility's semiprivate room rate.* *Confinement must immediately follow a Hospital stay or home health care utilization.* *Calendar Year Maximum: 100 days*	70% after Deductible	60% after Deductible
Sleep Disorder	70% after Deductible	60% after Deductible
Sleep Study	70% after Deductible	60% after Deductible
Spinal Manipulation Chiropractic Maximum 20 visits per Calendar Year	100% after $60 co-pay	60% after Deductible
Substance Abuse		
Inpatient Services	70% after Deductible	60% after Deductible
Partial Hospitalization	70% after Deductible	60% after Deductible
Outpatient	70% after Deductible	60% after Deductible
Office Visit	100% after $30 co-pay, no Deductible	60% after Deductible
Urgent Care Center	100% after $50 co-pay, no Deductible	100% after $50 co-pay, no Deductible
Wig after Chemotherapy *Limited to one every 24 months*	70% after Deductible	60% after Deductible

5.10 Summary of Benefits - Prescription Drug – Gold Plan

The following benefits are per Participant:

Covered Prescription Drug Expenses:	Participating Pharmacy[1]	Limits[2]
Plan Year Rx Deductible	$100	
Maximum Rx Out-of-Pocket Amount (includes Deductible)	Ind. $2,250/ Family $4,600	
Pharmacy Option: (Co-pays apply after Rx Deductible)		
Copayment, per prescription or refill, for generic	$10	See Article VIII
Copayment, per prescription or refill, for formulary name brands[3]	$40	See Article VIII
Copayment, per prescription or refill, for non-formulary name brands	$60	See Article VIII
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription	See Article VIII
Mail Order Option[4]:		
Copayment, per prescription or refill, for generic	$25	See Article VIII
Copayment, per prescription or refill, for formulary name brands[3]	$100	See Article VIII
Copayment, per prescription or refill, for non-formulary name brands	$150	See Article VIII
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription	See Article VIII

5.11 Summary of Benefits - Prescription Drug – Silver Plan

Covered Prescription Drug Expenses:	Participating Pharmacy[1]	Limits[2]
Plan Year Rx Deductible	$100	
Maximum Rx Out-of-Pocket Amount (includes Deductible)	Ind. $1,500/Family $3,100	
Pharmacy Option: (Co-pays apply after Rx Deductible)		
Copayment, per prescription or refill, for generic	$15	See Article VIII
Copayment, per prescription or refill, for formulary name brands[3]	$40	See Article VIII
Copayment, per prescription or refill, for non-formulary name brands	$65	See Article VIII

1 100% payment by Plan after copayment.

2 These limits are in addition to all other Plan exclusions, limitations and provisions set forth in this Plan. Please review the Plan carefully to determine benefits available.

3 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

4 Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription	See Article VIII
Mail Order Option[4]:		
Copayment, per prescription or refill, for generic	$37.50	See Article VIII
Copayment, per prescription or refill, for formulary name brands	$100	See Article VIII
Copayment, per prescription or refill, for non-formulary name brands[5]	$162.50	See Article VIII
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription	See Article VIII

[5] Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

ARTICLE VI
MEDICAL BENEFITS

6.01 Medical Benefits

Subject to the Plan's provisions, limitations and exclusions, the following are covered major medical benefits:

1. **Ambulance.** Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Third Party Administrator finds a longer trip was Medically Necessary;

2. **Anesthetic.** Charges for anesthetic;

3. **Blood.** Blood, when Medically Necessary, including:

    a. Administration costs of blood and blood plasma in conjunction with Covered Services;
    b. Autologous transfusion services; and
    c. Packed red blood cells, cryoprecipitate, Factor VII, and platelets are Covered. Other clotting factors or blood components such as Factor VIII or Factor IX, whether naturally or artificially derived, are covered only for acute traumatic events or Medically Necessary surgery;

4. **Cardiac Rehabilitation.** Cardiac rehabilitation as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a medical care facility as defined by this Plan. Coverage includes Phase I and Phase II. Phase III cardiac rehabilitation services are not covered;

5. **Chemotherapy.** Radiation or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included;

6. **Clinical Trials.**

Approved Clinical Trials in accordance with PHSA Section 2709 An "Approved Clinical Trial" means 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 Condition and is described in any of the following:

- Federally funded trials for studies or investigations which are approved or funded (which may include funding through in-kind contributions) by one or more of the following:

    - The National Institutes of Health.
    - The Centers for Disease Control and Prevention.
    - The Agency for Health Care Research and Quality.
    - The Centers for Medicare & Medicaid Services.
    - A cooperative group or center of any of the entities described in bullets 1 through 4 above or the Department of Defense or the Department of Veterans Affairs.
    - A qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants.

- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

A “Life-threatening Condition”, for purposes of this benefit, means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Benefits are available to a "Qualified Individual" who is a *covered person* eligible to participate in an Approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another Life-threatening Condition, and either (i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or (ii) the *covered person* provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Coverage is provided only for “Routine Patient Costs” which includes all items and services consistent with the coverage provided in the *Plan* that is typically covered for a *covered person* who is not enrolled in a clinical trial. Routine Patient Costs do not include the cost of:

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

Benefits for Routine Patient Costs that meet the conditions set forth above will be determined based upon the provider and type of service in accordance with the Schedule of Medical Benefits.

7. **Contact Lenses.** Initial contact lenses or glasses required following cataract surgery;

8. **Contraceptives.** The charges for all FDA approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines;

9. **Dental Services.** Dental Services including the removal of symptomatic, bony impacted third molars if Medically Necessary. Emergency Services required due to accidental Injury to sound, natural teeth that are rendered during the first 24 hours after accidental Injury. All other dental services are excluded, including, but not limited to: orthodontics, periodontics, endodontics, prosthodontics, preventive, cosmetic, or restorative dentistry;

10. **Dermatological Services.** Dermatological Services, when Medically Necessary;

11. **Diabetes Supplies.** Diabetes supplies including insulin pumps and insulin pump supplies for the treatment of Insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin using diabetes are provided if prescribed by a Provider legally authorized to prescribe such items under law;

    Diabetes equipment, supplies, and self-management training and education must comply with the Third Party Administrator's Utilization Management policies and procedures.

    Peritoneal Dialysis and Hemodialysis. Hemodialysis if deemed Medically Necessary and when provided at: (i) an outpatient or Inpatient facility in an acute general Hospital; (ii) an outpatient dialysis unit; or (iii) at home;

12. **Durable Medical or Surgical Equipment.** Rental of Durable Medical or Surgical Equipment if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Third Party Administrator.

    Benefit includes ostomy supplies, oxygen and respiratory equipment.

Wigs for patients of chemotherapy or radiation therapy are covered under the Durable Medical Equipment benefit. This cost for wigs contributes to any Benefit Maximum for Durable Medical Equipment.
Benefit payment for Durable Medical Equipment and medical supplies is provided as stated in the Schedule of Benefits;

13. **Eye.** Diagnosis and Medically Necessary treatment of diseases and injuries of the eye to include the first pair of cataract lenses or glasses following cataract removal surgery or lenses for the treatment of Keratoconus;

14. **Health Education.** Covered Services includes instructions on achieving and maintaining physical and mental health, and preventing Illness and Injury. Charges are subject to the limits as described in the Schedule of Benefits.

15. **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

    Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

    A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services;

16. **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Participant's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

    Covered Charges for Hospice Care Services and Supplies are payable as described in the Schedule of Benefits.

    Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family (covered Spouse and/or covered Dependent Children). Bereavement services must be furnished within three months after the patient's death;

17. **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

    Private Room provided when Medically Necessary;

18. **Infertility.** Care, supplies and services for the diagnosis of Infertility. Covered Services are payable as described in the Schedule of Benefits;

19. **Inhalation Therapy.** Charges for inhalation therapy;

20. **Jaw Conditions/Temporomandibular Joint syndrome (TMJ).** Medically Necessary services for care and treatment of jaw joint conditions, including Temporomandibular Joint TMJ syndrome (TMJ) when caused by acute traumatic dislocation, fractures, neoplasms, rheumatoid arthritis, ankylosing spondylitis, or disseminated lupus erythematosus;

21. **Laboratory Studies.** Covered Charges for diagnostic and preventive lab testing and services.

22. **Maternity.** Maternity including obstetrical care, prenatal, delivery and postpartum care, in an Inpatient setting and/or a home visit or visits in accordance with the medical criteria prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists is covered. A nurse midwife may provide obstetrical care;

23. **Medical Emergency.** A Medical Emergency is a sudden onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson to result in (i) serious jeopardy to the mental or physical health of the Participant; (ii) danger of serious impairment of the Participant's bodily functions; (iii) serious dysfunction of any of the Participant's bodily organs; or (iv) in the case of a pregnant woman, serious jeopardy to the health of the fetus. Screening and stabilization services provided in a Hospital emergency room for a Medical Emergency may be received from either Network or Non-Network Providers.

    A prudent layperson is someone without medical training who draws on his or her practical experience when making a decision regarding whether emergency medical treatment is needed. A prudent layperson will be considered to have acted "reasonably" if other similarly situated laypersons would have believed, on the basis of observation of the medical symptoms at hand, that emergency medical treatment was necessary.

    The Third Party Administrator reviews all information and documentation with respect to these claims in accordance with established medical criteria and guidelines. If this review results in the determination that the Participant did not experience a Medical Emergency, the Participant may be responsible for the entire bill. Claims resulting from a Medical Emergency are eligible for payment at the Participating Provider level of benefits. If a claim is denied when you believe a Medical Emergency existed, contact the Customer Service Department;

24. **Mental Disorders and Substance Abuse.** Treatment of Mental Disorders and Substance Abuse. For Plan Years beginning on or after October 3, 2009, regardless of any limitations on benefits for Mental Disorders and Substance Abuse Treatment otherwise specified in the Plan, any aggregate lifetime limit, annual limit, financial requirement, Non-Participating Provider exclusion or treatment limitation on Mental Disorders and Substance Abuse benefits imposed by the Plan shall comply with federal parity requirements, if applicable.

    Covered Charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be covered the same as for medical benefits.

    Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals;

25. **Mouth, Teeth and Gums.** Injury to or care of mouth, teeth and gums. Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

    a. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth;
    b. Emergency repair due to Injury to sound natural teeth rendered within 24 hours after accidental Injury;
    c. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth;
    d. Excision of benign bony growths of the jaw and soft and hard palate;
    e. External incision and drainage of cellulitis;
    f. Incision of sensory sinuses, salivary glands or ducts;
    g. Removal of impacted teeth; and

h. Excision of partial or completely bony impacted third molars Soft tissue removal of third molars is not covered. Anesthesia and associated services rendered in connection with the covered removal of impacted teeth are also covered if performed by a Provider licensed to do so;

26. **Nutritional Supplements.** Nutritional Supplements (formulas) deem Medically Necessary for the therapeutic treatment of phenylketonuria, branched-chain ketonuria, galactosemia, and homocystinuria as administered under the direction of a Physician. Other nutritional supplements for diagnoses other than those specifically named are not covered.

    Deductibles shall not apply to coverage for nutritional supplements;

27. **Occupational Therapy.** Occupational therapy by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy;

28. **Organ Transplant.** Services related to Medically Necessary organ transplants are covered when approved by the Third Party Administrator and performed at a Coventry Transplant Network participating facility approved by the Third Party Administrator. Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue (including bone marrow) transplant are subject to these limits:

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

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

    a. evaluating the organ or tissue;
    b. removing the organ or tissue from the donor; and
    c. transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

    Travel for Transplant Services. Travel expenses for Participants and living donors are covered according to the Plan transplant travel benefit. Details of the transplant travel benefit will be provided upon request;

29. **Ostomy Supplies** accrue toward the Medical Supplies benefit;

30. **Oxygen** when Medically Necessary and prescribed by a Physician;

31. **Physical Therapy.** Physical therapy by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

    Physical therapy rendered by a licensed chiropractor is covered;

32. **Physician Care.** The professional services of a Physician for surgical or medical services;

33. **Pregnancy.** The Maximum Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness.

    Group health plans 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's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers

may not, under Federal law, require that a Provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). The Participant has the option, with her physician's authorization, to leave the Hospital earlier than stated above and receive a home health visit within 72 hours of leaving the Hospital. Deductibles, Copayments and Coinsurance shall not apply to such home health visit;

34. **Prescription Drugs.** Prescription Drugs approved by the Food and Drug Administration for a specific use, which can, under federal or state law, be dispensed only pursuant to a Prescription Order (i.e. a legend medication) and has not been excluded from coverage;

35. **Preventive Care.** Benefits mandated through the PPACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).

    See http://www.uspreventiveservicestaskforce.org or https://www.healthcare.gov/preventive-care-benefits/ for more details.

    Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider and/or Physician of care to determine which services to provide; the Plan Administrator has the authority to determine which services will be covered;

    Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Patient Protection and Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

    Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved. With respect to infants, Children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA).

    A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/preventive-care-benefits/

    Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

    1. Well-woman visits;
    2. Gestational diabetes screening;
    3. HPV DNA testing;
    4. Sexually transmitted infection counseling;
    5. HIV screening and counseling;
    6. FDA-approved contraception methods and contraceptive counseling;
    7. Breastfeeding support, supplies and counseling; and
    8. Domestic violence screening and counseling.

    A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/preventive-care-benefits/;

36. **Prosthetic Devices.** The initial purchase, fitting and repair of fitted prosthetic devices which (i) replace all or part of a missing body organ and its adjoining tissue or all or part of the function of a permanently useless or malfunctioning body organ; and (ii) be an implantable prosthetic appliance or equivalent external device.

    Replacement coverage is limited to once every two (2) years due to irreparable damage and/or normal wear or a significant change in medical condition, unless otherwise required by law, and must be Preauthorized as Medically Necessary by Conifer Health. Replacement costs necessitated as a result of malicious damage, culpable neglect, or wrongful disposition of the equipment or device on the part of the Participant are not covered;

37. **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

    This mammoplasty coverage will include reimbursement for:

    a. reconstruction of the breast on which a mastectomy has been performed,
    b. surgery and reconstruction of the other breast to produce a symmetrical appearance, and
    c. coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas;
    d. in a manner determined in consultation with the attending Physician and the patient;

38. **Routine Patient Costs for Participation in an Approved Clinical Trial.** Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, as defined under PPACA, provided:

    a. The clinical trial is approved by:
        i. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
        ii. The National Institute of Health;
        iii. The U.S. Food and Drug Administration;
        iv. The U.S. Department of Defense;
        v. The U.S. Department of Veterans Affairs; or
        vi. An Institutional review board of an Institution in Pennsylvania that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
    b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

    Coverage will not be provided for:

    a. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
    b. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved 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 an Approved Clinical Trial;
    e. The cost of a health care service that is specifically excluded by the Plan; or
    f. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial;

39. **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

    a. the patient is confined as a bed patient in the facility;
    b. the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
    c. the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility;

40. **Speech Therapy.** Speech therapy by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

    Charges for Speech therapy are subject to the limits as described in the Schedule of Benefits;

41. **Specialty Drugs and Medicines.** Benefits for covered Specialty Drugs and Medicines supplied by Network Providers or other Providers (excluding Specialty Pharmacy Providers) in a Physician's office or clinic or in a home health care setting are payable under the Plan.

    NOTE: Specialty Drugs and Medicines supplied through a Specialty Provider (at a retail pharmacy) are payable under the Prescription Drug Benefit of the Plan.

    Specialty Drugs and Medicines means injectable drugs or medicines for the ongoing treatment of a chronic condition.

    NOTE: Specialty Drugs and Medicines received in a Hospital setting are payable under the Inpatient Hospital or Outpatient Facility benefits of the Plan.

42. **Spinal Manipulation/Chiropractic.** Spinal Manipulation/Chiropractic services by a licensed M.D., D.O. or D.C.

    Charges for Spinal Manipulation/Chiropractic Services are subject to the limits described in the Schedule of Benefits;

43. **Sterilization.** All FDA approved charges related to sterilization procedures. Benefits payable will be determined in accordance with the "Summary of Benefits". Reversal of Sterilization is not covered;

44. **Surgery.**
    a. **Oral Surgical Procedures.** Oral surgical services when Medically Necessary for: reduction or manipulation of fractures of facial bones; excision of lesions of the mandible, mouth, lip, or tongue; incision of accessory sinuses, mouth, salivary glands, or ducts; manipulation of dislocations of the jaw; reconstruction or repair of the mouth or lips necessary to correct functional impairment caused by a Congenital Condition and birth abnormalities (but not including orthognathic, orthodontic or prognathic procedures); treatment of malignant tumors; and other services normally performed by either a Physician or an oral surgeon for conditions common to both medicine and dentistry, as determined by the Third Party Administrator. All other oral surgery services are excluded, including, but not limited to, the oral surgery services expressly excluded under Plan Exclusions: and
    b. **Other Surgical Procedures.** Any surgical operations (major or minor) which are Medically Necessary, not otherwise excluded or limited under the Medical Benefits and Preauthorized for payment by the Third Party Administrator (unless Emergency Services);

45. **Surgical Dressings.** Surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations;

46. **Therapeutic Injections.** Therapeutic injections when FDA approved and Medically Necessary and when administered in an Inpatient setting or as the reason for a visit to an Outpatient facility or a Physician's office. Preauthorization is required;

47. **Urgent Care.** Urgent Care services, care for an unforeseen Illness, Injury or condition that requires immediate attention to prevent serious deterioration is covered when services are provided in an urgent care center or in a Physician's office;

48. **Well Newborn Nursery/Physician Care.** Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

    This coverage is only provided if the newborn child is an eligible Dependent and a parent (1) is a Participant who was covered under the Plan at the time of the birth, or (2) enrolls himself or herself (as well as the newborn child if required) in accordance with the Special Enrollment provisions with coverage effective as of the date of birth.

