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Westbrook Service Corporation Health Benefit Plan

Plan Document
&
Summary Plan Description

Plan Administered By:

Preferred
BENEFIT ADMINISTRATORS
INCORPORATED

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR
WESTBROOK SERVICE CORPORATION HEALTH BENEFIT PLAN
Effective March 1, 2019

INTRODUCTION

This document is a description of the Westbrook Service Corporation Health Benefit Plan (the Plan). The Plan described is designed to protect Plan Participants against catastrophic health expenses. This document is intended to serve as both the Summary Plan Description (SPD) and the Plan Document.

Para obtener asistencia en Espanol, llame al 1-888-524-2777 para conectarte a un interprete.

Changes in the Plan may occur in any or all parts of the Plan including Benefit Coverage, deductibles, maximums, Co-payments, exclusions, limitations, definitions and eligibility.

The purpose of the Plan is to pay covered medical expenses that are Medically Necessary and reasonable in amount. Charges in excess of reasonable fees will not be paid by the Plan.

The Plan will pay benefits only for expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage is terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan may be reduced or denied because of certain provisions in the Plan, such as Coordination of Benefits, subrogation, exclusions, and 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. These provisions are explained in summary fashion in this document; additional information is available from the Plan Administrator at no extra cost.

Westbrook Service Corporation may amend or terminate the Plan at any time and will provide notice to all Participants.

If the Plan is terminated, the rights of covered Participants shall be limited to covered charges incurred before the date of termination.

This Plan is an open access health plan that does not restrict member access to providers based on network affiliation.

Keep this document in a safe place for future use and reference. The Plan contains provisions, limitations and exclusions that could result in disqualifications, ineligibility, denial or loss of Benefits.

All questions regarding Coverage and Benefits should be directed to:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188

(407) 786-2777 or (888) 524-2777
www.PreferredTPA.com

The Benefits and Coverage described herein are provided through a plan established and funded by Westbrook Service Corporation.

UTILIZATION MANAGEMENT

This Plan *requires* that your Physician call the Medical Coordinator before all non-Emergency Hospital confinements. This requirement is ultimately your responsibility as the insured Participant. Therefore, you should verify with your Physician that the Medical Coordinator has been contacted.

If you are hospitalized for Emergency reasons, you or your Physician must call the Medical Coordinator within 48 hours after you are admitted. This requirement is ***mandatory*** and is in your best interest.

The services of the Medical Coordinator are provided to help you, your eligible family members, and your Physician find appropriate, quality care. The toll free number for obtaining approval of treatment is printed on your identification card.

The Medical Coordinator is responsible for overseeing that the length of the hospitalization and the treatment are consistent with the diagnosis. If, as a result of a review, the Medical Coordinator determines that care in the Hospital is no longer necessary, a minimum 24 hour notice will be given to the patient, the Hospital, the Physician and the Claims Administrator. This is to protect you from unnecessary costs.

If you are hospitalized out of town, you or the attending Physician must contact the Medical Coordinator within 24 hours of admission to receive authorization of treatment or alternatives.

Failure to comply with the Utilization Management requirements will result in reduced Benefits payable. Therefore, if you have a question about Utilization Management, please call the Medical Coordinator. The toll free number is printed on your identification card.

The treatment authorization provided by the Medical Coordinator is only for approval of the medical treatment plan. The Medical Coordinator does not have the authority to verify eligibility for Benefits or approve payment of Benefits. If you or any medical Provider have any questions concerning eligibility of Benefits or Coverage, Preferred Benefit Administrators, Inc. should be called. The toll free number is printed on your identification card.

In case of an Emergency, get the medical care you need as quickly as possible. Then, if you are admitted to a Hospital, have the Hospital or your Physician obtain authorization for your admission from the Medical Coordinator within 48 hours.

TABLE OF CONTENTS

I. PLAN NAME

The name of the Plan is the Westbrook Service Corporation Health Benefit Plan. In this Plan Document and Summary Plan Description it will be referred to as the "Plan".

II. PLAN IDENTIFICATION NUMBER

The Employer identification number (EIN) assigned by the Internal Revenue Service is 59-2924166 and the Plan number is 501. The Group number assigned by the Claims Administrator is 449.

III. PLAN ADMINISTRATOR AND HEADQUARTERS

Westbrook Service Corporation
1411 S Orange Blossom Trail
Orlando, FL 32805
Telephone Number: (407) 591-4594

IV. PLAN YEAR

The initial Plan Year is from March 1, 2019 through December 1, 2019. All future Plan Years will begin on January 1st of each Calendar Year and end on December 31st the same Calendar Year.

V. PLAN SPONSOR

Westbrook Service Corporation established and sponsors the Plan.

VI. LEGAL PROCESS

Legal process may be served on Westbrook Service Corporation, Plan Administrator, at the address shown above.

VII. PLAN CONTRIBUTIONS

Plan contributions are made jointly by Westbrook Service Corporation and its covered Employees. COBRA Participants are responsible for the full cost of Coverage and are subject to the premium payment requirements outlined in this document.

VIII. PLAN TYPE AND ADMINISTRATION

Comprehensive Major Medical type health Benefits are self-funded by the Plan. The self-funded Benefits are summarized in this document.

IX. CLAIMS ADMINISTRATOR

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188
(407) 786-2777 or (888) 524-2777

X. DEFINITIONS

The following definitions have distinctive meanings and when used in this Plan will be capitalized.

A. "**Accident**" means an unforeseeable, unintentional and unplanned event resulting in a traumatic injury to a Participant occurring while this Plan is in force and resulting directly and independently of all other causes of loss covered by this Plan.

B. "**Actively at Work**" means the expenditure of time and energy by an Employee in the service of the Employer except that an Employee shall be deemed Actively at Work on each day of regular paid vacation or on a regular non-working day, on which he/she is not disabled provided he/she was Actively at Work on the last preceding regular working day. The Employer is responsible for providing documentation of active service if requested by the Claims Administrator.

C. "**Adverse Benefit Determination**" means any denial, reduction or termination of Coverage, Benefits or payment (in whole or in part) with respect to a pre-service claim or a post-service claim. Any reduction or termination of Coverage, Benefits or payment in connection with a con-current care decision, as described in this section, shall also constitute an Adverse Benefit Determination.

D. "**Allowable Charge**" for a treatment, supply or other services rendered is determined by the Plan, at the Plan's discretion, by determining the amount established by a negotiated arrangement if one exists, or the lesser of:

- Specified Benefit Amount;
- Gross billed charge made by the provider;
- Usual, Customary and Reasonable payment for the same treatment, service, or supply;
- Prevailing fee charged in an area large enough to obtain a representative cross-section of providers rendering such treatment, supply or services for which the charge is made by Providers of similar skill and experience.
- For Covered Charges rendered by a Physician or other professional provider in a geographic area where applicable law dictates the maximum amount that can be billed by the rendering provider, the Allowable Charge shall mean the amount established by applicable law for that Covered Charge.

The Allowable Charges shall not include:

- Charges for any items billed separately that are customarily included in a global billing procedure code in accordance with American Medical Association's CPT® (Current Procedural Terminology) and/or the Healthcare Common Procedure Coding System (HCPCS) codes used by CMS;
- Charges for billing errors including, but not limited to, up-coding, duplicate charges, and charges for services not performed;
- Charges relating to clearly identifiable errors in medical care;
- Charges the Plan cannot identify or understand the item(s) being billed; or,
- Charges identified based upon a medical record review and audit, which determines that a different treatment or different quantity of a drug or supply was provided.

