AMENDMENT
TO THE PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR ADVANTAGE HEALTH PLANS TRUST GROUP MEDICAL PLAN

- **Advantage Health Plans Trust High Deductible 2500**
- **Advantage Health Plans Trust High Deductible 5000**
- **Advantage Health Plans Trust High Deductible 7500**

- **Advantage Health Plans Trust Choice Select High Deductible 7500**

This Amendment to each of the above Plans ("Plans") is made effective January 1, 2024.

It is agreed that the following be amended as noted below:

1. *It is agreed that ARTICLE IV, "ELIGIBILITY FOR COVERAGE; ENROLLMENT PERIODS; EFFECTIVE DATE OF COVERAGE", subsection 4.01D, "Retirees", will be amended to add the following:*

   Grandfather Provision: Any Retiree currently on the Plan and over the age of 65 will remain eligible for Retiree coverage under this Plan regardless of age. However, for any Retirees under age 65 who are currently on the Plan as a Retiree, such Retiree coverage will end when the Retiree reaches age 65.

2. *It is agreed that ARTICLE VII, "GENERAL LIMITATIONS AND EXCLUSIONS", will be amended to add the following:*

   Genetic Screening. Genetic screenings or pre-implantation genetic screenings, except to the extent they are required under the Affordable Care Act (ACA). General population-based genetic screening is a testing method performed in the absence of any symptoms or any significant, proven risk factors for genetically linked inheritable disease.

3. *It is agreed that ARTICLE VII, "GENERAL LIMITATIONS AND EXCLUSIONS", will be amended to remove "Obesity", in its entirety and replaced as follows:*

   Obesity. Services provided for weight loss, except as specifically outlined within this Plan.

4. *It Is agreed that ARTICLE IX, "CLAIM PROCEDURES; PAYMENT OF CLAIMS; APPEAL RIGHTS", subsection 9.01, "Health Claims", will be removed in its entirety and replaced as follows:*

   9.01 Health Claims
   All claims and questions regarding health claims should be directed to the Plan Administrator. Benefits under the Plan will be paid only if the Plan Administrator, in its sole discretion, determines that the Covered Person is entitled to them.

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

   A Covered Person has the right to request a review of an "Adverse Benefit Determination."

An Adverse Benefit Determination means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage; even if the rescission does not impact a current claim for benefits;
4. A termination of benefits;
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 Covered Person's eligibility to participate in the Plan; or
6. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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.

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.

Benefits will be payable to a Covered Person, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered. An Assignment of Benefits does not authorize the Provider to avail itself of the claims appeals process.

A claim submitted to the Plan for reimbursement must include:

1. Group Name;
2. Employee's name and ID number;
3. Name of patient and date of birth;
4. Name, address and telephone number of Provider of care;
5. Provider of care tax identification number and National Provider Identification (NPI) number;
6. Type of services rendered, with diagnosis and/or procedure codes;
7. Date of services;
8. Billed charges; and
9. Any other information necessary to process the claim.

Claims that are not submitted electronically should be mailed to the mailing address listed on the Covered Person's ID Card.

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

Types of Claims. According to Federal regulations which apply to the Plan, there are two types of claims: Concurrent Care and Post-service.

1. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either:

a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or
b. The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

5. *It Is agreed that ARTICLE IX, "CLAIM PROCEDURES; PAYMENT OF CLAIMS; APPEAL RIGHTS", subsection 9.01C, "Notification of an Adverse Benefit Determination", will be removed in its entirety and replaced as follows:*

9.01C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically, containing the following information:

1. Information sufficient to allow the Covered Person 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 provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan's review procedures and the time limits applicable to the procedures, including information on how to initiate the appeal and a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
7. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
8. Upon request, 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);
9. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request). 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 Covered Person, free of charge, upon request;

10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request;
11. Information about the availability of, and contact information for, an applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist Covered Persons with the internal claims and appeals and external review processes; and
12. 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."

6. *It Is agreed that ARTICLE IX, "CLAIM PROCEDURES; PAYMENT OF CLAIMS; APPEAL RIGHTS", subsection 9.02A, "Internal Appeal Procedure", will be revised to remove the final paragraph and subsequent list and replaced as follows:*

Both the First Level of Internal Review Decision and Second Level Review Decision will contain the same elements as outlined Section 9.01C above.

7. *It is agreed that ARTICLE XIII, "CARE MANAGEMENT SERVICES", subsection 13.06, "Cost Management Services", will be removed in its entirety.*

8. *It is agreed that ARTICLE XIII, "CARE MANAGEMENT SERVICES", subsection 13.06A, "Pre-Authorization", will be removed in its entirety.*

9. *It is agreed that ARTICLE XIII, "CARE MANAGEMENT SERVICES", subsection 13.06B, "Utilization Review", will be removed in its entirety and replaced as follows:*

13.06 Utilization Review

Utilization review is a program designed to preauthorize services and/or supplies to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. Please refer to the Covered Persons' ID card for the number to call for preauthorization.

The program consists of:

1. Preauthorization of the Medical Necessity for the following non-Emergency Services before medical and/or surgical services are provided (excluding Outpatient services provided under the KPP*Free*™ program as set forth in Section 13.02):

    a. Hospitalizations;
    b. Outpatient procedures;
    c. Sleep studies; and
    d. MRI, PET, and CT scans;

    The preauthorization or utilization review administrator will authorize services based on the specific requirement of the Plan.

2. Retrospective review of the Medical Necessity of the listed services provided within the timely filing parameters for the claim;
3. Concurrent review, based on the admitting diagnosis of the listed services requested by the attending Physician; and

4. Authorization of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine if the services and/or supplies being rendered are Medically Necessary. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care Provider.

Here's how the program works.

Preauthorization. Before a Covered Person enters a Medical Care Facility on a non-Emergency basis or receives other listed medical services, the utilization review administrator will review the documentation submitted by the attending Physician and determine if the services and/or supplies are Medically Necessary. A non-Emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person or a request from a Physician. Preauthorization of services should be requested **at least 7 business days before** services are scheduled to be rendered. Any request for preauthorization should include the following information:

1. The name of the Covered Person;
2. The name, member ID number and address of the Covered Person;
3. The name of the Employer;
4. The name and telephone number of the attending Physician;
5. The name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
6. The diagnosis including ICD-10 code(s);
7. The services and/or supplies being rendered including CPT code(s);
8. A detailed description of the proposed services and/or supplies;
9. All relevant medical records; and
10. All other documentation as may be required by the utilization review administrator.

If there is an **Emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 48 hours** of the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for Medical Necessity.

Covered Persons are highly encouraged to seek preauthorization; however, preauthorization is not required. Therefore, the request for preauthorization is not considered a pre-service claim under this Plan's Claims Procedure section. However, all claims submitted to this Plan must be Medically Necessary as defined herein. Failure to preauthorize a claim may result in delays in claims adjudication.

Non-Inpatient services provided under the KPP*Free*™ program, as set forth in Section 13.02, will be excluded from the Preauthorization requirements described herein.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered

Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been preauthorized, the attending Physician must request and receive approval for the additional services or days.

10. *It is agreed that ARTICLE XIII, "CARE MANAGEMENT SERVICES", subsection 13.06C, "Second and/or Third Opinion Program", will be removed in its entirety and replaced as follows, with the remaining sections renumbered accordingly:*

13.07 Second and/or Third Opinion Program

This Plan offers a Second and/or Third Opinion Program to ensure the services Covered Persons are receiving are medically appropriate based on the individual person's medical history and lifestyle. This Plan's Second Opinion Program is free to Covered Persons and can include clinical consulting and second opinions from specialized Physicians when appropriate and approved by the Plan Administrator.

Given the high rate of misdiagnosis and the variation and waste prevalent in health care, Covered Persons are highly encouraged to seek a second opinion when they receive a diagnosis and/or course of treatment that they are uncertain about, or if they would simply like additional information to better understand what options are available to them.

To seek a second opinion, please call the Claims Administrator.

11. *It is agreed that ARTICLE XIII, "CARE MANAGEMENT SERVICES", subsection 13.06E, "Case Management", will be removed in its entirety and replaced as follows, with the remaining sections renumbered accordingly:*

13.08 Case Management Program

Case Management is a program whereby a registered nurse consults with a Covered Person to discuss his or her diagnosis and/or treatment plan. Case Management is voluntary but highly encouraged. Case Management can help ensure personalized care plans, streamlined communication among health care providers, and enhanced patient education. Case Managers help Covered Persons navigate through the health care system and transition between levels of care. The result is improved patient outcomes, reduced hospital readmissions, and increased patient satisfaction. Case Management is collaborative and patient-centric which contributes to a more holistic and effective health care experience.

12. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.07, "Covered Charges", will be amended to remove item, "Dental", in its entirety and replaced as follows:*

Dental. The following expenses will be covered under the Plan:

a. **Accident.** Dental services or supplies needed to correct damage caused by an Accident; and the Accident occurred while medical expense benefits for the Covered Person are in effect;
b. **Hospital Expenses.** Anesthesia and facility charges associated with necessary dental services for the following groups who otherwise would not be able to receive the dental services:
    i. Covered children;
    ii. Severely disabled members; or
    iii. Covered Persons with certain medical or behavioral conditions; and

c. **Tumors and Cysts.** The treatment of tumors and the treatment of cysts which do not result from infection of the teeth or gums are covered under this Plan. This benefit is limited only to those services requiring treatment of tumors or cysts in the mouth area which are not caused by or created by any infection of the teeth or gums.

13. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.07, "Covered Charges", will be amended to add the following with the remaining sections renumbered accordingly:*

Genetic Testing. Medically Necessary genetic testing must meet the following requirements:

a. The test must not be considered Experimental, Investigational, or unproven;
b. The test must be performed by a CLIA-certified laboratory;
c. The test result must directly impact or influence the treatment of the Covered Person; and
d. In some cases, testing may be accompanied with pre-test and post-test counseling.

Genetic testing must also meet at least one of the following:

a. The patient has current signs and/or symptoms (i.e., the test is being used for diagnostic purposes);
b. Conventional diagnostic procedures are inconclusive;
c. The patient has risk factors or a particular family history that indicates a genetic cause;
d. The patient meets defined criteria that place him or her at high genetic risk for the condition; or
e. Prenatal testing is covered when the pregnancy is categorized as high-risk, including cases where the mother is 35 years of age or older, or if the mother or father has a family history that establishes him/her as at-risk for having a hereditary genetic disorder.

Generally, genetic testing is not covered for:

a. Population screening without a personal or family history, with the exception of preconception or prenatal carrier screening for certain conditions, such as cystic fibrosis, Tay-Sachs disease, sickle cell disease, and other hemoglobinopathies;
b. Informational purposes alone (e.g., testing of minors for adult-onset conditions and self-referrals or home testing); and/or
c. Experimental, Investigational, or unproven purposes.

14. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.07, "Covered Charges", will be amended to remove item, "Office Visit Co-Pay Benefit", in its entirety and replaced as follows:*

Office Visit Co-Pay Benefit. Physician office visits are covered including minor procedures, lab testing, x-rays, injections, allergy testing, allergy serum and allergy injections. IV infusions performed in a Physician's office will not be included in the Co-pay amount and will be subject to normal Coinsurance and Deductible provisions.

15. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.07, "Covered Charges", will be amended to remove item, "Obesity", in its entirety and replaced as follows:*

Weight Loss Treatments. The Plan will pay for charges for one bariatric surgical procedure. This benefit is only available to Covered persons with a BMI of 40 and above. The benefit is limited to only one treatment during the Covered Person's lifetime and is subject to the limitation in the Schedule of Benefits. The Plan requires a 12-month documented weight-loss and exercise program in combination with the additional required medical criteria guidelines before the bariatric surgical procedure is approved. Bariatric surgical procedure includes, but is not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery.

Prescription weight loss drugs may also be covered under the Plan when additional required medical criteria guidelines are satisfied. Health coaching is also available for Covered Persons, contact the Plan Administrator for additional information.

16. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.07, "Covered Charges", will be amended to remove, "VezaHealth", in its entirety and replaced as follows:*

Remote Second Opinion Program. Given the high rate of misdiagnosis and the variation and waste prevalent in health care, Covered Persons are highly encouraged to utilize this Plan's Remote Second Opinion Program when they receive a Diagnosis and/or a course of treatment that they are uncertain about, or if they would simply like additional information to better understand what options are available and what may best suit their individual health care needs. Remote Second Opinions are at no cost to the Covered Person, if allowed by applicable law. To engage with the Remote Second Opinion Program, please call (877) 313-1901.

17. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.08, "Schedule of Benefits", will be amended to update the following:*

KPP DEDUCTIBLE PER CALENDAR YEAR	
Per Covered Person	$1,600
Per Family Unit	$3,200

18. *It is agreed that ARTICLE XIV, "MEDICAL BENEFITS", subsection 14.08, "Schedule of Benefits", will be amended to remove, "VezaHealth", in its entirety and replaced as follows:*

Remote Second Opinion Program	No cost to Covered Person.
Note: Refer to the Covered Charges section for more information regarding these services.	

IN WITNESS WHEREOF, The Advantage Health Plans Trust Group Medical Benefits Plan as stated herein, by authority of the Trustees, executed on behalf of the Trust, as of the dates set forth above.

Advantage Health Plans Trust

Date:_____

By:_____
Chairperson, Board of Trustees

Plan Document and Summary Plan Description

OKLAHOMA CHOICE SELECT HDHP 7500 PLAN (NO PPO NETWORK)

Restated: January 2023

THE BENEFITS AND COVERAGE DESCRIBED HEREIN ARE FUNDED BY THE CONTRIBUTIONS FROM EMPLOYERS, EMPLOYEES, AND OTHER INDIVIDUALS ELIGIBLE FOR COVERAGE. THE BENEFITS AND COVERAGE DESCRIBED HEREIN ARE MANAGED THROUGH A TRUST ESTABLISHED BY ADVANTAGE HEALTH PLANS TRUST. THE TRUST FUND IS NOT SUBJECT TO ANY INSURANCE GUARANTY ASSOCIATION. OTHER RELATED FINANCIAL INFORMATION IS AVAILABLE FROM YOUR EMPLOYER OR FROM THE PLAN ADMINISTRATOR.

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ARTICLE I
ESTABLISHMENT OF THE PLAN

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, ("Plan Document") for the Advantage Health Plans Trust ("Plan"), as of January 1, 2023, hereby **amends and restates** the Plan Document and Summary Plan Description for Advantage Health Plans Trust, which was originally adopted by the Board of Trustees, effective January 1, 1985.

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 ("Effective Date").

1.02 Adoption of the Plan Document

The Plan is administered by a Board of Trustees which is elected by the Participating Employers. The day to day operations of the Plan are administered by The Kempton Company which is the Plan Administrator. The responsibilities of the Participating Employers, the Trustees, and the Plan Administrator are more fully described in the Section titled "Plan Administration" of this Plan Document and Summary Plan Description.

The Trustees, as the settlor(s) of the Trust, hereby adopt 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 Advantage Health Plans Trust Group Medical Benefits Plan is amended and stated herein, by authority of the Trustees, executed on behalf of the Trust, as of the dates set forth above this January 1, 2023.

Advantage Health Plans Trust

Date: January 1, 2023

By: _____
Chairman, Board of Trustees

ARTICLE II
INTRODUCTION AND PURPOSE; GENERAL PLAN INFORMATION

2.01 Introduction and Purpose

The purpose of the Plan is to provide reimbursement for Covered Charges Incurred as a result of Sickness or Injury of Eligible Employees, Directors, Retirees, and Dependents of the Participating Employers of Advantage Health Plans Trust, in accordance with the terms and conditions described herein.

No oral interpretations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses. The Plan has been adopted by your employer - called the "Participating Employer" - for the benefit of its Employees and Dependents, if Dependent coverage has been elected. In some cases, the Participating Employer may also elect to cover certain Directors and Retirees.

The Plan is intended, together with the related Trust, to constitute a funded welfare arrangement which qualifies under Section 419 and 419A of the Code subject to the exception applicable to a fund which provides benefits to Employees of ten or more employers. The Plan is also intended to constitute a self-funded accident and medical plan within the meaning of Section 105(h) of the Code, including appropriate Treasury Regulations.

The purpose in establishing the Plan is to help offset the economic effects arising from an Injury or Sickness for Eligible Employees, Directors, Retirees, and Dependents. To accomplish this purpose, the Board of Trustees must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow allocation of the resources available to help those individuals participating in the Plan to the maximum feasible extent.

Coverage under the Plan will take effect for an Eligible Employee and eligible Dependents when the Eligible Employee and eligible Dependents satisfy the Service Waiting Period and all the eligibility requirements of the Plan. Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for benefits. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan which may include but are not limited to coordination of benefits, third party recovery, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims, or lack of coverage.

Your Participating Employer has selected this medical plan option for its Employees. Contact your human resource department for the specific selection made by your Participating Employer for:

1. The class or classes of individuals who are eligible to be covered;
2. The Service Waiting Period that applies to you and your enrolled Dependents; and
3. The cost that you must pay for the coverage selected.

These selections are listed in the Adoption Agreement which is incorporated herein by reference in its entirety.

2.02 General Plan Information

Name of Plan:	Advantage Health Plans Trust Oklahoma Choice Select HDHP 7500 Plan
Plan Administrator:	The Kempton Company 13431 Broadway Extension, Suite 130 Oklahoma City, OK 73114 (405) 521-1711 or (800) 521-1711

Named Fiduciaries:	The named fiduciaries for purposes of ERISA are The Kempton Company and the Board of Trustees.
Tax ID No. (EIN):	73-1007826
Source of Funding:	Self-Funded
Plan Year:	The Plan and Trust records are kept on a fiscal year beginning each July 1 and ending the following June 30. This is the legal Plan Year for this Plan. To enable Covered Persons to manage their costs, the Plan monitors the Deductible and Out-of-Pocket requirements on a calendar year basis.
Plan Number:	501
Plan Status:	Non-Grandfathered
Applicable Law(s):	ERISA, and applicable state laws and regulations
Agent for Service of Process:	Steven C. Davis Hartzog Conger Cason 201 Robert S. Kerr Avenue, Suite 1600 Oklahoma City, OK 73102

2.03 Type of Administration

The Plan is a self-funded group health Plan. The benefits provided are derived from the contributions from employers, employees, and other individuals eligible for coverage. The Plan is not financed or administered by an insurance company. The Plan is administered by the Trustees and the Plan Administrator. The Trustees of the Trust have contracted with The Kempton Company to provide administrative services for the Plan. It serves as the Plan Administrator and has authority to manage and control the daily operation of the Plan.

2.04 Legal Entity; Service of Process

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

2.05 Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type 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 Participating Employer or to interfere with the right of the Employer 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 or employment contracts which may be entered into by the Employer with certain classes of employees.

2.06 Named Fiduciary

A "Named Fiduciary" is the one named in the Plan. A Named Fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the Named Fiduciary allocates its responsibility to other persons, the Named Fiduciary shall not be liable for any acts or omission of such person unless either:

- The Named Fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary, or continuing either the appoint or the procedures; or
- The Named Fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA

2.07 Federally Required Notices

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

Health Insurance Portability and Accountability Act of 1996. The Health Insurance Portability and Accountability Act (HIPAA) amended ERISA and was enacted, among other things, to improve portability and continuity of health care coverage. HIPAA also requires that Covered Person and beneficiaries receive a summary of any change that is a "Material Reduction in covered services or benefits under a group health plan" within sixty (60) days after the adoption of the modification or change, unless the Plan Sponsor provides summaries of modifications or changes at regular intervals of ninety (90) days or less.

Pregnancy Discrimination Act of 1978. Most Employers must provide coverage for Pregnancy expenses in the same manner as coverage is provided for any other Illness. This requirement applies to Pregnancy expenses of an Employee or a covered Dependent Spouse of an Employee.

Family and Medical Leave Act of 1993 ("FMLA"). So long as the Employer and/or applicable Employer division is subject to the FMLA, if a Covered Employee ceases Active Employment due to an Employer-approved Family Medical Leave of Absence in accordance with the requirements of applicable law, coverage availability will continue under the same terms and conditions which would have applied had the Employee continued in Active Employment. Contributions will remain at the same Employer/Employee levels as were in effect on the date immediately prior to the leave (unless contribution levels change for other Employees in the same classification).

Omnibus Budget Reconciliation Act of 1993 ("OBRA"). OBRA 1993 requires that an eligible Dependent Child of an Employee will include a Child who is adopted by the Employee or placed with him for adoption prior to age eighteen (18) and a Child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which is determined by the Plan Sponsor to be a Qualified Medical Child Support Order (QMCSO). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under State law and having the force and effect of law under State law and which satisfies the QMCSO requirements of ERISA (section 609(a)). Covered Persons may obtain a copy of the QMCSO procedures from the Plan Sponsor or Plan Administrator without charge.

Newborns' and Mothers' Health Protection Act of1996. The Newborns' and Mothers' Health Protection Act of 1996 establishes restrictions on the extent to which group health plans and health insurance issuers may limit the length of stay for mothers and newborn children following delivery, as follows: All applicable benefit provisions still apply, including existing Deductibles, Copayments and/or Coinsurance.

The Women's Health and Cancer Rights Act of 1998 (WHCRA). The Women's Health and Cancer Rights Act of 1998 (WHCRA) was signed into law on October 21, 1998. In the case of an Employee or Dependent who receives benefits under the Plan in connection with a Mastectomy or Lumpectomy and who elects breast reconstruction (in a manner determined in consultation with the attending *Physician* and the patient), coverage will be provided for:

- Reconstruction of the breast on which the Mastectomy or Lumpectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance
- Prostheses and treatment of physical complications at all stages of the Mastectomy and Lumpectomy, including lymphedemas.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage, and will be provided in consultation with you and your attending Physician.

Genetic Information Nondiscrimination Act of 2008 ("GINA"). GINA prohibits the Plan from:

1. Adjusting premiums or contribution amounts for the group as a whole on the basis of Genetic Information.
2. Requesting or requiring an individual or a family member to undergo a genetic test. However, subject to certain conditions, the Plan may request that an individual voluntarily undergo a genetic test as part of a research study as Jong as the results are not used for underwriting purposes.
3. Requesting, requiring or purchasing Genetic Information for underwriting purposes (which includes eligibility rules or determinations, computation of premium or contribution amounts and other activities related to the creation, renewal or replacement of coverage). The Plan is also prohibited from requesting, requiring or purchasing Genetic Information with respect to any individual prior to such individual's enrollment under the Plan or coverage. However, if the Plan obtains Genetic Information incidental to the collection of other information prior to enrollment, it will not be in violation of GINA as long as it is not used for underwriting purposes. GINA allows the group health Plan to obtain and use the results of genetic tests for purposes of making payment determinations.