    The benefit is limited to Maximum Allowable Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

    Charges for covered routine nursery care will be applied toward the Plan of the covered parent or newborn.

    Group health plans 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's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, Plans and issuers may not, under Federal law, require that a Provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

    Charges for Routine Physician Care. The benefit is limited to the Maximum Allowable Charges made by a Physician for the newborn child while Hospital confined as a result of the child's birth.

    Charges for covered routine Physician care will be applied toward the Plan of the covered newborn.

    X-Rays, Laboratory and Diagnostic Tests. The Plan will cover the services and mat*e*rials associated with x-ray and laboratory tests (including, but not limited to: diagnostic and therapeutic v-rays and isotopes, electrocardiograms, and electroencephalograms) when these services are administered in connection with other Covered Services. Coverage may require preauthorization. Please contact the Third Party Administrator for more information; and

49. **Wigs.** Wigs for patients of chemotherapy or radiation therapy are covered.

6.02 Exclusions

Some health care services are not covered by the Plan. In addition to the General Exclusions set forth in Article X, these include, but are not limited to, any charge for care, supplies, or services, which are:

1. **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy, fetus incapable with life, or the Pregnancy is the result of rape or incest;

2. **Accupressure.** Charges for acupressure;

3. **Acupuncture.** Relating directly or indirectly to acupuncture;

4. **Ambulance Service.** Ambulance service except as outlined in the Schedule of Benefits;

5. **Autopsy.** Expenses for or related to autopsy;

6. **Behavior Modification.** Charges for behavior modification;

7. **Biofeedback.** Biofeedback except as Preauthorized;

8. **Bionic Devices** (microprocessor controlled prosthetics) to include, but not limited to, C-Leg;

9. **Blood.** Blood, blood components, and blood products, including coagulation factors, whether derived from blood, artificially produced, or genetically engineered, except as specifically listed in the Covered Services Section;

10. **Blood Clotting.** Blood clotting factors for chronic prophylactic or maintenance therapy;

11. **Blood Donors.** Charges for blood donors and blood donation except as specified in the Schedule of Benefits;

12. **Blood from Umbilical Cord.** The drawing, preparation and storage of umbilical cord blood is not covered;

13. **Blood Transportation.** Charges associated with transportation of blood, blood components, or blood products;

14. **Braces.** Braces and supports needed for athletic participation or employment;

15. **Clothing.** Clothing or shoes of any type, including, but not limited to: orthopedic shoes, children's corrective shoes, shoes used in conjunction with leg braces, and shoe inserts except for inserts and shoes for Participants with diabetes or peripheral vascular disease;

16. **Cochlear Implants, Dental Implants and Nanometric Implants.** No coverage is provided for repair, replacement, or duplicates, nor is coverage provided for services related to the repair or replacement of covered implants, except due to a change in the Participant's medical condition;

17. **Corrective Appliances.** Corrective appliances that do not require prescription specifications and/or are used primarily for recreational sports. Also, corrective appliances used primarily for cosmetic purposes, including but not limited to cranial prostheses and molding helmets;

18. **Dietary Foods.** Dietary foods and supplements, and weight reduction programs;

19. **Disposable Medical Supplies.** Unless otherwise indicated in the Schedule of Benefits, disposable medical supplies, dressings and splints unless used for treatment of fracture reductions or dislocations; medical equipment of an expendable nature including, but not limited to: incontinence pads, catheters, irrigation kits, anti-embolic stockings with a pressure gradient of less than 20 MM HG, and ace bandages;

20. **Drug Abuse or Alcoholism.** Treatment of drug abuse or alcoholism when not rendered according to a written treatment plan approved and monitored by a psychiatrist (M.D. or D.O.) or a licensed psychologist (PhD or M.A.);

21. **Durable Medical Equipment.** Repair and maintenance of Durable Medical Equipment and corrective appliances:

    a. Routine servicing such as testing, cleaning, regulating and checking of equipment is not covered except as specified under Medical Benefits.
    b. Except as specified under Medical Benefits, repair and maintenance coverage is limited to:
        i. adjustment required by wear or by condition change when prescribed by a Network Provider; and
        ii. repairs necessary to make the equipment/appliance serviceable unless the repair costs exceed the cost of the equipment/appliance;

22. **Educational or Vocational Testing.** Services for educational or vocational testing or training, and for special education, counseling or care for learning deficiencies or behavioral problems, whether or not associated with a manifest Mental Disorder or other disturbance;

23. **Elective Home Delivery.** Elective home delivery for childbirth;

24. **Equipment.** Equipment primarily used for non-medical purposes such as for altering air quality or temperature;

25. **Exams.** Exams for employment, school, camp, sports, licensing, insurance, adoption, marriage, driver's license, foreign travel, passports, or those ordered by a third party;

26. **Exercise Programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan;

27. **Eye Care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan;

28. **Eye Exercises and Therapy.** Charges for or related to eye exercises and therapy;

29. **Failure to Provide Information.** Failure to provide any additional documentation or information as may be requested by the Third Party Administrator may result in no coverage;

30. **Food or Food Supplements.** Food or food supplements, vitamins or other nutritional and over-the-counter electrolyte supplements. Except as previously stated in this document;

31. **Foot Care.** Foot care except for foot care required to treat manifestations of systematic disease causing circulatory problems, such as diabetes or peripheral vascular disease. Foot care excluded from coverage under this Plan includes, but is not limited to: removal or reduction of warts, removal of toenails (except Medically Necessary surgery for ingrown toenails), treatment of corns, calluses, flat feet, weak feet, chronic foot strain, symptomatic complaints of the feet, or bunions, unless Medically Necessary;

32. **Foreign Travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services;

33. **Genetic Counseling.** Genetic counseling and genetic studies that are not required for diagnosis or treatment of genetic abnormalities according to Plan guidelines, except as specified under Preventive Care;

34. **Guest Meals.** Guest meals and accommodations;

35. **Hair Analysis and Hair Transplants.** Expenses related to hair analysis and hair transplants;

36. **Hair Loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy;

37. **Halfway Houses.** Treatment of drug abuse or alcoholism provided by halfway houses, boot camps and wilderness programs;

38. **Hearing Aids and Exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan;

39. **Hospital Employees.** Professional services billed by a Physician or nurse who is an Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service;

40. **Hypnotherapy.** Related to the use of hypnosis;

41. **Immunizations.** Immunizations for travel or employment;

42. **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence, unless as the result of Illness or Injury sustained while covered under the Plan;

43. **Infertility.** Care, supplies, medications, services and treatment for Infertility, except for diagnostic services rendered for Infertility evaluation as specified in the Schedule of Benefits. Infertility treatments, services and supplies, fetal reduction surgery, and artificial reproductive technology including but not limited to: artificial insemination, egg harvest, sperm donation, donor sperm or donor eggs, in vitro and in vivo fertilization (IVF), gamete intrafallopian transfer (GIFT), and zygote intrafallopian transfer (ZIFT), embryo transplants and similar procedures, cryopreservation and storage of sperm unless preauthorized, eggs and embryos, supplies, drug therapies, and drugs;

44. **Marital or Relationship Counseling.** Marital or relationship counseling family counseling; vocational or employment counseling; and sex therapy. Care and treatment for any of these types of counseling;

45. **Mental Retardation.** Treatment of mental retardation, unless covered as a biologically-based mental Illness;

46. **Milieu Therapy.** Milieu Therapy the treatment of Mental Disorder or maladjustment by making substantial changes in a patient's immediate life circumstances and environment in a way that will enhance the effectiveness of other forms of therapy is not covered. Also known as "situation therapy";

47. **Napropathic Services.** Napropathic services provided by a practitioner of naprapathy (a "naprapath") are not covered. Naprapathy is a system of treatment by manipulation of connective tissue and adjoining structures and by dietary measures that is held to facilitate the recuperative and regenerative processes of the body;

48. **Newborn Home Deliveries;**

49. **Non-Emergency Hospital Admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission;

50. **Non-Medical Expenses.** Non-Medical Expenses such as preparing medical reports, itemized bills or charges for mailing; for training, educational instructions or materials, even if they are performed or prescribed by a Physician; for legal fees and expenses incurred in obtaining medical treatment;

51. **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is, in any case, a part of the treatment plan for another Sickness. Specifically excluded are charges for bariatric surgery, including but not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery, including

reversals. Medically Necessary surgical and non-surgical charges for Morbid Obesity are not covered, except as specified under Preventive Care;

52. **Oral Surgery.** Oral surgery required as part of an orthodontic treatment program, required for correction of an occlusal defect (except when determined to be Medically Necessary), encompassing orthoganathic or prognathic surgical procedures;

53. **Oral and Dental Surgery.** Except as specified in the Schedule of Benefits, oral and dental surgery and related services and supplies including, but not limited to:

    Services and supplies related to dental care, dental appliances, dental prostheses, dental implants, or dental x-rays;

    a. Orthodontics, periodontics, endodontics, prosthodontics, preventive, cosmetic or restorative dentistry, even when associated with congenital anomalies;
    b. Oral surgery that is required as part of an orthodontic treatment program;
    c. Oral surgery that is required for the correction of an occlusal defect;
    d. Oral surgery that encompasses orthognathic, prosthodontics or prognathic surgical procedures;
    e. Charges for Physicians' services or x-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. This applies even if a condition requiring any of these services involves a part of the body other than the mouth, such as the treatment of Temporomandibular Joint Disorder or malocclusion involving joints or muscles by methods including, but not limited to: crowning, wiring, or repositioning of teeth; and
    f. Treatment of teeth, the nerves or roots of the teeth (excepted as stated under "Covered Services") or for the repair or replacement of a denture;

54. **Orthotics.** Charges in connection with orthotics, heel lifts, and arch supports. Foot orthotics are not covered, except as determined to be Medically Necessary by the Plan;

55. **Orthodontia.** Orthodontia and related services;

56. **Over-the-Counter Supplies.** Over-the-counter supplies such as ACE wraps/elastic supports/finger splints, and orthotics, except for orthotics necessary for the treatment of diabetes except as specified under Preventive Care;

57. **Personal Comfort Items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, and first-aid supplies and Non-Hospital adjustable beds;

58. **Plan Design Exclusions.** Charges excluded by the Plan design as mentioned in this document;

59. **Preauthorized.** Any care, treatment or supplies that are not preauthorized when preauthorization is required;

60. **Private Duty Nursing.** Charges in connection with care, treatment or services of a private duty nurse, except as stated in the Medical Benefits section of this document;

61. **Private Inpatient Room.** Private Inpatient room, unless Medically Necessary or if a semi-private room is unavailable;

62. **Prolotherapy.** Prolotherapy, the use of injections to strengthen tendons and ligaments;

63. **Psychiatric Evaluation or Therapy.** Psychiatric evaluation or therapy and/or chemical dependency treatment when related to judicial or administrative proceedings or orders to the extent permitted by law; when related to mental retardation, pervasive developmental disorder or autism; when employer requested; when required for school; for learning disabilities; when the Participant is eligible for Social Security

disability benefits for a mental or emotional disability; or for the purpose of submitting a disability application for a mental or emotional condition;

64. **Psychological Testing.** Psychological testing for learning disabilities, school-related issues, or for the purpose of obtaining or maintaining employment;

65. **Reconstructive Surgery.** Reconstructive surgery, except:

    a. for an Injury;
    b. for repair of defects which result from surgery; or
    c. for the reconstructive (not cosmetic) repair of a congenital defect which materially corrects a bodily malfunction;

66. **Rehabilitation Services.** Rehabilitation services, including, but not limited to: cognitive therapy, that are required to treat school-related problems, apraxic disorders (unless caused by accident or episodic Illness), stuttering, speech delay, articulation disorder, functional dysphonia, or speech problems resulting from psychoneurotic or personality disorders, are not covered by the Plan. Long term rehabilitation therapy, cardiac rehabilitation therapy, and pulmonary rehabilitation is not covered by the Plan;

67. **Replacement Braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Participant's physical condition to make the original device no longer functional.

68. **Robotics.** Charges related to robotics assistance during surgery are not covered;

69. **Sex Changes.** Care, services or treatment for non-congenital trans-sexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment;

70. **Sleep Disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary;

71. **Sports Medicine Treatment.** Sports medicine treatment plans, surgery, corrective appliances, or artificial aids primarily intended to enhance athletic functions;

72. **Stockings.** Jobst stockings, elastic hose and graduated compression (TED) hose, unless Medically Necessary and prescribed by a Physician;

73. **Surgery.** Surgery performed solely to address psychological or emotional factors;

74. **Surgical Sterilization Reversal.** Care and treatment for reversal of surgical sterilization;

75. **Surrogate Motherhood Services and Supplies.** Surrogate motherhood services and supplies, including, but not limited to, all services and supplies relating to the conception and Pregnancy of a Participant acting as a surrogate mother;

76. **Teeth.** Treatment of teeth, the nerves or roots of the teeth (excepted as stated under Covered Charges) or for the repair or replacement of a denture. Dental implants are not covered;

77. **Temporomandibular Joint syndrome (TMJ).** All diagnostic and treatment services related to the treatment of jaw joint problems including Temporomandibular Joint (TMJ) syndrome;

78. **Testicular Implants.** Services, supplies, care or treatment in connection with testicular implants;

79. **Therapy.** Habilitated therapy, including but not limited to:

    a. Physical or occupational therapy for the purpose of behavioral modification or for improving performance in school or sports;

b. Occupational therapy for the purpose of treating sensory hypersensitivity; or
c. Sensory Integration Therapy;

80. **Transplant Services.** Except as otherwise Preauthorized by this Plan, transplant services and all related services and supplies when received from any Provider not designated by this Plan as a Participating Coventry Transplant Network facility.

Transplant services, screening tests, and any related conditions or complications related to organ donation when a Participant is donating organ or tissue to a non-Participant;

81. **Travel or Accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge;

82. **Vision care** and optometry services except as specified in the Schedule of Benefits, except the following vision care and optometry services are never covered under this Plan:

a. Lenses not requiring a prescription from a vision care Provider;
b. Sunglasses available with or without a prescription;
c. Industrial (3mm) safety lenses and safety frames with side shields;
d. Replacement of lost, stolen, broken or damaged lenses, contact lenses or frames
e. Replacement of current lenses, contact lenses or frames when there is not a prescription change of $^{1}/_{2}$ diopter or more;
f. Services or supplies in connection with:
    i. examinations to determine the need for or change in prescription or other examination related to wearing eyeglasses or lenses of any type;
    ii. eyeglasses or lenses of any type, except as specified in the Schedule of Benefits;
    iii. eye surgery, such as radial keratotomy, laser corneal resurfacing, or other surgery, when the primary purpose is to correct myopia (nearsightedness), hyperopia (farsightedness) or astigmatism (blurring); or
    iv. vision training or orthotics;

83. **Vocational Therapy.** Expenses for vocational therapy; and

84. **Work Hardening Programs.** Charges for or related to work hardening programs.

ARTICLE VII
COST MANAGEMENT SERVICES

7.01 Cost Containment

7.01A Pre-certification Program

The Pre-certification Program administrator is Cigna. Cigna has established criteria which include recognized industry-standard resources and proprietary standard operating procedures established by expert medical professionals. Cigna, acting as the Pre-certification Program administrator, may determine both the medical necessity of the proposed treatment, and whether the treatment will be considered to be experimental or investigational, and such determination will be deemed to be in accordance with the terms of the Plan. Notwithstanding the foregroing, the final authority with respect to a determination of medical necessity and/or experimental or investigational treatment rests with the Plan Administrator.

The Pre-certification Program administrator for this Plan is Cigna. All questions and requests must be directed to: Integra Health & Wellness; P.O. Box 1178; Matthews, NC 28106; (888)488-4660.

In the event that any proposed treatment is not approved, you or your physician may appeal the decision. All questions and requests must be directed to Cigna in accordance with their instructions in the adverse benefit determination.

7.01B Pre-Certification Program for Inpatient Services

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

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

Because communication is the basis for the program, the Plan requires that you contact the Pre-certification Program administrator before any non-emergency inpatient admission. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.** The Plan will provide coverage only for inpatient stays which are determined to be medically necessary for treatment of a covered illness or injury.

Urgent Care or Emergency Admissions

Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health because of the requirements of this Program. For urgent, emergency admissions, follow your physician's instructions carefully, and contact the Pre-certification Program administrator within 48 hours of the first business day following admission. No penalty will be applied to your benefits if contact is made within this time period. Since the Plan does not require you or a covered dependent to obtain approval of a medical service prior to getting treatment for an urgent care or emergency situation, there are no "pre-service urgent care claims" under the Plan. In an urgent care or emergency situation, you or a covered dependent simply follow the Plan's procedures following the treatment and file the claim as a "post-service claim."

Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours). Notification is still encouraged 60 days before the expected delivery date, and again at the time of admission, and is required for any hospital stay that is in excess of the minimum length of stay. Failure to notify the Pre-certification Program administrator within 24 hours of any stay that is in excess of the minimum length of stay will result in application of a penalty to the hospital expenses. For a hospital stay that exceeds the time limits specified under federal law on a holiday or after 5:00 P.M. on Friday, contact must be made on the next regular business day. No penalty will be applied to your benefits if contact is made within this time period.

Concurrent Inpatient Review
Once the inpatient setting has been pre-certified, the on-going review of the course of treatment becomes the focus of the Program. Working directly with your physician, the Pre-certification Program administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses. The Plan will provide coverage only for continuing inpatient stays which are determined to be medically necessary for treatment of a covered illness or injury.

7.01C Pre-Certification Program for Other Services
The Plan's Pre-certification Program also includes certain services which are listed below. These typically are services that may not be covered expenses or that involve an on-going course of treatment on an outpatient basis. The purpose of pre-certifying these services is to identify non-covered expenses, or Plan limitations, in advance of incurring the expenses. Non-emergency care and services of the types listed below require pre-certification:

Pre-Certification is required for the following outpatient diagnostic and surgical procedures;

- Diagnostic Radiology
- Durable Medical Equipment
- Ear Devices
- Erectile Dysfunction
- Home and Home Infusion Therapy (home nursing care)
- Injectable Medications
- Oral Pharynx Procedures
- Orthotics and Prosthetics
- Outpatient Procedures (potentially cosmetic)
- Potential experimental/investigational/unproven procedures
- Sleep Management Program
- Speech Therapy
- Spinal Procedures
- Therapeutic Radiology
- Transplants
- Unlisted Procedures

Because communication is the basis for the Program, the Plan requires that you contact the Pre-certification Program administrator before the commencement of non-emergency services of the types listed in this section. The contact may be made by you, a friend or family member, or your physician or facility; however, it is important that you understand that it is your responsibility to make sure that the contact has been made. **Failure to contact the Program administrator within the time limits specified in this section will result in a penalty reducing the benefits otherwise payable.**

Urgent or Emergency Care
Do not delay seeking medical care for any covered person who has a serious condition that may jeopardize his life or health because of the requirements of this Program. Pre-certification of outpatient emergency care is not recommended or required under these circumstances. For urgent, emergency care of the types listed above, follow your physician's instructions carefully, and contact the Pre-certification Program administrator within 48

hours of the first business day following receipt of the services or supplies. No penalty will be applied to your benefits if contact is made within this time period.

The Pre-certification Program does not establish your eligibility for coverage for these services under the Plan, nor does it approve the services for coverage or reimbursement under the Plan. Those responsibilities rest with the Plan Administrator.

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

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

7.01D Pre-Certification Penalty

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

- Otherwise covered expenses will be reduced by 20% to a maximum of $500.00 before application of any required deductibles, copayment or coinsurance, and this penalty amount will not accumulate toward any out-of-pocket expense limits. No coverage is provided for inpatient room & board charges for any days which are found to be not medically necessary. Ancillary charges will be reduced as described above.

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

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective Surgical procedure. An elective Surgical procedure is one that can be scheduled in advance; that is, it is not an Emergency or of a life-threatening nature.

When a second opinion is requested, the Plan will pay 100% of Usual and Customary fees Incurred for that opinion along with laboratory, x-ray and other Medically Necessary services ordered by the second Physician without application of the Deductible. Second opinions for Cosmetic Surgery, normal obstetrical delivery and Surgeries that require only local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion as outlined above. The second or third opinion must be given within 90 days of the first.

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

7.01F Second Surgical Opinion

This is a service offered by the Plan to help you determine, in advance, whether there are alternative treatment options for a proposed surgical procedure. It is a voluntary provision, and you are under no obligation to obtain a second surgical opinion. However, you are encouraged to use this service to avoid incurring unnecessary or non-covered expenses for which you will be responsible.

Benefits will be provided for a second (and third, if necessary) opinion consultation to determine the Medical Necessity of an elective Surgical procedure. An elective Surgical procedure is one that can be scheduled in advance; that is, it is not an Emergency or of a life-threatening nature. Second opinions for Cosmetic Surgery, normal

obstetrical delivery and surgeries that require any local anesthesia are not covered. If the second opinion does not concur with the first, the Plan will pay for a third opinion. The second or third opinion must be given within 90 days of the first.

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

7.01G TELADOC
TELADOC
(800) 835-2362

TelaDoc Medical Services is a national network of state licensed, board certified primary care physicians providing cross coverage medical consultations 24 hours per day, 7 days per week, and 365 days per year. TelaDoc physicians diagnose, recommend treatment, and prescribe non DEA controlled substances for routine, acute, episodic medical conditions over the telephone. All Employees, Dependent Spouses, and Dependent children who are enrolled in the Plan are eligible to participate in the TelaDoc program.

A copayment of $10 will be charged for each TelaDoc (telephone) consultation with a Physician.
A charge of $12 will be applied if the Participant does not register on-line. Health history must be provided before the Physician can treat a Participant. If the health history is taken over the phone instead of on-line, there is a $12 charge to the Participant.

7.01H Case Management
If a covered person is requested to participate in the Plan's case management program, he or she must participate in order for related claims to be considered at the established benefit levels outlined in the Summary of Benefits. If the covered person does not participate or comply with the requirements of the case management program, related claims may be denied. The Plan Administrator reserves the right to reconsider any denied claims if the covered person becomes compliant with the requirements of the case management program.

Case management may recommend services that are ordinarily not covered by this Plan, however, when part of an approved case management program, such services will be considered as any other covered medical expense. Each case management program is tailored specifically to the covered person's situation. A service that may be recommended by case management for one covered person does not make it a covered benefit for others.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan, attending physician, patient and patient's family msut all agree to the alternative treatment plan. Case management will not interfere with your course of treatment or the physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

If you have any questions about the Case Management Program, please feel free to contact Conifer Health Solutions at (866)623-5045.

ARTICLE VIII
PRESCRIPTION DRUG BENEFITS

Gold Plan	
Covered Prescription Drug Expenses:	**Participating Pharmacy[6]**
Plan Year Rx Deductible	$100
Maximum Out-of-Pocket Amount (includes Deductible)	Ind. $2,250/Family $4,600
Pharmacy Option: (Copays apply after Rx Deductible)	
Copayment, per prescription or refill, for generic	$10
Copayment, per prescription or refill, for formulary name brands[7]	$40
Copayment, per prescription or refill, for non-formulary name brands	$60
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription
Mail Order Option[8]:	
Copayment, per prescription or refill, for generic	$25
Copayment, per prescription or refill, for formulary name brands[7]	$100
Copayment, per prescription or refill, for non-formulary name brands	$150
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription

Silver Plan	
Covered Prescription Drug Expenses:	**Participating Pharmacy[6]**
Plan Year Rx Deductible	$100
Maximum Out-of-Pocket Amount (includes Deductible)	Ind. $1,500/Family $3,100
Pharmacy Option:	
Copayment, per prescription or refill, for generic	$15
Copayment, per prescription or refill, for formulary name brands[7]	$40
Copayment, per prescription or refill, for non-formulary name brands	$65
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription
Mail Order Option[8]:	
Copayment, per prescription or refill, for generic	$37.50
Copayment, per prescription or refill, for formulary name brands[7]	$100.00
Copayment, per prescription or refill, for non-formulary name brands	$162.50
Copayment, per prescription or refill, for specialty	Participant pays 20% coinsurance to a maximum coinsurance of $500 per prescription

Benefits are provided for the purchase of drugs through the Plan's Prescription Drug Card Program. No reimbursement will be made when a Drug is purchased from a non-Participating Pharmacy or when the identification card is not used.

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6 100% payment by Plan after copayment.

7 Also includes cost difference between name brand and generic forms, unless prescription is not manufactured in generic form or Physician has indicated "dispense as written" or similar indication.

8 Prescription orders in excess of one refill must be obtained through the Mail Order Option in order to be eligible for benefits under the Plan.

The Plan's Prescription Drug Program is administered by MagellanRx. MagellanRx has a network of pharmacies which can identify covered persons and the Plan's coverage provisions. To find out which pharmacies participate, contact MagellanRx at the telephone number located on your ID card or the website at www.magellanrx.com. Participants will be held fully responsible for the consequences of any pharmacy identification card after termination of coverage.

Maximum coverage is provided for generic drugs. If a generic drug equivalent is not available, or your physician has ordered the prescription to be "dispensed as written", covered drugs will be reimbursed at the brand name drug benefit shown in the Schedule above. If you choose a brand name drug over a generic drug, you also will be required to pay the difference in the cost between the brand name drug and the generic equivalent in addition to the brand name copayment shown in the Schedule above. You will not be required to pay this difference if your doctor indicates "dispense as written".

The patient should discuss the prescription alternatives with his doctor to determine if a lower cost alternative is available and appropriate for his condition. The patient and the doctor should determine the treatment plan that is most appropriate for the condition. In some cases, this may mean the patient will pay the higher copay.

How the Program Works
There are two ways to purchase drugs through the MagellanRx Prescription Drug Card Program.

- To fill a prescription at a participating pharmacy (the Pharmacy Option), simply present your Plan ID card and pay your portion of the cost (shown in the Prescription Drug Schedule of Benefits). The pharmacist will file the claim for you.
    - To fill a prescription at a non-participating pharmacy, you must pay for the full cost of the drug and file a claim for reimbursement.
- To fill a prescription through the Prescription Drug Program's Mail Order Option:
    - Obtain a copy of the mail order form from your Benefits Department or from MagellanRx.
    - Send the completed form to the address on the form with your original prescription(s), along with your check for payment of your portion of the cost. You may give a valid credit card number instead.
    - You should receive your medication within 10 business days.

The Mail Order Option is available for maintenance medications (those that are taken for long periods of time, such as Drugs sometimes prescribed for heart Disease, high blood pressure, asthma, etc.). Because of the volume buying, Partners RX, the mail order pharmacy, is able to offer Participants significant savings on their prescriptions.

The copayment is applied to each charge and is shown on the Summary of Benefits, above.

8.01 Covered Expenses
The following are covered under the Plan:

1. **Acne Control.** Accutane and Retin-A;
2. **Allergy Sera.** Charges for allergy sera;
3. **Bee Sting Kits.** Charges for EPI PEN and Ana Kit;
4. **Compounded Prescriptions.** All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;

5. **Contraceptives.** All FDA approved contraceptives Drugs and methods, in accordance with HRSA guidelines;

6. **DESI Drugs.** Charges for DESI Drugs;

7. **Diabetes.** Insulins, insulin syringes and needles, diabetic supplies – legend, diabetic supplies – over the counter, and glucose test strips, when prescribed by a Physician;

8. **Gleevec.** Gleevec, for treatment of any of the following conditions:

    a. CML myeloid blast crisis;
    b. CML accelerated phase; or
    c. CML in chronic phase after failure of interferon treatment;

   Prior authorization is required. In order to obtain such authorization, information from the patients' Physician indicating the condition being treated must be submitted to the Plan;

9. **Growth Hormones.** Charges for growth hormones;

10. **Imitrex Injection.** Charges for Imitrex injections (migraine auto-injector);

11. **Immunizations.** Immunization agents or biological sera;

12. **Immunologicals.** Charges for immunologicals (vaccines);

13. **Injectables.** A charge for injectables;

14. **Legend Drugs.**

    a. Class V Drugs;
    b. Diabetic Supplies;
    c. Diagnostics;
    d. Legend Drugs with over-the-counter equivalents;
    e. Pre-natal vitamins;

15. **Over-the-Counter (OTC) Drugs.** OTC Drugs related to Preventive and Wellness Services as specified by the Patient Protection and Affordable Care Act of 2010. A description of these services can be found at: https://www.healthcare.gov/preventive-care-benefits/.

    This includes FDA-approved generic Drugs and Over-the-Counter (OTC) Drugs, devices and supplies related to Women's Preventive Services, as specified by the Patient Protection and Affordable Care Act of 2010.

    A description of FDA-approved contraceptive methods can be found at:

    http://www.fda.gov/ForConsumers/ByAudience/ForWomen/WomensHealthTopics/ucm117971.htm;

16. **Required by Law.** All Drugs prescribed by a Physician that require a prescription either by Federal or State law, except injectables (other than insulin) and the Drugs excluded below; and

17. **Smoking Deterrents.** A charge for Drugs or aids for smoking cessation, including, but not limited to, nicotine gum and smoking cessation patches; as covered under preventive health benefit.

8.02 Limitations

The benefits set forth in this Article will be limited to:

1. **Dosages.**
    a. With respect to the Pharmacy Option, any one prescription is limited a 30 day supply;
    b. With respect to the Mail Order Option, any one prescription is limited to a 90 day supply;
2. **Refills.**
    a. Refills only up to the number of times specified by a Physician; and
    b. Refills up to one year from the date of order by a Physician.

8.03 Exclusions

In addition to the General Exclusions set forth in Article VII, the following are not covered by the Plan:

1. **Administration.** Any charge for the administration of a covered Drug;

2. **Allergy Sera.** Charges for allergy sera; Covered under the medical plan when administered by physician's office:

3. **Anorexiants.** Anorexiants (weight loss Drugs);

4. **Blood and Blood Plasma.** Charges for blood and blood plasma;

5. **Consumed Where Dispensed.** Any Drug or medicine that is consumed or administered at the place where it is dispensed;

6. **Cosmetic Anti-Aging.** Retin-A;

7. **Devices.** Devices of any type, even though such devices may require a prescription, including, but not limited to, therapeutic devices, artificial appliances, braces, support garments or any similar device; See Medical Plan for Durable Medical Equipment:

8. **Excluded Items.** Any charge excluded under the Articles entitled "General Limitations and Exclusions," or "Summary of Benefits;"

9. **Experimental Drugs.** Experimental or investigational drugs and medicines; even though a charge is made to the Participant, including medications for non-FDA approved use. This does not pertain to compound drugs containing at least one prescription ingredient in a therapeutic quantity.

10. **Fertility Agents.** Charges for fertility agents;

11. **Impotency.** A charge for impotency medication, including Viagra;

12. **Injectables.** A charge for injectables; unless defined as a covered expenses;

13. **Institutional Medication.** A Drug or medicine that is to be taken by a Participant, in whole or in part, while confined in an Institution, including any Institution that has a facility for dispensing Drugs and medicines on its premises;

14. **Investigational Use Drugs.** A Drug or medicine labeled "Caution – limited by Federal law to Investigational use;"

15. **Medical Devices and Supplies.** Charges for legend and over the counter medical devices and supplies; See Medical Schedule of Benefits

16. **No Charge.** A charge for Drugs which may be properly received without charge under local, State or Federal programs;

17. **Non-Insulin Syringes/Needles.** Charges for non-insulin syringes and needles;

18. **Non-Prescription Drug or Medicine.** A Drug or medicine that can legally be bought without a prescription, except for injectable insulin;

19. **Occupational.** Prescriptions necessitated due to an occupational activity or event occurring as a result of an activity for wage or profit which an eligible person is entitled to receive without charge under any workers' compensation or similar law;

20. **Over-the-counter Drugs.** Charges for over the counter Drugs, except to the extent required by the Patient Protection and Affordable Care Act:
    a. Class V Drugs;
    b. Diagnostics;
    c. Medical Devices and Supplies;
    d. Pre-natal vitamins; and
    e. Vitamins;

21. **Rogaine.** Charges for Rogaine (topical minoxidil);

22. **Steroids.** Anabolic steroids; and

23. **Vitamins.** Vitamins, except pre-natal vitamins.

ARTICLE IX
DEFINITIONS

The following words and phrases shall have the following meanings when used in the Plan Document. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan, however they may be used to identify ineligible expenses; please refer to the appropriate sections of the Plan Document for that information.**

"Accident"
"Accident" shall mean an event which takes place without one's foresight or expectation, or a deliberate act that results in unforeseen consequences.

"Accidental Bodily Injury" or "Accidental Injury"
"Accidental Bodily Injury" or "Accidental Injury" shall mean an Injury sustained as the result of an Accident and independently of all other causes by an outside traumatic event or due to exposure to the elements.

"Actively At Work" or "Active Employment"
"Actively At Work" or "Active Employment" shall mean the Employee who has begun and is performing all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another designated location to which he or she may be required to travel to perform the duties of his or her employment. An Employee shall be deemed Actively at Work if the Employee is absent from work due to a health factor. An Employee will not be considered under any circumstances Actively at Work if he or she has effectively terminated employment.

"ADA"
"ADA" shall mean the American Dental Association.

"Adverse Benefit Determination"
"Adverse Benefit Determination" shall mean any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage;
4. A termination of benefits; or
5. A failure to provide or make payment (in whole or in 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 Claimant's eligibility to participate in the Plan.

"AHA"
"AHA" shall mean the American Hospital Association.

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

"Alternate Recipient"
"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.