Nothing in this section shall be construed to limit the Plan's discretion to deem a greater amount payable than the lesser of any of the above-referenced amounts. Furthermore, the Plan is not obligated to consider all factors. In the event that the Plan determines that insufficient information is available to identify the Allowable Charge for a specific service or supply using the listed guidelines above, the Plan reserves the right, in its sole discretion, to determine any Allowable Charge amount for certain conditions, services and supplies using accepted industry-standard documentation, applied without discrimination to any Covered Participant.

E. "**Ambulatory Surgical Center**" is a licensed facility that is used mainly for performing Outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

F. "**Artificial Insemination**" means a medical procedure in which sperm is placed into the female reproductive tract by a qualified healthcare provider for the purpose of producing a pregnancy.

G. "**Assignment of Benefits**" means an arrangement whereby a Plan Participant assigns his or her right to seek and receive payment of eligible Plan benefits to a healthcare Provider. The Plan Administrator may revoke an Assignment of Benefits at its discretion. If the Provider accepts the arrangement, the Provider's right to receive Plan Benefits are equal to those of the Plan Participant, and limited by the terms of the Plan. A Provider that accepts this arrangement indicates acceptance of the Assignment of Benefits as consideration in full for treatment, supplies and other services rendered, and is bound by the terms of this Plan Document & Summary Plan Description.

Benefits that are payable by the Plan to Direct Providers are automatically assigned to the Provider of services or supplies unless evidence of previous payment is submitted. All other Benefits payable by the Plan may be assigned to the Provider of services or supplies at the Plan Participant's option and at the Plan's discretion. Payments made in accordance with an assignment are made in good faith and release the Plan's obligation to the extent of the payment. Reimbursement to Medicaid will be made in accordance with applicable law.

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

H. "**Benefits**" or "**Coverage**" means Hospital, medical, surgical and authorized related expenses as hereinafter provided for which payment shall be made to or on behalf of a Participant.

I. "**Birthing Center**" means a licensed freestanding facility that:

1. Is licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located;
2. Accepts only patients with low risk pregnancies;
3. Is equipped and provides prenatal care, labor, delivery, and immediate postpartum care of a child;
4. Has a Physician or certified nurse midwife present at all births and during the immediate postpartum period;
5. Provides full-time nursing services directed by a registered nurse or certified nurse midwife;
6. Keeps medical records on each patient and child;
7. Has a written agreement with a Hospital in the area for Emergency transfers of a patient or child.

J. "**Calendar Year**" means the period of twelve (12) consecutive months commencing at 12:00 a.m. on January 1 and ending at 12:00 midnight on December 31 of a given year. For Participants enrolling during a Calendar Year, the "Calendar Year" begins on the effective date of their Coverage and ends on December 31 of that same year.

K. "**Chiropractic Care/Spinal Manipulation**" 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.

L. "**Claims Administrator**" means Preferred Benefit Administrators, Inc. or any Successor Corporation or entity.

M. "**COBRA**" means the Consolidated Omnibus Budget Reconciliation Act of 1985 (H.R. 3128) signed into law on April 7, 1986 as Public Law number 99-272 and as amended.

N. "**Coinsurance**" means that portion of a Covered Expense that is paid by the Plan as specified in the Schedule of Benefits.

O. "**Congenital Anomaly**" means a defective development or formation of a part of the body that is learned to have been present and discovered within the first three months following birth.

P. "**Continuation Coverage**" means Coverage under the Plan that, at the time it is being provided, is the same as Coverage under the Plan being provided to similarly situated Employees and Dependents for whom a Qualifying Event has not occurred.

Q. "**Convalescent Care Facility**" means an institution that is licensed to provide, and does provide, the following on an Inpatient basis for persons convalescing from Sickness or injury:

1. Professional nursing care by an R.N., or by an L.P.N. directed by a full-time R.N.;
2. Physical restoration services to help patients to meet a goal of self-care in daily living activities;
3. Twenty-four (24) hours a day nursing care by licensed nurses directed by a full-time R.N.;
4. Is supervised full-time by a Physician or R.N.;
5. Has a utilization review plan; and,
6. Is not mainly a place for rest, for the aged, for drug addicts, for alcoholics, for mental retardates, for custodial or educational care, or for care of mental disorders.

R. "**Co-pay/Co-payment**" means the portion of a Covered Expense that is paid by the Participant as specified in the Schedule of Benefits.

S. "**Cosmetic Surgery**" means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty.

T. "**Covered Expenses**" means expenses up to a reasonable fee, for the services outlined in this Plan. The amount of a Covered Expense paid by the Plan may be subject to limitations as further set forth in this Plan or in the Schedule of Benefits.

U. "**Custodial Care**" means services and supplies furnished to a Participant to train or help in activities of daily living, such as bathing, feeding, dressing, walking and taking oral medicine. Custodial Care also means services and supplies, such as dressing changes and catheter care, which can safely and adequately be supplied by persons other than licensed health care professionals. Custodial Care also means care that ambulatory patients customarily provide for themselves, such as ostomy care, measuring and recording urine and blood sugar levels and administering insulin. The Claims Administrator will decide if a service or treatment is Custodial Care.

V. "**Dependent**" means the Participant's legal spouse who is a resident of the same country in which the Participant resides. The Employee and spouse must have met all of the requirements to obtain a valid marriage contract under applicable state law. The Claims Administrator may require documentation substantiating legal marital relationships.

This Plan does not cover common law spouses or domestic partners.

The Definition of Dependent also includes any children from birth through the end of the Calendar month following the child's 26th birthday.

The term "children" shall include:

1. Any natural or legally adopted children of the Employee or children placed in the covered Employee's home in anticipation of adoption.
2. Any stepchildren of the Employee or the Employee's legal spouse.
3. Any other children for whom the Employee has been appointed by a court as a legal guardian or legal custodian.

A Totally Disabled child that has reached the maximum age for a Dependent under the Plan shall continue to be considered an eligible Dependent provided:

1. the child is incapable of self-sustaining employment by reason of mental or physical handicap;
2. the child is unmarried; and,
3. the child is dependent upon the Employee for support.

An eligible Dependent does not include a spouse of the Dependent child or a child of the Dependent child.

It shall be the responsibility of the Employee to furnish acceptable proof documenting any such incapacity or dependency to the Claims Administrator.

No person may be covered as an Employee and Dependent under this Plan and no person may be covered as a Dependent of more than one Employee under this Plan.

The Claims Administrator may request documentation substantiating all Dependent relationships to the Employee at the time of enrollment or at any other time while the Dependent is covered under this Plan.

Children under age 18 who are in the "pre-adoption period" are eligible Dependents under the Plan and are not subject to any waiting periods of the Plan. Such children are considered eligible Dependents under the Plan even though the adoption proceeding may not be final.

This Plan also recognizes Qualified Medical Child Support Orders (QMCSOs) by providing Benefits for Participants' children without regard to Plan limitations requiring that Participants have custody or that they are able to claim the Dependent for tax purposes. A child who is the subject of a QMCSO is considered to be an "alternate recipient" under the benefit Plan and shall be treated as a Participant under the Plan. Children subject to QMCSOs shall not be excluded from waiting periods.