What is "Genetic Information" under GINA? Under GINA, the term "Genetic Information" includes:

1. Information about an individual or his/her family member's genetic tests (defined as analyses of the individual's DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations or chromosomal changes);
2. The manifestation of a Disease or disorder in the family members of the individual. Family members are broadly defined under GINA to include individuals who are Dependents, as well as any other first, second, third or fourth degree relative. Further, Genetic Information includes that information of any fetus or embryo carried by a pregnant woman; and
3. Information obtained through genetic services (that is genetic tests, genetic counseling or genetic education) or participation in clinical research that includes genetic services.

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

Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA"). The Mental Health Parity and Addiction Equity Act requires that, if a group health plan provides coverage for mental health conditions or for substance use disorders, benefits for such conditions must be provided in the same manner as benefits for any Illness. Also, the Plan may not have separate cost-sharing arrangements that apply only to mental health or substance use disorder benefits.

Medicaid and The Children's Health Insurance Program ("CHIP") Offer Free Or Low-cost Health Coverage To Children And Families. If you are eligible for health coverage from your Employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for Employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov. If you or your Dependents are already enrolled in Medicaid or CHIP, you can contact your State Medicaid or CHIP office to find out if premium assistance is available. If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the

Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The Effective Date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*
If a State in which the Employee lives offers any type of subsidy, this Plan shall also comply with any other State laws as set forth in statutes enacted by State legislature and amended from time to time, to the extent that the State law is applicable to the Plan, the Employer and its Employees. **For more information regarding special enrollment rights, contact the Plan Administrator.**

No Surprises Act. The No Surprises Act, part of Title I of the Consolidated Appropriations Act of 2021, prohibits Physicians, health care providers, health care facilities and air ambulance companies from balancing billing Covered Persons or otherwise holding Covered Persons liable for any more than the applicable cost sharing amounts they would have owed for in-network care. Specifically, these balance billing protections apply when a Covered Person receives Emergency Services from an out-of-network provider or facility, when a Covered Person receives non-emergency services from an out-of-network provider at an in-network facility, and when a Covered Person receives out-of-network air ambulance services.

However, these protections against balance billing do not apply if the Covered Person consents to treatment by an out-of-network provider (this consent exception generally does not apply in emergency situations).

In addition, this Plan generally will cover Emergency Services without pre-authorization; cover Emergency Services by out-of-network providers; base cost sharing amounts on in-network benefits; count any cost sharing amounts for Emergency Services or out-of-network services toward a Covered Person's Deductible and out-of-pocket limit.

If a Covered Person believes he or she has received a balance bill that is protected under the No Surprises Act, please contact The Kempton Company for additional information.

Please visit www.dol.gov/agencies/ebsa/laws-and-regulations/laws/no-surprises-act for additional information regarding the No Surprises Act.

The Civilian Reservist Emergency Workforce Act of 2021 (CREW). Beginning September 29, 2022, the CREW Act provides Eligible Employees, who are called to service by the Federal Emergency Management Agency (FEMA) to respond to and perform services responding to natural disasters and emergencies, rights under the Uniformed Employment and Reemployment Rights Act (USERRA). See USERRA section for additional information regarding benefits and coverage during such leave.

ARTICLE III
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" means a sudden and unforeseen event, or a deliberate act resulting in unforeseen consequences.

"Actively At Work" or "Active Employment"
"Actively At Work" or "Active Employment" means performance by the Employee of all the regular duties of his or her occupation at an established business location of the Participating Employer, or at another location to which he or she may be required to travel to perform the duties of his or her employment. In no event will an Employee be considered Actively at Work if he or she has effectively terminated employment.

"Adoption Agreement"
"Adoption Agreement" means the agreement by which each Participating Employer adopts the eligibility conditions that apply to its employees and the specific medical benefits available under this Plan and thereby establishes its group medical plan as an employee welfare plan as such term is defined in ERISA. The Adoption Agreement is an integral part of this Plan and is incorporated by reference.

"Allowable Expenses"
"Allowable Expenses" means the Maximum Allowable Amount for any Medically Necessary, Reasonable eligible item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit.

"Alternate Recipient"
"Alternate Recipient" means any Child of an Eligible Employee, Director, or Retiree who is recognized under a medical child support order as having a right to enrollment under this Plan as the Eligible Employee's, Director's, or Retiree's eligible Dependent.

"Ambulatory Surgical Center"
"Ambulatory Surgical Center" means any public or private State licensed and approved (whenever required by law) establishment with an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures, with continuous Physician services and registered professional nursing service whenever a patient is in the facility, and which 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 (NIH), Centers for Disease Control and Prevention (CDCP), Agency for Healthcare Research and Quality (AHRQ), Centers for Medicare and Medicaid Services (CMS), Department of Defense (DOD) or Veterans Affairs (VA), or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new Drug application reviewed by the Food and Drug Administration (FDA) (if such application is required).

The 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 Physician has concluded that participation is appropriate or the Plan 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 Plan Participant; 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis; 4) and/or items and/or services to be paid for and or provided at no cost from a third party (including but not limited to a manufacturer.)

"Brand Name"
"Brand Name" means a trade name medication.

"Cardiac Care Unit"
"Cardiac Care Unit" means 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 treatment of patients who require special medical attention because of their critical condition;
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 beds for the accommodation of critically ill patients; and
5. It provides at least one professional registered nurse, who continuously and constantly attends the patient confined in such area on a 24-hour-a-day basis.

"Child"
"Child" means natural children, adopted children, children placed with the covered Employee in anticipation of adoption. Child also includes are an Alternate Recipient.

"Claim Determination Period"
"Claim Determination Period" means each calendar year.

"Claimant"
"Claimant" means a Covered Person or his or her Authorized Representative.

"Clean Claim"
A "Clean Claim" means 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 Charges 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 Charges 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 Covered Person has failed to submit required forms or additional information to the Plan as well.

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

"Code"
"Code" means the Internal Revenue Code.

"**Coinsurance**"
"Coinsurance" means a cost sharing feature which requires the Covered Person to pay an established percentage of the Maximum Allowable Amount for Covered Services and usually applies after the Deductible is met.

"**Copayment"**
"Copayment" means a specific dollar amount that a Covered Person must pay each time certain medical care is provided, as specified in the Schedule of Benefits.

"Covered Charge"
"Covered Charges" means the Maximum Allowable Amount for a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage in this Plan. Covered Charges 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 Charges 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 Schedule of Benefits and as determined elsewhere in this document.

"Covered Person"
"Covered Person" means an Employee, Director, Retiree, or Dependent who is covered under this Plan.

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

"Deductible"
"Deductible" means an amount of money that is paid once a calendar year by the Covered Person and Family Unit. Typically, there is one Deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services. Each calendar year, a new Deductible amount is required. **Deductibles do accrue toward the 100% maximum Plan Out-of-Pocket payment.**

"Dependent"
"Dependent" means an eligible Employee's eligible family members as outlined in Article IV.

"Diagnostic Service"
"Diagnostic Service" means a test or procedure performed for specified symptoms to detect or to monitor an Illness or Sickness. It must be ordered by a Physician or other professional Provider.

"Director"
"Director" means an outside Director of a Participating Employer who does not qualify as an Eligible Employee, Retiree, or Dependent.

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

"Durable Medical Equipment"
"Durable Medical Equipment" means equipment 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.

"Effective Date"
"Effective Date" means that date that coverage begins under this Plan.

"Eligible Employee"
"Eligible Employee" means an active Employee who is regularly scheduled to work at least thirty (30) hours per week, or such number of hours as may be required to conform with applicable Federal non-discrimination requirements.

An Employee who is on an authorized Leave of Absence shall be deemed an Eligible Employee for a period of up to 90 days during which such Employee would not otherwise be an Eligible Employee. In no event will any Employee be entitled to extend this period to qualify as an Eligible Employee beyond this 90 day period, unless otherwise required by the Participating Employer's handbook, applicable law, internal policies, or pursuant to a collective bargaining agreement.

"Emergency"
"Emergency" means a situation where necessary treatment is required as the result of a sudden and severe medical event or acute condition. An Emergency includes poisoning, shock, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, that an Emergency did exist. The Plan Administrator may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

"Emergency Services"
"Emergency Services" means an appropriate medical screening examination and associated services to treat a condition that requires immediate medical attention that would reasonably expect to result in: (a) serious jeopardy to the health of an individual (or in the case of a pregnant person, the health of the unborn child); (b) serious impairment to bodily function; or (c) serious dysfunction of any bodily organ or part that is within the capability of the emergency department of a Hospital or Independent Freestanding Emergency Department. Emergency Services include pre-stabilization services that are provided after a patient is moved out of the emergency department and admitted to a Hospital, as well as any additional services rendered after a patient is stabilized as part of outpatient observation or an Inpatient or outpatient stay with respect to the visit in which other emergency services are furnished. These services include those provided at an independent freestanding emergency department as well as a Hospital emergency department. A decision of what constitutes Emergency Services will not be defined solely on the basis of the diagnosis but rather will be a determination that takes into account the reasonableness of each situation as defined by a prudent layperson.

"Employee"
"Employee" means a person who is an Active Employee of the Participating Employer, regularly scheduled to work for the Participating Employer in an employer-employee relationship.

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

"Essential Health Benefits"
"Essential Health Benefits" means, under section 1302(b) of the 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 screenings. Self-funded plans such as this Plan are not required to cover all Essential Health Benefits as listed above.

"Experimental" and/or "Investigational"
"Experimental" and/or "Investigational" ("Experimental") means services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

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

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

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished;
2. If reliable evidence shows that the drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:
    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis; or
3. If reliable evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:
    a. maximum tolerated dose;
    b. toxicity;
    c. safety;
    d. efficacy; and
    e. efficacy as compared with the standard means of treatment or diagnosis.

Reliable evidence means:

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

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

"Family Unit"
"Family Unit" means the Employee, Director or Retiree and the family members who are properly enrolled and covered as Dependents under the Plan.

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

"FMLA Leave"
"FMLA Leave" means a Leave of Absence, which a Participating Employer that is subject to FMLA is required to extend to an Employee under the provisions of the FMLA.

"Generic"
"Generic" means a Prescription Drug which has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

"GINA"
"GINA" means 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.

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

"Home Health Care"
"Home Health Care" means 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" means an agency or organization which provides a program of Home Health Care and which:

1. Is approved as a Home Health Agency under Medicare;
2. Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
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 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" means an Institution that meets all of the following requirements:

1. It provides medical and Surgical facilities for the treatment and care of Injured or Sick persons on an Inpatient basis;
2. It is under the supervision of a staff of Physicians;
3. It provides 24-hour-a-day nursing service by registered nurses;
4. It is duly licensed as a hospital, except that this requirement will not apply in the case of a State tax-supported Institution that is not required to be licensed;
5. It is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type Institution, or an Institution which is supported in whole or in part by a Federal government fund; and
6. It is accredited by the Joint Commission on Accreditation of Hospitals sponsored by the American Medical Association and the AHA.

The requirement of surgical facilities shall not apply to a Hospital specializing in the care and treatment of mentally ill patients, provided such Institution is accredited as such a facility by the Joint Commission on Accreditation of Hospitals sponsored by the American Medical Association and the AHA.

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

The definition of "Hospital" shall be expanded to include the following:

1. A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates; and
2. A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full time facilities for bed care and full time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24 hour a day nursing service by a registered nurse (R.N.); has a full time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

"Identification Card" or "ID Card"
"Identification Card" or "ID Card" means the card issued to you by the Plan Administrator which identifies the specific coverage available to you. It also includes the telephone number that you must call for Pre-authorizations.

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

"Incurred"
"Incurred" means that a Covered Charge 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 Charges 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 Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

"Independent Freestanding Emergency Department"
"Independent Freestanding Emergency Department means a health are facility that is geographically separate and distinct, and licensed separately, from a Hospital under applicable law, and provides Emergency Services.

"Injury"
"Injury" means an Accident 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" means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for Room and Board is made by the Hospital.

"Institution"
"Institution" means a facility, operating within the scope of its license, whose purpose is to provide organized health care and treatment to individuals, such as a Hospital, Ambulatory Surgical Center, Psychiatric Hospital, community mental health center, residential treatment facility, psychiatric treatment facility, Substance Abuse Treatment Center, alternative birthing center, Home Health Care Center, or any other such facility that the Plan approves.

"Late Enrollee"
"Late Enrollee" means a Covered Person 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;
2. During the annual Open Enrollment; or
3. During the time permitted for a Special Enrollment.

Late Enrollees may only enroll during the next Open Enrollment Period.

"Leave of Absence"
"Leave of Absence" means leave of absence of an Employee that has been approved by his or her Participating Employer, as provided for in the Participating Employer's rules, policies, procedures and practices.

"Legal Guardian"
"Legal Guardian" means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor Child.

"Lumpectomy"
"Lumpectomy" means the surgical removal of a discrete portion or "lump" of the breast tissue.

"Manipulative Therapy"
"Manipulative Therapy" means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body.

Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

"Mastectomy"
"Mastectomy" means the surgical removal of all or part of a breast.

"Maximum Out of Pocket Amount"
" Maximum Out of Pocket Amount" means the maximum amount designated each year that a Covered Person will pay for Essential Health Benefits. This includes Deductibles, Copayments, and Coinsurance. Amounts for non-Covered Charges, penalties, and charges in excess of the Maximum Allowable Amount are not covered.

"Maximum Allowable Amount" or **"Maximum Allowable Charge**"
"Maximum Allowable Amount" and/or "Maximum Allowable Charge" means the benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Amount will be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Amount will be one of the following:
1. The allowable charge specified under the terms of the Plan;
2. The Medicare allowed amounts plus the designated percentage specified under the terms of the Plan;
3. The Usual and Customary amount;
4. The actual billed charges for the Covered Services; or
5. For claims subject to the No Surprises Act, an amount determined by an applicable all-payer model agreement; or; if no such amount exists, an amount determined by applicable state law; or if neither such amount exists, an amount deemed payable by a certified IDR entity or a court of competent jurisdiction, if applicable.

The Plan Administrator has the discretionary authority to decide the Usual and Customary amount for a given service or supply.

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" means 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 an Employee, Director or Retiree who is a Covered Person or directs such Covered Person to provide coverage under a health benefits plan pursuant to a State domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

"Medically Necessary"

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

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

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the 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."

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

The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

"Medicare"

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

"**Medicare Approved Amount"**

"Medicare Approved Amount" means the cost that Medicare pays for like services.

"Mental or Nervous Disorder"

"Mental or Nervous Disorder" means 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" means a notice that contains the following information:

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

"Network"
"Network" means the medical provider network with which the Plan contracts to access discounted fees for Covered Services for Covered Persons.

"**Open Enrollment Period"**
"Open Enrollment Period" means a period of time determined by the Participating Employer during which Employees may add or change the coverage selected for the next calendar year and during which eligible Dependents may be added or deleted to the coverage. Late Enrollees are eligible to elect coverage for the next calendar year only during the Open Enrollment Period. If the Participating Employer offers more than one coverage option (different plans), a changed in the coverage option selected by a Covered Person will only be allowed during Open Enrollment.

"Other Plan"
"Other Plan" means, 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 Covered Person;
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. Worker's 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.

"**Outpatient"**
"Outpatient" means treatment including services, supplies, and medicines provided and used at a Hospital under the direction of a Physician, to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory, or X-ray facility, an Ambulatory Surgery Center, or the patient's home.

"Participating Employer"
"Participating Employer" means any employer which is approved and accepted by the Trustees to offer group medical benefits to its Employees under this Advantage Health Plans Trust.

"Pharmacy"
"Pharmacy" means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

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

"Physician Assistant"
"Physician Assistant" means a health care professional, qualified by academic and clinical education, and

licensed by the applicable State Board of Licensure and Supervision in the state in which such person practices, to provide health care services in any patient care setting at the direction and under supervision of a Physician or group of Physicians. A Physician Assistant shall not include the Covered Person when providing service for himself or his family.

"Plan"
"Plan" means Advantage Health Plans Trust, which is a health benefit plan for certain Employees of the Participating Employers adopting this plan and is described in this document.

"Plan Administrator"
"Plan Administrator" means The Kempton Company which is delegated fiduciary responsibilities to manage the claims payments and daily operations of the Plan.

"Plan Year"
"Plan Year" means July 1st through the following June 30th. All official records of the Plan and Trust are retained on the fiscal year. Benefits are determined on the calendar year basis.

"Pre-admission Tests"
"Pre-admission Tests" means those Diagnostic Services done prior to a scheduled Surgery, provided that:

1. The tests are approved by both the Hospital and the Physician;
2. The tests are performed on an outpatient basis prior to Hospital admission; and
3. 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 Surgery.

"Pregnancy"
"Pregnancy" means carrying a Child, resulting childbirth, miscarriage and non-elective abortion. The Plan considers Pregnancy as a Sickness for the purpose of determining benefits.

"Prescription Drug"
"Prescription Drug" means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

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

"Provider"
"Provider" means a Physician, a licensed speech or occupational therapist, licensed professional physical therapist, physiotherapist, audiologist, speech language pathologist, licensed professional counselor, certified nurse practitioner, certified psychiatric/mental health clinical nurse, dentist or other practitioner or facility defined or listed herein, or approved by the Plan Administrator.

"Psychiatric Hospital"
"Psychiatric Hospital" means an Institution constituted, licensed, and operated as set forth in the laws that apply to Hospitals, which meets all of the following requirements:

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

The term Psychiatric Hospital does not include an Institution, or that part of an Institution, used mainly for nursing care, rest care, convalescent care, care of the aged, Custodial Care or educational care.

"Qualified Medical Child Support Order" or "QMCSO"
"Qualified Medical Child Support Order" or "QMCSO" means a domestic relations order, judgment, decree, or order which creates or recognizes the existence of an Alternate Recipient's right to, or assigns an Alternate Recipient's right to receive benefits under a group health plan.

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

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

Charge(s) and/or services are not considered to be Reasonable, and as such are not eligible for payment (exceed the Maximum Allowable Charge), when they result from Provider error(s) and/or facility-acquired conditions deemed "reasonably preventable" through the use of evidence-based guidelines, taking into consideration but not limited to CMS guidelines.

The Plan 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" means an Institution which mainly provides therapeutic and restorative services to Sick or Injured people. It is recognized as such if:

1. It carries out its stated purpose under all relevant Federal, State and local laws;
2. It is accredited for its stated purpose by either the Joint Commission on Accreditation of Hospitals or the Commission on Accreditation for Rehabilitation Facilities; or
3. It is approved for its stated purpose by Medicare.

"Retiree"
"Retiree" means an individual who meets the eligibility criteria set forth in Article IV.

"Room and Board"
"Room and Board" means a Hospital's charge for:

1. Room and linen service;
2. Dietary service, including meals, special diets and nourishment;
3. General nursing service; and
4. Other conditions of occupancy which are Medically Necessary.

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

"Service Waiting Period"
"Service Waiting Period" means an interval of time designated in the Adoption Agreement during which the Employee is in the continuous, Active Employment of his or her Participating Employer before the Employee is eligible for coverage under this Plan. The Participating Employer has sole and complete discretion to establish the Service Waiting Period applicable to its Plan. In no circumstances will the Service Waiting Period be more than ninety (90) days.

"Sickness"
"Sickness" means "Disease."

"Skilled Nursing Facility"
"Skilled Nursing Facility" means facility that fully meets all of these tests:

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided;
2. Its services are provided for compensation and under the full time supervision of a Physician;
3. It provides 24 hour per day nursing services by licensed nurses, under the direction of a full time registered nurse;
4. It maintains a complete medical record on each patient;
5. It has an effective utilization review plan;
6. It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, those suffering a mental defect, Custodial or educational care or care of Mental Disorders; and
7. It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

"Substance Abuse"
"Substance Abuse" means any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a drug. The DSM-IV definition is applied as follows:

1. A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one (or more) of the following, occurring within a 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. Recurrent substance-related legal problems (e.g., arrests for substance-related disorderly conduct); 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); or
2. The symptoms have never met the criteria for Substance Dependence for this class of substance.

"Substance Abuse Treatment Center"
"Substance Abuse Treatment Center" means an Institution which provides a program for the treatment of Substance Abuse by means of a written treatment plan approved and monitored by a Physician. This Institution

must be:

1. Affiliated with a Hospital under a contractual agreement with an established system for patient referral;
2. Accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or
3. Licensed, certified or approved as an alcohol or Substance Abuse treatment program or center by a State agency having legal authority to do so.

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

"Surgery" or Surgical Procedure
"Surgery" means any of the following:

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

"Total Disability" or "Totally Disabled"
"Total Disability" or "Totally Disabled" means an individual who is determined to be physically or mentally incapable of living on his or her own.

"Trust"
"Trust" means Advantage Health Plans Trust, as amended and restated, effective July 1, 2006, including any amendments thereto. The Trust is an integral part of this Plan and is hereby incorporated by reference as if set forth herein.

"Trustees"
"Trustees" mean the members of the Board of Trustees of the Trust elected by the Participating Employers in accordance with the terms of the Trust.

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

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

"**Usual and Customary**"
"Usual and Customary" (U&C) means Covered Charges which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

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

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

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator, in its sole discretion, will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, be determined and established by the Plan Administrator using data such as, but not limited to, Medicare allowed to charge ratios, average wholesale price (AWP) for prescriptions, manufacturer's retail pricing (MRP) for supplies and devices, Healthcare Blue Book or similar pricing, retail pricing, cash pricing, or any other reasonable pricing information available to the Plan Administrator.

Master charge list prices are not considered Usual and Customary. All other defined terms in this Plan Document shall have the meanings specified in the Plan Document where they appear.

ARTICLE IV
ELIGIBILITY FOR COVERAGE
ENROLLMENT PERIODS; EFFECTIVE DATE OF COVERAGE

4.01 Who Is Eligible for Coverage

Each Participating Employer chooses the classes of individuals that will be covered under its Plan. These choices are listed in the Adoption Agreement. If your Participating Employer has chosen not to cover Dependents, Directors or Retirees, they will not be eligible to receive any benefits under this Plan.

4.01A Employees

All Eligible Employees are eligible to participate under the Plan. "Eligible Employee" means an active Employee who is regularly scheduled to work at least thirty (30) hours per week.

An Employee who is commissioned-based only, shall be considered an Eligible Employee if the Participating Employer provides necessary information to the Plan Administrator that: (i) such commission-only employee works solely for the Participating Employer as an employee and not as independent contractor; (ii) such commission-only employee is expected to work at least 30 hours per week for the Participating Employer; and (iii) there is evidence of commissions paid to such commission-only employee after a reasonable period of time following employment and there is a pattern of commissions paid that would indicate commission-only employee is working at least 30 hours per week for the Participating Employer.