"AMA"
"AMA" shall mean the American Medical Association.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" shall mean any permanent public or private State licensed and approved (whenever required by law) establishment that operates exclusively for the purpose of providing Surgical Procedures to patients not requiring hospitalization with an organized medical staff of Physicians, with continuous Physician and nursing care by Registered Nurses (R.N.s) . The patient is admitted to and discharged from the facility within the same working day as the facility does not provide service or other accommodations for patients to stay overnight

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

The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

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

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

"Autism Service Provider"
Autism Service Provider shall mean a person, entity or group that provides Treatment of Autism Spectrum Disorders under a treatment plan approved by the Claims Administrator that is:

1. Appropriately licensed or certified in Pennsylvania to provide the service; or
2. Enrolled in Pennsylvania's Medical Assistance program on or before July 9, 2008.

"Autism Spectrum Disorder"
Autism Spectrum Disorder shall mean any pervasive developmental disorders defined by the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), or its successor, including autistic disorder, Asperger's disorder and pervasive developmental disorder not otherwise specified.

"Birthing Center"
Birthing Center shall mean any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

"Calendar Year"
"Calendar Year" shall mean the 12 month period from January 1 through December 31 of each year.

"Cardiac Care Unit"
"Cardiac Care Unit" shall mean a separate, clearly designated service area which is maintained within a Hospital and which meets all the following requirements:

1. It is solely for the care and treatment of critically ill patients who require special medical attention;
2. It provides within such area special nursing care and observation of a continuous and constant nature not available in the regular rooms and wards of the Hospital;
3. It provides a concentration of special lifesaving equipment immediately available at all times for the treatment of patients confined within such area;
4. It contains at least two (2) beds for the accommodation of critically ill patients; and
5. It provides at least one (1) professional Registered Nurse, in continuous and constant attendance of the patient confined in such area on a 24 hour a day basis.

"Centers of Excellence"
"Centers of Excellence" shall mean medical care facilities that have met stringent criteria for quality care in the specialized procedures of organ transplantation. These centers have the greatest experience in performing transplant procedures and the best survival rates. The Plan Administrator shall determine what Network Centers of Excellence are to be used.

Any Participant in need of an organ transplant may contact the Third Party Administrator to initiate the pre-certification process resulting in a referral to a Center of Excellence. The Third Party Administrator acts as the primary liaison with the Center of Excellence, patient and attending Physician for all transplant admission taking place at a Center of Excellence.

If a Participant chooses not to use a Center of Excellence, the payment for services will be limited to what would have been the cost at the nearest Center of Excellence.

Additional information about this option, as well as a list of Centers of Excellence, will be given to covered Employees and updated as requested.

"Child" and/or "Children"
"Child" shall mean the Employee's natural Child, any stepchild, legally adopted Child, or any other Child for whom the Employee has been named legal guardian, or an "eligible foster Child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction. For purposes of this definition, a legally adopted Child shall include a Child placed in an Employee's physical custody in anticipation of adoption. "Child" shall also mean a covered Employee's Child who is an

Alternate Recipient under a Qualified Medical Child Support Order, as required by the Federal Omnibus Budget Reconciliation Act of 1993.

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

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

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

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

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

"COBRA"
"COBRA" shall mean the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

"Cosmetic Surgery"
"Cosmetic Surgery" shall mean any expenses Incurred in connection with the care and treatment of, or operations which are performed for plastic, reconstructive, or cosmetic purposes or any other service or supply which are primarily used to improve, alter, or enhance appearance of a physical characteristic which is within the broad spectrum of normal but which may be considered displeasing or unattractive, except when required by an Injury.

"Covered Expense(s)"
"Covered Expense(s)" means a Usual and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Participant's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

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

"Creditable Coverage"
"Creditable Coverage" shall mean health coverage of an individual such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, an individual health insurance policy, Medicaid, Medicare, or public health plans. Creditable Coverage does not include coverage consisting solely of dental or vision benefits. If further clarification is needed with respect to coverage that qualifies as Creditable Coverage, please see the complete definition of Creditable Coverage that is set forth in 45 C.F.R. § 146.113(a).

"Custodial Care"
"Custodial Care" shall mean care or confinement designated principally for the assistance and maintenance of the Participant, in engaging in the activities of daily living, whether or not Totally Disabled. This care or confinement could be rendered at home or by persons without professional skills or training. This care may relieve symptoms or pain but is not reasonably expected to improve the underlying medical condition. Custodial Care includes, but is not limited to, assistance in eating, dressing, bathing and using the toilet, preparation of special diets, supervision of medication which can normally be self administered, assistance in walking or getting in and out of bed, and all domestic activities.

"Deductible"
"Deductible" shall mean the aggregate amount for certain expenses for covered services that is the responsibility of the Participant to pay for him or herself each Calendar Year before the Plan will begin its payments.

"Dentist"
"Dentist" shall mean a properly trained person holding a D.D.S. or D.M.D. degree and practicing within the scope of a license to practice dentistry within their applicable geographic venue.

"Dependent"
"Dependent" shall mean one or more of the following person(s):

1. An Employee's present spouse, married under any State law, and thereby possessing a valid marriage license, not annulled or voided in any way. A Dependent spouse shall therefore not be one whom is divorced from the Employee. For purposes of this section, "marriage or married" means a legal union as defined by the state of residence;
2. An Employee's Child through the end of the month in which a child reaches 26 years of age; or
3. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age as stated in the numbers above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age as stated in the numbers above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age as stated in the numbers above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

Members of any armed force shall not be deemed to be "Dependents."

Residents of a country other than the United States shall not be deemed to be "Dependents."

"Diagnosis"
"Diagnosis" shall mean the act or process of identifying or determining the nature and cause of a Disease or Injury through evaluation of patient history, examination, and review of laboratory data.

"Diagnostic Service"
"Diagnostic Service" shall mean an examination, test, or procedure performed for specified symptoms to obtain information to aid in the assessment of the nature and severity of a medical condition or the identification of a Disease or Injury. The Diagnostic Service must be ordered by a Physician or other professional Provider.

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

"Drug"
"Drug" shall mean an FDA approved Drug or medicine that is listed with approval in the *United States Pharmacopeia, National Formulary* or *AMA Drug Evaluations* published by the American Medical Association (AMA), that is prescribed for human consumption, and that is required by law to bear the legend: "Caution—Federal Law prohibits dispensing without prescription," or a State restricted Drug (any medicinal substance which may be dispensed only by prescription, according to State law), legally obtained and dispensed by a licensed Drug dispenser only, according to a written prescription given by a Physician and/or duly licensed Provider. "Drug" shall also mean insulin for purposes of injection.

"Durable Medical Equipment"
"Durable Medical Equipment" shall mean equipment and/or supplies ordered by a health care Provider for everyday or extended use which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Generally is not useful to a person in the absence of an Illness or Injury; and
4. Is appropriate for use in the home.

"Emergency"
"Emergency" shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Medical Condition"
"Emergency Medical Condition" shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

"Emergency Services"
"Emergency Services" shall mean, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary

services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

"Employee"
"Employee" shall mean a person who is an active full time Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an Employer-Employee relationship. Such person must be scheduled to work at least 30 hours per week in order to be considered "full time."

"Employer"
"Employer" is Cooper-Booth Wholesale Company LP.

"ERISA"
"ERISA" shall mean the Employee Retirement Income Security Act of 1974, as amended.

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

"Experimental" and/or "Investigational"
"Experimental" means services, supplies, care, procedures, treatments or courses of treatment, which:

- Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

- Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

Coverage ma;y be provided for certain Routine Patient Costs as described in the section, "Medical Benefits" for Approved Clinical Trials.

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

Whether a service or supply is experimental or investigational will be determined by the Plan based upon industry-standard resources and the standards, policies and procedures established by the Pre-certification Program administrator.

"Family Unit"
"Family Unit" shall mean the Employee, and his or her Dependents covered under the Plan.

"Final Internal Adverse Benefit Determination"
"Final Internal Adverse Benefit Determination" shall mean an Adverse Benefit Determination that has been upheld by the Plan at the conclusion of the internal claims and appeals process, or an Adverse Benefit Determination with respect to which the internal claims and appeals process has been deemed exhausted.

"FMLA"
"FMLA" shall mean the Family and Medical Leave Act of 1993, as amended.

"FMLA Leave"
"FMLA Leave" shall mean an unpaid, job protected Leave of Absence for certain specified family and medical reasons, which the Company is required to extend to an eligible Employee under the provisions of the FMLA.

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

"Habilitation/Habilitative Services"
"Habilitation Services" shall mean services designed to assist individuals in acquiring, retaining and improving the self-help, socialization and adaptive skills necessary to reside successfully in home and community based settings.

"HIPAA"
"HIPAA" shall mean the Health Insurance Portability and Accountability Act of 1996, as amended.

"Home Health Care"
"Home Health Care" shall mean the continual care and treatment of an individual if:

1. The institutionalization of the individual would otherwise have been required if Home Health Care was not provided;
2. The treatment plan covering the Home Health Care service is established and approved in writing by the attending Physician; and
3. The Home Health Care is the result of an Illness or Injury.

"Home Health Care Agency"
"Home Health Care Agency" shall mean an agency or organization which provides a program of Home Health Care and which:

1. Is a Federally certified Home Health Care Agency and approved as such under Medicare;
2. Meets the established standards and is operated pursuant to applicable laws in the jurisdiction in which it is located and, is licensed and approved by the regulatory authority having the responsibility for licensing, where licensing is required; or
3. Meets all of the following requirements:
    a. It is an agency which holds itself forth to the public as having the primary purpose of providing a Home Health Care delivery system bringing supportive services to the home;
    b. It has a full time administrator;
    c. It maintains written records of services provided to the patient;
    d. Its staff includes at least one (1) Registered Nurse (R.N.) or it has nursing care by a Registered Nurse (R.N.) available; and
    e. Its Employees are bonded and it provides malpractice insurance.

"Hospital"
"Hospital" shall mean an Institution, accredited by the Joint Commission on Accreditation of Hospitals (sponsored by the AMA and the AHA), under the supervision of a staff of Physicians that maintains diagnostic and therapeutic facilities on premises, for the provision of medical (including Surgical facilities for all Institutions other than those specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the AMA and the AHA), diagnosis, treatment, and care to Injured or sick persons, on an Inpatient basis, with 24 hour a day nursing service by Registered Nurses.

To be deemed a "Hospital," the facility must be duly licensed if it is not a State tax supported Institution, and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution; or an Institution which is supported in whole or in part by a Federal government fund.

Institutions and/or facilities not deemed to be a "Hospital" in accordance with Medicare, shall not be deemed to be Hospitals for this Plan's purposes.

"Hospital" shall also have the same meaning, where appropriate in context, set forth in the definition of "Ambulatory Surgical Center."

"Illness"
"Illness" shall have the meaning set forth in the definition of "Disease."

"Impregnation and Infertility Treatment"
"Impregnation and Infertility Treatment" shall mean any services, supplies or Drugs related to the Diagnosis or treatment of infertility.

"Incurred"
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 which 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"
"Injury" shall mean an Accidental Bodily Injury, which does not arise out of, which is not caused or contributed to by, and which is not a consequence of, any employment or occupation for compensation or profit.

"Inpatient"
"Inpatient" shall mean a Participant who receives care as a registered and assigned bed patient while confined in a Hospital, other than in its outpatient department, where a room and board is charged by the Hospital.

"Institution"
"Institution" shall mean a facility created and/or maintained for the purpose of practicing medicine and providing organized health care and treatment to individuals, operating within the scope of its license, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Agency, or any other such facility that the Plan approves.

"Intensive Care Unit"
"Intensive Care Unit" shall have the same meaning set forth in the definition of "Cardiac Care Unit."

"Late Enrollee"
"Late Enrollee" shall mean a Participant who enrolls in the Plan other than:

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

"Leave of Absence"
"Leave of Absence" shall mean a period of time during which Employee must be away from his/her primary job with Employer, while maintaining the status of Employee during said time away from work, generally requested by an Employee and having been approved by his or her Participating Employer, and as provided for in the Participating Employer's rules, policies, procedures and practices where applicable.

"Legal Separation"
"Legal Separation" shall mean an arrangement to remain married but live apart, following a court order.

"Mastectomy"

"Mastectomy" shall mean the Surgery to remove all or part of breast tissue as a way to treat or prevent breast cancer.

"Maximum Amount" or "Maximum Allowable Charge"
"Maximum Amount" and/or "Maximum Allowable Charge" shall mean the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

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

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

The **Maximum Allowable Charge** will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

"Medical Child Support Order"
"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 Child of a Participant 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. Is made pursuant to a law relating to medical child support described in §1908 of the Social Security Act (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medically Necessary"
"Medically Necessary" means services or supplies which are determined by the Plan Administrator to be:

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

For hospital stays, this means that acute care as in inpatient is necessary due to the kind of services the covered person is receiving or the severity of the covered person's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a physician does not mean that it is "medically necessary". In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary".

Medical necessity for a service or supply will be determined by the Plan based upon industry-standard resources and the standards, policies and procedures established by the Pre-certification Program administrator.

Off-label Drug use is considered Medically Necessary when all of the following conditions are met:

1. The Drug is approved by the FDA;
2. The prescribed Drug use is supported by one of the following standard reference sources:
    a. DRUGDEX;

b. The American Hospital Formulary Service Drug Information;
c. Medicare approved Compendia; or
d. Scientific evidence is supported in well-designed clinical trials published in peer-reviewed medical journals, which demonstrate that the Drug is safe and effective for the specific condition; and

3. The Drug is Medically Necessary to treat the specific condition, including life threatening conditions or chronic and seriously debilitating conditions.

"Medically Necessary Leave of Absence"
"Medically Necessary Leave of Absence" shall mean a Leave of Absence by a full-time student Dependent at a postsecondary educational Institution that:

1. Commences while such Dependent is suffering from a Illness or Injury;
2. Is Medically Necessary; and
3. Causes such Dependent to lose student status for purposes of coverage under the terms of the Plan.

"Medical Record Review"
"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 which is not supported in the billing, then the Plan Administrator may determine the **Maximum Allowable Charge** according to the Medical Record Review and audit results.

"Medicare"
"Medicare" shall mean the Federal program by which health care is provided to individuals who are 65 or older, certain younger individuals with disabilities, and individuals with End-Stage Renal Disease, administered in accordance with parameters set forth by CMS and Title XVIII of the Social Security Act of 1965, as amended, by whose terms it was established.

"Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA"
"The Mental Health Parity Provisions" shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

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

"Mental or Nervous Disorder"
"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.

"National Medical Support Notice" or "NMSN"
"National Medical Support Notice" or "NMSN" shall mean a notice that contains the following information:

1. The name of an issuing State child support enforcement agency; Name and mailing address (if any) of an Employee who is a Participant under the Plan;
2. The name and mailing address (if any) of the Employee who is a Participant under the Plan or eligible for enrollment;
3. The name and mailing address of each of the Alternate Recipients (i.e., the Child or Children of the Participant) or the name and address of a State or local official may be substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

"Network"
"Network" shall mean the facilities, providers and suppliers who have by contract via a medical Provider Network agreed to allow the Plan access to discounted fees for service(s) provided to Participants, and by whose terms they have agreed to accept Assignment of Benefits and the discounted fees thereby paid to them by the Plan as payment in full for Covered Expenses. The applicable Provider Network will be identified on the Participant's identification card.

"No-Fault Auto Insurance"
"No-Fault Auto Insurance" is the basic reparations provision of a law providing for payments without determining fault in connection with automobile Accidents.

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

"Open Enrollment Period"
"Open Enrollment Period" shall mean an annual period of time each Plan Year.

"Other Plan"
"Other Plan" shall include, but is not limited to:

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

"Participant"
"Participant" shall mean any Employee or Dependent who is eligible for benefits under the Plan.

"Physician"
"Physician" shall mean a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Psychologist (Ph.D.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Occupational Therapist, Physiotherapist, Speech Language Pathologist, psychiatrist, midwife, and any other practitioner of the healing arts who is licensed and regulated by a State or Federal agency, acting within the scope of that license.

"Plan Year"
"Plan Year" shall mean a period commencing on the Effective Date or any anniversary of the adoption of this Plan and continuing until the next succeeding anniversary.

"Pre-Admission Tests"
"Pre-Admission Tests" shall mean those medical tests and Diagnostic Services completed prior to a scheduled procedure, including Surgery, or scheduled admissions to the Hospital or Inpatient health care facility provided that:

1. The Participant obtains a written order form the Physician;
2. The tests are approved by both the Hospital and the Physician;
3. The tests are performed on an outpatient basis prior to Hospital admission; and
4. The tests are performed at the Hospital into which confinement is scheduled, or at a qualified facility designated by the Physician who will perform the procedure or Surgery.

"Pregnancy"
"Pregnancy" shall mean a physical state whereby a woman presently bears a Child or Children in the womb, prior to but likely to result in childbirth, miscarriage and/or non-elective abortion. Pregnancy is considered a Sickness for the purpose of determining benefits under this Plan.

"Preventive Care"
"Preventive Care" shall mean certain Preventive Care services.

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

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

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org or at https://www.healthcare.gov/preventive-care-benefits/.

For more information, you may contact the Plan Administrator/Employer.

"Prior Plan"
"Prior Plan" shall mean the coverage provided on a group or group type basis by the group insurance policy, benefit plan or service plan that was terminated on the day before the Effective Date of the Plan and replaced by the Plan.