W. "**Domestic Partner / Domestic Partnership**" means two people of the same or opposite sex who live together and share a domestic life, but aren't married or joined by a civil union.

X. "**Durable Medical Equipment**" means equipment that is:

1. Medically Necessary;
2. prescribed by a Physician;
3. made for and mainly used in the treatment of an injury or Illness;
4. not primarily and customarily used for a non-medical purpose;
5. needed for functional rather than cosmetic reasons;
6. made to withstand prolonged use and suited for use in the home;
7. not disposable;
8. not for altering air quality or temperature or for exercise or training (including, but not limited to, air conditioners, humidifiers, dehumidifiers, purifiers, exercise bicycles, whirlpool baths, sun lamps, heat lamps or heating pads); and

9. not customarily found in a Physician's office.

Y. "**Emergency or Life-Threatening**" means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular Accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

In addition, Emergency includes a mental health or chemical dependency condition when the lack of medical treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Examples of Emergency or Life-Threatening situations are:

- Serious breathing difficulties
- Suspected heart attack
- Major burns
- Spinal injuries
- Convulsions
- Poisoning
- Unconsciousness
- Unusual or excessive bleeding
- Sudden onset of chest pain
- Shock
- Severe broken bones

Z. "**Employee**" means a person who is an active, regular Employee of the Employer, who is regularly scheduled to work thirty (30) or more hours per week and holds a valid social security number.

AA. "**Employer**" means Westbrook Service Corporation and any subsidiaries, as defined in the Claims Administration Contract creating the Health Benefit Plan.

BB. "**Employment Waiting Period**" means the continuous period of time after full time employment begins before an Employee is first eligible to enroll. The Employment Waiting Period is two (2) months with Coverage becoming effective on the first day of the month following completion of the Employment Waiting Period.

CC. "**ERISA**" is the Employee Retirement Income Security Act of 1974, as amended.

DD. "**Experimental and/or Investigational**" means services, supplies, care and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Claims Administrator shall obtain an independent evaluation of the Experimental/non-Experimental standings of specific technologies.

The Experimental and/or Investigational procedure is any medical or surgical procedure, treatment, course of treatment, equipment, drug or medicine:

1. that is under investigation or is limited to research;
2. that is restricted to use in disciplined clinical efforts and scientific studies;
3. which is not proven in an objective way to have therapeutic value or benefit;
4. whose effectiveness is medically questionable;
5. which is not generally accepted by the medical community; or
6. which is a drug or device that has not received a required approval of the U.S. Food and Drug Administration.

This does not include any drug, or the Medically Necessary services associated with the administration of that drug, prescribed for the treatment of cancer that is not approved by the U.S. Food and Drug Administration for a particular indication, if that drug is recognized for treatment of that indication in a standard reference compendium or recommended in the medical literature.

If a technology does not meet the above criteria, in whole or in significant part, it will be deemed Experimental and/or Investigational. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decisions of the Plan Administrator will be final and binding on the Plan.

EE. "**Generic Drug**" means a Prescription Drug that 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.

FF. "**HIPAA**" means Health Insurance Portability & Accountability Act of 1996.

GG. "**Home Health Care Agency**" means a business that provides Home Health Care and is licensed by the state or jurisdiction where treatment is received.

HH. "**Home Health Care Plan**" is a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it states the diagnosis; and it specifies the type and extent of home health care required for the treatment of the patient.

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

JJ. "**Hospice Care**" means care given to a terminally ill Participant by or under arrangements with a Hospice Care Agency.

KK. "**Hospice Care Agency**" means an organization which meets all of the following criteria:

1. Has twenty-four (24) hour Hospice Care available;
2. Is licensed and certified in accordance with the state in which the service is provided;
3. Provides skilled nursing services, medical social services, psychological and dietary counseling;
4. Provides Physician services, physical therapy, part-time home health aide services and Inpatient care;
5. Keeps medical records; and,
6. Has a full-time administrator.

LL. "**Hospital**" means an institution which is licensed and operated in accordance with the laws of the state in which the service is provided and which is primarily engaged in furnishing for compensation, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of a staff of Physicians who are duly licensed to practice medicine; which continuously provides twenty-four (24) hour a day nursing service by Registered Graduate Nurses; and which is not, other than incidentally, a sanitarium, nursing home, place for rest, place for the aged, place for drug addicts or place for alcoholics. "**Hospital**" also means:

1. An institution that is an "Ambulatory Surgical Center" as defined in and licensed by the state in which the service is provided.
2. A psychiatric Hospital that is an institution legally constituted and licensed as a psychiatric Hospital and properly accredited to provide psychiatric, diagnostic and therapeutic services for the treatment of patients who have mental and nervous disorders.

MM. "**Hospital Service**" means and includes receiving a Participant into a Hospital for services set forth in this Plan Document and outlined on the Hospital bill and subject to the rules and regulations of the Hospital for and during such time only as the Participant is necessarily treated on an Inpatient or Outpatient basis in the Hospital, under the treatment and care of a Physician for any conditions covered hereunder.

NN. "**Illness**" means bodily disorder, Sickness, disease or infirmity of a Participant that has been or is diagnosed by a Physician.

OO. "**Immediate Family**" means a covered Employee's mother, father, sister, brother, spouse or child(ren).

PP. "**Impacted Teeth**" means a tooth or teeth so placed in the jawbone(s) that eruption is impossible.

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

RR. "**Inpatient**" means a patient who has been admitted as a bed patient upon order of a Physician for treatment in a Hospital and incurs expense for room and board.

SS. "**Late Entrant**" means an individual who enrolls for Coverage during an Open Enrollment Period after waiving initial eligibility to the Plan. Note, however, a Special Enrollee shall not be considered a Late Entrant.

TT. "**Legal Separation**" means a marital and residential separation of a husband and wife whose respective rights and responsibilities to each other have been reduced to a legally binding agreement.

UU. "**Lifetime Maximum**" means the maximum liability of the Plan as set forth in the Schedule of Benefits, with respect to each Participant.

VV. "**Medical Coordinator**" means the organization that conducts pre-hospitalization screening for treatment approval and oversees the concurrent utilization of the hospitalization. This organization cannot approve Benefits, only treatment.

WW. "**Medically Necessary**" means treatment, care or services that are consistent with the diagnosis, that comply with acceptable medical standards, are not primarily for the Participant's convenience and are the most appropriate level of service which can be safely provided. When applied to Hospital Inpatient care, it means that care cannot be safely provided on an Outpatient basis. In addition, care that has not received federal approval will not be considered Medically Necessary.

The Medical Coordinator must approve the medical necessity of certain services.

XX. "**Medicare**" is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

YY. "**Morbid Obesity**" means a diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight based on sex, height, and frame as reflected in the Claims Administrator's standard ideal weight chart.

ZZ. "**Open Enrollment Period**" means the one-month period prior to the beginning of each Plan Year in which a Late Entrant may access the Plan upon completion of an enrollment application.

AAA. "**Osseous Surgery**" means, for purposes of the Plan, surgery relating to bone tissue of the upper and lower jawbones (maxilla and mandible).

BBB. "**Outpatient**" means a patient who has not been admitted to a Hospital as an Inpatient.

CCC. "**Participant**" means and includes the Employee and any of his or her legal Dependents covered under this Plan. Participant also means a Late Entrant and Special Enrollee and includes those Employees and their Dependents who qualify for Continuation Coverage under COBRA. Any Employee retiring shall not be eligible to participate in the Plan and shall not be a Participant.