4.01B Dependents

If the Participating Employer elects in the Adoption Agreement to include Dependents, then the following persons are eligible for coverage under the Plan. Eligible Dependents includes:

1. An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, to be a "Spouse," the person must be recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator will require marriage licenses, or verification of common law marriages, for all newly enrolled Spouses to establish a legal marital relationship;
2. An Employee's Child up to age of 26. For this purpose "Child" shall mean the Employee's own blood descendant of the first degree or lawfully adopted Child, and a Child placed with a covered Employee in anticipation of adoption. Child shall also include a child who is an Alternate Recipient under a Qualified Medical Child Support Order, expires but only if the parent who is ordered to provide health coverage is covered Employee, or the Spouse of a covered Employee and covered under the Plan.
3. A Dependent includes a Child up to the age of 26 of the Spouse of the Employee ("Stepchild"), if the Spouse is covered under the Plan.
4. A Child who does not meet the conditions above, but for whom the Employee is the Legal Guardian of such Child, lives with the Employee in a regular parent-child relationship, and is related to the Employee by blood or marriage.
5. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age under the items above, who is Totally Disabled. Such Child must have Totally Disabled prior to attaining the limiting age under the items above. Written proof satisfactory to the Plan must be furnished and approved by the Plan within at reasonable intervals following the date the Child attains the limiting age under the items above. The time limit for written proof of Total Disability is 30 days following the original eligibility date for a new or re-enrolling Employee. The Plan Administrator may require, at reasonable intervals, subsequent proof satisfactory to the Plan Administrator of such status.

It is the Employee's responsibility to notify the Plan Administrator if a Dependent ceases to meet the eligibility requirements set forth above. The Plan Administrator may require, upon enrollment, and at any time thereafter, sufficient documentation to substantiate the status of any given Dependent.

If both mother and father are Employees, a Child will be covered as Dependents of the mother or father, but not of both. If both mother and father are Employees, one spouse cannot be covered under the Plan as a Dependent and also as an Employee.

Grandfather provision: Any stepchild who does not meet the above criteria, but was eligible and enrolled in coverage prior to January 2021 will be Grandfathered and eligible to continue coverage under this Plan.

Additional terms regarding Stepchild(ren): In the event the biological parent of a Stepchild dies, the Stepchild(ren) shall be allowed to remain on this Plan provided that the biological parent (i.e. Spouse) and any and all Stepchild(ren) were enrolled in the Plan immediately prior to the biological parent's death and there has been no break in coverage.

An enrolled Dependent who fails to satisfy the applicable requirements will not be covered under this Plan. The premiums paid for such person will be refunded retroactively from the initial date of the improper enrollment. The Employee must refund to the Plan the amount of any benefits paid for such ineligible dependent. If you have any questions about whether or not a person qualifies as your Dependent, contact the Plan Administrator.

Ineligible Dependents. The following persons are specifically excluded as Dependents:

1. Other individuals living in the covered Employee's home, but who are not eligible as defined;
2. The legally separated or divorced former Spouse of the Employee;
3. Any person who is on active duty in any military service of any country or who is a resident of a Country outside the United States; or
4. Any person who is covered under the Plan as an Employee.

This is not an exhaustive list. If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for Deductibles and all amounts applied to maximums.

In the event the Participating Employer elects coverage for Directors or Retirees, the criteria for Dependent coverage listed above is applicable to Dependents of Directors and Retirees in the same manner as covered Employees.

4.01C Directors

An individual is eligible for Director coverage if:

1. The individual serves as a Board member for the Participating Employer with full voting capacity and has served in that position for at least (1) year. The Plan Administrator may, in its sole discretion, require proof that a Director qualifies as such as defined by this Plan.
2. The Participating Employer has elected Director coverage in the applicable Adoption Agreement.

The Plan Administrator may, in its sole discretion, from time to time, require proof that a Director qualifies or continues to qualify as such as defined by this Plan. The date of eligibility flows from the Director's appointment date as a Director.

4.01D Retirees

An individual is eligible for Retiree coverage if:

1. A former active full time Eligible Employee who has terminated his or her employment with a Participating Employer, and
    a. Who has attained age 62, has completed the last 10 years of service in the same industry as the Participating Employer, and has been continuously employed for the last five (5) years by the Participating Employer; or
    b. Who has attained the age of 55, has completed 25 years of service in the same industry as the Participating Employer, and has been continuously employed for the last five (5) years by the Participating Employer; or
2. A former Director who has attained age 62 and has terminated his relationship as a Director of the Participating Employer, and
    a. Who has been on the Board of Directors of the Participating Employer for at least 12 consecutive years; and

b. Who has been covered under this Plan as a Director in the Participating Employer's Plan for the five (5) years immediately prior to electing Retiree coverage;

A Retiree will be eligible for coverage as a Retiree of a Participating Employer only so long as the Participating Employer who covers the Retiree continues to provide coverage under this Plan to its Eligible Employees and continues to provide Retiree coverage. The Plan Administrator may, in its sole discretion, from time to time require proof that a Retiree qualifies or continues to qualify as such as defined by this Plan.

4.02 When You Must Enroll and When Coverage is Effective

This Section describes when Eligible Employees must enroll and when coverage becomes effective.

4.02A Employees

Service Waiting Period. For new Eligible Employee, coverage will be effective after satisfaction of the Service Waiting Period. The Service Waiting Period is selected by each Participating Employer in the Adoption Agreement. The Service Waiting Period will be no more than ninety (90) days.

Initial Enrollment Period. Upon completing the Service Waiting Period, Eligible Employees must enroll in the Plan during your Initial Enrollment Period. This is the 31- day period that begins the first day of the month after completion the Service Waiting Period. Properly enrolled means that the Plan Administrator must receive a properly completed enrollment form during the Initial Enrollment Period. If the Plan Administrator does not receive a properly completed enrollment form within such period of time, the Employee will be deemed to have waived coverage and will be deemed a Late Enrollee.

Effective Date of Coverage. Upon completion of the Service Waiting Period and proper enrollment during the Initial Enrollment Period, the Effective Date of Coverage is the first day of the month coincident with or next following the date the Eligible Employee satisfies the Service Waiting Period.

4.02B Dependents

If a Participating Employer elects to offer coverage for Dependents in the Adoption Agreement, an Eligible Employee may elect to cover him or herself and their eligible Dependents as a Family Unit.

The Effective Date of Coverage for Dependents is the *earliest of*:

1. The date of the Eligible Employee's Effective Date of Coverage; a written enrollment form listing the Dependent is executed by the Eligible Employee, Director or Retiree, and received by the Plan Administrator during the Initial Enrollment Period. This means the form must be received by the Plan Administrator no later than 31 days from the Effective Date of Coverage of the Eligible Employee; or
2. The date the Dependent first becomes a Dependent of the Eligible Employee. This happens when the person was not previously a dependent. In this case, the Effective Date of Coverage is the first day of the month coincident with or following satisfaction of the eligibility criteria for Dependents; provided, a written enrollment form is executed by the Eligible Employee enrolling the Dependent and received by the Plan Administrator no later than 31 days from satisfaction of the eligibility criteria for Dependents;

Failure to enroll an eligible Dependent at the earlier of the two dates noted above will cause the Dependent to be considered a Late Enrollee and you will not have an opportunity to enroll the Dependent in the Plan until the next Open Enrollment Period unless a Special Enrollment Right applies.

In the event the Participating Employer elects coverage for Directors or Retirees, the Effective Date of Coverage for Dependent coverage listed above is applicable to Dependents of Directors and Retirees in the same manner as covered Employees.

4.02C Retirees

Upon retirement, and if the Participating Employer has elected Retiree coverage, a retiring Employee can choose between COBRA Continuation Coverage or continue coverage under the Plan as a Retiree if they satisfy the

eligibility requirements of Retiree coverage. If the retiring Employee is eligible and elects Retiree coverage, he or she will forfeit their right to elect COBRA Continuation Coverage. If the retiring Employee instead elects COBRA Continuation Coverage, he or she will forfeit their right to elect Retiree coverage.

Spouses and Dependent Child(ren) will not be eligible for Retiree coverage under this Plan if they have access to employer sponsored coverage elsewhere, regardless of if they enroll in such other employer sponsored coverage. The Spouse and/or Dependnet Child(ren) must notify the Plan Administrator when he or she becomes eligible for employer sponsored coverage when enrolled in Retiree coverage.

The Plan will not provide coverage to a Retiree of a Participating Employer unless the Participating Employer continues to provide coverage under this Plan to its Eligible Employees.

Grandfather Provision: Any Retiree currently on the Plan and over the age of 65 will remain eligible for Retiree coverage under this Plan regardless of age. However, for any Retirees under age 65 who are currently on the Plan as a Retiree, such Retiree coverage will end when the Retiree reaches age 65.

4.02D Director
If the Participating Employer elects to cover Directors, the Effective Date of Coverage will be governed by the same rules that apply to Eligible Employees as outlined in 4.02A. Dependents of a Director will be governed by the same rules that apply to Dependents as outlined in 4.02B.

4.03 Other Enrollment Periods.

4.03A Late Enrollment
An enrollment is "late" if it is not made on a timely basis during your Initial Enrollment Period, during a Special Enrollment Period, or during Open Enrollment.

If an individual loses eligibility for coverage as a result of terminating employment, a reduction in hours, or a general suspension of coverage under the Plan, then upon becoming eligible again due to resumption of employment or due to resumption of Plan coverage, only the most recent period of eligibility will be considered for purposes of determining whether the individual is a Late Enrollee.

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Service Waiting Period. Coverage begins as specific in the Open Enrollment Section.

4.03B Special Enrollment Period
Federal law provides a special enrollment period under limited circumstances as described below. Individuals included in the classes below are not required to wait for the next Open Enrollment Period but may enroll earlier if one of the below conditions are met:

1. Adopted Children or Children Placed for Adoptions. A Child who is an adopted or is Placed for Adoption with an Eligible Employee, may be enrolled as a Dependent within 31 days of the date of adoption or the date he or she is Placed for Adoption.
2. Newborns. A Newborn may be enrolled as a Dependent within 31 days of his or her birth.
3. Loss of Other Coverage. If an Employee declined enrollment for himself or herself or his or her Dependents (including his or her spouse) because of other health coverage, he or she may enroll for coverage for himself or herself and/or his or her Dependents **if** the other health coverage is lost. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost.

   An Eligible Employee or Dependent who would qualify as a Late Enrollee may enroll earlier for coverage under this Plan if **all** of the following conditions are satisfied:
   a. The Employee or Dependent was covered under another group health plan or had health coverage at the time that he or she was initially eligible to enroll; and

b. The Employee or Dependent stated *in writing* at the time the coverage under this Plan was *initially offered* that it was being *declined because of such coverage*; and
c. The coverage described in (a) was terminated as a result of:
    i. Legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent Child under the plan), death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that is measured by reference to any of the foregoing;
    ii. In the case of coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because the individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);
    iii. In the case of coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live, or work in the service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of individual), and no other benefit package is available to the individual; and
    iv. A situation in which a plan no longer offers any benefits to the classes of similarity situated individuals (as described in § 2590.702(d)) that includes the individual; and
d. The Plan Administrator receives a signed enrollment form requesting coverage from the Employee or Dependent within 31 days after the date coverage is exhausted or terminated as described above.

An Employee who is already enrolled may enroll a Dependent of that Employee who has a Special Enrollment Right in the Plan because the Dependent lost eligibility for other coverage. The Employee must make written application for special enrollment within 31 days of the date the other health coverage was lost.

The Employee or Dependent is not eligible for this Special Enrollment Right if:
a. The other coverage was COBRA continuation coverage and the Employee or Dependent did not exhaust the maximum time available to him or her for that COBRA coverage; or
b. The other coverage was lost due to non-payment of requisite contribution/premium, or the loss of coverage was for cause such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other plan; or
c. The Employee or Dependent voluntarily dropped coverage for any reason other than those specified above.

A properly completed enrollment form must be received by the Plan Administrator within 31 days. If so, the Effective Date of Coverage for the Employee or Dependent will be 12:01 A.M. on the first day of the first calendar month beginning after the date the written request is received by the Plan. The Plan Administrator may require appropriate documentation to substantiate the event that allows a Special Enrollment Right.

4.03C Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Notice or receives "Qualified Medical Child Support Order" ("QMCSO") if such an individual is not already covered by the Plan as an eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth in applicable law.

4.03D Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA).

Employees and their Dependents who are otherwise eligible for coverage under the Plan but who are not enrolled can enroll in the Plan provided that they request enrollment in writing within 60 days from the date of the following loss of coverage or gain in eligibility:

- The eligible person ceases to be eligible for Medicaid or Children's Health Insurance Program (CHIP) coverage; or
- The eligible person becomes newly eligible for a premium subsidy under Medicaid or CHIP.

If eligible, the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan.

This Dependent Special Enrollment Period is a period of 60 days and begins on the date of the loss of coverage under the Medicaid or CHIP plan OR on the date of the determination of eligibility for a premium subsidy under Medicaid or CHIP. To be eligible for this Special Enrollment, the Employee must request enrollment in writing during this 60-day period. *The Effective Date of coverage will begin the first day of the first calendar month following the date of loss of coverage or gain in eligibility.*

4.04 Rehiring a Terminated Employee

Unless otherwise required by applicable law, a terminated Employee who was covered under the Plan at the time of termination and is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

ARTICLE V
TERMINATION OF COVERAGE

5.01 Termination of Coverage

Coverage for a Covered Person will terminate on the **earliest** of the following dates:

1. The ***last day of the month*** in which an Employee, Director or Retiree, voluntarily ceases coverage for himself and/or his Dependents under this Plan based on a condition that allows coverage to be terminated during the year.
2. The ***last day of the month*** in which an Employee ceases to be an Eligible Employee of the Participating Employer. This may occur due to a change in the regular hours worked, termination of employment, death or otherwise.
3. The ***last day of the month*** in which a Director ceases to be an Eligible Director of the Participating Employer. This may occur due to termination of directorship or death.
4. The ***last day of the month*** during which a Dependent ceases to be an eligible Dependent. This may occur because of a divorce, the death of the covered Employee or a Child attaining the limiting age.
5. The ***last day of the month*** during which a Participating Employer eliminates coverage for Directors, Retirees and / or Dependents. Coverage for all Covered Persons included in such class(es) under this Plan through that Participating Employer will terminate.
6. The ***first day of the birth month*** in which the Retiree reaches age 65.
7. The ***last day of the month*** in which the Participating Employer terminates its Plan under Advantage Health Plans Trust. Coverage for all Covered Persons covered under this Plan through that Participating Employer will terminate.

If Employee, Director, or Retiree coverage terminates, and that individual elected coverage for his or her Dependents, coverage for the Dependents will cease on the same date as that of the Employee, Director, or Retiree. Under certain circumstances, Continuation Coverage may be available. See the Section titled Continuation of Coverage.

5.02 Rescission

A Covered Person's coverage may be rescinded (retroactively terminated) if:

1. The Covered Person (or a person seeking coverage on behalf of the Covered Person) performs an act, practice or omissions that constitutes fraud; or
2. The Covered Person (or a person seeking coverage on behalf of the Covered Person) makes an intentional misrepresentation of material fact.

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

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

This is not an exhaustive list. Any Covered Person who knowingly and with intent to defraud the Plan, files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any material fact, commits a fraudulent act. The Covered Person may be subject to prosecution by the United States Department of Labor. Fraudulently claiming benefits may be punishable by a substantial fine, imprisonment, or both. Any recissions or retroactive termination of coverage will include proper notice under applicable law.

5.03 Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a Covered Person under this Plan to use any identification card issued, the Plan Administrator, may in its sole discretion, give the Covered Person written notice that his or her (and the Family Unit's) coverage will be terminated thirty-one (31) days from the date written notice is given.

5.04 Voluntary Termination of Coverage During the Year

Once enrolled in the Plan, Covered Persons may not change or terminate coverage during the year unless there is a Special Enrollment Right or the following conditions are met:

1. You enroll in Medicare Part A and/or B and request to voluntarily drop coverage under this Plan;
2. Your spouse and/or your Dependents enroll in Medicare Part A and/or B coverage and you request to voluntarily drop coverage under this Plan for such spouse and/or Dependent;
3. You and/or your Dependents enroll for coverage in the federal Marketplace/Exchange.

The Plan Administrator may, in its sole discretion, allow other election changes or voluntary termination of coverage consistent with the Participating Employers' practices.

Upon receipt of notification to the Plan Administrator, the coverage will be terminated as of the date your other coverage begins. You will not be able to re-enroll in this Plan until the next Open Enrollment Period unless you have a Special Enrollment right. This provision does not allow you to change the options you have selected for the year.

5.05 Retirees

If the Participating Employer elects Retiree coverage, and such Retiree coverage is elected, Retiree coverage will end on the first day of the birth month in which the Retiree reaches age 65. If the Retiree has elected coverage for his or her Spouse and Child(ren), the Spouse and Child(ren) of a Retiree will be allowed to remain on the Plan when the Retiree reaches age 65, provided the Spouse is under agre 65. Such coverage for the Spouse and Child(ren) will cease on the first day of the birthn month in which the Spouse reaches age 65. The Spousal's loss of coverage under this Plan at age 65 is not eligible for continuation coverage under COBRA.

If the Participating Employer elects Retiree coverage *and* the Surving Spousal election through the Adoption Agreement, and the Retiree dies, the Retiree's Spouse and/or Child(ren) who were enrolled in the Plan at the time of the Retiree's death will be allowed to continue coverage under the Plan until the Spouse reaches age 65.

ARTICLE VI
CONTINUATION OF COVERAGE

6.01 Continuation During Periods of Employer Certified Disability or Authorized Leave of Absence

An Eligible Employee may remain eligible for a limited time if Active Employment ceases due to a disability or if the Eligible Employee is on an authorized Leave of Absence.

A "Leave of Absence" means any absence authorized by the Participating Employer under the standard personnel practice which is applied to all persons under similar circumstances in a uniform manner and whether or not the Participating Employer pays any compensation to an Eligible Employee on such leave. In addition, such term will include:

1. A Leave of Absence of 30 days or less due to military service during which an Employee's re-employment rights are protected by law; or
2. A Leave of Absence authorized by the Participating Employer for a period of up to 90 days. In no event will any Eligible Employee, who is covered under the Plan immediately prior to his or her Leave of Absence, be entitled to extend this period beyond 90 days unless otherwise required by the Participating Employer's handbook, internal policies, pursuant to a collective bargaining agreement, or due to the requirements of any applicable federal or state law or regulation; or
3. A Leave of Absence with or without pay if such leave is authorized by the Participating Employer pursuant to the Family Medical Leave Act of 1993 ("FMLA"). This extended coverage shall apply only to a Participating Employer who is required to comply with such Act. Each Participating Employer which is required to comply with the Family and Medical Leave Act of 1993, and supporting regulations promulgated by the Department of Labor, will be able to meet its obligation to continue coverage during such leave. During any leave taken under the Family and Medical Leave Act, the Participating Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the Covered Employee had been continuously employed during the entire leave period. This provision is also intended to comply with any and all applicable state leave laws.

The coverage continued during this period will be the same coverage as was in effect on the last day worked as an Active Employee. However, if benefits are reduced for others in the class, they will also be reduced for you.

If an Eligible Employee or Director chooses not to continue coverage during FMLA leave or coverage is terminated during such leave pursuant to applicable law, coverage will be restored immediately upon return from the FMLA leave to the same extent that it was in force when that coverage terminated.

6.02 Continuation During USERRA

Eligible Employees who are absent from employment because they are in the Uniformed Services may elect to continue their coverage (including coverage for Dependents) under this Plan. The maximum period of coverage of a person under such an election shall be the ***lesser*** of:

1. The 24 month period beginning on the date on which the person's absence begins; or
2. The day after the date on which the person was required to apply for or return to a position of employment and fails to do so.

Eligible employees who elect to continue coverage under this Plan will be required to pay up to 102% of total premium costs per month, similar to COBRA. Only the Eligible Employee has election rights under USERRA. Dependents do not have any independent right to elect USERRA health plan continuation.

Eligible employees on military leave for 30 days or less will be allowed to continue coverage as if he or she is actively working as described in Section 6.01.

An exclusion or Service Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Service Waiting Period may be imposed for coverage of any Sickness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

6.03 Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage called "COBRA Coverage" where coverage under the Plan would otherwise end. This notice is intended to inform you as a Covered Person and beneficiary of your rights and obligations under the continuation coverage provisions of COBRA. The right to COBRA Coverage will be interpreted in accordance with regulations issued by the Internal Revenue Service. This notice is intended to reflect the law and does not grant or take away any rights under the law.

COBRA Coverage is administered by the Plan Administrator, The Kempton Company, 13431 Broadway Extension, Suite 130, Oklahoma City, OK 73114, 800-521-1711. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

6.03A What is COBRA coverage

COBRA Coverage is the temporary extension of group health plan coverage that must be offered to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA Coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan ("Qualifying Event"). The coverage must be identical to the coverage that the Qualified Beneficiary had under the Plan immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated non-COBRA Covered Persons.

6.03B Who Can Become a Qualified Beneficiary

Generally, a Qualified Beneficiary is:

1. Any individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being on that day either a covered Employee, the spouse of a covered Employee, or a Dependent Child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event;
2. Any Child who is born to or Placed for Adoption with a covered Employee during a period of COBRA Coverage, and any individual who is covered by the Plan as an Alternate Recipient under a Qualified Medical Support Order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event; or
3. A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Participating Employer, as is the spouse, surviving spouse or Dependent Child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or Dependent Child was a beneficiary under the Plan.

The term "covered Employee" includes Eligible Employees, Directors, and Retirees who have coverage under the Plan which the Participating Employer has elected in the Adoption Agreement to be covered under this Plan. Each Qualified Beneficiary (including a Child who is born to or Placed for Adoption with a covered Employee during a period of COBRA Coverage) must be offered the opportunity to make an independent election to receive COBRA Coverage.

6.03C What is a Qualifying Event

A Qualifying Event is any of the following events which would cause a Covered Person to lose coverage under this Plan but for the election to take COBRA Coverage. The events are limited to the following:

1. The death of a covered Employee;
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment or the termination of a directorship;

3. The divorce or legal separation of a covered Employee from the Employee's spouse. If the Employee reduces or eliminates the Employee's spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation;
4. A covered Employee's enrollment in any part of the Medicare program;
5. A Dependent Child's ceasing to satisfy the Plan's requirements for a Dependent Child (for example, attainment of the maximum age for dependency under the Plan); or
6. A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to a Participating Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the covered spouse or a Dependent Child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Participating Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event because the Eligible Employee will be deemed to have continued eligibility during the first 90 days of leave. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA Coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA Coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

6.03D What factors should be considered when determining to elect COBRA Coverage

You should take into account that a failure to continue your group health coverage will affect your rights under federal law.