"Prior to Effective Date" or "After Termination Date"
"Prior to Effective Date" or "After Termination Date" are dates occurring before a Participant gains eligibility from the Plan, or dates occurring after a Participant loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

"Privacy Standards"
"Privacy Standards" shall mean the standards of the privacy of individually identifiable health information, as pursuant to HIPAA.

"Provider"

"Provider" shall mean an entity whose primary responsibility is related to the supply of medical care. Each Provider must be licensed, registered, or certified by the appropriate State agency where the medical care is performed, as required by that State's law where applicable. Where there is no applicable State agency, licensure, or regulation, the Provider must be registered or certified by the appropriate professional body. The Plan Administrator may determine that an entity is not a "Provider" as defined herein if that entity is not deemed to be a "Provider" by CMS for purposes arising from payment and/or enrollment with Medicare; however, the Plan Administrator is not so bound by CMS' determination of an entity's status as a Provider.

"Psychiatric Hospital"
"Psychiatric Hospital" shall mean an Institution, appropriately licensed as a Psychiatric Hospital, established for the primary purpose of providing diagnostic and therapeutic psychiatric services for the treatment of mentally ill persons either by, or under the supervision of, a Physician. As such, to be deemed a "Psychiatric Hospital," the Institution must ensure every patient is under the care of a Physician and their staffing pattern must ensure the availability of a Registered Nurse 24 hours each day. Should the Institution fail to maintain clinical medical records on all patients permitting the determination of the degree and intensity of treatment to be provided, that Institution will not be deemed to be a "Psychiatric Hospital."

To be deemed a "Psychiatric Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" shall mean a Medical Child Support Order, in accordance with applicable law, and which 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 eligible Dependent is entitled under this Plan. A QMSCO must contain the content described herein, under the applicable Section titled "Qualified Medical Child Support Orders."

"Reasonable"
"Reasonable" and/or "Reasonableness" shall mean in the Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. 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 evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) CMS and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. 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.

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

"Rehabilitation Hospital"
"Rehabilitation Hospital" shall mean an appropriately licensed Institution, which is established in accordance with all relevant Federal, State and other applicable laws, to provide therapeutic and restorative services to individuals seeking to maintain, reestablish, or improve motor-skills and other functioning deemed Medically Necessary for daily living, that have been lost or impaired due to Sickness and/or Injury. To be deemed a "Rehabilitation Hospital," the Institution must be legally constituted, operated, and accredited for its stated purpose by either the

Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities, as well as approved for its stated purpose by CMS for Medicare purposes.

To be deemed a "Rehabilitation Hospital," the Institution must be duly licensed and must not be primarily a place for rest, the aged, and/or a nursing home, custodial, or training institution.

"Room and Board"
"Room and Board" shall mean a Hospital's charge for:

1. Room and complete linen service;
2. Dietary service including all meals, special diets, therapeutic diets, required nourishment's, dietary supplements and dietary consultation;
3. All general nursing services including but not limited to coordinating the delivery of care, supervising the performance of other staff members who have delegated member care and member education; and
4. Other conditions of occupancy which are Medically Necessary.

"Scheduled Benefit" or "Scheduled Benefit Amount"
"Scheduled Benefit" or "Scheduled Benefit Amount" shall mean a specified dollar amount that will be considered for reimbursement under the Plan for a particular type of medical care, service or supply provided. Scheduled Benefits are based upon Covered Expenses not otherwise limited or excluded under the terms of the Plan. A partial listing of Scheduled Benefit Amounts may be found in the section, "Summary of Benefits". A complete listing of Scheduled Benefit Amounts may be obtained on the web site at www.cooperboothbenefits.com, or free of charge on request to:

Cooper-Booth
200 Lincoln West Drive
Mountville PA 17554
Phone: (800) 992-0592

"Security Standards"
"Security Standards" shall mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

"Service Waiting Period"
"Service Waiting Period" shall mean an interval of time that must pass before an Employee or Dependent is eligible to enroll under the terms of the Plan. The Employee must be a continuously Active Employee of the Employer during this interval of time.

"Sickness"
"Sickness" shall have the meaning set forth in the definition of "Disease."

"Substance Abuse"
"Substance Abuse" shall mean any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 12 month period:
    a. Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);
    b. Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

c. Craving or a strong desire or urge to use a substance; or
d. Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" shall mean an Institution whose facility is licensed, certified or approved as a Substance Abuse treatment center by a Federal, State, or other agency having legal authority to so license; which is affiliated with a Hospital and whose primary purpose is providing diagnostic and therapeutic services for treatment of Substance Abuse. To be deemed a "Substance Abuse Treatment Center," the Institution must have a contractual agreement with the affiliated Hospital by which a system for patient referral is established, and implement treatment by means of a written treatment plan approved and monitored by a Physician. Where applicable, the "Substance Abuse Treatment Center" must also be appropriately accredited by the Joint Commission on Accreditation of Hospitals.

"**Substance Dependence**"
"Substance Dependence" shall mean substance use history which includes the following: (1) Substance Abuse (see above); (2) continuation of use despite related problems; (3) development of tolerance (more of the drug is needed to achieve the same effect); and (4) withdrawal symptoms.

"Surgery"
"Surgery" shall in the Plan Administrator's discretion mean the treatment of Injuries or disorders of the body by incision or manipulation, especially with instruments designed specifically for that purpose, and the performance of generally accepted operative and cutting procedures, performed within the scope of the Provider's license.

"Surgical Procedure"
"Surgical Procedure" shall have the same meaning set forth in the definition of "Surgery."

"Third Party Administrator"
"Third Party Administrator" shall mean the Third Party Administrator which provides customer service and claims payment services only and does not assume any financial risk or obligation with respect to those claims.

"Total Disability"
"Total Disability" shall mean an individual is determined as being disabled for Social Security purposes and provides such evidence to the Plan of the determination as the Plan Administrator may, in its sole discretion, require.

"Totally Disabled"
"Totally Disabled" shall have the same meaning set forth in the definition of "Total Disability."

"Uniformed Services"
"Uniformed Services" shall mean the Armed Forces, the Army National Guard and the Air National Guard, when engaged in active duty for training, inactive duty training, or full time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President of the United States in time of war or Emergency.

"USERRA"
"USERRA" shall mean the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

"Usual and Customary"
"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 (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area,

county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

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

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

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

All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE X
GENERAL LIMITATIONS AND EXCLUSIONS

Coverage is not available from the Plan for charges arising from care, supplies, treatment, and/or services:

Administrative Costs. That are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation;

After the Termination Date. That are Incurred by the Participant on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation;

Alcohol. That arise from a Participant taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Participants other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

Broken Appointments. That are charged solely due to the Participant's having failed to honor an appointment;

Confined Persons. That are for services, supplies, and/or treatment of any Participant that Incurred while confined and/or arising from confinement in a prison, jail or other penal institution;

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

Custodial Care. That do not restore health, unless specifically mentioned otherwise;

Deductible. That are amounts applied toward satisfaction of Deductibles and expenses that are defined as the Participant's responsibility in accordance with the terms of the Plan;

Excess. That are for charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document;

Experimental. That are Experimental or Investigational;

Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare;

Government-Operated Facilities.

1. That are furnished to the Participant in any veteran's Hospital, military Hospital, Institution or facility operated by the United States government or by any State government or any agency or instrumentality of such governments; and
2. That can be paid for by any government agency, even if the patient waives his rights to those services or supplies.

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

Hazardous Pursuit or Activity. That are of an Injury or Sickness that results from engaging in a hazardous pursuit. A pursuit or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Participant's customary occupation; considered as involving unusual or exceptional risks; characterized by a constant threat of danger or risk of bodily harm; and travel to countries with advisory warnings;

Illegal Acts. That are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. 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. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions);

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

Immediate Family Member. That are rendered by a member of the immediate Family Unit or person regularly residing in the same household, whether the relationship is by blood or exists in law;

Incurred by Other Persons. That are expenses actually Incurred by other persons;

Medical Necessity. That are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary;

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

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

Negligence. That are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator;

No Coverage. That are Incurred at a time when no coverage is in force for the applicable Participant and/or Dependent;

No Legal Obligation. That are for services provided to a Participant for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the Participant or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Participant or the Plan, may be liable for necessitating the fees, care, supplies, or services;

No Physician Recommendation. Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Participant is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness;

Non-Covered Treatments. Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered;

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

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

Not Specified As Covered. That are not specified as covered under any provision of this Plan;

Occupational. That are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers' compensation or another form of occupational Injury medical coverage is available;

Other than Attending Physician. That are other than those certified by a Physician who is attending the Participant as being required for the treatment of Injury or Disease, and performed by an appropriate Provider;

Postage, Shipping, Handling Charges, Etc. That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges;

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder, except as specifically provided herein;

Professional (and Semi-Professional) Athletics (Injury/Illness). That are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice;

Prohibited by Law. That are to the extent that payment under this Plan is prohibited by law;

Provider Error. That are required as a result of unreasonable Provider error;

Self-Inflicted. That are incurred due to an intentionally self inflicted Injury or Illness, not definitively arising from (a) being the victim of an act of domestic violence, or (b) resulting from a documented medical condition (including both physical and mental health conditions);

Subrogation, Reimbursement, and/or Third Party Responsibility. That are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions;

Unreasonable. That are not "Reasonable;" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan

Administrator in its sole discretion, gave rise to the expense are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es);

Vehicle Accident. For treatment of any Injury where it is determined that a Participant was involved in a motorcycle Accident while not wearing a helmet or in an automobile Accident while not wearing a seatbelt; and

War/Riot. That Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Participant is a member of the armed forces of any country, or during service by a Participant in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Participant who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from being the victim of an act of domestic violence or a medical condition.

ARTICLE XI
CLAIM PROCEDURES; PAYMENT OF CLAIMS

In accordance with applicable law, the Plan will allow an authorized representative to act on a Claimant's behalf in pursuing or appealing a benefit claim. For the purposes of this Article, "Claimant" shall mean any plan Participant or beneficiary submitting a claim to the Plan and thereby seeking to receive Plan benefits.

The availability of health benefit payments is dependent upon Claimants complying with the following:

11.01 Health Claims

Full and final authority to adjudicate claims and make determinations as to their payability by and under the Plan belongs to and resides solely with the Plan Administrator. The Plan Administrator shall make claims adjudication determinations after full and fair review and in accordance with the terms of this Plan, applicable law, and with ERISA. To receive due consideration, claims for benefits and questions regarding said claims should be directed to the Third Party Administrator. The Plan Administrator may delegate to the Third Party Administrator responsibility to process claims in accordance with the terms of the Plan and the Plan Administrator's directive(s). The Third Party Administrator is not a fiduciary of the Plan and does not have discretionary authority to make claims payment decisions or interpret the meaning of the Plan terms.

Written proof that expenses eligible for Plan reimbursement and/or payment were Incurred, as well as proof of their eligibility for payment by the Plan, must be provided to the Plan Administrator via the Third Party Administrator. Although a provider of medical services and/or supplies may submit such claims directly to the Plan by virtue of an Assignment of Benefits, ultimate responsibility for supplying such written proof remains with the Claimant. The Plan Administrator may determine the time and fashion by which such proof must be submitted. No benefits shall be payable under the Plan if the Plan Administrator so determines that the claims are not eligible for Plan payment, or, if inadequate proof is provided by the Claimant or entities submitting claims to the Plan on the Claimant's behalf.

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 Claimant 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 Claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the claims procedures properly, the Claimant 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 Claimant, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered.

According to Federal regulations which apply to the Plan, there are four (4) types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service.

1. Pre-service Claims. A "Pre-service Claim" occurs when issuance of payment by the Plan is dependent upon determination of payability prior to the receipt of the applicable medical care; however, if the Plan does not require the Claimant to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim."

Urgent care or Emergency medical services or admissions will not require notice to the Plan prior to the receipt of care. Furthermore, if in the opinion of a Physician with knowledge of the Claimant's medical condition, pre-determination of payability by the Plan prior to the receipt of medical care (a Pre-service Claim) would result in a delay adequate to jeopardize the life or health of the Claimant, hinder the Claimant's ability to regain maximum function (compared to treatment without delay), or subject the Claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim, said claim may be deemed to be a "Pre-service Urgent Care Claim." In such circumstances, the Claimant is urged to obtain the applicable care without delay, and communicate with the Plan regarding their claim(s) as soon as reasonably possible.

If, due to Emergency or urgency as defined above, a Pre-service claim is not possible, the Claimant must comply with the Plan's requirements with respect to notice required after receipt of treatment, and must file the claim as a Post-service Claim, as herein described.

Pre-admission certification of a non-Emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days. The rules regarding Pre-service Claims will apply to that determination only. Once a Claimant has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. If a Claimant requires an on-going course of treatment over a period of time or via a number of treatments, the Plan may approve of a "Concurrent Claim." In such circumstances, the Claimant must notify the Plan of such necessary ongoing or routine medical care, and the Plan will assess the Concurrent Claim as well as determine whether the course of treatment should be reduced or terminated. The Claimant, in turn, may request an extension of the course of treatment beyond that which the Plan has approved. If the Plan does not require the Claimant 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, and the Claimant must simply comply with the Plan's requirements with respect to notice required after receipt of treatment, as herein described.

3. Post-service Claims. A "Post-service Claim" is a claim for benefits from the Plan after the medical services and/or supplies have already been provided.

11.01A When Claims Must Be Filed

Post-service health claims (which must be Clean Claims) must be filed with the Third Party Administrator within 365 days of the date charges for the service(s) and/or supplies 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 Third Party Administrator in accordance with the Plan's procedures.

A Post-service Claim is considered to be filed when the following information is received by the Third Party Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the Provider of the services or supplies;
3. The place where the services were rendered;
4. The Diagnosis and procedure codes;
5. The amount of charges, which reflect any applicable PPO re-pricing ;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be initiated with the Plan.

The Third Party Administrator will determine if enough information has been submitted to enable proper consideration of the claim (a Clean Claim). If not, more information may be requested as provided herein. This additional information must be received by the Third Party Administrator within 45 days (48 hours in the case of Pre-service urgent care claims) from receipt by the Claimant of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

11.01B Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, 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:

1. Pre-service Urgent Care Claims:
    a. If the Claimant has provided all of the necessary information, as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim.
    b. 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 72 hours after receipt of the claim.
    c. The Claimant will be notified of a determination of benefits as soon as possible, but not later than 72 hours, taking into account the medical exigencies, after the earliest of:
        i. The Plan's receipt of the specified information; or
        ii. The end of the period afforded the Claimant to provide the information.
    d. If there is an Adverse Benefit Determination, a request for an expedited appeal may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the Claimant may request an expedited review under the external review process.
2. Pre-service Non-urgent Care Claims:
    a. 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.
    b. 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 five (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 Plan Administrator and the Claimant (if additional information was requested during the extension period).
3. Concurrent Claims:
    a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), notification will occur 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 to allow the Claimant 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.
    b. Request by Claimant Involving Urgent Care. If the Plan Administrator receives a request from a Claimant to extend the course of treatment beyond the period of time or number of treatments involving urgent care, notification will occur as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Claimant makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Claimant submits the request with less than 24 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.

c. Request by Claimant Involving Non-urgent Care. If the Plan Administrator receives a request from the Claimant 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).

d. Request by Claimant Involving Rescission. With respect to rescissions, the following timetable applies:

i. Notification to Claimant	30 days
ii. Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:
   a. If the Claimant 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.
   b. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the Claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.
   c. If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant 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 Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.
      i. Extensions – Pre-service Urgent Care Claims. No extensions are available in connection with Pre-service urgent care claims.
      ii. 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 Claimant, 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.
      iii. 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 Claimant, 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.
5. 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.

11.01C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically (or, in the case of urgent care claims, by telephone, facsimile or similar method, with written or electronic notice following within 3 days), containing the following information:

1. Information sufficient to allow the Claimant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of 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 Document 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, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
6. A 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 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);
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, or a statement that such explanation will be provided to the Claimant, free of charge, upon request; and
10. In a claim involving urgent care, a description of the Plan's expedited review process.

11.02 Appeal of Adverse Benefit Determinations

11.02A Full and Fair Review of All Claims

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

1. At least 180 days following receipt of a notification of an initial Adverse Benefit Determination within which to appeal the determination;
2. The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. The opportunity to review the Claim file and to present evidence and testimony as part of the internal claims and appeals process;
4. 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;
5. A review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
6. 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;
7. Upon requrest, the identity 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;
8. That a Claimant will be provided, free of charge: (a) reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim in possession of the Plan Administrator or Third Party Administrator; (b) information regarding any voluntary appeals procedures offered by the Plan; (c) information regarding the Claimant's right to an external review process; (d) any internal rule, guideline, protocol or other similar criterion relied upon, considered or generated in making the adverse determination; and (e) an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances; and
9. That a Claimant will be provided, free of charge, and sufficiently in advance of the date that the notice of Final Internal Adverse Benefit Determination is required, with new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for a denial at the internal appeals stage, and a reasonable opportunity for the Claimant to respond to such new evidence or rationale.

11.02B Requirements for Appeal
The Claimant must file an appeal regarding a Post-service claim and applicable Adverse Benefit Determination, in writing within at least 180 days following receipt of the notice of an Adverse Benefit Determination.