Participant also means and includes those Employees who qualify for and take leave under the Family Medical Leave Act of 1993.

DDD. "**Pharmacy**" means a licensed establishment where Prescription drugs are dispensed by a pharmacist licensed under the laws of the state where the pharmacist practices and acting within the scope of his/her license.

EEE. "**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 or Chiropractic (D.C.), Psychologist (Ph.D.), Licensed Professional Physical Therapist, Physio-therapist, Licensed Professional Counselor, Psychiatrist, Audiologist, Speech Language Pathologist, Midwife, Licensed Social Worker, Licensed Mental Health Professional 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.

FFF. "**Plan**" means this Plan Document and Summary Plan Description including any Schedule of Benefits and Amendments attached hereto.

GGG. "**Plan Administrator**" means Westbrook Service Corporation, unless a person or committee of persons is designated by the Employer to administer the Plan on behalf of the Employer.

HHH. "**Pre-Admission Authorization**" means the process in which the Medical Coordinator is contacted to obtain the approval of the medical necessity of the requested treatment.

III. "**Pre-Existing Condition**" In compliance with the Affordable Care Act (ACA), this Plan does not contain Pre-Existing Condition limitations.

JJJ. "**Prescription**" means a request for medication or supplies by a Physician and/or pharmacist acting within the scope of their license.

KKK. "**Prosthetic Device**" means a Medically Necessary replacement of a missing body part by an artificial substitute, such as an artificial extremity.

LLL. "**Provider**" means a person or organization providing services deemed to be Covered Expenses. To the extent that an item or service is a covered benefit under the Plan, the terms of the Plan shall be applied in a manner that does not discriminate against a health care provider who is acting within the scope of the provider's license or other required credentials under applicable State law. This provision does not preclude the Plan from setting limits on benefits, including cost sharing provisions, frequency restrictions on the methods or settings in which treatments are provided and does not require the Plan to accept all types of providers as a Provider.

MMM. "**Qualifying Event**" means the occurrence of an event as defined by COBRA and as specified in the Plan Document.

NNN. "**Reasonable and Customary**" means the common paid amount for the same or comparable service in the geographic area in which the service or supply is furnished. Reasonable and Customary payment is based upon:

- Amount of resources expended to deliver the treatment;
- Complexity of the treatment rendered;
- Generally accepted billing practices for unbundling or multiple procedures;
- Medicare reimbursement rates for comparable services or supplies;
- Costs of provider for providing the service or supply;
- Charging protocols and billing practices generally accepted by the medical community; and
- Amounts paid after discounts under government and private plans.

Nothing in this Section shall be construed to limit the discretion of the Plan. The Plan is not obligated to consider all factors listed above.

OOO. "**Registered Graduate Nurse**" or "**Licensed Practical Nurse**" means a person duly licensed as such by the state in which such person is engaged in the practice of nursing.

PPP. "**Registered Occupational Therapist**" means a person who is duly registered as such by the state in which such person is engaged in occupational therapy practice.

QQQ. "**Registered Physical Therapist**" means a person who is duly registered as such by the state in which such person is engaged in physical therapy practice and who is a member of the American Registry of Physical Therapists. It shall not include a Physical Therapist Technician, a masseur, nor anyone not specifically named as covered.

RRR. "**Second Surgical Opinion**" means a concurring opinion made prior to surgery by a Board Certified Specialist who is not financially associated with the referring Physician. The purpose of the Second Surgical Opinion is to obtain another opinion as to the medical necessity of the recommended surgery.

SSS. "**Sickness**" means a bodily disorder, Illness, or infirmity that has been or is diagnosed by a Physician.

TTT. "**Skilled Nursing Facility**" is a facility that fully meets all of these requirements:

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 Graduate Nurse (R.N.) or by a Licensed Practical Nurse (L.P.N.) under the direction of a Registered Graduate 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.

A Skilled Nursing Facility shall also include a Convalescent Care Facility and Rehabilitation Facility.

UUU. "**Special Enrollee**" means an eligible Employee or Dependent who is entitled to and requests enrollment in the Plan in accordance with a Special Enrollment Period.

VVV. "**Special Enrollment Period**" means the thirty (30) day period following an individual's loss of other health coverage due to ineligibility, exhaustion of COBRA coverage, termination of employment, reduction in work hours or termination of employer contributions. Voluntary termination of coverage does not constitute a loss of eligibility.

An individual's loss of other health coverage may not be the result of the individual's failure to pay premiums or for cause (such as making a fraudulent claim).

It shall also mean the thirty (30) day period following marriage of the Employee or the birth, adoption or placement for adoption of a dependent child.

An individual has sixty (60) days from the termination date of Medicaid or CHIP coverage to enroll for coverage under the Special Enrollment provisions of this Plan.

WWW. "**Specified Benefit Amount**" means the charges for services and supplies, listed and included as Covered Charges under the Plan, which are Medically Necessary for the care and treatment of Illness or Injury, but only to the extent that such fees do not exceed the Specified Benefit Amount. The determination that a charge does not exceed the Specified Benefit Amount include, but are not limited to, the following guidelines:

- 1.4 times the Medicare allowed amount for a Hospital facility, facility which is owned and operated by a Hospital, or an Ambulatory Surgery Centers;
- 1.15 times the Medicare allowed amount for pharmacy charges;
- 1.4 times the Medicare allowed amount for Physician and other eligible Providers;
- 100% of the Organ Procurement Organization's invoice cost; and,
- 100% of the National Marrow Donor Program's invoice cost.

XXX. "**TMJ**" is the abbreviation for temporal mandibular joint, which is the joint between the temporal bone in the skull (temple area) and the mandible (lower jawbone).

YYY. "**Totally Disabled / Total Disability**" means a medically determinable physical or mental impairment which renders a Participant so incapacitated as to be unable to engage in most of the normal activities of a person of like age and sex in good health.

ZZZ. "**Urgent Care**" means care/treatment required to prevent serious deterioration of a Participants health within 48 hours of an unforeseen Sickness or Injury.

AAAA. "**Utilization Management**" means the process of pre-screening and reviewing all Hospital admissions to authorize the plan of treatment, length of stay and medical necessity.

XI. ELIGIBILITY OF EMPLOYEES AND DEPENDENTS

A. A full-time Employee, as defined in Section X., Item Z. of this document, is eligible to participate in this Plan upon completion of the Employment Waiting Period.

B. Dependents eligible to participate are outlined in Section X., Item V. of this document. Benefits may be continued for a Dependent child who is physically or mentally handicapped.

C. If an Employee is eligible for Benefits, he/she is not eligible as a Dependent, except when both the Employee and the Employee's spouse are eligible Employees and he/she desires Dependent child(ren) Coverage. In this case the Employee may cover his/her spouse and children as Dependents for health Benefits.

D. Participants who are active in the armed services are not eligible under this Plan.

E. Employees who meet the eligibility requirements for Coverage through the Plan following the Employer's look-back / measurement period, as required by the Affordable Care Act (ACA), shall be offered the opportunity to enroll for Coverage in the Plan. If elected, the Employee will be enrolled in the Plan and shall remain covered by the Plan for the duration of the stability period following the Employee's enrollment, subject to any premium payment requirements established by the Employer.