1. You should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 31 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA Coverage if you elect COBRA Coverage for the maximum time available to you.
2. You may enroll in the state or federally run Marketplace. Information about the health insurance policies you may purchase on the Marketplace can be found at https://www.healthcare.gov. However, if you fail to enroll in the Marketplace on a timely manner, you may be required to wait for the open enrollment period on the Marketplace to be able to obtain coverage for the next calendar year. If you elect COBRA Coverage rather than enrolling in the Marketplace, you will not be able to enroll in the Marketplace until the next open enrollment period on the Marketplace or when your COBRA Coverage term ends.

6.03E Procedure for obtaining COBRA Coverage

The Plan has conditioned the availability of COBRA Coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

6.03F What is the election period and how long must it last?

The election period is the time period within which the Qualified Beneficiary must elect COBRA Coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA Coverage. ***If coverage is not elected within the 60 day period, all rights to elect COBRA Coverage are forfeited.***

6.03G Notifying the Plan Administrator of the occurrence of a Qualifying Event

A covered Employee or Qualified Beneficiary is responsible for informing the Plan Administrator of the occurrence of a Qualifying Event. The Plan will offer COBRA Coverage to Qualified Beneficiaries only after the Plan Administrator has been ***timely*** notified that a Qualifying Event has occurred. Your Employer will notify the Plan Administrator of the Qualifying Event within 31 days following the date coverage ends when the Qualifying Event is:

1. The end of employment or reduction of hours of employment;
2. Death of the Employee;
3. Commencement of a proceeding in bankruptcy with respect to the Participating Employer; or
4. Enrollment of the Employee in any part of Medicare.

IMPORTANT:

***For the other Qualifying Events*:**

1. Divorce or legal separation of the covered Employee and spouse; or
2. A Dependent Child's losing eligibility for coverage as a Dependent Child;

You or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator during the 60-day notice period, a spouse or Dependent Child who loses coverage will NOT be offered the option to elect COBRA coverage. You must notify the Plan Administrator when these events occur.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

The Kempton Company
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **name of the Participating Employer's Plan** under which you lost or are losing coverage,
- the **name and address of the Eligible Employee** covered under the Plan,
- the **name(s) and address(es) of the Qualified Beneficiary(ies)**, and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a **divorce or legal separation**, your notice must include **a copy of the divorce decree or the legal separation agreement**.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator **receives *timely notice*** that a Qualifying Event has occurred, COBRA Coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA Coverage. Covered Employees may elect COBRA Coverage for their spouses, and parents may elect COBRA Coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA Coverage, such coverage will begin on the date that Plan coverage would otherwise have been lost. ***If you or your spouse or Dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.***

6.03H Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights?

If, during the election period, a Qualified Beneficiary waives COBRA Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA Coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator.

6.03I Is COBRA Coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?

Qualified Beneficiaries who are entitled to elect COBRA Coverage may do so even if they were covered under another group health plan or were entitled to Medicare benefits on or before the date of the Qualifying Event. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, ***after*** electing COBRA, he becomes entitled to Medicare or becomes covered under other group health plan coverage.

6.03J When may a Qualified Beneficiary's COBRA Coverage be terminated?

During the election period, a Qualified Beneficiary may waive COBRA Coverage. Except for an interruption of coverage in connection with a waiver, COBRA Coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period;
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary;
3. The date upon which the Participating Employer ceases to provide any group health plan (including a successor plan) to any Employee;
4. The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary. Keep in mind that under the new Affordable Care Act, pre-existing conditions are no longer allowed to be considered by plans;
5. The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier); or
6. In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
    a. (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 31 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    b. The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan Administrator can terminate the coverage of a Qualified Beneficiary for cause on the same basis that the Plan Administrator terminates the coverage of similarly situated non-COBRA beneficiaries for cause, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

6.03K What is the maximum coverage period for COBRA Coverage?

The maximum coverage period is based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

1. In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
2. In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:
    a. 36 months after the date the covered Employee becomes enrolled in the Medicare program; or
    b. 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.
3. In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered Retiree ends on the date of the Retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered spouse, surviving spouse or Dependent Child of the Retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the Retiree.
4. In the case of a Qualified Beneficiary who is a Child born to or placed for adoption with a covered Employee during a period of COBRA Coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA Coverage during which the Child was born or placed for adoption.
5. In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

6.03L Under what circumstances can the maximum coverage period be expanded?

If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the COBRA Administrator in accordance with the procedures above.

6.03M How does a Qualified Beneficiary become entitled to a disability extension?

A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA Coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the COBRA Administrator in accordance with the procedures above.

6.03N Does the Plan require payment for COBRA Coverage?

For any period of COBRA Coverage under the Plan, Qualified Beneficiaries who elect COBRA Coverage must pay for COBRA Coverage. Qualified Beneficiaries will pay up to 102% of the applicable cost and up to 150% of the applicable cost for any expanded period of COBRA Coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA Coverage as of the first day of any month for which timely payment is not made.

Must the Plan allow payment for COBRA Coverage to be made in monthly installments? Yes

What is Timely Payment for payment for COBRA Coverage? Timely Payment means a period of a month. However, the initial payment must be made no later than the 45th day following the date the election is made. Subsequent payments are required to be made no later than the last day of each month.

Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 31 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

6.03O Must a Qualified Beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA Coverage?

This Plan does not provide a conversion health plan. You are responsible for obtaining other coverage when COBRA Coverage terminates.

6.03P Questions

If you have questions about your COBRA Coverage, contact the Plan Administrator. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa or call their toll-free number at 1-866-444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.

6.03Q Address Changes

To protect your family's rights, keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

6.04 Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

The Kempton Company
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114
(405) 521-1711 or
(800) 521-1711

ARTICLE VII
GENERAL LIMITATIONS AND EXCLUSIONS

This section applies to all benefits provided under any section of this Plan. This Plan does NOT cover any charge for care, supplies, treatment, and/or services related to the following:

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

Acupuncture. Care, services and supplies in connection with acupuncture or acupressure;

Bereavement. Care and treatment in connection with bereavement counseling;

Biofeedback. Charges for Biofeedback unless when used to treat an acquired brain injury;

Cochlear Implants. Services and supplies in connection with Cochlear Implants unless deemed to be Medically Necessary. All Covered Charges are subject to applicable Copayments, Deductibles and Coinsurance. Cochlear Implant devices are subject to the Implant limitations and available under the applicable medical/surgical covered health services categories in this Plan;

Complications of Non-Covered Treatments. That are required as a result of complications from a treatment not covered under the Plan are not covered;

Confinements for Other Than Sickness or Injury. For hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any physical examinations, testing, or executive health programs not connected with the actual Sickness or Injury;

Cosmetic Procedures. Incurred in connection with the care or treatment of or surgery performed for a Cosmetic Procedure. A Cosmetic Procedure means a procedure performed solely for the improvement of a Covered Person's appearance rather than for the improvement or restoration of a bodily function. This exclusion does not apply when such treatment is rendered to correct a condition resulting from an accidental Injury sustained while coverage is in effect or when rendered to correct a congenital anomaly, such as a birth defect, for a Covered Person who is a Dependent. It also does not apply to reconstructive breast surgery to the other breast immediately following a mastectomy or Lumpectomy;

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

Dental Services. For dental services or supplies of any kind under the medical benefit provisions of the Plan. Dental services or supplies mean those performed or provided in connection with treatment to alter, correct, fix, improve, remove, replace, reposition, or treat:

1. Teeth;
2. The gums and tissues around the teeth;
3. The parts of the upper or lower jaws which contain the teeth (the alveolar processes and ridges);
4. The jaw, or any jaw implant;
5. The meeting of upper and lower teeth; or
6. The chewing muscles.

These are dental services or supplies even if they are needed because of symptoms, sickness, or injury which affect some other part of the body. Dental services or supplies also include any other services or supplies performed or provided in connection with any examination or treatment of the teeth, gums, jaw, or chewing muscles, because of pain, injury, decay, malformation, disease, or infection;

Educational or Vocational Testing. Services for educational or vocational testing or training, self-help programs, or stress management, except as otherwise specified in this Plan;

Employment or Travel Related. For employment, camp, school, flight, or insurance physicals or immunizations required for international travel or employment unless otherwise authorized by the Plan Administrator;

Error. That are required to treat injuries that are sustained or an illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense;

Excess. That are not payable under the Plan due to application of the Maximum Allowable Amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator's determination as set forth by and within the terms of this document;

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

Experimental. Care and treatment that is Experimental or Investigational or is a Clinical Trial not otherwise covered under this Plan;

Eye care. For radial keratotomy or other eye surgery to correct refractive disorders. In addition, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting are not covered. The exclusion applies without regard to whether or not the Covered Person is suspect or has a family history of glaucoma or cataracts. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages. This exclusion shall not apply to an eye examination if the Covered Person is diagnosed with glaucoma nor to the initial purchase of eyeglasses or contact lenses following cataract surgery;

Family Member. That are performed by a person who is related to the Covered Person as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of "blood" or "in law"; except that if the family member is a Provider rendering services in the normal course of such Provider's business, the exclusion shall not apply;

Foot Care. For treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease);

Foreign Travel. For care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining elective medical services unless otherwise authorized by the Plan Administrator;

Government. Care for services, supplies, and treatment that the Covered Person obtains but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws and regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person 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 Medicare and Medicaid;

Growth Hormones. For provision of human or synthetic growth hormones, except that growth hormones required due to the removal of the pituitary gland will be covered;

Hypnotism. For hypnotism; holistic medicine; marriage counseling; any goal oriented therapy; or services by a counselor or therapist, except as required for the Affordable Care Act (ACA);

Illegal Acts. For any Injury or Sickness resulting from, or in consequence of, 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. To a Covered Person for Injury or Sickness resulting from, or in consequence of, that Covered Person'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 Covered Persons 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 documented medical condition (including both physical and mental health conditions;

Impotence. For care, treatment, services, supplies or medication in connection with treatment for impotence or sexual dysfunction;

Incomplete Billings. For charges contained in statements that are incomplete. The documentation submitted by a Covered Person must include itemized statements identifying the patient, date of treatment, diagnosis and type of service provided, and charge for each service. Examples of unacceptable statements are photocopies, cash register receipts, canceled checks and similar documents;

Incurred by Other Persons. For expenses actually Incurred by a person who is not the Covered Person;

Infertility. For infertility, including but not limited to, artificial insemination or in vitro fertilization;

Marital or Pre-marital Counseling. For marital or pre-marital counseling, except as required for the Affordable Care Act (ACA);

Massage Therapy. For care, services and supplies in connection with massage therapy;

Medical Necessity. For care and treatment that is not Medically Necessary and/or arises from services and/or supplies that are not Medically Necessary as defined by this Plan;

Midwife. For care, treatment, services and supplies rendered by a midwife;

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

No Charge. For which there would not have been a charge if no coverage had been in force;

No Legal Obligation. That are provided to a Covered Person for which the Provider of a service customarily makes no direct charge, or for which the Covered Person is not legally obligated to pay, or for which no charges would be made in the absence of this coverage, including but not limited to fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or this Plan, ***may be liable*** for necessitating the fees, care, supplies, or services;

No Physician Recommendation. Not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person 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-Compliance. In connection with treatments or medications where the patient either is in non-compliance with or is discharged from a Hospital or Skilled Nursing Facility against medical advice;

Non-Covered Providers. Charges for services rendered at Cancer Treatment Centers of America (with the exception of the Canter Treatment Centers of American located in Tulsa, OK) and affiliated entities operating for it, or for drugs purchased at Walgreens, and any other provider excluded by the Trustees from the Plan.

Non-Emergency Hospital Admissions. 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;

Non-Generally Accepted Procedures. For services, supplies or treatments not recognized by organized medicine as generally accepted and Medically Necessary for the diagnosis and/or treatment of an active Sickness or Injury; or charges for procedures, surgical or otherwise, which are specifically listed by organized medicine as having no medical value;

Non-Medical Care. Incurred in connection with Custodial Care, education or training, except as required for the Affordable Care Act (ACA);

Non-Medical Charges. For copy fees or similar charges that are not directly related to the treatment of a Sickness or Injury; provided, if medical records are provided to the Plan Administrator at the request of the Plan Administrator, the fees charged for such copies will be reimbursed at an amount which the Plan Administrator deems reasonable;

Not Acceptable. For care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of Physician or Provider. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness;

Not Actually Rendered. Charges for care, treatment, supplies, or services that are billed different than the services actually rendered or for services that were not rendered;

Not Specifically Covered. Non-traditional medical services, treatment, and supplies which are not specific as covered under this Plan;

Nursing Services. For professional nursing services if rendered by a provider other than a Registered Nurse or Licensed Practical Nurse, unless such care was vital as a safeguard of the Covered Person's life and such care is specifically listed as a Covered Charge elsewhere in the Plan;

Nutritional Supplements/Immunizations. Incurred for nutritional supplements which are not necessary for the treatment of a Sickness or Injury and immunizations not otherwise specifically provided in the Preventive Care Benefits;

Obesity. For 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. One bariatric surgery which is Medically Necessary for Morbid Obesity will be covered subject to the limitation in the Schedule of Benefits. Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person, except as required for the Affordable Care Act (ACA);

Personal Comfort Items. For personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, exercise classes and equipment, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, first-aid supplies, non-hospital adjustable beds, swimming pools, jacuzzi pumps, saunas, hot tubs, lift chairs, motorized equipment, adaptive equipment for cars and items not used exclusively by the Covered Person;

Pregnancy of Dependent. For Pregnancy and Complications of Pregnancy for a Dependent who is not the spouse, other than those preventative services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force;

Prior to Coverage. That are rendered or received prior to or after any period of coverage hereunder;

Prohibited by Law. To the extent that payment under this Plan is prohibited by law;

Provider Error. Required as a result of unreasonable provider error;

Recreational Therapy. For Recreational Therapy unless the services are an integral part of a treatment for Inpatient substance abuse;

Routine Care. For routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits;

Self-inflicted. That are the result of intentionally self-inflicted Injuries or Illnesses. 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);

Sleep Disorders. For sleep disorders unless deemed Medically Necessary;

Smoking Cessation. For smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma, except as required for the Affordable Care Act (ACA);

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

Surgical Sterilization Reversal. For reversal of surgical sterilization;

Syringes. For syringes, alcohol swabs and lancets; provided, that charges for syringes shall be Covered Charges only if required for the treatment of diabetes and if they are obtained through the pharmacy benefit program;

Temporomandibular Joint Syndrome. For all diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome, unless services are rendered at a Kempton Premier Provider;

Third Party Liability. Payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(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.

Travel or Accommodations. For travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a Covered Charge, unless approved by the Plan Administrator or associated with care rendered at a Kempton Premier Provider and are part of the applicable case rate;

Vision Therapy. For orthometric vision therapy and orthoptics;

Vitamins. For vitamins; except when deemed Medically Necessary for the treatment of an Illness or Sickness;

War. Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression, when the Covered Person is a member of the armed forces of any Country, or during service by a Covered Person in the armed forces of any Country. This exclusion does not apply to any Covered Person who is not a member of the armed forces; and

Work Related or Self Employment. Of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment. Charges arising out of injuries occurring while in the course of any occupation for wage or profit, or for which the Covered Person is entitled to benefits under any worker's compensation, occupational disease law, or any such similar law whether or not the Covered Person has acquired such coverage. Covered Persons who rely on this Plan for medical benefits should ensure proper coverage is available to cover any charges for injuries Incurred while in the course of self-employment. The only exception to this provision shall be Covered Persons whose primary self-employment is ranching and/or farming on his/her own land.

If you are covered as a Dependent under this Plan and you are self-employed or employed by an employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all.

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 an act of domestic violence or a medical condition.

ARTICLE VIII
PLAN ADMINISTRATION

Advantage Health Plans Trust is a multiple employer welfare arrangement. Its success is based on the participation of many employers. To assure proper day to day administration of Advantage Health Plans Trust, the Plan designates responsibilities for administration of Advantage Health Plans Trust among the Participating Employers, the Trustees, and the Plan Administrator.

8.01 Participating Employers

The Participating Employer is your employer which has adopted this Plan. The Participating Employer chooses classes of employees who are to be covered under this Plan.

8.02 Trustees

The Participating Employers have delegated to the Board of Trustees authority to administer the Plan and Trust. The Trustees have final authority and responsibility for the administration and interpretation of the Plan. For purposes of ERISA, the Board of Trustees is the Administrator" of the Plan and its "Named Fiduciary."

The Trustees may from time to time allocate or delegate to the Plan Administrator, any committee, subcommittee or member of the Trustees, or to any administrative service manager, such duties relative to the administration and interpretation of the Plan as it deems necessary or appropriate, including matters involving the exercise of discretion. The Trustees may remove, with or without cause, at any time, any person or entity to whom duties have been delegated.

To the maximum extent permitted by ERISA, every action and determination of the Trustees made in good faith in accordance with this Plan shall be final and binding upon each Covered Person and other person entitled to or claiming participation in the Plan or benefits from the Plan. No Trustees shall be entitled to act on or decide any matter relating solely to himself or any of his rights or benefits under the Plan.

Right to Amend or Terminate. The Trustees shall have the right at any time to amend or modify the Plan, retroactively or otherwise, or to terminate or partially terminate the Plan, to determine its policies, to appoint and remove service providers, adjust their compensation (if any) and exercise general administrative authority over the Plan.

Effect of Termination. Upon complete or partial termination of the Plan, the Plan Administrator shall, after the payment or provision for the payment of benefits to each Covered Person who has Incurred Covered Charges with respect to which benefits are payable on the date of termination and all expenses and charges properly payable hereunder, including all expenses Incurred and to be Incurred in the liquidation and distribution of the Trust Fund, direct the disposition of all remaining assets held in the Trust Fund to the cost of any successor Illness, Injury or health care program adopted by the Trustees for the benefit of participants of the Trust, subject to the limitations contained herein and any applicable requirement of law or regulation.

If the Plan is terminated, the rights of Covered Persons are limited to Covered Charges Incurred before termination. In the event of Plan termination, the remaining assets of the Plan shall be applied to pay Covered Charges Incurred before termination.

Termination of Participating Employer's Participation. Any Participating Employer may terminate its participation in the Plan by giving the Plan Administrator advance written notice in which the Participating Employer specifies a termination date at least 30 days prior to termination.

A Participating Employer's participation in the Trust may be rescinded for fraud or intentional misrepresentation. A rescission is a cancellation or discontinuance of coverage that has retroactive effect. A notice of the intent to rescind shall be provided at least 30 days in advance.

8.03 Plan Administrator

To ensure the day-to-day administrative matters are handled properly, the Trustees have delegated to The Kempton Company, the duties of the Plan Administrator. The Plan Administrator is required to administer the Plan in accordance its terms and the provisions of ERISA and any applicable state law. The Plan Administrator serves at the discretion of the Board of Trustees.

8.04 Trust Fund

The Trustees shall have responsibility for the administration of the Trust Fund and management of assets held under the Trust Fund as provided in the Trust. Payment of all benefits and other amounts which are related to the administration of the Plan shall be paid from the Trust Fund.

8.05 Excluded Providers

Whenever the Board of Trustees, determines that a provider routinely provides unconventional treatment options and/or has charges that are excessive and/or unwarranted, such that it would cause the Trust Fund to be used in a manner that is not in the best interests of all Covered Persons, the Trustees, may in their sole discretion, direct the Plan Administrator to exclude such provider from the Plan. Any services received by Covered Person at such provider shall be non-covered services under the Plan. However, in no event may a provider be excluded if Covered Persons would be left without access to any providers that treat the Illness or Injury generally treated by the excluded provider.

ARTICLE IX
CLAIM PROCEDURES; PAYMENT OF CLAIMS; APPEAL RIGHTS

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

9.01 Health Claims

All claims and questions regarding health claims should be directed to the Plan Administrator. Benefits under the Plan will be paid only if the Plan Administrator, in its sole discretion, determines that the Covered Person is entitled to them.

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

A Covered Person has the right to request a review of an "Adverse Benefit Determination."

An ***Adverse Benefit Determination*** means any of the following:

1. A denial in benefits;
2. A reduction in benefits;
3. A rescission of coverage; even if the rescission does not impact a current claim for benefits;
4. A termination of benefits;
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 Covered Person's eligibility to participate in the Plan;
6. A denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review; or
7. A failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate.

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.

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.

Benefits will be payable to a Covered Person, or to a Provider that has accepted an Assignment of Benefits as consideration in full for services rendered. **An Assignment of Benefits does not authorize the Provider to avail itself of the claims appeals process**.

A claim submitted to the Plan for reimbursement must include:

1. Group Name;
2. Employee's name and ID number;
3. Name of patient and date of birth;
4. Name, address, telephone number, and tax identification number of the provider of services or supplies;
5. Diagnosis;

6. Type of services rendered, with diagnosis and/or procedure codes;
7. Date of services; and
8. Charges.

Claims that are not submitted electronically should be mailed to the mailing address listed on the Covered Person's I.D. Card.

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

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

1. Pre-service Claims. A "pre-service claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
   a. A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
   b. If the Plan does not require the Covered Person to obtain approval of any urgent care or Emergency Services or admissions prior to getting treatment for an urgent care or Emergency situation, there is no pre-service claim. The Covered Person simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and either:
   a. The Plan Administrator determines that the course of treatment should be reduced or terminated; or
   b. The Covered Person requests extension of the course of treatment beyond that which the Plan Administrator has approved.

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

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

9.01A When Claims Must Be Filed

Post-service Claims must be filed with the Plan Administrator as soon as it is reasonably feasible, but in no event later than 12 months following the date charges for the service were Incurred if there is a reasonable basis for the delayed filing. **Claims filed later than that date shall be denied.** Benefits are based upon the Plan's provisions at the time the charges were Incurred.

9.01B Timing of Claim Decisions

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any Adverse Benefit Determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions

that a claim is payable in full) within the following timeframes:

1. Pre-service Urgent Care Claims:
   a. If the Covered Person 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 Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 24 hours after receipt of the claim.
   c. The Covered Person will be notified of a determination of benefits as soon as possible, but not later than 48 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 Covered Person 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 Covered Person. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the Covered Person by telephone, facsimile, or other similarly expeditious method. Alternatively, the Covered Person may request an expedited review to the Board of Trustees, or if applicable, under the external review process.

2. Pre-service Non-urgent Care Claims:
   a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

3. Concurrent Claims:
   a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments, the Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated. 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 Covered Person Involving Urgent Care. If the Plan Administrator receives a request from a Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care, as soon as possible, taking into account the medical exigencies, but not later than 24 hours after receipt of the claim, as long as the Covered Person makes the request at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. If the Covered Person 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 Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving urgent care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a pre-service non-urgent claim or a post-service claim).