For Pre-service urgent care claims, if the Claimant chooses to initiate an appeal orally, the Claimant may telephone:

Integra BMS
P.O. Box 1178
Matthews, NC 28106
Fax: 704-845-5629

Oral appeals should be submitted in writing as soon as possible after it has been initiated.

To file any appeal in writing, the Claimant's appeal must be addressed as follows:

1. For Pre-service Claims:
   Claimants should refer to their identification card for the name and address of the utilization review administrator. All pre service claims must be sent to the utilization review administrator.

2. For Post-service Claims:

Integra BMS
P.O. Box 1178
Matthews, NC 28106
Fax: 704-845-5629

It shall be the responsibility of the Claimant 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/Claimant;
2. The Employee/Claimant's identification 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 Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

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

11.02C Timing of Notification of Benefit Determination on Review
The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Urgent Care Claims: As soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the appeal;
2. 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;
3. 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; and
4. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

5. 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.

11.02D Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Claimant with notification, with respect to Pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, 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, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. 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, and a discussion of the decision;
3. A reference to the specific portion(s) of the plan provisions upon which a denial is based;
4. 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); 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;
5. 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;
6. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
7. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
8. 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; 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
9. 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."

11.02E 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.

11.02F Decision on Review

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.

11.02G External Review Process

External Review of Adverse Benefit Determinations

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

The request for an external review must be filed by the *covered person* within four months following the *covered person*'s receipt of the notice of adverse benefit determination or final internal adverse benefit determination. However, if the *Plan* fails to strictly adhere to all the requirements of the internal claims and appeals process with respect to a claim, the *covered person* will be deemed to have exhausted the internal claims and appeals process, and the *covered person* may initiate an external review and pursue any available remedies under applicable law, such as judicial review.

The *Plan's* external review process applies to any adverse benefit determination or final internal adverse benefit determination on appeal, except that a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a claimant fails to meet the requirements for eligibility under the terms of the *Plan,* or the claim denial did not have a medical component. A medical component includes denials based upon the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, effectiveness of the health care service or treatment requested, or a determination that a treatment is experimental or investigational is not eligible for the external review process.

There are two types of external reviews; standard and expedited. An external review is a standard external review unless the timing required to perform a standard external review involves circumstances that would seriously jeopardize the life or health of the *covered person* or would jeopardize the *covered person'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 *covered person* received emergency services but has not yet been discharged from the facility. In such cases, the *Plan* will consider the external review to be an expedited review.

Expedited External Review for Urgent or Emergency Care

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

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

Procedures for Initiation of an External Review

Standard External Review

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

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

Within one business day following completion of the preliminary review, the *Plan* will notify the *covered person* in writing whether the request is eligible for external review.

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

- If the request is incomplete, the notice will describe the information or materials needed to make the request complete. The *covered person* must submit the information or materials needed within 48 hours following receipt of the notice, or the expiration of the original four-month filing period, whichever is later.

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

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

Within five business days after the date of assignment of the IRO, the *Plan* must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the *Plan* to timely provide the documents and information will not delay the conduct of the external review, and the IRO may decide to reverse the adverse benefit determination or final internal adverse benefit determination. In this case, the IRO will notify the *Plan* and the *covered person* within one business day following the decision to reverse the determination.

The assigned IRO will forward any information which is submitted by the *covered person* to the *Plan*, and the *Plan* may reconsider its adverse benefit determination or final internal adverse benefit determination; however, reconsideration by the *Plan* will not delay the external review. If the *Plan* decides to reverse its adverse benefit determination or final internal adverse benefit determination, it may terminate the external review and notify the IRO and the *covered person* within one business day of the decision.

The IRO will provide written notice to the *covered person* and the *Plan* of the final external review decision within 45 days following receipt of the request for review. The notice will contain:

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

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

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

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

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

- A statement that judicial review may be available to the *covered person*; and

- Current contact information, including a phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

Expedited External Review

A final internal adverse benefit determination concerning an admission, availability of care, continued stay, or health care item or service for which the *covered person* received *emergency* services but has not yet been discharged from the facility will be considered for an expedited external review. These are considered to be *pre-service* ***non-urgent*** *care claims* and *concurrent claims*.

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

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

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

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

- The IRO must provide notice of the final external review decision as expeditiously as the *covered person*'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, the assigned IRO must provide written confirmation of the decision to the *covered person* and the *Plan* within 48 hours following the notice.

Decision Following an External Review
Upon receipt of a notice from the IRO reversing the decision of an adverse benefit determination, the *Plan* will immediately provide coverage or payment for the claim. An external review decision is binding on the *Plan* as well as the *covered person*, except to the extent other remedies are available under State or Federal law.

11.02H Deemed Exhaustion of Internal Claims Procedures and De Minimis

Exception to the Deemed Exhaustion Rule

A Claimant will not be required to exhaust the internal claims and appeals procedures described above if the Plan fails to adhere to the claims procedures requirements. In such an instance, a Claimant may proceed immediately to the External Review Program or make a claim in court. However, the internal claim and appeals procedures will not be deemed exhausted (meaning the Claimant must adhere to them before participating in the External Review Program or bringing a claim in court) in the event of a de minimis violation that does not cause, and is not likely to cause, prejudice or harm to the Claimant as long as the Plan Administrator demonstrates that the violation was for good cause or due to matters beyond the control of the Plan, the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and the Claimant, and the violation is not reflective of a pattern or practice of non- compliance.

If a Claimant believes the Plan Administrator has engaged in a violation of the claims procedures and would like to pursue an immediate review, the Claimant may request that the Plan provide a written explanation of the violation, including a description of the Plan's basis for asserting that the violation should not result in a "deemed exhaustion" of the claims procedures. The Plan will respond to this request within ten days. If the External Reviewer or a court rejects a request for immediate review because the Plan has met the requirements for the "de minimis" exception described above, the Plan will provide the Claimant with notice of an opportunity to resubmit and pursue an internal appeal of the claim.

11.03 Appointment of Authorized Representative

A Claimant may designate another individual to be an authorized representative and act on his or her behalf and communicate with the Plan with respect to a specific benefit claim or appeal of a denial. This authorization must be

in writing, signed and dated by the Claimant, and include all the information required in the authorized representative form. The appropriate form can be obtained from the Plan Administrator or the Third Party Administrator.

The Plan will permit, in a medically urgent situation, such as a claim involving Urgent Care, a Claimant's treating health care practitioner to act as the Claimant's authorized representative without completion of the authorized representative form.

Should a Claimant designate an authorized representative, all future communications from the Plan will be conducted with the authorized representative instead of the Claimant, unless the Plan Administrator is otherwise notified in writing by the Claimant. A Claimant can revoke the authorized representative at any time. A Claimant may authorize only one person as an authorized representative at a time.

Recognition as an authorized representative is completely separate from a Provider accepting an Assignment of Benefits, requiring a release of information, or requesting completion a similar form. An Assignment of Benefits by a Claimant shall not be recognized as a designation of the Provider as an authorized representative. Assignment and its limitations under this Plan are described below.

11.04 Physical Examinations

Should there be, in the Plan Administrator's discretion, any question as to the Claimant's health or physical condition, such that the Medical Necessity of care sought by the Claimant is called into question, the Plan may, at its own expense, have a Physician of its choice perform a physical examination, as necessary to confirm Medical Necessity. Should the Claimant refuse to comply with said exam, the care may be deemed to be excluded by the Plan, at the Plan Administrator's discretion.

11.05 Autopsy

Upon receipt of a claim for a deceased Claimant for any condition, Sickness, or Injury is the basis of such claim, the Plan maintains the right to request an autopsy be performed upon said Claimant. The request for an autopsy may be exercised only where not prohibited by any applicable law.

11.06 Payment of Benefits

Where benefit payments are allowable in accordance with the terms of this Plan, payment shall be made in U.S. Dollars (unless otherwise agreed upon by the Plan Administrator). Payment shall be made, in the Plan Administrator's discretion, to an assignee of an Assignment of Benefits, but in any instance may alternatively be made to the Claimant, on whose behalf payment is made and who is the recipient of the services for which payment is being made. Should the Claimant be deceased, payment shall be made to the Claimant's heir, assign, agent or estate (in accordance with written instructions), or, if there is no such arrangement and in the Plan Administrator's discretion, the Institute and/or Provider who provided the care and/or supplies for which payment is to be made – regardless of whether an Assignment of Benefits occurred.

11.06A Assignments

Assignment by a Claimant to the Provider of the Claimant's right to submit claims for payment to the Plan, and receive payment from the Plan, may be achieved via an Assignment of Benefits, if and only if the Provider accepts said Assignment of Benefits as consideration in full for services rendered. If benefits are paid, however, directly to the Claimant – despite there being an Assignment of Benefits – the Plan shall be deemed to have fulfilled its obligations with respect to such payment, and it shall be the Claimant's responsibility to compensate the applicable Provider(s). The Plan will not be responsible for determining whether an Assignment of Benefits is valid; and the Claimant shall retain final authority to revoke such Assignment of Benefits if a Provider subsequently demonstrates an intent not to accept it as payment in full for services rendered. As such, payment of benefits will be made directly to the assignee unless a written request not to honor the assignment, signed by the Claimant, has been received.

No Claimant shall at any time, either during the time in which he or she is a Claimant in the Plan, or following his or her termination as a Claimant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A Provider which accepts an Assignment of Benefits, in accordance with this Plan as consideration in full for services rendered, is bound by the rules and provisions set forth within the terms of this document.

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, agrees to be bound by the terms of this Plan and agrees to submit claims for reimbursement in strict accordance with applicable law, ICD, and/or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer.

11.06B Non U.S. Providers

A Provider of medical care, supplies, or services, whose primary facility, principal place of business or address for payment is located outside the United States shall be deemed to be a "Non U.S. Provider." Claims for medical care, supplies, or services provided by a Non U.S. Provider and/or that are rendered outside the United States of America, may be deemed to be payable under the Plan by the Plan Administrator, subject to all Plan exclusions, limitations, maximums and other provisions. Assignment of Benefits to a Non U.S. Provider is prohibited absent an explicit written waiver executed by the Plan Administrator. If Assignment of Benefits is not authorized, the Claimant is responsible for making all payments to Non U.S. Providers, and is solely responsible for subsequent submission of proof of payment to the Plan. Only upon receipt of such proof of payment, and any other documentation needed by the Plan Administrator to process the claims in accordance with the terms of the Plan, shall reimbursement by the Plan to the Claimant be made. If payment was made by the Claimant in U.S. currency (American dollars), the maximum reimbursable amount by the Plan to the Claimant shall be that amount. If payment was made by the Claimant using any currency other than U.S. currency (American dollars), the Plan shall utilize an exchange rate in effect on the Incurred date as established by a recognized and licensed entity authorized to so establish said exchange rates. The Non U.S. Provider shall be subject to, and shall act in compliance with, all U.S. and other applicable licensing requirements; and claims for benefits must be submitted to the Plan in English.

11.06C Recovery of Payments

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

A Claimant, 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 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 Claimant 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 Claimant and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan

and agree to submit claims for reimbursement in strict accordance with their State's health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Claimant, Provider or other person or entity to enforce the provisions of this section, then that Claimant, Provider or other person or entity agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

Further, Claimants and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Claimants) 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 Claimant (s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

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

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two (2) years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Claimant 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 Claimant or by any of his covered Dependents if such payment is made with respect to the Claimant or any person covered or asserting coverage as a Dependent of the Claimant.

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

11.06D Medicaid Coverage

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

ARTICLE XII
COORDINATION OF BENEFITS

12.01 Benefits Subject to This Provision
This following shall apply to the entirety of the Plan and all benefits described therein.

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

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

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

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

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

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

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

12.06 Effect on Benefits

12.06A Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 110% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

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

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

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

12.06B Order of Benefit Determination

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

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

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

12.07 Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provisions or any provision of similar purpose of any Other Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

12.08 Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay an amount pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

12.09 Right of Recovery

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

ARTICLE XIII
MEDICARE

13.01 Applicable to Active Employees and Their Spouses Ages 65 and Over

An active Employee and his or her 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.

13.02 Applicable to All Other Participants Eligible for Medicare Benefits

To the extent required by Federal regulations, this Plan will pay before any Medicare benefits. There are some circumstances under which Medicare would be required to pay its benefits first. In these cases, benefits under this Plan would be calculated as secondary payor (as described under the Article entitled "Coordination of Benefits"). The Participant 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.

13.03 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Participants Who Are Covered Under This Plan

If any Participant is eligible for Medicare benefits because of ESRD, 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.

ARTICLE XIV
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

14.01 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 Participants, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "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 guarantor(s) of a third party (collectively "Coverage").

2. 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 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 Participant(s) agrees the Plan shall have an equitable lien on any funds received by the 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 Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

3. In the event a Participant(s) settles, recovers, or is reimbursed by any Coverage, the Participant(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Participant(s). If the Participant(s) fails to reimburse the Plan out of any judgment or settlement received, the 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 Participant(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

14.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the 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 Participant(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any 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 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 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. Workers' compensation or other liability insurance company; or
e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

14.03 Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the 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 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, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

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

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

14.04 Excess Insurance

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

The Plan's benefits shall be excess to:

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

14.05 Separation of Funds

Benefits paid by the Plan, funds recovered by the Participant(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Participant(s), such that the death of the Participant(s), or filing of bankruptcy by the 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.

14.06 Wrongful Death

In the event that the 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, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Participant(s) and all others that benefit from such payment.

14.07 Obligations

1. It is the 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 Participant may have against any responsible party or Coverage.

2. If the 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 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 Participant(s).

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

14.08 Offset

If timely repayment is not made, or the Participant and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Participant's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Participant(s) in an amount equivalent to any outstanding amounts owed by the Participant to the Plan.

14.09 Minor Status

1. In the event the 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.

14.10 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.

14.11 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.

ARTICLE XV
CONTINUATION OF COVERAGE

15.01 Employer Continuation Coverage
Eligible Participants may seek to continue Coverage upon the occurrence of:

1. Total Disability; coverage will continue for 12 weeks concurrent with FLMA leave following termination of Active Employment; and/or
2. Leave of Absence (not meeting the definition of a FMLA Leave); coverage will Terminate.

15.02 Continuation During Family and Medical Leave Act (FMLA) Leave
Regardless of the established leave policies mentioned above, the Plan shall at all times comply with FMLA. It is the intention of the Plan Administrator to provide these benefits only to the extent required by applicable law and not to grant greater rights than those so required. During a FMLA Leave, coverage will be maintained in accordance with the same Plan conditions as coverage would otherwise be provided if the covered Employee had been a continuously active employee during the entire leave period. If Plan coverage lapses during the FMLA Leave, coverage will be reinstated for the person(s) who had coverage under the Plan when the FMLA Leave began, upon the Employee's return to work at the conclusion of the FMLA Leave.

15.02A Family and Medical Leave Act of 1993 (FMLA)
This applies to Employers with 50 or more Employees within 75 miles for at least 20 workweeks in the current or preceding Calendar Year. The following are some definitions identified by the FMLA:

Covered Service Member
"Covered Service Member" shall mean current service members and covered veterans who are undergoing medical treatment, recuperation, or therapy due to a serious Injury or Illness, rather than just current service members. A covered veteran is an individual who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to when the eligible Employee takes FMLA Leave to care for the covered veteran.

Eligible Employee
"Eligible Employee" shall mean an individual who has been employed by the Company for at least 12 months, has performed at least 1,250 hours of service during the previous 12 month period, and has worked at a location where at least 50 Employees are employed by the Employer within 75 miles.

Family Member
"Family Member" shall mean the (a) Employee's biological, step, or foster parent or (b) a natural, adopted, foster, or stepchild, or a legal ward under 18 years of age, or 18years and older and incapable of self-care because of a mental or physical disability or (c) spouse.

Serious Illness or Injury (of a service member or covered veteran)
"Serious Illness or Injury" shall mean an Illness or Injury Incurred in the line of duty that may render the service member medically unfit to perform his or her military duties. A serious Injury or Illness for a current service member includes an Injury or Illness that existed before the beginning of the service member's active duty and was aggravated by service in the line of duty on active duty in the armed forces. A serious Injury or Illness for a covered veteran means an Injury or Illness that was Incurred or aggravated by the service member in the line of duty on active duty in the armed forces and manifested itself before or after the service member became a veteran.

These definitions are listed as a guide and the actual wording of the FMLA, as amended, shall supersede these definitions.

15.02B Basic Leave Entitlement
FMLA requires covered Employers to provide up to 12 weeks of unpaid, job-protected leave to eligible Employees for the following reasons:

1. for incapacity due to Pregnancy, prenatal medical care or Child birth;
2. to care for the Employee's Child after birth, or placement for adoption or foster care;
3. to care for the Employee's spouse, son, daughter or parent, who has a serious health condition; or
4. for a serious health condition that makes the Employee unable to perform the Employee's job.

15.02C Military Family Leave Entitlements
Eligible Employees whose spouse, son, daughter or parent is on covered active duty or call to covered active duty status may use their 12 week leave entitlement to address certain qualifying exigencies. Qualifying exigencies may include attending certain military events, arranging for alternative childcare, addressing certain financial and legal arrangements, attending certain counseling sessions, and attending post-deployment reintegration briefings.