The Employer's classification of an eligible Employee is conclusive and binding for purposes of determining eligibility under this Plan. As long as the Employee remains employed by the Employer, no reclassification of an Employee's status, for any reason, will change a person's eligibility for benefits during the following stability period.

XII. ENROLLMENT AND COVERAGE EFFECTIVE DATE

A. To be covered under this Plan, an Employee must enroll for medical Benefits offered by the Employer, unless covered for medical care under a government plan or as a Dependent under his/her spouse's plan.

B. For an Employee who was enrolled and covered under a prior Employer sponsored Plan immediately before the effective date of this Plan, including Dependent Coverage if such is elected, Coverage shall commence as of the effective date of the Employer without interruption as to eligibility.

C. To be assured Coverage, the Employee must complete an enrollment application before the end of the Employment Waiting Period. The Employee's Dependents should be enrolled at the same time, if they are eligible. The enrollment application must be completed in its entirety and must include social security numbers for all members enrolling in the Plan, as required by CMS-Medicare Secondary Payer Mandatory Reporting provisions (MMSEA Section 111).

D. If an Employee enrolls during the Employment Waiting Period and the enrollment application is received by the Claims Administrator no later than thirty (30) days following the eligibility date, Coverage will begin on the first day of the month following completion of the Employment Waiting Period.

E. Those eligible Employees who refuse Coverage under this Plan or fail to apply for Coverage within thirty (30) days following their eligibility date, may apply for Coverage during the next scheduled Open Enrollment Period or Special Enrollment Period, if applicable.

F. If an Employee was covered under this Plan and Coverage terminated because his/her employment terminated and he/she then returns to eligible employment within 13 weeks, Coverage may be reinstated without serving a new waiting period if he/she enrolls within thirty (30) days after resuming full-time employment. If the rehired Employee fails to enroll within thirty (30) days or returns to full-time employment after the 13 week rehire period, the Employee shall be subject to a new Employment Waiting Period.

G. Coverage for a person who becomes an eligible Dependent of an Employee due to marriage shall become effective provided the Employee files an application within thirty (30) days of marriage and the Employee is duly enrolled. The effective date of such Coverage shall be the first day of the month following receipt by the Claims Administrator of notification. If the Employee fails to apply within the thirty (30) day period Coverage may not be requested until the next Open Enrollment Period or during a Special Enrollment Period, if applicable.

H. When changing Coverage due to the birth of a baby, a Change Application must be completed within thirty (30) days of the baby's birth for Coverage to be effective at the time of birth. If Coverage is not changed to family Coverage within this thirty (30) day period, Coverage may not be requested until the next Open Enrollment Period or Special Enrollment Period, if applicable.

A Dependent child of a Participant having Coverage for that Dependent is entitled to the same Benefits as the Participant including maternity Benefits.

I. In the event an actively working Employee or spouse of an actively working Employee reaches age 65 or above, the Employee and/or spouse may elect to continue to be covered for the same Benefits available to Employees and spouses under age 65. If the Employers Health Plan is elected as the primary payor of claims, this Plan will pay all eligible expenses first and Medicare will process any remaining Medicare eligible expenses. If Medicare is elected as the primary Coverage, the Participant will not be eligible for Benefits under this Plan.

J. A covered Employee may remain eligible for a limited time if active, full-time work ceases due to disability. This continuance, for disability leave only, will end on the last day of the month following the three (3) calendar month period that the person last worked as an active Employee.

While continued, Coverage will be that which was in force on the last day worked as an active Employee. However, if Benefits reduce for other covered Employees, they will also reduce for the continued person.

K. Regardless of the established leave policies mentioned above and herein, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family Medical Leave Act, the 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.

XIII. TERMINATION OF COVERAGE

Important Notice: If an Employee or any covered Dependent no longer meets the eligibility requirements of the Plan, the Employee and/or covered Dependents are responsible for notifying the Employer or Claims Administrator of the change in status. Coverage will not continue beyond the last date of eligibility even if notice has not been given to the Employer or Claims Administrator. Lack of timely notice could void COBRA eligibility.

Unless a Participant or his/her Dependents elect to continue Coverage under the provisions of the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985:

A. Coverage for an Employee and any covered Dependents will terminate on the last day of the month following termination of employment of the Employee.

B. Coverage will terminate if the covered Employee fails to remit required contributions for Coverage when due.

C. Coverage will terminate on the day a covered Participant enters the military, naval or air force of any country or international organization on a full-time active duty basis other than scheduled drills or other training not exceeding one (1) month in any Calendar Year. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA).

D. Coverage will terminate when a covered Participant ceases to maintain full-time residency in the United States of America or Canada.

E. Coverage for an Employee shall automatically cease at the end of the month such Employee no longer meets the definition of an Employee in this Plan.

F. Coverage for the spouse of an Employee shall automatically cease at the end of the month upon a divorce or Legal Separation of the spouse and Employee.

G. Coverage for the spouse and Dependents of an Employee shall automatically cease at the end of the month upon the death of the Employee.

H. Coverage for a Dependent child of an Employee shall automatically cease at the end of the month when the child no longer meets the definition of a Dependent.

I. Coverage for a spouse and Dependents will automatically cease when the Employee becomes entitled to and elects to receive primary Benefits provided under Title XVIII of the Social Security Act (Medicare).

J. Coverage for all Participants shall cease upon termination of this Plan.

XIV. CONTINUATION COVERAGE FOR COBRA PARTICIPANTS

As required by COBRA, each qualified beneficiary who will lose Coverage under the Plan as a result of a Qualifying Event shall be entitled to elect, within the election period, Continuation Coverage under the Plan.

A. "Qualifying Events" are:

1. The death of a covered Employee.

2. The termination of a covered Employee's employment, or the reduction in hours of a covered Employee's employment, except by reason of gross misconduct, ("termination/reduction").

3. The divorce or Legal Separation of the covered Employee.

4. A Dependent child ceasing to be eligible for Coverage as a Dependent child under the Plan.

5. The covered Employee becoming entitled to Medicare Benefits.

B. Qualified beneficiaries are specified individuals who will lose Coverage under the Plan as a result of a Qualifying Event. In general, an individual is deemed to "lose Coverage" under the Plan if Coverage under the Plan will no longer be available to him/her under the same terms and conditions as in effect prior to the Qualifying Event. For all Qualifying Events, "qualified beneficiaries" are the spouse and Dependent children of a covered Employee who are Participants on the day before a Qualifying Event. In the case of a Qualifying Event that is a termination/reduction, the covered Employee is also a qualified beneficiary.

C. Subject to this Section, Continuation Coverage for COBRA Participants and paragraph E of this Section, the maximum required period of Continuation Coverage shall be determined as follows:

1. For a termination/reduction, the period of Continuation Coverage begins on the date of the termination/ reduction and ends eighteen (18) months later. If a qualified beneficiary is Totally Disabled at the time of or within sixty (60) days following the Qualifying Event as determined under Title II or XVI of the Social Security Act, Continuation Coverage may extend to a maximum of twenty-nine (29) months, provided the qualified beneficiary has given notice of Total Disability to the Plan Administrator before the end of the eighteen (18) months.

2. For any other Qualifying Event, the period of Continuation Coverage begins on the date of the Qualifying Event and ends thirty-six (36) months later. EXCEPTION: If a Qualifying Event other than a termination/reduction occurs within the eighteen (18) months following a termination/reduction, then the thirty-six (36) month period of Continuation Coverage begins on the date of the termination/reduction. (Also see paragraph G.2. of this Section.)