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

Notification to Covered Person	30 days
Notification of Adverse Benefit Determination on appeal	30 days

4. Post-service Claims:
   a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
   b. If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.

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.

9.01C Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically (or, in the case of Pre-service Urgent Care Claims, by telephone, facsimile or similar method, with written or electronic notice), containing the following information:

1. Information sufficient to allow the Covered Person 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 provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the claim;
4. A description of any additional information necessary for the Covered Person 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 information on how to initiate the appeal and a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an Adverse Benefit Determination on final review;
6. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
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 Covered Person, free of charge, upon request). 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 Covered Person, 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 Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request;
10. In a claim involving urgent care, a description of the Plan's expedited review process.

9.02 Full and Fair Review of Appeals of Adverse Benefit Determination

A Covered Person may appeal an Adverse Benefit Determination as follows:

- The Plan offers a one-level internal review process for Pre-Service Claims for Urgent Care;

- The Plan offers a two-level internal review procedure for a Pre-Service Claim (non-Urgent Care), Concurrent Care Claim, and Post Service Claim.

The Plan Administrator will provide for a review that does not give deference to the previous benefit determination and that is conducted by someone other than the person or persons involved in the original benefit determination. In addition, the Plan Administrator may:

- Take into account all comments, documents, records and other information submitted by the Claimant related to the claim, without regard as to whether this information was submitted or considered in a prior level of review.
- Provide to the Claimant, free of charge, any new or additional information or rationale considered, relied upon or created by the Plan in connection with the Claim. This information or new rationale will be provided sufficiently in advance of the response deadline for the final notice of the determination so that the Claimant has a reasonable amount of time to respond.
- Consult with an independent health care professional who has the appropriate training and experience in the applicable field of medicine related to the Claimant's benefit determination if that determination was based in whole or in part on medical judgment, including determinations on whether a treatment, drug, or other item is Experimental and/or Investigational, or not Medically Necessary. A health care professional is "independent" to the extent the health care professional was not consulted on a prior level of review or is a subordinate of a health care professional who was consulted on a prior level of review. The Plan may consult with vocational or other experts regarding the Initial Benefit Determination.

9.02A Internal Appeal Procedure

First Level of Internal Review. To appeal a denial of a Claim, the Claimant must submit in writing, a request for a review of the Claim. The Claimant should include in the appeal letter: his or her name, ID number, group health plan name, and a statement of why the Claimant disagrees with the denial. The Claimant may include any additional supporting information, even if not initially submitted with the Claim.

The written request for review must be submitted within 180 days of the Claimant's receipt of an Adverse Benefit Determination.

The written request for review should be addressed to:

The Kempton Company
Plan Administrator--Appeals
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114
(405) 521-1711 or (800) 521-1711
Fax (405) 521-9804

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the initial denial within the prescribed time period will render that determination final. The Claimant cannot proceed to the next level of internal or external review if the Claimant fails to submit a timely appeal.

The First Level of Internal Review will be performed by the Plan Administrator. The Plan Administrator will review the information initially received and any additional information provided by the Claimant, and determine if the Initial Benefit Determination was appropriate based upon the terms and conditions of the Plan and other relevant information. The Plan Administrator will send a written or electronic Notice of Determination on First Level of Internal Review to the Claimant within:

- 72 hours of the receipt of the appeal for an Urgent Care Claim;
- 15 days of the receipt of the appeal for a Pre-Service Claim or a Concurrent Care Claim; or
- 30 days of the receipt of the appeal for a Post Service Claim.

Second Level of Internal Review. If the Claimant does not agree with the Plan Administrator's Notice of Determination on First Level of Internal Review, the Claimant may submit a second level appeal in writing. The

Claimant may request a second level appeal on Pre-service Claims (non-Urgent Care) and Post-Service only along with any additional supporting information. The written request for review of the First Level of Internal Review must be submitted within 60 days of the Claimant's receipt of the first level of internal review.

The written request for review should be addressed to:

The Kempton Company
Plan Administrator—Appeals
c/o Board of Trustees
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114
(405) 521-1711 or (800) 521-1711
Fax (405) 521-9804

An appeal will not be deemed submitted until it is received by the Plan Administrator. Failure to appeal the determination from the first level of review within the prescribed time period will render that determination final. The Claimant cannot proceed to an external review or file suit if the Claimant fails to submit a timely appeal.

The Second Level of Internal Review will be done by the Board of Trustees, or its designee. The Board of Trustees, or its designee will review the information initially received and any additional information provided by the Claimant, and make a determination on the appeal based upon the terms and conditions of the Plan and other relevant information. The Board of Trustees, or its designee will send a written or electronic Notice of Determination on Second Level of Internal Review to the Claimant within:

- 15 days of the Plan's receipt of Claimant's second level appeal on a Pre-Service Claim (non-Urgent Care);
- 15 days of the Plan's receipt of Claimant's second level appeal on a Concurrent Care Determination;
- 30 days of the Plan's receipt of Claimant's second level appeal on a Post-Service Claim.

If the Claimant is not satisfied with the outcome of the Notice of Determination on Second Level of Internal Review (also known as the *Final Internal Adverse Benefit Determination)*, the Claimant may be eligible for an External Review. The Claimant must exhaust both levels of the Internal Review Procedure before requesting an External Review. In certain circumstances, the Claimant may also request an expedited External Review.

Both the First Level of Internal Review Decision and Second Level of Internal Review Decision will contain the following:

1. Information sufficient to allow the Covered Person 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. Reference to the specific portion(s) of the plan provisions on which the denial is based;
4. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
7. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
8. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon

in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;

9. If the Adverse Benefit Determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request. If this is not practical, a statement will be included that such explanation will be provided to the Covered Person, free of charge, upon request;
10. A description of the Plan's review procedures and the time limits applicable to the procedures. This description includes information on how to initiate the appeal and a statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following an Adverse Benefit Determination on final review; and
11. 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."

9.02B External Review Procedure

The External Review Procedure applies only to:

1. Determination by the Plan that involves medical judgment, including, but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental and/or Investigational;
2. A rescission of coverage, whether or not the rescission has any effect on any particular benefit at that time; and
3. An Adverse Benefit Determination that involves whether the Plan complies with the No Surprises Act, as applicable.

Request for External Review. The Plan will allow a Covered Person to file a request for an External Review with the Plan if the request is filed within four (4) months after the date of receipt of a Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

1. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   a. The Covered Person is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   b. The Final Adverse Benefit Determination does not relate to the Covered Person's failure to meet the requirements for eligibility under the terms of the Plan;
   c. The Covered Person has exhausted the Plan's internal appeal process unless the Claimant is not required to exhaust the internal appeals process under applicable law; and
   d. The Covered Person has provided all the information and forms required to process an External Review.

   Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the Covered Person. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number (866) 444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a Claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.
2. Referral to Independent Review Organization. The Plan will assign an Independent Review Organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting

organization to conduct the External Review. The Plan Administrator will contract with at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection).

3. Reversal of Plan's decision. Upon receipt of a Notice of a Final External Review Decision reversing the Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim.

Request for Expedited External Review. The Plan will allow a Covered Person to make a request for an Expedited External Review with the Plan at the time the Covered Person receives:

a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the Covered Person for which the timeframe for completion of an Internal Appeal would seriously jeopardize the life or health of the Covered Person or would jeopardize the Covered Person's ability to regain maximum function and the Covered Person has filed a request for an expedited internal appeal; or
b. A Final Internal Adverse Benefit Determination, if the Covered Person has a medical condition where the timeframe for completion of a standard External Review 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 been discharged from a facility.

1. Preliminary review. Immediately upon receipt of the request for Expedited External Review, the Plan Administrator will determine whether the request meets the reviewability requirements for standard External Review.

2. Referral to Independent Review Organization. Upon a determination that a request is eligible for External Review following the preliminary review, the Plan Administrator will assign an IRO. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO.

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

3. Notice of Final External Review Decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO to provide Notice of the Final External Review Decision, no more than 72 hours after the IRO receives the request for an Expedited External Review.

Note: All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year of the date the Claim.

9.03 Appointment of Authorized Representative

A Covered Person is permitted to appoint an Authorized Representative to act on his or her behalf with respect to a benefit claim or appeal of a denial. An Assignment of Benefits by a Covered Person to a Provider will not constitute appointment of that Provider as an Authorized Representative. To appoint such a representative, the Covered Person must complete a form which can be obtained from the Plan Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's Authorized Representative without completion of this form. In the event a Covered Person designates an Authorized Representative, all future communications from the Plan will be with the Authorized Representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

9.04 Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan.

This right may be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

9.05 Autopsy

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

9.06 Payment of Benefits

All benefits under this Plan are payable, in U.S. Dollars, to the Covered Person whose Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a Covered Person and in the absence of written evidence to this Plan of the qualification of a guardian for his or her estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Covered Person.

9.07 Assignment of Benefits

When a Covered Person receives Covered Services from a provider, this Plan may pay the provider subject to a valid Assignment of Benefits only. A Covered Person's right to receive payment hereunder is personal to that Covered Person and may not be assigned or be subject to anticipation, garnishment, attachment, execution, or levy of any kind, or be liable for the debts or obligations of a Covered Person, except for assignment of the right to receive benefits to a provider under a valid Assignment of Benefits.

The term "Assignment of Benefits" shall mean an arrangement whereby the Covered Person assigns their right to seek and receive payment from the Plan for eligible Covered Services to a provider, in strict accordance with the conditions and limitations of such rights provided under the terms of this Plan Document.

<u>Conditions and Limitations of an Assignment of Benefits:</u>

- The validity of an Assignment of Benefits by a Covered Person to a provider is limited by the terms of this Plan Document. An Assignment of Benefits is considered valid on the condition that the provider accepts the payment received from the Plan as consideration, in full, for Covered Charges. This amount does not include any cost sharing amounts (i.e. Copayments, Deductibles, or Coinsurance), or charges for non-covered services; the Provider may bill the Covered Person directly for these amounts. .
- An Assignment of Benefits does not allow a provider to avail itself to the claims procedure on behalf of a Covered Person. The Covered Person does not, under any circumstances, have the right to assign to any Provider (or their representative) through an Assignment of Benefits any right to initiate any cause of action against the Plan that the Covered Person themself may be afforded under applicable law. This includes, but is not limited to, any right to bring suit as such is afforded to Covered Person under ERISA section 502(a). The assignment of any right to initiate suit against the Plan to a provider. is strictly prohibited.
- An Assignment of Benefits does not grant the Provider any rights other than those specifically set forth herein.
- The Plan Administrator may disregard an Assignment of Benefits at its discretion and continue to treat the Covered Person as the sole recipient of the benefits available under the terms of the Plan.
- An Assignment of Benefits by a Covered Person to a provider will not constitute the appointment of an Authorized Representative.

By submitting a claim to the Plan and accepting payment by the Plan, the provider is expressly agreeing to the foregoing conditions and limitations of an Assignment of Benefits in addition to the terms of the Plan Document. The provider further agrees that the payments received constitute an "accord and satisfaction" and consideration, in full, for the Covered Charges rendered. The provider agrees that the conditions and limitations of an Assignment of Benefits as set forth herein shall supersede any previous terms and/or agreements. The provider agrees to the specific condition that the Covered Person cannot be balance billed for any amount beyond applicable cost sharing amounts (i.e. Copayments, Deductibles, or Coinsurance), or charges for non-covered services. If a provider refuses to accept an Assignment of Benefits under the conditions and limitations as set

forth herein, any benefits payable under the terms of the Plan Document will be payable directly to the Covered Person, and the Plan will be deemed to have fulfilled its obligations with respect to such Covered Charges.

9.08 Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a Provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") may be payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions. However, the benefits may not be assigned under the Assignment of Benefits rights set forth in this Plan. Payment will be determined in the Plan Administrator's sole discretion, taking into account exchange rates, all applicable licensing requirements, and any other factors the Plan Administrator deems appropriate.

9.09 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. In this case, the Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Covered Person or Dependent on whose behalf such payment was made.

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

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

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

1. In error;

2. Pursuant to a misstatement contained in a claim for benefits or fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery if a Covered Person fails to comply with the Plan's Third Party Recovery, Subrogation and Reimbursement provisions; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

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

If the Plan Administrator 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 Covered Person, abstain from billing the Covered Person for any outstanding amount(s).

9.10 Limitation of Action

A Covered Person cannot bring any legal action against the Plan, the Trustees, or the Plan Administrator for any reason unless the Covered Person first completes all the steps in the appeal process described in this section. After completing that process, if the Covered Person wants to bring a legal action against the Plan, the Trustees or the Plan Administrator, the Covered Person must do so within one (1) year of the date the Covered Person is notified of the final internal or external appeal, whichever is applicable, or the Covered Person will lose any rights to bring such an action against the Plan, the Trustees, or the Plan Administrator.

Any action required by a Covered Person who is a minor or is incompetent to bring suit, must be brought by the Legal Guardian or other properly authorized person within the time period indicated above.

ARTICLE X
COORDINATION OF BENEFITS

DEFINED TERMS

Allowable Expense(s) means the Maximum Allowable Amount for any Medically Necessary, eligible item of expense, at least a portion of which is covered under this Plan. When some other plan pays first in accordance with the Application to Benefit Determinations provision in this 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 (rather than cash payments), the Plan Administrator shall assess the value of said benefit(s) and determine the reasonable cash value of the service or services rendered, by determining the amount that would be payable in accordance with the terms of the Plan. Benefits payable under any other plan include the benefits that would have been payable had the claim been duly made therefore, whether or not it is actually made.

Other plan includes, 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 Covered Person.
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.
8. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Coordination of the Benefit Plans. Coordination of benefits sets out rules for the order of payment of Covered Expenses when two or more plans, including Medicare, are paying. When a Covered Person is covered by this Plan and another plan, the plans will coordinate benefits when a claim is received.

Standard Coordination of Benefits. The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable charges.

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

10.01 Excess Insurance

If at the time of Injury, Sickness or Disease, there is available, or potentially available any other 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. Worker's compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

10.02 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.

10.03 Effect on Benefits

10.03A 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 one hundred percent (100%) of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than fifty (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.

10.03B 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; 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.

10.04 Right to Receive and Release Necessary Information

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

10.05 Facility of Payment

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

10.06 Right of Recovery

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

10.07 Medicare Secondary Payer Act

The Plan will act as primary payer regardless of whether the Employer applies for and qualifies for the Medicare Secondary Payer Act Small Employer Exception.

10.08 Medicaid Coverage

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

10.09 Applicable to Active Employees and Their Spouses Ages Sixty-Five (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 benefit 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.

10.10 Applicable to Medicare Services Furnished to End Stage Renal Disease ("ESRD") Covered Persons who Are Covered Under This Plan

If any Covered Person is eligible for Medicare benefits because of ESRD, the benefits of the Plan will be determined before Medicare benefits for the first 30 months of Medicare entitlement, 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 XI
THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

11.01 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 Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(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. Covered Person(s), his or her attorney, and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts;
3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money; and
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 Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

11.02 Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan and the Trust the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to pursue said rights and/or action;
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan and Trust to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of release, or receipt of applicable funds;
3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan;
4. If the Covered Person(s) fails to file a claim or pursue damages against:
    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' compensation or other liability insurance company; or
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan and Trust or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

11.03 Right of Reimbursement

1. The Plan shall be entitled to recover one hundred percent (100%) of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved;
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan;
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights;
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s); and
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.

11.04 Covered Person is a Trustee Over Plan Assets

Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or Accident. By virtue of this status, the Covered Person understands that he or she is required to:

1. Notify the Plan or its Authorized Representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds.
2. Instruct his or her attorney to ensure that the Plan and/or its Authorized Representative is included as a payee on all settlement drafts.
3. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its Authorized Representative as a payee on the settlement draft.
4. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys'

fees, for which he or she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

11.05 Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Persons obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

11.06 Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

11.07 Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

11.08 Obligations

1. It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
    a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
    b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;
    c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
    d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement;
    e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
    f. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage;
    g. To instruct his or her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
    h. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
    i. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.
2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the

Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s); and

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

11.09 Offset

If timely repayment is not made, or the Covered Person and/or his or 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 Covered Person'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 Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

11.10 Reimbursement Due to Surrogacy Arrangement

If a Covered Person enters into a Surrogacy Arrangement, the Covered Person must reimburse the Plan for Covered Expenses received related to conception, Pregnancy, delivery, or postpartum care in connection with that Surrogacy Arrangement. The reimbursed amount shall not exceed the payments or other compensation the Covered Person or another person is entitled to receive under the Surrogacy Arrangement.

A "Surrogacy Arrangement" is one in which a Covered Person agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the Covered Person receives payment for being a surrogate.

A Surrogacy Arrangement does not affect a Covered Person's obligation to pay any and all patient responsibility amounts for these services. These amounts will be taken into account at the time of reimbursement.

After a Covered Person surrenders a baby to the legal parents, the Plan is not obligated to pay for any services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

As set forth above, as a condition precedent to the Covered Person receiving benefits under the Plan, the Covered Person automatically assigns to the Plan any right to receive payments that are payable to the Covered Person or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure the Plan's rights, the Plan will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy the Plan's lien.

Within 30 days after entering into a Surrogacy Arrangement, the Covered Person must send written notice of the arrangement to the Plan, including all of the following information:

1. Names, addresses and telephone numbers of all parties to the arrangement;
2. Names, addresses and telephone numbers of any escrow or trustee;
3. Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for the services of baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover the services that the baby (or babies) receive;
4. A signed copy of any contracts and other documents explaining the details of the Surrogacy Arrangement; and
5. Any other information the Plan requests in order to satisfy its rights.

Information must be sent to:

Plan Administrator
The Kempton Company
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114

The Covered Person must complete and send the Plan all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for the Plan to determine the existence of any rights the Plan may have under this Surrogacy Arrangement and to satisfy those rights. The Covered Person may not agree to waive, release, or reduce the Plan's rights without the Plan's prior, written consent.

If a Covered Person's estate, parent, guardian, or conservator asserts a claim against a third party based on the Surrogacy Arrangement, the estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to the Plan's liens and other rights to the same extent as if the Covered Person had asserted the claim against the third party. The Plan may assign its rights to enforce its liens and/or other rights.

11.11 Minor Status

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

11.12 Language Interpretation

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

11.13 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.

11.14 Rights of Trustees and Plan Administrator

1. The Plan Administrator has a right to request reports of any settlement. The Trustees shall have sole discretion to approve or reject a settlement to the Trust; and
2. If a Covered Person fails to comply with the provisions of this Section, the Covered Person will be responsible for any and all expenses incurred by the Plan or associated with the Plan's attempt to recover the amounts conditionally advanced. The Plan Administrator may in its sole discretion, withhold payments that would otherwise be available to the Covered Person under this Plan until the Plan and Trust has received one hundred percent (100%) reimbursements of the amounts due to it under this Subrogation provision.

ARTICLE XII
MISCELLANEOUS PROVISIONS

12.01 Applicable Law
This is a self-funded benefit plan subject to the provisions of the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), and any applicable state law(s). The Plan is funded solely with Employee and/or Participating Employer contributions. When applicable, federal law and jurisdiction preempt state law and jurisdiction.

12.02 Clerical Error/Delay
Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the Effective Dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

12.03 Conformity with Applicable Laws
This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

12.04 Headings
The headings used in this Plan Document are used for convenience of reference only.

12.05 No Waiver or Estoppel
No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

12.06 Uncashed Checks
If a check issued to or on behalf of a Covered Person remains uncashed after three (3) years from the date the check was issued, the Plan Administrator shall direct that such uncashed check be forfeited and canceled. Failure to cash a check within the time provided above shall be deemed a waiver by the named payee of its right to the amount of the check.

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

12.08 Protection Against Creditors
No benefit payment under this Plan shall be subject in any way to alienation, sale, transfer, pledge, attachment, garnishment, execution or encumbrance of any kind, and any attempt to accomplish the same shall be void. However, at the discretion of the Plan Administrator, benefit payments may be assigned to health care Providers.

ARTICLE XIII
CARE MANAGEMENT SERVICES

13.01 Care Management Services

Please understand that YOU ARE AN OWNER OF THIS PLAN. Advantage Health Plans Trust is a self-funded group health plan funded by contributions from Covered Persons (that is you!) and Participating Employers. When you save money for the Plan, you save yourself money too! Therefore, it is important for you to be a conscientious consumer. The Plan has a number of programs available to Covered Persons to help save money.

13.02 Kempton Premier Providers (KPP)

A Kempton Premier Provider is a provider that has contracted with the Plan to offer transparent, direct, and often bundled pricing. When a Covered Person seeks Covered Services from a Kempton Premier Provider, the Plan pays 100% of the Maximum Allowable Amount. There is no Deductible or Copayment paid by the Covered Person. Any services not covered by the Plan will not be covered even if rendered by a Kempton Premier Provider. This benefit is subject to all other applicable exclusions, limitations, and restricted listed in the Plan.

To find a list of Kempton Premier Provider, please visit www.advantagehealthplans.com or contact a Kempton Care Advocate at (405) 608-5103 or toll free at 1-866-898-7219. This list is subject to change at any time. Therefore, Covered Persons must check the website or call for the most current list of Kempton Premier Providers.

Upon calling a Kempton Care Advocate, he or she will assist you in making arrangements to see a Kempton Premier Provider. Most often, you will be provided a Voucher which allows you to obtain services from the Kempton Premier Provider. The Plan Administrator may, in its sole discretion, approve a reimbursement for reasonable travel and/or accommodation costs incurred when seeking services from a Kempton Premier Provider.

A Covered Person is not *required* to use a Kempton Premier Provider. A Covered Person and his or her medical professional is ultimately responsible for determining the appropriate course of medical treatment. Neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any provider, including a Kempton Premier Provider.

The Plan Administrator wants to encourage Covered Persons to be better consumers of health care. Therefore, if a Covered Person is seeking treatment from a provider who is not a Kempton Premier Provider, but who will provide the Covered Person with a cash price or a price that is competitive with the price charged by a Kempton Premier Provider for similar services, the Plan Administrator may, in its sole discretion, approve the payment under the same terms that would have applied had the provider been a Kempton Premier Provider. Such payments will be subject to the Plan co-pays for office visits, exclusions, limitations or other restrictions listed in the Plan. In no event may the Plan Administrator reimburse costs under this paragraph that are in excess of the lower of the actual charges, Reasonable and Customary Charges, or the amount charged by a Premier Provider for the same service. You are required to submit the proper documentation for a claim to be paid or to be reimbursed.