FMLA also includes a special leave entitlement that permits eligible Employees to take up to 26 weeks of leave to care for a covered service member during a single 12 month period. A covered service member is: (1) a current member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious Injury or Illness*; or (2) a veteran who was discharged or released under conditions other than dishonorable at any time during the five-year period prior to the first date the eligible Employee takes FMLA Leave to care for the covered veteran, and who is undergoing medical treatment, recuperation, or therapy for a serious Injury or Illness.*

***The FMLA definitions of "serious Injury or Illness" for current service members and veterans are distinct from the FMLA definition of "serious health condition".**

15.02D Benefits and Protections
During FMLA Leave, the Employer must maintain the Employee's health coverage under any "group health plan" on the same terms as if the Employee had continued to work. Upon return from FMLA Leave, most Employees must be restored to their original or equivalent positions with equivalent pay, benefits, and other employment terms.

Use of FMLA Leave cannot result in the loss of any employment benefit that accrued prior to the start of an Employee's leave.

15.02E Eligibility Requirements
Employees are eligible if they have worked for a covered Employer for at least 12 months, have 1,250 hours of service in the previous 12 months*, and if at least 50 Employees are employed by the Employer within 75 miles.

***Special hours of service eligibility requirements apply to airline flight crew Employees.**

15.02F Definition of Serious Health Condition
A serious health condition is an Illness, Injury, impairment, or physical or mental condition that involves either an overnight stay in a medical care facility, or continuing treatment by a health care Provider for a condition that either prevents the Employee from performing the functions of the Employee's job, or prevents the qualified family member from participating in school or other daily activities.

Subject to certain conditions, the continuing treatment requirement may be met by a period of incapacity of more than three (3) consecutive calendar days combined with at least two (2) visits to a health care Provider or one (1) visit and a regimen of continuing treatment, or incapacity due to Pregnancy, or incapacity due to a chronic condition. Other conditions may meet the definition of continuing treatment.

15.02G Use of Leave
An Employee does not need to use this leave entitlement in one block. Leave can be taken intermittently or on a reduced leave schedule when Medically Necessary. Employees must make reasonable efforts to schedule leave for planned medical treatment so as not to unduly disrupt the Employer's operations. Leave due to qualifying exigencies may also be taken on an intermittent basis.

15.02H Substitution of Paid Leave for Unpaid Leave
Employees may choose or Employers may require use of accrued paid leave while taking FMLA Leave. In order to use paid leave for FMLA Leave, Employees must comply with the Employer's normal paid leave policies.

15.02I Employee Responsibilities
Employees must provide 30 days advance notice of the need to take FMLA Leave when the need is foreseeable. When 30 days notice is not possible, the Employee must provide notice as soon as practicable and generally must comply with an Employer's normal call-in procedures.

Employees must provide sufficient information for the Employer to determine if the leave may qualify for FMLA protection and the anticipated timing and duration of the leave. Sufficient information may include that the Employee is unable to perform job functions, the family member is unable to perform daily activities, the need for hospitalization or continuing treatment by a health care Provider, or circumstances supporting the need for military family leave. Employees also must inform the Employer if the requested leave is for a reason for which FMLA Leave was previously taken or certified. Employees also may be required to provide a certification and periodic recertification supporting the need for leave.

15.02J Employer Responsibilities
Covered Employers must inform Employees requesting leave whether they are eligible under FMLA. If they are, the notice must specify any additional information required as well as the Employees' rights and responsibilities. If they are not eligible, the Employer must provide a reason for the ineligibility.

Covered Employers must inform Employees if leave will be designated as FMLA-protected and the amount of leave counted against the Employee's leave entitlement. If the Employer determines that the leave is not FMLA-protected, the Employer must notify the Employee.

15.02K Unlawful Acts by Employers
FMLA makes it unlawful for any Employer to:

1. Interfere with, restrain, or deny the exercise of any right provided under FMLA; and
2. Discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA.

15.02L Enforcement
An Employee may file a complaint with the U.S. Department of Labor or may bring a private lawsuit against an Employer.

FMLA does not affect any Federal or State law prohibiting discrimination, or supersede any State or local law or collective bargaining agreement which provides greater family or medical leave rights.

FMLA section 109 (29 U.S.C. § 2619) requires FMLA covered Employers to post the text of this notice. Regulation 29 C.F.R. § 825.300(a) may require additional disclosures.

For additional information:
1-866-4US-WAGE (1-866-487-9243) TTY: 1-877-889-5627
WWW.WAGEHOUR.DOL.GOV
U.S. Department of Labor Wage and Hour Division
WHD Publication 1420 · Revised February 2013

15.03 Continuation During USERRA
Participants who are absent from employment because they are in the Uniformed Services may elect to continue their coverage under this Plan for up to 24 months. To continue coverage, Participants must comply with the terms of the Plan, including election during the Plan's annual enrollment period, and pay their contributions, if any. In addition, USERRA also requires that, regardless of whether a Participant elected to continue his or her coverage under the Plan, his or her coverage and his or her Dependents' coverage be reinstated immediately upon his or her

return to employment, so long as he or she meets certain requirements contained in USERRA. Participants should contact their participating Employer for information concerning their eligibility for USERRA and any requirements of the Plan.

15.04 Continuation During COBRA – Introduction

The right to this form of continued coverage was created by a Federal law, under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to Participants when they otherwise would lose their group health coverage. It also can become available to other members of the Participants family who are covered under the Plan when they otherwise would lose their group health coverage. Under the Plan, Qualified Beneficiaries that elect COBRA Continuation Coverage must pay the entire cost of the coverage, including a reasonable administration fee. There are several ways coverage will terminate, including the failure of the Participant or their covered Dependents to make timely payment of contributions or premiums. For additional information, Participants should contact the Participating Employer to determine if COBRA applies to him or her and/or his or her covered Dependents.

Participants may have other options available when group health coverage is lost. For example, a Participant may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, the Participant may qualify for lower costs on his or her monthly premiums and lower out-of-pocket costs. Additionally, the Participant may qualify for a 30-day special enrollment period for another group health plan for which the Participant is eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

15.04A COBRA Continuation Coverage

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event." COBRA (and the description of COBRA Continuation Coverage contained in this Plan) does not apply to the following benefits (if available as part of the Employer's plan): life insurance, accidental death and dismemberment benefits and weekly income or long term disability benefits. The aforementioned benefits are not considered for continuation under COBRA. The Plan provides no greater COBRA rights than what COBRA requires – nothing in this Plan is intended to expand the Participant's rights beyond COBRA's requirements.

15.04B Qualifying Events

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." A Qualified Beneficiary is someone who is or was covered by the Plan, and has lost or will lose coverage under the Plan due to the occurrence of a Qualifying Event. The Employee and/or Employee's Dependents could therefore become Qualified Beneficiaries if applicable coverage under the Plan is lost because of the Qualifying Event.

An Employee, who is properly enrolled in this Plan and is a covered Employee, will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because either one of the following Qualifying Events happens:

1. The hours of employment are reduced; or
2. The employment ends for any reason other than gross misconduct.

The spouse of a covered Employee will become a Qualified Beneficiary if he or she loses his or her coverage under the Plan because any of the following Qualifying Events happens:

1. The Employee dies;
2. The Employee's hours of employment are reduced;
3. The Employee's employment ends for any reason other than his or her gross misconduct;
4. The Employee becomes entitled to Medicare benefits (under Part A, Part B, or both); or
5. The Employee becomes divorced or legally separated from his or her spouse.

Dependent Children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-covered Employee dies;
2. The parent-covered Employee's hours of employment are reduced;
3. The parent-covered Employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The Child stops being eligible for coverage under the Plan as a Dependent Child.

15.04C Employer Notice of Qualifying Events
When the Qualifying Event is the end of employment (for reasons other than gross misconduct), reduction of hours of employment, death of the covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the covered Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

15.04D Employee Notice of Qualifying Events
In certain circumstances, the covered Employee or Qualified Beneficiary, in order to protect his or her rights under COBRA, is required to provide notification to the Plan Administrator in writing, either by U.S. First Class Mail or hand delivery. These circumstances are:

1. **Notice of Divorce or Separation:** Notice of the occurrence of a Qualifying Event that is a divorce or Legal Separation of a covered Employee (or former Employee) from his or her spouse;
2. **Notice of Child's Loss of Dependent Status:** Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a Dependent Child under the terms of the Plan;
3. **Notice of a Second Qualifying Event:** Notice of the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA Continuation Coverage with a maximum duration of 18 (or 29) months;
4. **Notice Regarding Disability:** Notice that a Qualified Beneficiary entitled to receive COBRA Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at any time during the first 60 days of COBRA Continuation Coverage; and
5. **Notice Regarding End of Disability:** Notice that a Qualified Beneficiary, with respect to whom a notice described above in #4 has been provided, has subsequently been determined by the SSA to no longer be disabled.

As indicated above, Notification of a Qualifying Event must be made in writing. Notice must be made by submitting the "Notice of Qualifying Event" form and mailing it by U.S. First Class Mail or hand delivery to the Plan Administrator. This form is available, without charge, from the Plan Administrator.

Notification must include an adequate description of the Qualifying Event or disability determination. Please see the remainder of this Article for additional information.

Notification must be received by the Plan Administrator is:

Cooper-Booth Wholesale Company LP
200 Lincoln West Drive
Mountville, Pennsylvania 17554

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

15.04E Deadline for providing the notice
For Qualifying Events described above, notice must be furnished within 60 days of the latest occurring event set forth below:

1. The date upon which the Qualifying Event occurs;

2. The date upon which the Qualified Beneficiary loses (or would lose) Plan coverage due to a Qualifying Event; or
3. The date upon which the Qualified Beneficiary is notified via the Plan's SPD or general notice, and/or becomes aware of their status as a Qualified Beneficiary and/or the occurrence of a Qualifying Event; as well as their subsequent responsibility to comply with the Plan's procedure(s) for providing notice to the Plan Administrator regarding said status.

As described above, if an Employee or Qualified Beneficiary is determined to be disabled under the Social Security Act, the notice must be delivered no more than 60 days after the latest of:

1. The date of the disability determination by the SSA;
2. The date on which a Qualifying Event occurs;
3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or
4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be provided within the first 18 months of COBRA Continuation Coverage.

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

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or
2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's SPD or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

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

15.04F Who Can Provide the Notice

Any individual who is the covered Employee (or former Employee) with respect to a Qualifying Event, or any representative acting on behalf of the covered Employee (or former Employee) or Qualified Beneficiary, may provide the notice. Notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event

15.04G Required Contents of the Notice

After receiving a notice of a Qualifying Event, the Plan must provide the Qualified Beneficiary with an election notice, which describes their rights to COBRA Continuation Coverage and how to make such an election. The notice must contain the following information:

1. Name and address of the covered Employee or former Employee;
2. Name of the Plan and the name, address, and telephone number of the Plan's COBRA administrator;
3. Identification of the Qualifying Event and its date (the initial Qualifying Event and its date if the Qualifying Participant is already receiving COBRA Continuation Coverage and wishes to extend the maximum coverage period);
4. A description of the Qualifying Event (for example, divorce, Legal Separation, cessation of Dependent status, entitlement to Medicare by the covered Employee or former Employee, death of the covered Employee or former Employee, disability of a Qualified Beneficiary or loss of disability status);

a. In the case of a Qualifying Event that is divorce or Legal Separation, name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan, date of divorce or Legal Separation, and a copy of the decree of divorce or Legal Separation;
b. In the case of a Qualifying Event that is Medicare entitlement of the covered Employee or former Employee, date of entitlement, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
c. In the case of a Qualifying Event that is a Dependent Child's cessation of Dependent status under the Plan, name and address of the Child, reason the Child ceased to be an eligible Dependent (for example, attained limiting age, lost student status or other);
d. In the case of a Qualifying Event that is the death of the covered Employee or former Employee, the date of death, and name(s) and address(es) of spouse and Dependent Child(ren) covered under the Plan;
e. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;
f. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination;

5. Identification of the Qualified Beneficiaries (by name or by status);
6. An explanation of the Qualified Beneficiaries' right to elect continuation coverage;
7. The date coverage will terminate (or has terminated) if continuation coverage is not elected;
8. How to elect continuation coverage;
9. What will happen if continuation coverage isn't elected or is waived;
10. What continuation coverage is available, for how long, and (if it is for less than 36 months), how it can be extended for disability or second qualifying events;
11. How continuation coverage might terminate early;
12. Premium payment requirements, including due dates and grace periods;
13. A statement of the importance of keeping the Plan Administrator informed of the addresses of Qualified Beneficiaries;
14. A statement that the election notice does not fully describe COBRA or the plan and that more information is available from the Plan Administrator and in the SPD; and
15. A certification that the information is true and correct, a signature and date.

If a copy of the decree of divorce or Legal Separation or the SSA's determination cannot be provided by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or Legal Separation or the SSA's determination within 30 days after the deadline. The notice will be timely if done so. However, no COBRA Continuation Coverage, or extension of such Coverage, will be available until the copy of the decree of divorce or Legal Separation or the SSA's determination is provided.
If the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the covered Employee (or former Employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

15.04H Electing COBRA Continuation Coverage
Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of the Qualifying Event. The individual then has 60 days in which to elect COBRA Continuation Coverage. The 60 day period is measured from the later of the date coverage terminates and the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60 day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of all other Qualified Beneficiaries, including their spouses, and parents or a legal guardian may elect COBRA Continuation Coverage on behalf of their Children.

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

15.04I Duration of COBRA Continuation Coverage

The maximum time period shown below shall dictate for how long COBRA Continuation Coverage will be available. The maximum time period for coverage is based on the type of the Qualifying Event and the status of the Qualified Beneficiary. Multiple Qualifying Events that may be combined under COBRA will not ordinarily continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36 month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the covered Employee (or former Employee), the covered Employee's (or former Employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), a divorce or Legal Separation, or a Dependent Child's losing eligibility as a Dependent Child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the covered Employee's hours of employment, and the covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered Employee becomes entitled to Medicare eight months before the date on which his or her employment terminates, COBRA Continuation Coverage for his or her spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two (2) ways in which this 18 month period of COBRA Continuation Coverage can be extended.

15.04J Disability Extension of COBRA Continuation Coverage

Disability can extend the 18 month period of continuation coverage for a Qualifying Event that is a termination of employment or reduction of hours, if an Employee or anyone in an Employee's family covered under the Plan is determined by the Social Security Administration ("SSA") to be disabled, and the Employee notifies the Plan Administrator. The Employee and his or her Dependents may thereby be entitled to an additional 11 months of COBRA Continuation Coverage, for a total of 29 months, if the disability started at some time before the 60th day of COBRA Continuation Coverage and lasts at least until the end of the 18 month period of COBRA Continuation Coverage. The Plan can charge 150% of the premium cost for the extended period of coverage.

15.04K Second Qualifying Event Extension of COBRA Continuation Coverage

If an Employee's family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, Dependents may receive up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the second Qualifying Event is provided to the Plan Administrator or COBRA Administrator in accordance with the procedures set forth herein. This extension may be applicable to the Employee's death, Medicare Parts A and/or B eligibility, divorce or legal separation, or a loss of Dependent status under the terms of the Plan if the event would have also caused the spouse or Dependent Child to lose coverage under the Plan regardless of whether the first Qualifying Event had occurred.

15.04L Shorter Duration of COBRA Continuation Coverage

COBRA establishes required periods of coverage for continuation health benefits. A plan, however, may provide longer periods of coverage beyond those required by COBRA. COBRA Qualified Beneficiaries generally are eligible for group coverage during a maximum of 18 months after Qualifying Events arising due to employment termination or reduction of hours of work. Certain Qualifying Events, or a second Qualifying Events during the initial period of coverage, may permit a Qualified Beneficiary to receive a maximum of 36 months of coverage.

It is not necessary that COBRA Continuation Coverage be in effect for the maximum period of time, as set forth herein. COBRA Continuation Coverage may conclude prior to the latest possible date if the Employer ceases to provide a group health plan to any Employee; the Qualified Beneficiary fails to make timely payment of any required contributions or premium; the Qualified Beneficiary gains coverage under another group health plan (as an Employee or otherwise) or becomes entitled to either Medicare Part A or Part B (whichever comes first) (except as stated under COBRA's special bankruptcy rules); and/or any other event occurs which enables the Plan Administrator to terminate coverage without offering COBRA Continuation Coverage (such as the commission of fraud by the Qualified Beneficiary and/or their Dependent). COBRA Continuation Coverage for pre-existing conditions shall be extended for the lesser of the duration of the pre-existing condition's treatment or the COBRA maximum time period; or upon the first day of the month 30 days (or more) subsequent to the date upon which the SSA determined that the Qualified Beneficiary is no longer disabled.

15.04M Contribution and/or Premium Requirements

The cost of the elected COBRA Continuation Coverage must be paid within 45 days of its election. Payments will then be subsequently due on the first day of each month. COBRA Continuation Coverage will be canceled and will not be reinstated if any payment is made late; however, the Plan Administrator may allow for a 30 day grace period during which a late payment may still be made without the loss of COBRA Continuation Coverage.