D. Continuation Coverage for all qualified beneficiaries shall end on the date the Employer ceases to provide any group health plan to any Employee or on the date the maximum Continuation Coverage period expires for a Qualifying Event. Furthermore, Continuation Coverage for a qualified beneficiary shall not be provided on or after the date the first of the following occurs:

1. Payment of a contribution for the qualified beneficiary's Continuation Coverage is not made within thirty (30) days of the date it is due.

2. The qualified beneficiary is covered under another group health plan, unless the other group health plan excludes or limits Pre-Existing Conditions, and the qualified beneficiary has a Pre-Existing Condition.

Note: Qualified beneficiaries who are covered under another group health plan on the date of election may elect Continuation Coverage, however, this Plan shall be considered the secondary payor for all claims incurred.

3. The qualified beneficiary is entitled to Medicare Benefits.

E. Qualified beneficiaries shall make contributions for Continuation Coverage which shall not exceed 102% of the reasonable estimate of the cost of providing Coverage for similarly situated Employees and Dependents for whom a Qualifying Event has not occurred, as determined on an actuarial basis in accordance with any regulations under COBRA. Employers may charge 150% of the reasonable estimate of the cost for disabled qualified beneficiaries beginning in month nineteen (19) to month twenty-nine (29). Contributions for Continuation Coverage shall be made in monthly installments. If an election is made after the Qualifying Event, a qualified beneficiary shall have forty-five (45) days from the date of election to pay the applicable contribution for Coverage that was in effect prior to the date of election.

F. The "election period" begins no later than the date Coverage under the Plan would otherwise terminate and ends sixty (60) days following the later of the date notice is sent to qualified beneficiaries or the date Coverage under the Plan would otherwise terminate. Continuation Coverage shall not be provided to any qualified beneficiary for whom an election is not made during the election period.

G. The following notice requirements apply:

1. In the event of a covered Employee's death or termination/reduction, the Employer shall within thirty (30) days notify the Plan Administrator. The Plan Administrator shall then, within fourteen (14) days, notify qualified beneficiaries of their right to elect Continuation Coverage.

2. In the event of a covered Employee's divorce or Legal Separation or a Dependent child ceasing to be eligible for Coverage as a Dependent under the Plan, the Employee or the qualified beneficiary is required to notify the Plan Administrator within sixty (60) days of the Qualifying Event. Upon receipt of notice, the Plan Administrator shall, within fourteen (14) days, notify qualified beneficiaries of their right to elect Continuation Coverage. Continuation Coverage shall not be provided to any qualified beneficiary on whose behalf notification of divorce, Legal Separation or a Dependent child ceasing to be eligible for Coverage as a Dependent under the Plan is not made to the Plan Administrator within sixty (60) days.

3. Qualified beneficiaries must notify the Plan Administrator within sixty (60) days after it has been determined that they were disabled at the time of or within sixty (60) days following the Qualifying Event, as determined under Title II or XVI of the Social Security Act, and within thirty (30) days after a determination has been made that the qualified beneficiary is no longer disabled. The Participant must submit their letter from the Social Security Administration confirming the disability status.

4. Notice to qualified beneficiaries shall be by first class mail to their last known address. The Employer shall notify the Claims Administrator as soon as possible of an election of Continuation Coverage.

H. If a qualified beneficiary's Continuation Coverage lasts the maximum required period, the qualified beneficiary may apply for any conversion Plan otherwise generally available during the last one hundred and eighty (180) days of his/her Continuation Coverage.

XV. DEDUCTIBLE & CO-PAYMENTS

A. The deductible amount is the amount of covered charges for which no Benefits will be paid. Before Benefits can be paid in a Calendar Year a covered person must meet the deductible shown in the Schedule of Benefits.

B. The Deductible applies to all covered medical expenses, unless otherwise noted in the Schedule of Benefits. The following expenses will not be used to satisfy the Deductible amount:

1. amounts which a Covered Person is required to pay as a result of a reduction in covered charges due to failure to comply with this Plan's Utilization Review Program;

2. amounts which are greater than Reasonable and Customary Charges;

3. charges incurred for treatment, services or supplies which are not covered under this Plan;

4. charges in excess of benefit limitations (e.g. number of days, months, visits or dollar amounts).

C. *Individual Deductible:* The individual deductible is the dollar amount of covered expenses that each Participant must incur during each Calendar Year before the Plan pays applicable Benefits. The individual deductible amount is specified in the Schedule of Benefits.

Family Deductible: If covered family members incur covered expenses that are subject to the Calendar Year deductible, each family member will be charged no more than the individual deductible and all charges will accumulate towards the family deductible. Any number of family members may help meet the family deductible amount, but no more than each person's individual deductible amount will be applied toward satisfaction of the family deductible.

No family will be charged more than the family deductible specified in the Schedule of Benefits. The family deductible will be considered satisfied for all family members for the Calendar Year once total family deductible expenses equal the family deductible.

D. If a covered Participant has a change in status from an Employee to Dependent or Dependent to Employee, and the Participant was covered under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to benefit maximums.

XVI. MAXIMUM EXPENSE TO PARTICIPANTS

Benefits payable at the Coinsurance rate as indicated in the Schedule of Benefits will be increased to a Coinsurance rate of 100% in accordance with the Schedule of Benefits once the Out-of-Pocket Maximum has been satisfied.

XVII. CONDITIONS FOR RENDERING SERVICE

A. The Participant should present the identification card issued by the Claims Administrator when applying for Hospital or Physician services.

B. The Plan does not confer upon the Claims Administrator or any Hospital any rights to select a Physician for the Participant. The Participant is at liberty to select his or her Physician provided such Physician is acceptable for practice in the Hospital to which the Participant is admitted. Nothing contained herein shall interfere with the ordinary relationship between the Participant and the Physician selected by the Participant.

C. The Plan does not undertake to furnish any services but merely to pay a Hospital or Physician for services to the Participant to the extent herein specified. The Plan shall not, in any event, be liable for any negligence, misfeasance, nonfeasance, malfeasance, malpractice or any act of commission or omission on the part of any Physician, Hospital, or other health care Provider, or the agent or employee of any Physician, Hospital, or other health care Provider.

XVIII. COVERED EXPENSES

Each Participant is entitled to the services listed below when incurred while the Plan is in force and when necessary and consistent with the Accident or Sickness for which the Participant is being treated. All Benefits are subject to the Calendar Year deductible, Co-payments and Coinsurance, as specifically stated in the Schedule of Benefits.

A. Inpatient Hospital Services

1. Hospital room and board.

2. Intensive Care Unit (not to exceed 3 times the average semi-private room rate).

3. Progressive Care Unit (not to exceed 1 ½ times the average semi-private room rate).

4. Use of operating, delivery, recovery or other specialty service rooms and any equipment or supplies therein.

5. All drugs and medications (including intravenous injections and solutions) for use while in the Hospital and which are released for general use and are commercially available to Hospitals.

B. Other Medical Services and Supplies

1. Physician care. The professional services of a Physician for surgical or medical services.

2. Hospital charges for emergency room care or for surgical services performed in the Outpatient department of the Hospital.

3. Emergency professional ambulance service to the nearest Hospital able to provide the care required for the patient. All other ambulance services/charges are subject to prior approval by the Claims Administrator.