13.03 In-Network Providers - None

This Plan does not have a Preferred Provider Organization. All benefits are paid to Providers under Section 13.05. This allows you to use the consumer driven options which will generate the best benefit to you.
Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, 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. Neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Provider

13.04 How Charges are Determined

This Plan has no network. Before getting any Covered Services, tell the Provider you have a Non-Network Plan so that you may try to negotiate the payment from the Plan as payment in full so the Provider. Payment in full means the Provider will not balance bill you**.**

The Maximum Allowable Amount, using the Medicare Approved Amount plus a percentage, is as follows:

- Physicians and other Providers will be limited to 130% of their current Medicare Approved Amount.
- Facilities and Hospitals will be limited to 160% of their current Medicare Approved Amount.
- Laboratory Services will be limited to 100% of their current Medicare Approved Amount.
- Anesthesia performed by an anesthesiologist will be limited to 250% and CRNA will be limited to 200% of their current Medicare Approved Amount.
- Emergency Room services will be limited to 200% of their current Medicare Approved Amount.
- Ambulance services will be limited to 120% for air ambulance and ground ambulance will be limited to 200% of their current Medicare Approved Amount.

If a Covered Services does not have a Medicare Approved Amount, the Maximum Allowable Amount will be determined using the Usual and Customary amount as described in this Plan.

While some Providers will accept the Maximum Allowable Amount as payment in full for services rendered, some may not. If a Provider does not accept the Maximum Allowable Amount as payment in full from the Plan, the Provider may bill you for the difference between the billed charges and the Maximum Allowable Amount as determined by this Plan. ***This is called "balance billing***." A Covered Person is responsible for any amounts in excess of the Maximum Allowable Amount.

13.05 Voluntary Clinical Care Program

The Plan's Voluntary Clinical Care Program is a voluntary benefit offered by the Plan to Eligible Employees which allows direct access to primary care and preventative services through a list of approved Kempton Direct Access Providers. The purpose of the Voluntary Clinical Care Program is to allow easy access to most primary care services including but not limited to lab work, screening, annual physicals, health risk assessments, medication management, among other services.

Eligible Employees who choose to utilize the program will have access to all of the services offered by the Kempton Direct Access Providers and when utilizing a Kempton Direct Access Provider through the Program, it should be easier to schedule office visits with the providers for a majority of primary care and comprehensive care management services.

For a list of Kempton Direct Access Providers that are available through the Voluntary Clinical Care Program, please visit www.advantagehealthplans.com. By using these Kempton Direct Access Providers, you will save money and the Plan will save money. If you are not able to see the information online, please contact the Plan Administrator who will provide you the information you need.

The Voluntary Clinical Care Program is in addition to any other benefits covered and payable under the terms of the Plan, including any Preventative Services that may otherwise by payable at 100% pursuant to the Schedule of Benefits. If an Eligible Employee elects to participate in the Program, he or she retains access to all of the Plan's other benefits, provided they are otherwise eligible.

If an Eligible Employee elects to participate in the Program, he or she must initiate the Program by scheduling an appointment with a Kempton Direct Access Provider for an initial comprehensive visit, complete with a health risk assessment, valued at $840, within six months of entering the Program. To remain eligible for the Program, the Eligible Employee must schedule and attend at least one comprehensive visit within the first six months of each Plan year. For Eligible Employees being managed for a chronic condition, the Kempton Direct Access Provider may require and/or recommend more frequent visits. If an Eligible Employee does not utilize the Program as set forth herein, or as otherwise recommended by a Kempton Direct Access Provider, he or she will no longer be eligible to participate in the Program during the then current Plan year. If this were to occur, the

Eligible Employee would still be able to continue seeing the Kempton Direct Access Provider, the Plan simply would discontinue any future payments as set forth in the Summary of Medical Benefits to the Kempton Direct Access Provider as a result of the Program.

This benefit program is only available to Eligible Employees, as defined by this Plan. This benefit program is not available to Eligible Dependents.

13.06 Cost Management Services

Cost Management Services attempt to monitor and control the costs incurred by the Plan. Cost Management Services consists of:

- Pre-authorization;
- Utilization services;
- Second or Third Opinion Program;
- Pre-Admission Testing;
- Ambulatory Surgeries; and
- Case management for alternative treatments or for catastrophic conditions.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not authorized, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was authorized before incurring charges.

Payment for any of the expenses listed below is subject to all Plan exclusions, limitations and provisions, including, but not limited to, the Plan Administrator's determination that expenses are the Maximum Allowable Amount, are for services deemed to be Reasonable and Medically Necessary.

Failure to comply with Utilization Management will result in a higher cost to Covered Persons.

13.06A Pre-Authorization

Before a Covered Person seeks certain services on a non-emergency basis, he or she must seek Pre-Authorization. These non-emergency services which require Pre-Authorization include:

- Hospitalizations;
- Outpatient surgical procedures; and
- Sleep studies.

Requests for Pre-Authorization of these services must be made at least 48 in advance of services being rendered. In order to request Pre-Authorization, a Covered Person (or his or her family member, Authorized Representative, or Provider) must contact the medical management vendor at the telephone number on your ID card **at least 48 hours before** services are scheduled to be rendered with the following information:

1. The medical group number;
2. The member ID;
3. The name of the patient and relationship to the covered Employee;
4. The name and address of the covered Employee;
5. The name and telephone number of the attending Physician;
6. The name of the Medical Care Facility, proposed date of admission, and proposed length of stay;
7. The diagnosis and/or type of surgery; and
8. The proposed medical services.

Failure to Pre-Authorize these services will result in a denied claim.

This Plan does not require Pre-Authorization for outpatient surgical procedures or sleep studies when services take place at a Kempton Premier Provider.

If there is an **Emergency** admission, the Covered Person (or his or her family member, Authorized Representative, or Provider) must contact the utilization review administrator **within 48 hours** after the first business day following admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment**. If the Covered Person does not receive authorization as explained in this section, the benefit payment is not covered**. If you request a retrospective review of the claim and the services are allowed after such review, the reimbursement rate will be subject to the applicable Coinsurance.

Pursuant to applicable law, the Plan does not require Pre-Authorization of a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery, it is important to have your Physician call to obtain Pre-Authorization in case there is a need to have a longer stay.

A denied claim due to failure to follow cost management procedures will not accrue toward the Maximum Out-of-Pocket Amount.

13.06B Utilization Review

Concurrent review. Review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

Discharge Planning. If the attending Physician feels that it is Medically Necessary for a Covered Person to received additional services or to stay in a medical facility for a greater length of stay than has been Pre-Authorized, the attending physician msut request additional services or days of hospitalization;

13.06C Second and/or Third Opinion Program

Certain treatments and/or procedures are performed either inappropriately or unnecessarily. The Plan offers, and in some cases will require, Covered Persons to seek a second opinion (or third, if necessary) related to certain diagnoses and/or recommended treatments. The Plan Administrator has sole discretion to determine which treatments and/or procedures are eligible for the Second and/or Third Opinion Program.

13.06D Pre-Admission Testing Service

If a Covered Person is scheduled to be admitted for hospitalization on a non-emergent basis, one set of laboratory tests and x-ray examinations performed on an outpatient basis within seven (7) days prior to such Hospital admission will be paid, with no Deductible, at 100% of the Maximum Allowable Amount, provided that the following conditions are met:

1. The tests are related to the performance of the scheduled surgery or treatment that is a Covered Service under this Plan;
2. The tests have been ordered by a Physician after an Injury or Sickness requiring surgery or treatment has been diagnosed and Hospital admission has been requested by a Physician and confirmed by the facility;
3. The Covered Person is subsequently admitted to the Hospital, or admission is cancelled or postponed because a Hospital bed is unavailable, or if, after the tests are reviewed, the Physician determines that admission is unnecessary.

13.06E Case Management

Case Management is generally required when there is a catastrophic event that requires either long term services or very specialized services to treat an Illness or Sickness. The case manager will coordinate and implement a

Case Management program for the treatment plan by working in conjunction with the attending physician, the patient or the patient's family to provide the most appropriate treatment plan.

The Plan Administrator may elect, in its sole discretion, when acting on a basis that precludes individual selection, to provide alternative benefits that are otherwise excluded under the Plan. The alternative benefits, called "Case Management," are determined on a case-by-case basis. Participation in Case Management is mandatory. Case Management may be required when there are alternative treatments that may be used to treat an Illness or Sickness that may not be covered but would result in a more efficient utilization of the Plan.

A case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

1. Personal support to the patient;
2. Contacting the family to offer assistance and support;
3. Monitoring Hospital or Skilled Nursing Facility;
4. Determining alternative care options; and
5. Assisting in obtaining any necessary equipment and services.

Case Management occurs when treatment or alternate benefit will be beneficial to both the patient and the Plan. 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 Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient even one with the same diagnosis. The Plan Administrator's determination to provide the benefits in one instance does not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

13.07 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 to review certain claims. 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 in excess of the Maximum Allowable Amount and/or not Medically Necessary and Reasonable, if any, and may include review of billing records, medical records, and any and all other documentation that the Plan Administrator determines, in its sole discretion, should be reviewed. Any amounts determined to be in excess of the Maximum Allowable Amount through a Claims Audit will not be payable under the terms of this Plan.
feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-authorized, the attending Physician must request the additional services or days.

ARTICLE XIV
MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Sickness.

14.01 Benefit Limitation
The Plan does not have a dollar limitation on the aggregate amount that it will pay for a Covered Person during a calendar year. However, there are some benefits which are limited.

14.02 Deductible
A Deductible is an amount of money that a Covered Person must pay each Calendar Year before any money is paid by the Plan for any Covered Charges. Each January 1, a new Calendar Year Deductible amount is required. Deductibles count towards the Maximum Out-of-Pocket Amount. A Covered Person's Deductible is shown in the Schedule of Benefits.

Family Unit Limit – When the maximum number of people shown in the Schedule of Benefits has satisfied their full Deductible then the Deductibles of all member of that Family Unit will be considered satisfied for that Calendar Year. However, if a member of the Family Unit has met the individual Deductible but the Family Deductible has not been satisfied, the Plan will pay benefits for that individual only subject to the Maximum Out-of-Pocket Amount.

14.03 Co-Payments
A **Copayment** is the amount of money that a Covered Person must pay each time a particular service is used. There are co-payments on some services but not all. Co-payments count towards the 100% Maximum Out-of-Pocket Amount. A Covered Person's Copayments are shown in the Schedule of Benefits

14.04 Coinsurance
Coinsurance is a predetermined percentage that a Covered Person must pay for Covered Charges as listed in the Schedule of Benefits.

14.05 Maximum Out-of-Pocket Amount
The Maximum Out-of-Pocket Amount is the maximum amount that a Covered Person, or Family Unit pays each calendar year. This amount includes Deductible, Copayments, and Coinsurance indicated for some benefits. When a Covered Person satisfies the Maximum Out-of-Pocket Amount, the Plan will *generally* pay at a rate of 100% of the Maximum Allowable Amount for the remainder of the calendar year. However, certain amounts do not count toward the Maximum Out-of-Pocket Amount and include:

- Amounts for non-Covered Services
- Amounts in excess of the Maximum Allowable Amount
- Amounts for penalties
- Amounts not attributable to Essential Health Benefits

14.06 Maximum Allowable Amount
The Maximum Allowable Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges Incurred by a Covered Person during any one calendar year.

14.07 Covered Charges
Subject to the Plan's provisions, limitations and exclusions, the following are Covered Charges:

1. **Allergy Services.** Charges related to the Treatment of allergies;

2. **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 Plan Administrator finds a longer trip was Medically Necessary. Air Ambulance subject to Medical Necessity.

3. **Ambulatory Surgical Center.** Services of an Ambulatory Surgical Center for Medically Necessary care provided;

4. **Anesthesia.** Anesthesia, anesthesia supplies, and administration of anesthesia by facility staff;

5. **Applied Behavioral Analysis Therapy.** Applied Behavioral Analysis Therapy for the treatment of Autism Spectrum Disorder for a covered Child up to age 21, who is diagnosed with Autism Spectrum Disorder prior to the Child's 10th birthday. Covered Charges must be delivered by a Provider who is a board-certified behavior analyst or a licensed doctoral-level psychologist; benefits for applied behavior analysis are limited to 26 visits per Plan Year. Any additional visits are subject to Medical Necessity review;

6. **Birthing Center.** Services of a Birthing Center for Medically Necessary care provided within the scope of its license;

7. **Blood and Plasma.** Blood transfusions, plasma and blood derivatives and charges for whole blood not donated or replaced by a blood bank. Covered Charges do not include the cost for any blood or plasma which is replaced by or on behalf of the Covered Person;

8. **Cardiac Rehabilitation.** As deemed Medically Necessary, provided services are rendered (1) under the direct supervision of a Physician; (2) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (3) initiated within 12 weeks after other treatment for the medical condition ends; and (4) in a Medical Care Facility as defined by this Plan;

9. **Chemotherapy.** Charges for chemotherapy/radiation. The materials and services of technicians are included;

10. **Colorectal Cancer Screening (Preventive).** Covered Charges for screening of colorectal cancer for a Covered Person. Certain Covered Charges will be covered as preventive if the Covered Person is at least 45 years of age and at normal risk for developing cancer, or for those under age 45 subject to a Medical Necessity Review. These preventive services include:
    a. An annual fecal occult blood test once every Calendar Year;
    b. Cologuard® limited to once every 3 years;
    c. CT colonoscopy and flex sigmoidoscopy limited to once every 5 years; and
    Colonoscopies limited to once every 10 years;

11. **Contact Lenses or Glasses.** Only if required following cataract surgery. No other eye care is covered under the Plan;

12. **Dental.** The following expenses will be covered under the Plan:
    a. **Accident.** Dental services or supplies needed to correct damage caused by an Accident; and the Accident occurred while medical expense benefits for the Covered Person are in effect;
    b. **Hospital Expenses.** Outpatient Hospital charges, or if necessary, Hospital Room Charges and Hospital miscellaneous expenses, will be covered when dental services are rendered only if the Hospital services are required because there is no other alternative available under the circumstances. This benefit is intended to be very limited and shall be provided only when the Plan Administrator determines the Covered Person had a special need to receive such services at a Hospital; and
    c. **Tumors and Cysts.** The treatment of tumors and the treatment of cysts which do not result from infection of the teeth or gums are covered under this Plan. This benefit is limited only to those services requiring treatment of tumors or cysts in the mouth area which are not caused by or created by any infection of the teeth or gums;

13. **Diabetes Treatment.** Care and treatment of diabetes for a Covered Person who has been diagnosed with: insulin dependent or non-insulin dependent diabetes; elevated blood glucose levesl induced by pregnancy; or another medical condition associated with elevated blood glucose levels. Specifically, the following services and supplies are covered:
    a. Diabetes equipment and supplies as follows: blood glucose monitors, including monitors for use by or adapted for the legally blind; test strips for use with a corresponding glucose monitor; lancet and lancet devices; visual reading strips and urine testing strips and tablets which test for glucose, ketones and protein; insulin and insulin analog preparations; injection aids, including devices used to assist with insulin injection and needleless systems; insulin syringes; biohazard disposal containers; insulin pumps, both external and implantable, and associated appurtenances, which include: insulin infusion devices; batteries; skin preparation items; adhesive supplies; infusion sets; insulin cartridges; durable and disposable devices to assist in the injection of insulin; and other required disposable supplies; repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump; prescription drugs and medications available without a prescription for controlling the blood sugar level, unless covered under the Prescription Drug benefit; and podiatric appliances, including up to two pairs of therapeutic footwear per calendar year, for the prevention of complications associated with diabetes; glucagon emergency kits, unless covered under the Prescription Drug benefit; and other treatment and monitoring equipment, approved by the United States Food and Drug Administration, if medically necessary and deemed appropriate by the treating physician through a written order;
    b. Immunizations for influenza and pneumococcus; and
    c. Diabetes self-management training for which a practitioner has written an order for the Covered Person or for the caretaker of a Covered Person as follows: 1) a diabetes self-management training program recognized by the American Diabetes Association; 2) diabetes self-management training given by a multidisciplinary team, the non-doctor members of which are coordinated by a Certified Diabetes Educator, who is certified by the National Certification Board for Diabetes Educators, or a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and includes a combination of diabetes-related educational principles and behavioral strategies; such team consisting of at least a dietician and a nurse educator and possibly including a pharmacist or a social worker; provided that all team members, except a social worker, must have recent didactic and experiential preparation in diabetes clinical and educational issues; as determined by the team member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training; 3) diabetes self-management training given by a Certified Diabetes Educator, certified by the National Certification Board for Diabetes Educators; or 4) diabetes self-management training in which one or more of the following components are provided: the nutrition counseling component provided by a licensed dietician, for which the licensed dietician shall be paid; the pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid; any component of training provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except for providing a nutrition counseling or pharmaceutical component unless a licensed dietician or pharmacist is unavailable to provide that component; or any component of the training provided by a doctor of medicine; provided however that a person may not provide a component of diabetes self-management training unless the subject matter of the component is within the scope of the person's practice and the person meets the education requirements, as determined by the person's licensing agency, in consultation with the commissioner of public health.

For purposes of Diabetes Treatment only, a "practitioner" means a doctor of medicine, doctor of osteopathy, advance practice nurse, doctor of dentistry, physician assistant, doctor of podiatry or other licensed person with prescriptive authority.

For the purposes of the self-management training, a "caretaker" means a family member or significant other of the Covered Person who is responsible for insuring that a Covered Person, who is not able to manage his or her diabetes, due to age or infirmity, is properly managed, including oversight of diet, administration of medications and use of equipment and supplies. Self-management training will include: the development of an individualized management plan created for and in collaboration with the Covered Person; and medical nutritional counseling and instructions on the proper use of diabetes equipment and supplies.

Self-management training will be provided to the Covered Person or to a caretaker for the Covered Person upon: the initial diagnosis of diabetes; a written order of a practitioner indicating that a significant change in the Covered Person's symptoms or condition requires changes in the Covered Person's regime; or a written order of a practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

Notwithstanding any provision to the contrary, the following provisions shall apply:

a. There is no limitation of Durable Medical Equipment (DME) to the extent it is provided for treatment of diabetes;
b. Over the counter drugs necessary for the treatment of diabetes shall be Covered Charges;
c. Charges for the administration of a drug connection with diabetes self-management training programs shall be covered;
d. Charges for professional services performed by a person who ordinarily resides in the Covered Person's home, or who is an Employee of the practitioner rendering the service or related to the Covered Person as a spouse, parent, Child, brother or sister, whether the relationship is by blood or exists in law, shall be covered to extent such services are provided for diabetes self-management training; and
e. Charges for the treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails shall be covered to the extent needed in treatment of a metabolic or peripheral-vascular disease, or diabetes and is deemed Medically Necessary;

14. **Diagnostic Tests; Examinations.** Charges for x-rays, microscopic tests, laboratory tests, esophagoscopy, gastroscopy, proctosigmoidoscopy, colonoscopy and other diagnostic tests and procedures;

15. **Durable Medical or Surgical Equipment.** Rental of durable medical or surgical equipment if deemed Medically Necessary. These items may be bought rather than rented if the cost will not exceed the fair market value of the equipment at the time of purchase but **only** if the Plan Administrator agrees in advance. Replacement of worn or damaged equipment will be covered, if deemed Medically Necessary.

    CPAP and supplies; Charges are covered for CPAPs and associated supplies which include face masks, tubes, hosing, filters, humidifiers and other required supplies may be covered based on proof of patient compliance and Medically Necessary Review.

    Charges are covered for repairs and necessary maintenance of CPAP and CPAP devices not otherwise provided for under a manufacturer's warranty or purchase agreement. Replacement pumps are covered only when equipment is no longer serviceable or functional.

    Includes non-manual breast pump covered as noted in the Schedule of Benefits;

16. **Hearing Aids and Exams.** Medically Necessary charges incurred in connection with the purchase or fitting of hearing aids, or such similar aid devices related to the diagnosis or treatment of a specific Injury or Illness. Charges are subject to the limits included in the Schedule of Medical Benefits;

17. **Hearing Loss.** Medically Necessary charges incurred in connection with office visits, evaluations and testing for hearing impairment related to the diagnosis or treatment of a specific Injury or Illness. Covered Charges are subject to the limits included in the Schedule of Medical Benefits;

18. **Hemodialysis, Peritoneal Dialysis, Administration, Drug, and Supplies.** Benefits provided under this Plan for treatment received in connection with dialysis, to include, outpatient dialysis, inpatient dialysis (hemodialysis) or home dialysis (peritoneal dialysis) are subject to the following provisions:
    - Covered hemodialysis and peritoneal dialysis charges, including the administration, the drugs and/or supply charges will be paid as a single charge and not in components.;

19. **Home Health Care.** 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. A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be:

    A ***Home Health Care Plan*** must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

    Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.) provided through a Home Health Care Agency (this does not include general housekeeping services); physical, and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

    NOTE: Transportation services are not covered under this benefit;

20. **Hospice.** The Plan provides limited benefits for Hospice services. Hospice means a Health Care Program providing a coordinated set of services rendered at home, in Outpatient settings, or in institutional settings, for Covered Persons suffering from a condition with a terminal prognosis. There are specific requirements which must be satisfied before these benefits are approved. The following definitions apply:

    A ***Hospice Care Program*** is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

    Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a facility or separate Hospital unit or other licensed facility, home care, and family counseling during the bereavement period;

21. **Hospital Care.** The medical services and supplies furnished by a Hospital, Ambulatory Surgical Center or a birthing center. Covered Charges for Room and Board will be payable as shown in the Schedule of Benefits. After 48 observation hours, outpatient services will be considered an inpatient confinement and payable as described in the Schedule of Benefits. Observation charges in excess of 48 hours shall be determined based on Medical Necessity. Observation services less than 48 hours are covered subject to the Deductible and applicable Coinsurance. Charges for an Intensive Care Unit stay are payable as described in the Schedule of Benefits. *NOTE: The Plan will not pay for any charges for nursing services regardless of name used by a Hospital;*

22. **Implants and Medical Devices.**
This is a LIMITED BENEFIT.

The Maximum Allowable Charge for Implants and Medical Devices will be determined based on one the following:

a. Covered Charges will be paid in accordance with a direct agreement negotiated between the Plan and the provider and/or facility if one exists;
b. For Plans that participate in a Preferred Provider Organization other than the Health Care Highways Network, Covered Charges will be limited to 200% the invoice cost of the amount listed in the purchase order, invoice or similar document from the entity from which the implants and medical devices are acquired, or the PPO allowable, *whichever is less*;
    i. If the invoice cost is not provided to the Plan Administrator within a reasonable time, the Plan Administrator may use its discretion to determine a reasonable cost for the implants and/or medical devices.
c. For Plans that participate in the Health Care Highways Network, Covered Charges will be paid at the rate(s) set forth in the applicable PPO agreement; or
d. For Plans that do not participate in a Preferred Provider Organization, Covered Charges will be the Medicare Approved Amount plus a percentage, depending on where services are rendered.