15.05 Additional Information

Please contact the Plan Administrator with any questions about the Plan and COBRA Continuation Coverage at the following:

Cooper-Booth Wholesale Company, LP
200 Lincoln West Drive
Mountivlle, Pennsylvania 17554
(800)992-0592

Also, for more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

Questions concerning the Plan or COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about a Participant's rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

15.06 Current Addresses

Important information is distributed by mail. In order to protect the rights of the Employee's family, the Employee should keep the Plan Administrator (who has been previously identified in this Article) informed of any changes in the addresses of family members.

ARTICLE XVI
PLAN ADMINISTRATION

The Plan Administrator has been granted the authority to administer the Plan. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other technical services. Subject to the claims processing and other technical services delegated to the Third Party Administrator, the Plan Administrator reserves the unilateral right and power to administer and to interpret, construe and construct the terms and provisions of the Plan, including without limitation, correcting any error or defect, supplying any omission, reconciling any inconsistency and making factual determinations.

16.01 Plan Administrator

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

The Plan Administrator may delegate to one or more individuals or entities part or all of its discretionary authority under the Plan, provided that any such delegation must be made in writing.

The Plan shall be administered by the Plan Administrator, in accordance with its terms. Policies, interpretations, practices, and procedures are established and maintained by the Plan Administrator. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make all interpretive and factual determinations as to whether any individual is eligible and entitled to receive any benefit under the terms of this Plan, to decide disputes which may arise with respect to a Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. Benefits will be paid under this Plan only if the Plan Administrator, in its discretion, determines that the Participant is entitled to them.

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

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

16.02 Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Participant's rights and/or availability of benefits;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third Party Administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether a Medical Child Support Order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

16.03 Amending and Terminating the Plan

This Plan was established for the exclusive benefit of the Employees with the intention it will continue indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the trust agreement (if any). All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

The process whereby amendments, suspension and/or termination of the Plan is accomplished, or any part thereof, shall be decided upon and/or enacted by resolution of the Plan Sponsor's directors and officers if it is incorporated (in compliance with its articles of incorporation or bylaws and if these provisions are deemed applicable), or by the sole proprietor in his or her own discretion if the Plan Sponsor is a sole proprietorship, but always in accordance with applicable Federal and State law, including – where applicable – notification rules provided for and as required by ERISA.

If the Plan is terminated, the rights of the Plan Participants are limited to expenses Incurred before termination. In connection with the termination, the Plan Sponsor may establish a deadline by which all Claims must be submitted for consideration. Benefits will be paid only for Covered Expenses Incurred prior to the termination date and submitted in accordance with the rules established by the Plan Sponsor. Upon termination, any Plan assets will be used to pay outstanding claims and all expenses of Plan termination. To the extent that any Plan assets remain, they will be used for the benefit of covered Participants in accordance with ERISA.

ARTICLE XVII
MISCELLANEOUS PROVISIONS

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

17.02 Clerical Error/Delay
Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes to such records will not invalidate coverage otherwise validly in force or continue coverage validly terminated. Contributions made in error by Participants due to such clerical error will be returned to the Participant; coverage will not be inappropriately extended. Contributions that were due but not made, in error and due to such clerical error will be owed immediately upon identification of said clerical error. Failure to so remedy amounts owed may result in termination of coverage. Effective Dates, waiting periods, deadlines, rules, and other matters will be established based upon the terms of the Plan, as if no clerical error had occurred. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable

17.03 Conformity With Applicable Laws
Any provision of this Plan that is contrary to any applicable law, regulation or court order (if such a court is of competent jurisdiction) will be interpreted to comply with said law, or, if it cannot be so interpreted, shall be automatically amended to satisfy the law's minimum requirement. It is intended that the Plan will conform to the requirements of ERISA, as it applies to Employee welfare plans, as well as any other applicable law.

17.04 Fraud
Under this Plan, coverage may be retroactively canceled or terminated (rescinded) if a Participant acts fraudulently or intentionally makes material misrepresentations of fact. It is a Participant's responsibility to provide accurate information and to make accurate and truthful statements, including information and statements regarding family status, age, relationships, etc. It is also a Participant's responsibility to update previously provided information and statements. Failure to do so may result in coverage of Participants being canceled, and such cancellation may be retroactive.

If a Participant, or any other entity, submits or attempts to submit a claim for or on behalf of a person who is not a Participant of the Plan; submits a claim for services or supplies not rendered; provides false or misleading information in connection with enrollment in the Plan; or provides any false or misleading information to the Plan as it relates to any element of its administration; that shall be deemed to be fraud. If a Participant is aware of any instance of fraud, and fails to bring that fraud to the Plan Administrator's attention, that shall also be deemed to be fraud. Fraud will result in immediate termination of all coverage under this Plan for the Participant and their entire Family Unit of which the Participant is a member.

A determination by the Plan that a rescission is warranted will be considered an Adverse Benefit Determination for purposes of review and appeal. A Participant whose coverage is being rescinded will be provided a 30 day notice period as described under The Patient Protection and Affordable Care Act (PPACA) and regulatory guidance. Claims Incurred after the retroactive date of termination shall not be further processed and/or paid under the Plan. Claims Incurred after the retroactive date of termination that were paid under the Plan will be treated as erroneously paid claims under this Plan.

17.05 Headings
The headings used in this Plan Document are used for convenience of reference only. Participants are advised not to rely on any provision because of the heading.

17.06 No Waiver or Estoppel

All parts, portions, provisions, conditions, and/or other items addressed by this Plan shall be deemed to be in full force and effect, and not waived, absent an explicit written instrument expressing otherwise; executed by the Plan Administrator. Absent such explicit waiver, there shall be no estoppel against the enforcement of any provision of this Plan. Failure by any applicable entity to enforce any part of the Plan shall not constitute a waiver, either as it specifically applies to a particular circumstance, or as it applies to the Plan's general administration. If an explicit written waiver is executed, that waiver shall only apply to the matter addressed therein, and shall be interpreted in the most narrow fashion possible.

17.07 Plan Contributions

The Plan Administrator shall, from time to time, evaluate the funding method of the Plan and determine the amount to be contributed by the Participating Employer and the amount to be contributed (if any) by each Participant.

The Plan Sponsor shall fund the Plan in a manner consistent with the provisions of the Internal Revenue Code, ERISA, and such other laws and regulations as shall be applicable to the end that the Plan shall be funded on a lawful and sound basis The manner and means by which the Plan is funded shall be solely determined by the Plan Sponsor, to the extend allowed by applicable law.

Notwithstanding any other provision of the Plan, the Plan Administrator'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 Employer and eligible Employees shall have no further obligation to make additional contributions to the Plan and the Plan shall have no obligation to pay claims Incurred after the termination date of the Plan.

17.08 Right to Receive and Release Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or person any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine and apply the provisions and benefits of this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

17.09 Written Notice

Any written notice required under this Plan which, as of the Effective Date, is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

17.10 Right of Recovery

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

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

Any dispute or claim, of whatever nature, arising out of, in connection with, or in relation to this Plan, or breach or rescission thereof, or in relation to care or delivery of care, including any claim based on contract, tort or statute, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. Any dispute regarding a claim for damages within the jurisdictional limits of the small claims court will be resolved in such court.

The Federal Arbitration Act shall govern the interpretation and enforcement of all proceedings under this BINDING ARBITRATION provision. To the extent that the Federal Arbitration Act is inapplicable, or is held not to require arbitration of a particular claim, State law governing agreements to arbitrate shall apply.

The Participant and the Plan Administrator agree to be bound by this Binding Arbitration provision and acknowledge that they are each giving up their right to a trial by court or jury.

The Participant and the Plan Administrator agree to give up the right to participate in class arbitration against each other. Even if applicable law permits class actions or class arbitrations, the Participant waives any right to pursue, on a class basis, any such controversy or claim against the Plan Administrator and the Plan Administrator waives any right to pursue on a class basis any such controversy or claim against the Participant.

The arbitration findings will be final and binding except to the extent that State or Federal law provides for the judicial review of arbitration proceedings.

The arbitration is begun by the Participant making written demand on the Plan Administrator. The arbitration will be conducted by Judicial Arbitration and Mediation Services ("JAMS") according to its applicable Rules and Procedures. If, for any reason, JAMS is unavailable to conduct the arbitration, the arbitration will be conducted by another neutral arbitration entity, by mutual agreement of the Participant and the Plan Administrator, or by order of the court, if the Participant and the Plan Administrator cannot agree.

The costs of the arbitration will be allocated per the JAMS Policy on Consumer Arbitrations. If the arbitration is not conducted by JAMS, the costs will be shared equally by the parties, except in cases of extreme financial hardship, upon application to the neutral arbitration entity to which the parties have agreed, in which cases, the Plan Administrator will assume all or a portion of the costs of the arbitration.

17.11 Unclaimed Self-Insured Plan Funds

In the event a benefits check issued by the Third Party Administrator for this self-insured Plan is not cashed within one year of the date of issue, the check will be voided and the funds will be returned to this Plan and applied to the payment of current benefits and administrative fees under this Plan. In the event a Participant subsequently requests payment with respect to the voided check, the Third Party Administrator for the self-insured Plan shall make such payment under the terms and provisions of the Plan as in effect when the claim was originally processed. Unclaimed self-insured Plan funds may be applied only to the payment of benefits (including administrative fees) under the Plan pursuant to ERISA.

ARTICLE XVIII
HIPAA PRIVACY

The Plan provides each Participant with a separate Notice of Privacy Practices. This Notice describes how the Plan uses and discloses your personal health information. It also describes certain rights you have regarding this information. Additional copies of our Notice of Privacy Practices are available by calling (800) 992-0592.

The following is a description of certain uses and disclosures that may be made by the *Plan* of your health information, including genetic information as defined in the Genetic Information Nondiscrimination Act of 2008:

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

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

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

Disclosure of Protected Health Information *("PHI")* to the *Plan Sponsor* for *Plan Administration* Purposes
In order that the *Plan Sponsor* may receive and use *PHI* for *plan administration* purposes, the *Plan Sponsor* agrees to:

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

determining compliance by the *Plan* with part 164, subpart E, of the *privacy standards* (45 CFR 164.500 *et seq*);

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

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

    - The *Plan Sponsor* shall only allow access to *PHI* to certain named employees, or classes of employees, or other persons under control of the *Plan Sponsor* who have been designated to carry out *plan administration* functions. A list of such employees will be made available upon request and free of charge.

    - The access to and use of *PHI* by the individuals described above shall be restricted to the *plan administration* functions that the *Plan Sponsor* performs for the *Plan.*

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

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

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

- The *Plan* documents have been amended to incorporate the above provisions; and

- The *Plan Sponsor* agrees to comply with such provisions.

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

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

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

Breach of Privacy or Security Standards

Agents and *"business associates"* of the *Plan* are required to notify and report to the *Plan* any use or disclosure of *PHI* not permitted by *HIPAA* which compromises the privacy or security of *PHI*. Such notice will be made following discovery and without unreasonable delay, but in no event later than sixty (60) calendar days following discovery of a "*breach*" of "*unsecured protected health information*".

- "*Business associate*" shall mean a person who performs functions or activities on behalf of, or certain services for, a *Plan* that involve the use or disclosure of protected health information.

  A *business associate* also includes:

  - A *subcontractor* that creates, receives, maintains, or transmits protected health information on behalf of the *business associate*;
  - A Patient Safety Organization;
  - A Health Information Organization, E-prescribing Gateway, or other person that provides data transmission services with respect to protected health information to a covered entity and that requires routine access to such protected health information; and
  - A person who offers a personal health record to one or more individuals on behalf of a covered entity.

- *"Subcontractor"* shall mean a person who acts on behalf of a *business associate* other than in the capacity of a member of the workforce of such *business associate* to whom the *business associate* has delegated a function, activity, or service that the *business associate* has agreed to perform for a covered entity or *business associate*. A *subcontractor* is then a *business associate* where that function, activity, or service involves the creation, receipt, maintenance, or transmission of protected health information.

- "*Breach*" shall mean an impermissible use or disclosure of *unsecured protected health information w*hich compromises the security or privacy of such information unless the covered entity or *business associate*, as applicable, demonstrates that there is a low probability that the protected health information has been compromised. "*Breach*" does not include:

  - Any unintentional acquisition, access, or use of *PHI* by a workforce member or person acting under the authority of a *Plan* or a *business associate*, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted under *HIPAA*.

  - Any inadvertent disclosure by a person who is authorized to access *PHI* for this *Plan* or a *business associate* to another person authorized to access *PHI* for the *Plan* or *business associate*, or organized health care arrangement in which the *Plan* participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under *HIPAA*.

- "*Unsecured protected health information*" shall mean *PHI* that is not secured through the use of technology or methodology specified by the Secretary of the Department of Health and Human Services ("DHHS") that renders *PHI* unusable, unreadable or indecipherable to unauthorized individuals.

Any terms not otherwise defined in this section shall have the meanings set forth in the *privacy standards* and the *security standards*.

Agents and *business associates* shall cooperate with the *Plan* in investigating any *breach* and in meeting the *Plan's* obligations to you and DHHS and any other security *breach* notification laws.

The *Plan* will notify you (in the manner required by law) of any use or disclosure of *PHI* not permitted by *HIPAA* which compromises the privacy or security of *PHI*. If your *unsecured protected health information* has been, or is reasonably believed by the *Plan*, to have been accessed, acquired, or disclosed during a *breach*, you will be notified, including;

- A brief description of what happened, including the date of the *breach* and the date of the discovery of the *breach*, if known;

- A description of the types of *unsecured protected health information* that were involved in the *breach* (such as whether full name, social security number, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved);

- Any steps you should take to protect yourself from potential harm resulting from the *breach*;

- A brief description of what the *Plan* involved is doing to investigate the *breach*, to mitigate harm to individuals, and to protect against any further *breaches*; and

- Contact procedures for you to ask questions or learn additional information, which shall include a toll free telephone number, an e-mail address, Web site, or postal address.

Notice of a discovery of a *breach* by a *business associate* to the *Plan* shall include:

- The identification, to the extent possible, of each individual whose *unsecured protected health information* has been, or is reasonably believed to have been, acquired, used, or disclosed during the *breach*; and

- Any other available information that the *Plan* is required to include in the notification to you, as described above, at the time notification is required or as promptly thereafter as information becomes available.

The *Plan* has the right to terminate any contract with any agents and *business associates*, if the other party has engaged in a pattern of activity or practice that constitutes a material breach or violation of agents and *business associates,* or the *Plan's* respective obligations regarding *PHI*, and, on notice of such material breach or violation from the *Plan*, fails to take reasonable steps to cure the material breach or violation.

Effective with the required compliance date of any regulation or amendment to a regulation promulgated by DHHS that affects the Plan's obligations with respect to the use or disclosure of *PHI*, this *Plan* will automatically amend so that such obligations imposed on the *Plan* are in compliance with the regulation or amendment to the regulation. This *Plan* will at all times comply with the *HIPAA privacy standards* and *security standards*.

Contact Information

Privacy Compliance Coordinator Contact Information:

Cooper-Booth Wholesale Company LP
200 Lincoln West Drive
Mountville, Pennsylvania 17554
Phone: 800-992-0592
Email/Website: www.cooperbooth.com

ARTICLE XIX
HIPAA SECURITY

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

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

- Implement Administrative, Physical, and Technical Safeguards that reasonably and appropriately protect the Confidentiality, Integrity and Availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the *Plan*;

- Ensure that adequate separation between the *Plan* and the *Plan Sponsor*, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures;

- Ensure that any agent, including a subcontractor, to whom the *Plan Sponsor* provides Electronic PHI created, received, maintained, or transmitted on behalf of the *Plan*, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI; and

- Report to the *Plan* any Security Incident of which it becomes aware.

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

ARTICLE XX
PARTICIPANT'S RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants 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 and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

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

ARTICLE XXI
GENERAL PLAN INFORMATION

Name of Plan:	**Cooper-Booth Wholesale Company LP Health and Medical Benefits Plan**
Plan Sponsor:	**Cooper-Booth Wholesale Company LP** **200 Lincoln West Drive** **Mountville, Pennsylvania 17554** **Phone: 800-992-0592** **email www.cooperbooth.com**
Plan Administrator: **(Named Fiduciary)**	**Cooper-Booth Wholesale Company LP** **200 Lincoln West Drive** **Mountville, Pennsylvania 17554** **Phone: 800-992-0592** **Email/Website: www.cooperbooth.com**
Plan Sponsor ID No. (EIN):	**23-1401684**
Source of Funding:	**Self-Funded**
Plan Status:	**Non-Grandfathered**
Applicable Law:	**ERISA**
Plan Year:	**July 1 – June 30**
Plan Number:	**501**
Plan Type:	**Medical** **Prescription Drug**
Third Party Administrator:	**Integra BMS** **PO Box 1178** **Matthews, North Carolina 28106** **Phone: 1-888-488-4660** **Website:** www.integrahealth.com
Participating Employer(s):	**Cooper-Booth Wholesale Company LP** **23-1404684** **Cooper-Booth Transportation Company, L.P** **51-0478551**
Agent for Service of Process:	**Cooper-Booth Wholesale Company LP** **Plan Administrator** **200 Lincoln West Drive** **Mountville, Pennsylvania 17554** **Phone: 800-992-0592** **Email/Website: www.cooperbooth.com**