4. Solutions, including glucose.

5. Dressings, including ordinary casts.

6. Splints, casts and trusses.

7. Insulin, needles, syringes, clinitest, glucose strips and chemstrips.

8. Initial (under this Plan) Prosthetic Appliances. There is Coverage for replacement due to growth if the Participant is younger than 18 years old. Repair, replacement and duplicates are not covered regardless whether the prostheses was purchased before or during Coverage under this Plan.

9. Crutches, braces, standard model wheelchair or other mechanical appliances Medically Necessary for the correction of conditions arising out of injury or Sickness. The Claims Administrator shall have the right to buy or rent such appliances as they may elect.

10. Services of a Registered Nurse or Licensed Practical Nurse.

11. Initial eye glasses or contact lenses resulting only from cataract or glaucoma surgery (including those surgically implanted).

12. Transfusion supplies and services including blood administration expenses, blood, blood plasma and/or blood derivatives not donated or replaced by a blood bank or otherwise.

13. Anesthesia services including supplies and equipment for regional, intravenous, inhalation, intraspinal and caudal anesthesia services. It shall also include the services of a Certified Registered Nurse Anesthetist (CRNA).

14. Diagnostic x-ray, laboratory and pathology services.

15. Oxygen therapy, diathermy and physiotherapy.

16. Electrocardiograms and electroencephalograms.

17. Therapeutic treatment by a radiologist including radium, radon, isotope therapy, x-ray and cobalt bomb therapy when in connection with proven malignancies.

18. Cardiac Pacemakers.

19. Obstetrical Care. The expense will be considered incurred at the termination of the pregnancy. In compliance with Public Law 95-555 maternity Benefits will be provided subject to the same limitations and exclusions as all other conditions covered under this Plan.

    Complications of pregnancy are deemed to be a Sickness and are payable on this same basis as any other Sickness.

20. Initial amniocentesis and sonogram. Additional tests will be reviewed based on medical necessity.

21. Newborn Care - Benefits are provided under this Plan for a newborn Dependent child of a Participant from the moment of birth for covered injury or Sickness; including necessary care or treatment of medically diagnosed congenital defects, birth abnormalities, or prematurity. Also covered are routine Inpatient Hospital Physician charges at birth.

    NOTE: If the covered Employee does not have Dependent Coverage, the Employee must make application for Coverage within thirty (30) days of the birth of the newborn. Application

must be received and approved by the Claims Administrator within this thirty (30) day period for the newborn to be covered. If an Employee fails to apply for Coverage during this thirty (30) day period Coverage may not be requested until the next scheduled Open Enrollment Period.

22. Birthing Center. Services rendered by a Birthing Center inclusive of all charges for services and supplies to a Participant for:

- Prenatal care;
- Delivery; and,
- Postpartum care rendered within twenty-four (24) hours of delivery.

23. Transportation of a newborn child to and from the nearest available facility appropriately staffed and equipped to treat the newborn's condition. The attending Physician must certify that transportation is necessary to protect the child's health and safety.

24. Services and supplies for sterilization procedures such as tubal ligation or vasectomy.

25. Dental care and treatment rendered by a Physician or dentist, when as the result of an Accident, sound natural teeth have been damaged or a fractured or dislocated jaw requires setting and such treatment is begun within ninety (90) days of the date of the Accident. A sound natural tooth refers to a tooth that is free from defect or disease, and is not artificial. Inpatient Hospital charges required for dental care not otherwise covered are eligible if Medically Necessary due to a Life-Threatening Illness or disease.

26. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

27. Treatment and services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.

28. Excision of benign bony growths of the jaw and hard palate.

29. External incision and drainage of cellulitis.

30. Incision of sensory sinuses, salivary glands or ducts.

31. Prescription medicines when ordered by a Physician consistent with the treatment of a specific diagnosis and when dispensed by a Licensed Pharmacist. Vitamins (except pre-natal vitamins), minerals and over-the-counter medications dispensed on an Outpatient basis are not eligible for reimbursement even though prescribed by a Physician.

32. Oral Contraceptives (birth control pills).

33. Contraceptive devices including the insertion or removal of intrauterine devices, diaphragms, injectable contraceptives and implanted hormonal contraceptives.

34. Infertility services including office visits, diagnosis, and diagnostic procedures to determine the cause of infertility, laboratory work and treatment of infertility. Benefits are limited to testing, Artificial Insemination, and surgical procedures to correct conditions causing infertility.

35. Autism Spectrum Disorder services shall be provided to a covered Dependent under the age of 18, or if 18 years or older, is attending High School and was diagnosed with Autism Spectrum Disorder prior to his or her 9th birthday consisting of:

a. well-baby and well-child screening for the presence of Autism Spectrum Disorder;

b. Applied Behavior Analysis, when rendered by an individual who is certified by the state to render such analysis; and

c. Physical Therapy performed by a Physical Therapist, Occupational Therapy performed by a Occupational Therapist and Speech Therapy performed by a Speech Therapist. Covered therapies performed for the treatment of Autism Spectrum Disorders are covered even though they may be habilitative in nature (provided to teach a function) and are not necessarily limited to restoration of a function or skill that has been lost.

The Claims Administrator reserves the right to request a formal written treatment plan signed by the treating Physician to include the diagnosis, the proposed treatment type, the frequency and duration of treatment, the anticipated outcomes stated as goals, and the frequency with which the treatment plan will be updated, but no less than every 6 months.

36. Routine Patient costs associated with a qualified individual participating in an approved clinical trial. An approved clinical trial must be in Phase I, Phase II, Phase III or Phase IV and is:

- Conducted in connection with the prevention, detection or treatment of cancer or other life-threatening condition and is federally funded;
- Conducted in connection with an investigational new drug application reviewed by the FDA; or
- Exempt from investigational new drug application requirements.

A qualified individual is to be considered a covered Participant who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening condition and either:

- The referring health care professional is a participating provider and has concluded that the individual's participation in the clinical trial would be appropriate; or
- The individual provides medical and scientific information establishing that his or her participation in the clinical trial would be appropriate.

Routine Patient Costs do not include: (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the Patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

37. Mastectomy services are provided, in accordance with the Women's Health and Cancer Rights Act of 1998, for the reasonable fees for Inpatient Hospital and Physician services associated with the surgical procedure known as a mastectomy, defined herein to mean the removal of all or a part of the breast if determined Medically Necessary by a Physician. Prosthetic Devices and reconstructive surgery incidental to the mastectomy, shall be covered as follows:

- Coverage for reconstruction of the breast on which the mastectomy has been performed.
- Coverage for surgery and reconstruction of the other breast to produce symmetrical appearance.
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedema; in a manner determined in consultation with the Physician and patient.

38. Treatment of sleep apnea, including sleep studies.

39. Charges incurred by the Plan for medical records necessary to properly evaluate a participant's medical condition.

C. Alcohol and Substance Abuse Benefit

Benefits for the treatment of alcoholism, alcohol abuse or substance abuse are eligible as specified in the Schedule of Benefits.

D. Chiropractic Services

The reasonable fees for all chiropractic services shall be covered as specified in the Schedule of Benefits.

E. Durable Medical Equipment

Durable Medical Equipment required for temporary therapeutic use shall be eligible as specified in the Schedule of Benefits. The Claims Administrator, on behalf of the Plan, shall have the right to buy or rent such equipment as they may elect.