The Plan Administrator has the sole discretion to determine the Maximum Allowable Charge, even if such amount differs from the aforementioned amounts. Covered Charges of less than $2,500 for Implants may not require an invoice.

23. **Intraoperative procedures. Including neurophysiologic Monitoring.** Charges for intra-operative procedures provided it is Medically Necessary under the circumstances;

24. **Laboratory Tests.** Covered Charges include charges for laboratory services. Laboratory tests are often expensive. The Plan has contracted with a laboratory provider to help keep the costs down. The laboratory designated by the Plan is listed on your ID Card. You are not required to use the laboratory listed on your ID Card; however, you may save the Plan and yourself some costs if you do. The Plan will pay Covered Charges for laboratory tests and test results performed at the laboratory listed on your ID Card at 100%, Deductible waived, as described under *Laboratory Card Program* in the Schedule of Benefits. ***You must request the service.*** You must request that the specimen taken at the Physician's office be sent to the laboratory listed on your ID Card for testing. The Physician's office will call the laboratory designated on your ID Card to pick up the specimen taken and the test results will be returned only to the Physician;

25. **Mammograms.** Covered Charges are paid subject to the limitations noted in the Schedule of Benefits;

26. **Manipulative Therapy.** Covered Charges for the care and service for analysis and adjustment of spinal subluxation or for diagnosis and manipulative therapy or related treatment of the musculoskeletal structure.

    The Plan limits this benefit to a total of twenty-six (26) visits (combined benefit with Physical Therapy) per year. Visits in excess of 26 per year are subject to Medical Necessity. Manipulative Therapy visits are limited to a maximum of $95 per visit. Charges in excess of these amounts are not Covered Charges and are expressly excluded from coverage under the Plan;

27. **Mastectomy, Lumpectomy, and Reconstructive Surgery.** Pursuant to the Women's Health and Cancer Rights Act, the law mandates that individuals receiving benefits for a Medically Necessary Mastectomy or Lumpectomy will also receive coverage for:
    a. Reconstruction of the breast on which the Mastectomy or Lumpectomy has been performed;
    b. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

c. Prostheses and physical complications from all stages of Mastectomy and Lumpectomy, including lymphedemas.
    i. Prostheses are limited to:
        1. Silicone Forms – 1 per affected breast every 2 years
        2. Foam Forms – 1 per affected breast every 6 months
        3. Mastectomy Bras – Limited to 2 every 6 months
        4. Camisoles – Limited to 2 every 3 months until fitted with permanent prosthesis

Additional prothesis and supplies in excess of plan limitations are subject to Medical Nessesity Review.

This coverage will be subject to the same annual Deductible and Coinsurance provisions that currently apply to Mastectomy and Lumpectomy coverage, and will be provided in consultation with you and your attending Physician;

28. **Mental Disorders and Substance Abuse.** Covered Charges for care, supplies, and treatment of Mental Disorders and Substance Abuse will be payable as any other medical condition;

29. **Newborn Care.** Hospital and Physician nursery care for Newborns who is eligible Dependent and a parent (1) is a Covered Person 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 Amount Charges for nursery care for the newborn Child while Hospital confined as a result of the Child's birth. Benefits will be provided under the Child's coverage, and the Child's own Deductible and Coinsurance provisions will apply;
    a. Hospital routine care for a Newborn during the Child's initial Hospital Confinement at birth; and
    b. The following Physician services for well-baby care during the Newborn's initial Hospital Confinement at birth:
        i. Newborn examination; and
        ii. Circumcision.

    NOTE: The Plan will cover Hospital and Physician nursery care for an ill Newborn as any other medical condition, provided the Newborn is properly enrolled in the Plan. These benefits are provided under the baby's coverage;

30. **Obesity.** The Plan will pay for charges for one Bariatric Surgical procedure for the care and treatment of Morbid Obesity. The benefit is limited to only one treatment during the Covered Person's lifetime and is subject to the limitation in the Schedule of Benefits. Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. The Plan requires a 12- month documented weight-loss and exercise program in combination with the additional required medical criteria guidelines before the Bariatric Surgical procedure is approved. "Bariatric Surgical Procedure" includes, but is not limited to, gastric bypass, stapling and intestinal bypass, and lap band surgery. No other benefit is provided under the Plan for the treatment of obesity or any other weight related condition;

31. **Occupational Therapy.** Therapy provided by a licensed occupational therapist provided that it is ordered by a Physician as a result of an Injury or Sickness and which is to improve the strengthening of a body function is covered. Any other occupational therapy is not covered;

32. **Office Visit Co-Pay Benefit.** Office visits in a Physician's office includes minor procedures, lab testing, x-rays, injections, allergy testing, allergy serum, allergy injections, and IV infusion and are payable as described in the Schedule of Benefits.

This benefit is not available for any services rendered outside the Physician's office or for services which are not rendered in a single office visit. Charges for immunizations, therapies or modalities, surgeries, casting or such similar procedures which are customarily billed separately from the office visit are not included in the Office Visit benefit but may be allowable under other provisions of the Plan. Charges for chemotherapy, dialysis, advanced imaging, and major surgical procedures which are customarily billed separately from the Office Visit are not covered under this benefit but may be Covered Charges allowable under the other provisions of the Plan;

33. **Organ Transplants.** The Plan provides benefits for human organ and tissue transplants if the transplant is pre-authorized and the services are rendered at an approved facility. BEFORE YOU ARRANGE FOR AN ORGAN TRANSPLANT, CONTACT THE PLAN ADMINISTRATOR. ALL ORGAN OR TISSUE TRANSPLANTS WILL BE COORDINATED WITH CASE MANAGEMENT. Transplants which are not pre-authorized through the case management program are not covered under the Plan.

    Covered Charges are determined in the same manner as for any other Sickness.

    Transplant benefits are subject to the general exclusions, restrictions and limitations. ***You must be a Covered Person to receive benefits as a donor or recipient.*** **Charges otherwise covered under the Plan that are Incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:**

    a. The transplant must be performed to replace an organ or tissue;
    b. Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. This Plan will NOT pay any benefits for the donor until the other coverage has determined the amount it shall pay. The benefits under this Plan will be reduced by those payable under the donor's plan. Donor charges include those for:
        i. Evaluating the organ or tissue; and
        ii. Removing the organ or tissue from the donor;
    c. The plan will **not** pay for the:
        i. Cost of procuring an organ or tissue from an institution or individual. Such costs include but are not limited to: acquisition, preservation, storage and transportation costs related to the donated organ or tissue from a living donor or a cadaver;
        ii. Cost related to a donor search nor the costs related to testing or typing the organ to determine if a donation is compatible for the recipient;
        iii. Costs for removing an organ from a living donor or a cadaver NOR costs to retrieve organs or tissue from a Covered Person who has been declared clinically dead but has been maintained on life support systems to preserve the organ or tissue;
        iv. Costs related to maintaining or transporting the organ or tissue after it has been removed; and
        v. Costs to the donor if the donor sells the organ or tissue.

    Notwithstanding anything to the contrary, the Plan will pay the cost for travel and accommodations only if the transplant has been pre-authorized at a designated facility that has agreed to a bundled fee that includes such travel and accommodations.

    Covered Persons must contact the Plan Administrator in advance of any procedure to ensure availability of benefits;

34. **Orthotic Appliances.** The initial purchase and fitting of orthotic appliances such as braces, splints or other appliances which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness. The Plan does not pay for the repair or replacement of any orthotic appliances. Foot orthotics are not covered;

35. **Physical Therapy.** The therapy must be provided by a licensed physical therapist and 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.

    The Plan limits this benefit to a total of twenty-six (26) visits (combined benefit with Manipulative Therapy) per year. Visits in excess of 26 per year are subject to Medical Necessity. Physical Therapy visits are limited to a maximum of $95 per visit. Charges in excess of these amounts are not Covered Charges and are expressly excluded from coverage under this Plan;

36. **Physician Care.** Covered Charges include charges for the professional services of a Physician for surgical or medical services. Covered Charges include expenses for services of a Physician Assistant so long as the Physician Assistant's services are rendered in lieu of services by the Physician;

    Charges for **multiple surgical procedures** will be a Covered Charge subject to the following provisions:

    a. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Maximum Allowable Amount that is allowed for the primary procedure; 50% of the Maximum Allowable Amount be allowed for the second procedure; 25% of the Maximum Allowable Amount will be allowed for the third procedure; and 10% of the Maximum Allowable Amount will be allowed for any additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
    b. If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Amount for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowable Amount percentage allowed for that procedure; and
    c. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Maximum Allowable Amount allowance.

    The Trustees may limit the amount that will be paid for specific procedures;

37. **Pre-admission Testing.** The Plan pays 100% of the Covered Charges for pre-admission testing performed on an Outpatient basis up to 7 days before surgery for a covered Sickness or Injury. The Deductible does not apply to these charges;

38. **Pregnancy Expenses.** Dependent Children are not eligible for coverage for any expenses in connection with Pregnancy, unless such expenses are those preventative services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force;

39. **Preventive Care – Wellness Benefits.** Wellness benefits are designed to provide preventive care – meaning that the services are provided by a Physician that is not to treat an Injury or Sickness. The most up-to-date listing of preventive care benefits can be found at https://www.healthcare.gov/prevention.

    Well Adult Care
    Includes the following guidelines for Affordable Care Act (ACA).

    a. Abdominal Aortic Aneurysm (1) one lifetime screening for men age 65-75 who have smoked;
    b. Osteoporosis screening for women (bone density testing) every 24 months starting at age 60;
    c. Colorectal cancer screening (fecal occult blood testing, colonoscopy or sigmoidoscopy) limited to age 50 or older, once every 5 years;
    d. Screening, counseling & interventions for: Alcohol Misuse, Blood Pressure, Cholesterol, Depression, Type 2 Diabetes, HIV, Obesity, Sexually Transmitted Infection (STI);
    e. Smoking and tobacco use cessation counseling;

f. Behavioral and nutritional counseling for those at higher risk for cardiovascular, cholesterol or chronic disease;
g. Breast Feeding interventions to support and promote breast feeding. The Plan will provide one manual breast pump per childbirth as part of the preventive services.
h. Counseling related to Aspirin use for men and women to prevent cardiovascular disease; and
i. Office Exam, Pap, PSA, Lab & X-ray.
j. All other evidence-based items or services with a rating of "A" or "B" in the current recommendations of the USPSTF, as well as coverage for preventive care and screening as provide for the in the comprehensive guidelines released by HRSA.

Note: This is only a summary and is subject to change as the Patient Protection and Affordable Care Act (ACA) regulations are clarified.

Immunization/Vaccine
Adult & Children up to age 26

Includes**:** Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma virus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumonia, Tetanus, Diphtheria, Pertussis, Varicella and those recommended by the Centers for Disease Control and Prevention (CDC) or other applicable law.

Mammogram Screening
a. Age 35-39 100% limited to one (1) baseline; and
b. Age 40 and over limited to one (1) per Calendar Year.

Well Child Care
Includes the following guidelines for Patient Protection and Affordable Care Act (ACA).
a. Autism Screening 18-24 months;
b. Oral Health assessment and Vision screening for Dependents under age 6;
c. Screening, counseling & interventions for: Alcohol Misuse, Blood Pressure, Cholesterol, Congenital Hypothyroidism, Developmental, Dyslipidemia, Height, Weight and Body Mass Index measurements, Depression, Type 2 Diabetes, HIV, Iron supplements, Lead, Obesity, Sexually Transmitted Infection (STI), Tuberculin, Hematocrit, Hemoglobin or Hemoglobinopathies;
d. Behavioral and nutritional counseling for those at higher risk for cardiovascular, cholesterol or chronic disease; and
e. Office Exam, Pap, Lab & X-ray.

Note: This is only a summary and is subject to change as the Affordable Care Act (ACA) regulations are clarified.

Immunizations / Vaccines Children

Includes**:** Diphtheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papilloma virus, Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Rotavirus, Varicella and those recommended by the Centers for Disease Control and Prevention (CDC);

For preventive services received outside the recommended ACA age limits or other Plan age limits are subject to the benefits listed in the Schedule of Benefits. These specific preventative services are subject to all applicable plan provisions, including limitations and exclusions;

40. Prosthetics, Orthotics, Supplies and Surgical Dressings. Prosthetic devices (other than dental) to replace all or part of an absent body organ or part, including replacement due to natural growth or pathological change, but not including charges for repair or maintenance. Orthotic devices but excluding orthopedic shoes and other supportive devices for the feet. However, Covered Charges do **not** include the replacement cost or the maintenance cost of such braces, appliances, limbs or other devices;

41. **Radiation Therapy.** Charges for radiation and dialysis therapy and treatment;

42. **Respiration Therapy.** Respiration therapy services, when rendered in accordance with a Physician's written treatment plan;

43. **Second Surgical Opinions.** Charges for second surgical opinions;

44. **Skilled Nursing Facility.** Charges made by a Skilled Nursing Facility or a convalescent care facility, up to the limits set forth in the Schedule of Benefits in connection with convalescence from an Illness or Injury for which the Covered Person is confined;

45. **Smoking Cessation Counseling.** Charges for smoking cessation counseling;

46. **Speech Therapy.** The speech therapy must be ordered by a Physician and must be provided by a licensed speech therapist. The treatment must 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;

47. **Sterilization.** Charges related to sterilization procedures;

48. **Surgical dressings.** Splints, casts and other devices used in the reduction of fractures and dislocations;

49. **Telehealth.** Benefits are provided for the use of interactive audio, video, or other electronic medical for the purpose of consultation, diagnosis, or treatment of the patient. Benefits for telehealth services shall be provided by a health care provider to deliver health care services within the scope of the provider's practice at a site other than the site where the patient is located. Telehealth services do not include an audio-only telephone, electronic mail messages, or facsimile transmission between a provider and patient. Telehealth services under this section are separate and apart from those offered under the Telemedicine Program;

50. **Telemedicine Program.** This Plan has a benefit allowing Covered Persons to receive telephone or web-based video consultations through a network of physicians that is designed to facilitate cross-coverage medical consultations when a patient's primary care physician is unavailable.

    Once enrolled, a Covered Person may call the telephone number listed on the Covered Person's enrollment packet and request a consultation with a physician. Typically, a licensed physician will respond within one hour. If a Covered Person requests a video consultation, it will be scheduled and an appointment reminder will be sent prior to the appointed time. When appropriate, the physician will provide a diagnosis, recommend therapy, and if necessary, write a prescription. The prescription will be called into the pharmacy of the Covered Person's choice. Benefits for this Telemedicine Program are shown in the Schedule of Benefits.

    This Telemedicine Program may not be used for Drug Enforcement Agency controlled Prescriptions, charges for telephone or online consultations with physicians and/or providers who are not contracted with this Plan's Telemedicine Program, or web-based video consultations provided in states that do not allow telemedicine programs;

51. **VezaHealth.** VezaHealth is a medical appropriateness and clinical education program which allows Covered Persons to receive clinical consulting services and remote second opinions from specialized Physicians, when appropriate and approved by the Plan Administrator.

    Given the high rate of misdiagnosis and the variation and waste prevalent in health care, Covered Persons are highly encouraged to seek a remote second opinion when they receive a diagnosis and/or a course of treatment that they are uncertain about, of if they would simply like additional information to better understand what options are available and what may best suit their individual health care needs.

A remote second opinion obtained through VezaHealth is at no cost to the Covered Person. Travel expenses, if necessary, may also be covered at the discretion of the Plan Administrator.

To utilize VezaHealth, the Covered Person should first connect with a VezaHealth Registered Nurse by calling (800) 970-6571 or via email at consultant@vezahealth.com.

VezaHealth, and certain Covered Charges recommended through VezaHealth are only available when mutually beneficial to the Covered Person and the Plan, or when otherwise approved by the Plan Administrator. Certain cost-sharing amounts and visits limits may also be waived if recommended through VezaHealth and consistent with applicable law. The Plan Administrator, in its sole discretion, shall determine whether this benefit is available to a Covered Person on a case-by-case basis.; and

52. **Wigs.** Charges associated with the initial purchase of a wig after chemotherapy. Subsequent wigs are not covered.

14.08 Schedule of Benefits

SCHEDULE OF MEDICAL BENEFITS	
DEDUCTIBLE, PER CALENDAR YEAR	
Per Covered Person	$5,000 **KPP Deductible:** $1,500
Per Family Unit	$10,000 Aggregate (One Family member is $5,000) **KPP Deductible:** $3,000 embedded
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR, This amount INCLUDES the plan Deductible	
Per Covered Person	$7,500
Per Family Unit	$15,000 Aggregate (One Family member is $7,500)
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 Calendar Year unless stated otherwise. Each individual never has to meet more than the individual annual Out-of-Pocket maximum annually.	
The following charges do not apply toward the Plan's Out-of-Pocket Amount and are never paid at 100%: Amounts in excess of the Maximum Allowable Charge Amounts specified in the Plan that are not applied to the Plan Out-of-Pocket Charges for Bariatric procedures Cost containment penalties Expenses for services not covered by the plan	
FEDERAL LIMITATION AMOUNT, PER CALENDAR YEAR for Medical and RX. The Plan has chosen to use the lesser Plan Out-of-Pocket Maximum instead of the Federal ACA limits. The current Federal ACA limits can be obtained at https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/.)	
COVERED CHARGES – HIGH DEDUCTIBLE PLANS Unless noted otherwise, the services listed below are reimbursed **only after the applicable Deductible has been satisfied**. The Plan will then pay a percentage as indicated until you meet the Maximum Plan Out-of-Pocket Amount required. All references to Covered Charges means only the Maximum Allowable Amount. Charges which are not Covered Charges or are in excess of Maximum Allowable Amount are not covered and are your responsibility.	
VOLUNTARY CONSUMER SAVINGS PROGRAMS	
NOTE: Kempton Premier Provider™ benefits will only apply if the Plan is the primary Plan. If the Plan is secondary, this benefit is not available. Coordination for Kempton Premier Provider™ benefits will be handled by calling a Kempton Care Advocate at 866-898-7219. ***Non-inpatient services provided under the Kempton Premier Provider™ program will be excluded from the Pre-Authorization requirements.***	

Kempton Premier Providers™ "Consumer Driven Options"	100% of Covered Charges, ***after the KPP Deductible*** ***NOTE:*** may approve a reimbursement for reasonable travel and/or accommodation costs
Laboratory Card Program	100% of Covered Charges, ***after the KPP Deductible***, when the laboratory designated on your ID Card is used.
Other 100% Labs (Direct Contract Labs) ➢ Clinical Pathology Laboratories, Inc. ➢ Heart of Texas Healthcare Systems (lab services only) ➢ Lavaca Medical Center (lab services only) ➢ Share Medical Center (lab services only)	100% of Covered Charges, ***after the KPP Deductible,*** when a direct contracted lab provider is used.
PHYSICIAN SERVICES	
Physician Office Services • Includes: office visits, laboratory blood test, x-rays, injections, minor surgical procedures, allergy services (testing,serum, and injections), and IV Infusion.	80% of Covered Charges after the Deductible
Urgent Care Services	80% of Covered Charges after the Deductible
Other Office Surgery	80% of Covered Charges after the Deductible
Other Physician Services • Inpatient visits • Surgery (not in the office)	80% of Covered Charges after the Deductible
HOSPITAL AND OTHER FACILITY SERVICES	
Room & Board and Ancillary Services • Including ICU	80% of Covered Charges after the Deductible
Observation Room • Observation over 48 hours will be considered Inpatient	80% of Covered Charges after the Deductible
Emergency Room	80% of Covered Charges after the Deductible
Skilled Nursing Facility • Limited to 30 days per Calendar Year	80% of Covered Charges after the Deductible
Outpatient Surgery • Includes non-routine Colonoscopies	80% of Covered Charges after the Deductible
Outpatient Procedures / Diagnostic Testing Including but not limited to: Bone Density, Mammograms, Stress Test	80% of Covered Charges after the Deductible
ADVANCED RADIOLOGY	
MRIs, CT Scans, PET Scans, or Nuclear Medicine	80% of Covered Charges after the Deductible
LAB AND X-RAY	
Outpatient X-ray services	80% of Covered Charges after the Deductible
Outpatient Laboratory Services	80% of Covered Charges after the Deductible
MENTAL HEALTH AND SUBSTANCE ABUSE	
Inpatient Hospital	80% of Covered Charges after the Deductible
Outpatient Hospital	80% of Covered Charges after the Deductible
Office setting	80% of Covered Charges after the Deductible
THERAPY SERVICES	
Applied Behavior Analysis Therapy • **This is a LIMITED BENEFIT.** For a covered Child up to age 21, who is diagnosed with autism spectrum disorder by age 10 (ten). Limited to 26 visits per Plan Year. Additional visits subject to Medical Necessity review.	80% of Covered Charges after the Deductible
Manipulative Therapy • Limited to 26 visits combined with Physical Therapy- per Calendar Year. Additional visits require Medical Necessity review	80% of Covered Charges after the Deductible up to $95 per visit, excess Not covered
Occupational Therapy • Limitations apply	80% of Covered Charges after the Deductible

Physical Therapy • Limited to 26 visits combined with Manipulative Therapy- per Calendar Year. Additional visits require Medical Necessity review	80% of Covered Charges after the Deductible up to $95 per visit, excess Not covered
Speech Therapy • Limitations apply	80% of Covered Charges after the Deductible
OTHER MEDICAL SERVICES AND PROCEDURES	
Ambulance Service, Air or Ground	80% of Covered Charges after the Deductible
Bariatric Procedures • Only one procedure per Covered Person's Lifetime & • Available only after the Covered Person has a 12 month documented Weight loss and exercise program.	**This is a LIMITED BENEFIT.** 50% of Covered Charges after the Deductible, does not apply toward the Plan's Out-of-Pocket Amount. No benefit available unless pre-authorized and under Case Management.
Breast Pump Manual • One per pregnancy	100% of Covered Charges, Deductible waived
Breast Pump Non-Manual • $250 limit • 1 per lifetime	100% of Covered Charges, Deductible waived, up to Maxiumum allowable of $250
Dialysis Services	80% of Covered Charges after the Deductible
Durable Medical Equipment • Replacement of worn or damaged equipment is covered, if deemed Medically Necessary. • CPAP Equipment and supplies may becovered based on compliance / Medical Necessity review • All other replacement equipment, supplies and parts are not covered	80% of Covered Charges after the Deductible
Hearing Aids and Testing** **Age 18 and over –** • limited to $2,500 per Lifetime (per ear) • limited to a single purchase (including repair/replacement) per hearing impaired ear every 3 years **Under age 18 –** • Limited to 1 hearing aid per hearing impaired ear every 48 months **Age 2 and under-** • 4 additional ear molds per year ***Impairment must be related to injury or illness.*	80% of Covered Charges after the Deductible
Home Health Care	80% of Covered Charges after the Deductible
Hospice Care	80% of Covered Charges after the Deductible
Implants and Medical Devices	80% of Covered Charges after the Deductible
Intraoperative Monitoring	**This is a LIMITED BENEFIT.** Limited to a maximum allowable of $4,000 for all related charges. 80% of Covered Charges after the Deductible
Maternity • Dependent Children are **NOT** covered, except for routine services required under the USPSTF.	80% of Covered Charges after the Deductible
Organ Transplant • **CONTACT THE CLAIMS ADMINISTRATOR TO UTILIZE THIS BENEFIT**	80% of Covered Charges after the Deductible only if services are pre-authorized and under Case Management.
Sterilization – Males only	80% of Covered Charges after the Deductible
TMJ related services	Not covered except for services rendered under the KPP*Free* program
Wig and Scalp Prosthesis • Limited to 1 per lifetime after chemotherapy treatment	80% of Covered Charges after the Deductible

PREVENTIVE CARE	
A full description of Preventive and Wellness Services can be found at www.healthcare.gov/coverage/preventive-care-benefits or uspreventiveservicestaskforce.org/uspstf/recommendation-topics/uspstf-and-b-recommendations	
Routine Services outside the ACA and USPSTF recommend age range • Must be Medically Necessary	80% of Covered Charges after the Deductible
ADULT PREVENTIVE CARE	
Well Adult Exam	100% of Covered Charges, Deductible waived
Immunizations / Vaccines	100% of Covered Charges, Deductible waived
Includes**:** Hepatitis A, Hepatitis B, Herpes Zoster, Human Papilloma virus, Influenza, Measles, Mumps, Rubella, Meningococcal, Pneumonia, Tetanus, Diphtheria, Pertussis, Varicella and those recommended by the Centers for Disease Control and Prevention (CDC).	
Bone Density/ Osteoporosis Screening • Women age 60 and over • Once every 24 months	100% of Covered Charges, Deductible waived
Colorectal Cancer Screening Limited to age 45 and older: • Fecal Occult Blood Test limited to once every Calendar Year. • Cologuard® limited to once every 3 years. • CT Colonoscopy and Flex sigmoidoscopy limited to once every 5 years. • Colonoscopies limited to once every 10 years. **Colorectal Cancer Screening that is considered non-Preventive falls under standard Covered Charges	100% of Covered Charges, Deductible and Copay waived
Mammogram Screening • Age 35 – 39 • Limited to (1) one baseline mammogram	100% of Covered Charges, Deductible waived
Mammogram Screening • Age 40 and over • Limit 1 per calendar year	100% of Covered Charges, Deductible waived
Routine Patient Costs Associated With Approved Clinical Trials	Covered as any other medical condition. See type of service (Office, Hospital, etc.)
Smoking Cessation Counseling • 2 Quit attempts per year • 4 Counseling Session (visits, telephone, individual or group sessions) per year	100% of Covered Charges, Deductible waived
WOMEN'S PREVENTIVE HEALTH.	
Well Women Exam	100% of Covered Charges, Deductible and Copay waived
Birth Control Services • IUD or Implantable Rods – including removal • Cost and fitting of contraceptive devices • Birth control injections and related office services	100% of Covered Charges, Deductible waived
Sterilization Services - Women	100% of Covered Charges, Deductible waived
CHILDREN'S PREVENTIVE HEALTH	
Well Child Exam	100% of Covered Charges, Deductible waived
Immunizations / Vaccines	100% of Covered Charges, Deductible waived
Includes**:** Diphtheria, Tetanus, Pertussis, Haemophilus influenza type b, Hepatitis A, Hepatitis B, Human Papilloma virus, Inactivated Poliovirus, Influenza, Measles, Mumps, Rubella, Meningococcal, Rotavirus, Varicella and those recommended by the Centers for Disease Control and Prevention (CDC).	
VEZAHEALTH	
Clinical Consulting and Remove Second Opinion	No cost to Covered Persons
Note: Refer to the Covered Charges section for more information regarding VezaHealth services.	

ARTICLE XV
PRESCRIPTION DRUG BENEFITS

15.01 Prescription Drug Benefits

The Plan provides Prescription Drug benefits. Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs. A Covered Person's ID card identifies the Pharmacy Benefit Manager (PBM). The Covered Person must present his or her ID Card in order to obtain Prescription Drug benefits. Covered Persons are responsible for all costs for a drug purchased from a non-participating pharmacy, or from a participating pharmacy the ID card is not given.

Costco and Walgreens are not covered Pharmacies under this Plan.

15.02 Covered Prescription Drugs

1. All drugs prescribed by a Physician that require a prescription either by federal or state law. This includes oral contraceptives, patches and injectables to prevent pregnancy, but excludes any drugs stated as not covered under this Plan.
2. All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity. Compounded prescriptions may be subject to a clinical review before they can be approved.
3. Insulin and other diabetic supplies when prescribed by a Physician. Contact your Cost Management Services for information on the Diabetic Management Program.

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a Physician.
2. Refills up to one calendar year from the date of order by a Physician.

15.03 Tiers and Co-Payments

Tiers of Prescription Drug	Co-Payment Per Prescription	Co-Payment Per Prescription *Maintenance Drugs
Premier Tier	$0 after Medical Deductible is met	N/A
Generic Tier	10% after Medical Deductible is met	10% after Medical Deductible is met
Brand Name Tier	20% after Medical Deductible is met	20% after Medical Deductible is met
Specialty Tier • Generic • Brand Name	 10% after Medical Deductible is met 20% after Medical Deductible is met	N/A

NOTE: If you elect to use a Brand Name drugs and there is a Generic drug available, you will be required to pay the Co-Payment indicated above PLUS the difference in cost between the Brand Name drug and the Generic drug.

Premier Tier. In some cases, medications which were previously available only with a prescription are now available over-the-counter. The Plan allows Covered Persons to acquire certain over-the-counter medications, and certain prescriptions at no cost if filled at a Participating Pharmacy. To review a list of over-the-counter medical and prescription medications that are available at no cost, please visit:

https://www.advantagehealthplans.com/Premier_Drug_Tier_List.php.

The Plan Administrator, in consultation with the Pharmacy Benefit Manager, may add other medications to this Premier Tier.

Maintenance Drugs. In addition, the Co-Payment that applies for prescriptions that are for 35-102 day supply applies only to those prescriptions which are listed as "maintenance" drugs on the Pharmacy Benefit Manager (PBM) section of www.advantagehealthplans.com. The prescription ***may*** be filled at your local pharmacy or through mail order service. You will be required to send your Co-payment with your order. Information about the mail order service is available online at www.advantagehealthplans.com. You may also contact the Plan Administrator for information about this service.

Therapeutic Alternative Drug. Specific high cost drugs, which have a therapeutic alternative at a lower cost, will have a Co-pay of 50% of the drug cost. If you receive a 90-day supply, your Co-pay will be 50% of the cost of a 90-day supply. All Therapeutic Alternative substitutions require physician intervention. Take a copy of the Therapeutic Alternative list to your next physician's visit to assist in selection of the lowest cost medications. This alternative drug list can be found on the Advantage Health Plans Trust website www.advantagehealthplans.com or contact your PBM.

Specialty Medications. Certain "Specialty Medications" may ***only*** be obtained from designated specialty pharmacies. These drugs are subject to a separate Co-Payment of $150 per prescription.

Because there are limited pharmacies that carry these types of medications, these prescriptions will generally be handled through a mail order service**.** Generally, the participating pharmacy will reject the prescription but will provide you information on how you can have the prescription filled at the Specialty Pharmacy. In some cases you will be referred to a Case Management Program. Specialty Medications include, but are not limited to, drugs used for the treatment of:

- Chronic Renal Disease
- Crohn's Disease
- Hemophilia
- HIB Adjunct
- Hepatitis C
- Immune System
- Multiple Sclerosis
- Oncology / Oncology Adjunct
- Osteoarthritis and Rheumatoid Arthritis
- Psoriasis
- RSV: AWP
- Transplants

Note: Other miscellaneous and similar conditions may be added from time to time.

A Covered Person should contact the Plan Administrator to obtain additional information about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

15.04 Flexible Copay Program

In addition to the Plan's existing Prescription Drug coverage, the Plan has partnered with pharmaceutical manufacturers, either directly or through third-party intermediaries or foundations, to provide manufacturer copay subsidies that assist in a Covered Person's out-of-pocket costs.

Under this Program, the Covered Person's out-of-pocket cost of prescription drugs may be reduced or eliminated by a manufacturer copay subsidy. Any manufacturer copay subsidy obtained under this Program will not accumulate toward the Covered Person's Deductible Amount or Out-of-Pocket Amount Limit. Only the Covered Person's true out-of-pocket cost will accumulate toward his or her Deductible Amount or Out-of-Pocket Amount Limit. Any refund, debit card, or other subsidy received by the Covered Person prior to or after a prescription is filled may be considered a manufacturer copay subsidy. The Plan Administrator has sole discretion to determine what constitutes a manufacturer copay subsidy.

Not all prescription drugs have a manufacturer copay subsidy. If a prescription drug is not eligible for a manufacturer copay subsidy, the Covered Person's copay obligation will be the copay amount listed for the drug in the standard Prescription Drug coverage under the Plan.

15.05 Manufacturer Assistance Program (MAP)
Certain specialty drugs are excluded under the Plan's formulary. When a Covered Person requires a Medically Necessary specialty drug that is excluded under the formulary, ScriptSourcing offers a Manufacturer's Assistance Program ("MAP"). These drugs can be obtained through the MAP at no cost or a lower cost for those Covered Persons who are eligible under the MAP.

If an attempt by ScriptSourcing to acquire such a Drug from its manufacturer at no cost or a lower cost is unsuccessful, the specialty drug can be obtained through the Plan's integrated Medical Expense Reimbursement Plan (MERP).

15.06 Expenses Not Covered. This benefit will not cover a charge for any of the following:

1. **Acthar** is not covered**.**

2. **Administration.** Any charge for the administration of a covered Prescription Drug.

3. **Allergy Serums or Vaccines.** A charge for allergy medications.

4. **Appetite Suppressants.** A charge for appetite suppressants, dietary supplements or vitamin supplements, except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.

5. **Consumed on Premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.

6. **Costco** Charges for Prescription Drugs filled at Costco.

7. **Devices.** Devices of any type, even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.

8. **Drugs used for Cosmetic Purposes.** Charges for drugs used for cosmetic purposes, such as anabolic steroids or medications for hair growth or removal.

9. **Experimental.** Experimental drugs and medicines, even though a charge is made to the Covered Person.

10. **Growth Hormones.** Charges for drugs to enhance physical growth or athletic performance or appearance.

11. **Hyperalimentation Products.**

12. **Immunization.** Immunization agents or biological sera.

13. **Impotence.** A charge for impotence medication.

14. **Infertility.** A charge for infertility medication.

15. **Injectable Supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).

16. **Inpatient Medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.

17. **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use."

18. **Medical Exclusions**. A charge excluded under Medical Plan Exclusions.

19. **Nexium.** Nexium is not covered unless it is obtained over-the-counter;

20. **No Charge.** A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

21. **Non-FDA Approved.** Any drug not approved by the Food and Drug Administration.

22. **Non-Legend Drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

23. **Non-Prescription.** A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.

24. **Refills.** Any refill that is requested more than one calendar year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

25. **Retin A.** Charges for Retin A is not covered unless it is prescribed to a Covered Person under age 25 if used for the treatment of acne.

26. **Smoking Cessation.** A charge for Prescription Drugs, such as nicotine gum or smoking deterrent patches, for smoking cessation, unless required by ACA.

27. **Walgreens.** Charges for Prescription Drugs filled at Walgreens.

ARTICLE XVI
HIPAA PRIVACY

For purposes of this Article, the following are defined terms:

Breach means an unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") or Electronic Protected Health Information ("ePHI") that violates the HIPAA Privacy Rule and that compromises the security or privacy of the information.

Protected Health Information ("PHI") means individually identifiable health information, as defined by HIPAA, that is created or received by us and that relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

Commitment to Protecting Health Information

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

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

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

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

How Health Information May be Used and Disclosed

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

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

Disclosure of PHI to the Plan Administrator for Plan Administration Purposes

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

1. Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);
2. Ensure that any agents, including a subcontractor, to whom the Plan Administrator provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the Plan Administrator with respect to such PHI;
3. Establish safeguards for information, including security systems for data processing and storage;

4. Maintain the confidentiality of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
5. Receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions;
6. If a Plan engages in underwriting: 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 Administrator, except pursuant to an authorization which meets the requirements of the Privacy Standards;
7. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Administrator becomes aware;
8. Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);
9. Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);
10. Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);
11. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);
12. Report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Administrator becomes aware;
13. Train employees in privacy protection requirements and appoint a privacy compliance coordinator responsible for such protections;
14. If feasible, return or destroy all PHI received from the Plan that the Plan Administrator still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
15. Ensure that adequate separation between the Plan and the Plan Administrator, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
    a. The following employees, or classes of employees, or other persons under control of the Plan Administrator, shall be given access to the PHI to be disclosed:
        i. Privacy Officer: The access to and use of PHI by the individuals described above shall be restricted to the plan administration functions that the Plan Administrator performs for the Plan.
    b. In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. The Plan Administrator will promptly report such violation or non-compliance to the Plan and will cooperate with the Plan to correct violation or non-compliance to impose appropriate disciplinary action or sanctions. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

Disclosure of Summary Health Information to the Plan Administrator

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

Disclosure of Certain Enrollment Information to the Plan Administrator

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 Administrator information on whether an individual is participating in the Plan or is enrolled in or

has un-enrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Administrator.

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

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

Other Disclosures and Uses of PHI:

Primary Uses and Disclosures of PHI

1. **Treatment, Payment and Health Care Operations.** The Plan has the right to use and disclose a Covered Person's PHI for all activities as included within the definitions of Treatment, Payment, and Health Care Operations and pursuant to the HIPAA Privacy Rule;
2. **Business Associates**. The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf. In performance of these functions or to provide services, Business Associates will receive, create, maintain, use, or disclose PHI, but only after the Plan and the Business Associate agree in writing to contract terms requiring the Business Associate to appropriately safeguard the Covered Person's information; and
3. **Other Covered Entities.** The Plan may disclose PHI to assist health care Providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care Provider when needed by the Provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations. The Plan may also disclose or share PHI with other insurance carriers (such as Medicare, etc.) in order to coordinate benefits, if a Covered Person has coverage through another carrier.

Other Possible Uses and Disclosures of PHI

1. **Required by Law.** The Plan may use or disclose PHI when required by law, provided the use or disclosure complies with and is limited to the relevant requirements of such law.
2. **Public Health and Safety.** The Plan may use or disclose PHI when permitted for purposes of public health activities, including disclosures to:
    a. a public health authority or other appropriate government authority authorized by law to receive reports of child abuse or neglect;
    b. report reactions to medications or problems with products or devices regulated by the Federal Food and Drug Administration or other activities related to quality, safety, or effectiveness of FDA-regulated products or activities;
    c. locate and notify persons of recalls of products they may be using; and
    d. a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading a disease or condition, if authorized by law.
3. **Government Authority.** The Plan may disclose PHI to a government authority, except for reports of child abuse or neglect, when required or authorized by law, or with the Covered Person's agreement, if the Plan reasonably believes he/she to be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform the Covered Person that such a disclosure has been or will be made unless the Plan believes that informing him/her would place him/her at risk of serious harm (but only to someone in a position to help prevent the threat). Disclosure generally may be made to a minor's parents or other representatives although there may be circumstances under Federal or State law when the parents or other representatives may not be given access to the minor's PHI.
4. **Health Oversight Activities**. The Plan may disclose PHI to a health oversight agency for oversight activities authorized by law. This includes civil, administrative or criminal investigations; inspections; claim audits; licensure or disciplinary actions; and other activities necessary for appropriate oversight of a health care system, government health care program, and compliance with certain laws.
5. **Lawsuits and Disputes**. The Plan may disclose PHI when required for judicial or administrative proceedings. For example, the Covered Person's PHI may be disclosed in response to a subpoena,

discovery requests, or other required legal processes when the Plan is given satisfactory assurances that the requesting party has made a good faith attempt to advise the Covered Person of the request or to obtain an order protecting such information, and done in accordance with specified procedural safeguards.

6. **Law Enforcement**. The Plan may disclose PHI to a law enforcement official when required for law enforcement purposes concerning identifying or locating a suspect, fugitive, material witness or missing person. Under certain circumstances, the Plan may disclose the Covered Person's PHI in response to a law enforcement official's request if he/she is, or are suspected to be, a victim of a crime and if it believes in good faith that the PHI constitutes evidence of criminal conduct that occurred on the Participating Employer's or Plan's premises.
7. **Decedents**. The Plan may disclose PHI to a coroner, funeral director or medical examiner for the purpose of identifying a deceased person, determining a cause of death or as necessary to carry out their duties as authorized by law. The decedent's health information ceases to be protected after the individual is deceased for 50 years;
8. **Research**. The Plan may use or disclose PHI for research, subject to certain limited conditions.
9. **To Avert a Serious Threat to Health or Safety**. The Plan may disclose PHI in accordance with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a threat to health or safety of a person or to the public.
10. **Workers' Compensation**. The Plan may disclose PHI when authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
11. **Military and National Security**. The Plan may disclose PHI to military authorities of armed forces personnel under certain circumstances. As authorized by law, the Plan may disclose PHI required for intelligence, counter-intelligence, and other national security activities to authorized Federal officials.

Required Disclosures of PHI

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

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

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

Instances When Required Authorization Is Needed From Covered Persons Before Disclosing PHI.

1. Most uses and disclosures of psychotherapy notes, ***if the Plan maintains psychotherapy notes***;
2. Uses and disclosures for marketing;
3. Sale of PHI; and
4. Other uses and disclosures not described in can only be made with authorization from the Covered Person. The Covered Person may revoke this authorization at any time.

Rights to Individuals

The Covered Person has the following rights regarding PHI about him/her:

1. **Request Restrictions.** The Covered Person has the right to request additional restrictions on the use or disclosure of PHI for treatment, payment, or health care operations. The Covered Person may request that the Plan restrict disclosures to family members, relatives, friends or other persons identified by him/her who are involved in his/her care or payment for his/her care. The Plan is not required to agree to these requested restrictions.
2. **Right to Receive Confidential Communication.** The Covered Person has the right to request that he/she receive communications regarding PHI in a certain manner or at a certain location. The request must be made in writing and how the Covered Person would like to be contacted. The Plan will accommodate all reasonable requests.
3. **Right to Receive Notice.** The Covered Person is entitled to receive a paper copy of this notice at any time. To obtain a paper copy, contact the Privacy Compliance Coordinator.
4. **Accounting of Disclosures.** The Covered Person has the right to request an accounting of disclosures the Plan has made of his/her PHI. The request must be made in writing and does not apply to disclosures for treatment, payment, health care operations, and certain other purposes. The Covered Person is entitled to such an accounting for the six (6) years prior to his/her request. Except as provided below, for each disclosure, the accounting will include: (a) the date of the disclosure, (b) the name of the entity or person who received the PHI and, if known, the address of such entity or person; (c) a description of the PHI disclosed, (d) a statement of the purpose of the disclosure that reasonably informs the Covered Person of the basis of the disclosure, and certain other information. If the Covered Person wishes to make a request, please contact the Privacy Compliance Coordinator.
5. **Access.** The Covered Person has the right to request the opportunity to look at or get copies of PHI maintained by the Plan about him/her in certain records maintained by the Plan. If the Covered Person requests copies, he/she may be charged a fee to cover the costs of copying, mailing, and other supplies. To inspect or copy PHI contact the Privacy Compliance Coordinator. In very limited circumstances, the Plan may deny the Covered Person's request. If the Plan denies the request, the Covered Person may be entitled to a review of that denial.
6. **Amendment**. The Covered Person has the right to request that the Plan change or amend his/her PHI. The Plan reserves the right to require this request be in writing. Submit the request to the Privacy Compliance Coordinator. The Plan may deny the Covered Person's request in certain cases, including if it is not in writing or if he/she does not provide a reason for the request.

Questions or Complaints

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

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

Contact Information:

Privacy Compliance Coordinator Contact Information:

Compliance Officer
The Kempton Company
13431 Broadway Extension, Suite 130
Oklahoma City, OK 73114

ARTICLE XVII
HIPAA SECURITY

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

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

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

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

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

1. 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.
2. Ensure that adequate separation between the Plan and the Plan Administrator, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.
3. Ensure that any agent, including a subcontractor, to whom the Plan Administrator provides Electronic PHI created, received, maintained, or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate administrative, physical, and technical safeguards to protect the confidentiality, integrity, and availability of the Electronic PHI, and report to the Plan any security incident of which it becomes aware.
4. Report to the Plan any security incident of which it becomes aware.

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

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

1. Notify the Covered Person whose PHI has been, or is reasonably believed to have been, assessed, acquired, used, or disclosed as a result of the breach, in writing, without unreasonable delay and in no case later than 60 calendar days after discovery of the breach. Breach notifications will be provided to individuals by mail to the last known address of the Covered Person, or if specified by the Covered Person, email. If an urgent notice is required, the Plan Administrator may contact the Covered Person by phone. The information provided to the Covered Person of a Breach Notification will include:
   - a brief description of what happened;
   - when it happened and when it was discovered;
   - the type of unsecured PHI involved (e.g., name, Social Security number, date of birth, home address, account number);
   - the steps the Covered Person should take to provide him or herself from potential harm; and
   - what the Plan is doing to investigate the breach and mitigate losses to the Covered Person and what the Plan is doing to protect itself against further breaches.

2. Notify the media if the breach affected more than 500 residents of a State or jurisdiction. Notice must be provided to prominent media outlets serving the State or jurisdiction without unreasonable delay and in no case later than 60 calendar days after the date the breach was discovered.
3. Notify the HHS Secretary if the breach involves 500 or more individuals, contemporaneously with the notice to the affected individual and in the manner specified by HHS. If the breach involves less than 500 individuals, an internal log or other documentation of such breaches must be maintained and annually submitted to HHS within 60 days after the end of each calendar year.
4. When a Business Associate, which provides services for the Plan and comes in contact with PHI in connection with those services discovers a breach has occurred, that Business Associate will notify the Plan without unreasonable delay and in no case later than 60 calendar days after discovery of a breach so that the affected Covered Persons may be notified. To the extent possible, the Business Associate should identify each individual whose unsecured PHI has been, or is reasonably believed to have been, breached.

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

ARTICLE XVIII
COVERED PERSON'S RIGHTS

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

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites 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 Plan Administrator may make a reasonable charge for the copies.

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this 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 Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your 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.