F. Extended Care Facility

If a Participant is confined in a Skilled Nursing Facility, rehabilitation facility or extended care facility immediately following a Hospital confinement, benefits are payable as specified in the Schedule of Benefits.

G. Home Health Care

This Plan will pay for services of a Home Health Care Agency for services furnished for Home Health Care as specified in the Schedule of Benefits. A copy of a Treatment Plan must be submitted as part

of the claim submission. Charges made by a Home Health Care Agency include charges for the following Home Health Care Services furnished to a Participant in the home in accordance with a Home Health Care Plan.

1. Part-time or intermittent nursing care by or under the supervision of a Registered Graduate Nurse (R.N.), if Medically Necessary;
2. Part-time or intermittent Home Health Aide services;
3. Occupational therapy, speech therapy and physical therapy provided by a Home Health Care Agency;
4. Medical supplies and drugs prescribed by a Physician;
5. Laboratory services.

H. Hospice Care Benefit

Hospice Care Benefits are payable for services reasonable and necessary for the palliation or management of a terminal Illness. Benefits shall be payable as specified in the Schedule of Benefits. Hospice Care will only be approved once for a Participant.

A Participant will be eligible for Hospice Care Benefits under the Plan if the Participant meets all of the following conditions:

1. The Participant is eligible for Benefits under the Plan.
2. A written statement is submitted by the hospice facility and attending Physician:
   a. Attesting that the patient is terminally ill;
   b. Attesting that the patient has a life expectancy of six (6) months or less; and,
   c. Indicating the type and extent of care required for the treatment of the patient.

I. Mental and Nervous Condition Services

The reasonable fees for the services of Physicians, Psychiatrists, Licensed Psychologists, Licensed Social Workers, Licensed Mental Health Professionals and Hospitals for the treatment of mental and nervous conditions are provided as specified in the Schedule of Benefits.

J. Outpatient Physician Office Visit

Benefits rendered by a Physician during an office visit shall be payable as specified in the Schedule of Benefits. This shall include coverage for the office visit charge, supplies & minor surgical procedures performed in the Physician's office during the office visit and x-ray, laboratory, diagnostic services even though they may be sent to an outside facility for processing/evaluation.

If a Physician refers the patient to an outside facility to have x-ray or laboratory services performed, an additional Co-payment or the deductible and Coinsurance provisions of the Plan shall apply as specified in the Schedule of Benefits.

K. Outpatient Surgical Procedures

Benefits for outpatient surgical procedures shall be payable as specified in the Schedule of Benefits.

L. Outpatient X-Ray and Laboratory Services

Services for Outpatient Hospital and Physician charges for diagnostic x-ray, laboratory and pathology shall be payable as specified in the Schedule of Benefits.

M. Prescription Drug Card & Mail Order Drug Program

When using your Prescription Drug Card or the Mail Order Drug Program, benefits shall be payable for Brand or Generic Prescriptions as specified in the Schedule of Benefits. Benefits are NOT available for Prescriptions purchased from non-participating Pharmacies.

N. Rehabilitative Therapy Services

The following rehabilitative therapy services shall be covered by the Plan as specified in the Schedule of Benefits:

Services of a Registered Physical Therapist for physical therapy provided on an Outpatient basis are covered as specified in the Schedule of Benefits, provided such services are ordered by a Physician. Physical Therapy treatment includes the necessary treatment of Sickness or injury by physical means, such as massage, hydrotherapy or heat treatment.

Services of a licensed Registered Occupational Therapist for occupational therapy performed on an Inpatient or Outpatient basis are provided as specified in the Schedule of Benefits.

Services of a licensed speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness, other than a functional nervous disorder, or due to surgery on account of an Illness are provided as specified in the Schedule of Benefits. If the speech loss or impairment is due to a Congenital Anomaly, surgery to correct the anomaly must have been performed prior to the therapy.

Services of a cardiac rehabilitation facility for cardiac rehabilitation on an Outpatient basis are eligible as specified in the Schedule of Benefits, provided such services are prescribed by a Physician and are under the direct supervision of a Physician. A Participant who is eligible for this Benefit must meet one of the following criteria:

1. Myocardial Infarction - A post myocardial infarction patient may enter the program any time at the discretion of and referral from a Physician.
2. Post-Op Cardiovascular Surgery - The Participant must be a minimum of three weeks post aorta-coronary bypass surgery, or at the discretion of and referral from his/her Physician.
3. The patient must require adequate control of complications, such as angina, congestive heart failure or arrhythmias.
4. Pacemaker patients with any of the above diagnoses and/or with decreasing functional capacity may enter this program.

O. Routine Well Adult Care

The reasonable fees charged for physical examinations and testing, which are not required for the treatment of an Illness or injury, will be eligible as specified in the Schedule of Benefits. A list of eligible routine services is outlined in the Schedule of Benefits.

Benefits for mammograms shall be included in the Routine Well Adult Care benefit subject to the following:

1. A baseline mammogram for women who are 35 years of age or older, but younger than 40 years of age.
2. A mammogram for women who are 40 years of age or older, but younger than 50 years of age every 2 years, or more frequently based upon the patient's Physician's recommendation.
3. A mammogram every year for women who are 50 years of age or older.

P. Routine Well Child Care

The reasonable fees charged by a Physician for physical examinations, appropriate immunizations and laboratory tests which are not required for the treatment of Sickness or injury, histories, developmental assessments and anticipatory guidance in keeping with prevailing medical standards from the moment of birth to 18 years of age are payable as specified in the Schedule of Benefits subject to the following:

1. Benefits are limited to one visit and are payable to only one Provider for all services provided or ordered at that visit.
2. If an appropriate immunization, lab test or part of an examination cannot be performed at a particular age, such service will be covered on the next scheduled visit.

Q. Transplant Benefit

Medically Necessary charges incurred for the care and treatment due to an organ or tissue transplant that is not considered Experimental or Investigational, subject to the following criteria:

1. Charges do not exceed the Allowable Charge;
2. Transplant must be performed to replace an organ or tissue;
3. Charges for obtaining donor organs or tissues are Covered Charges under the Plan only when the recipient is a Plan Participant. When the donor has medical coverage, his or her Plan will pay first. The donor benefits under this Plan will be reduced by those payable under the donor's Plan.

Donor charges include those for:

1. Evaluating the organ or tissue;
2. Removing the organ or tissue from the donor;
3. Transportation of the organ or tissue from within the United States or Canada to the facility where the transplant is to be performed; and,

4. Charges listed above that are not in violation of any federal or state law.

If a transplant is performed pursuant to a negotiated arrangement and the Plan Participant resides 50 miles or more from the transplant facility, the Plan will pay for the following services incurred during the transplant benefit period subject to the maximum benefit as specifically stated in the Schedule of Benefits:

- Transportation expenses to and from the Center of Excellence facility for the following individuals:
  - The Plan Participant; and
  - One or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child); or
  - One adult to accompany the Plan Participant; and,
  - Living donor (if applicable under the Plan).

Transportation expenses include commercial transportation (coach class only).

Reasonable lodging and meal expenses incurred for the living donor, Plan Participant, and one or both parents of the Plan Participant (only if the Plan Participant is a Dependent minor child), or one adult companion who is accompanying the Plan Participant, only while the Plan Participant is receiving transplant-related services at the Directly Contracted Provider.

Lodging, for purposes of this Plan, will not include private residences.

XIX. UTILIZATION MANAGEMENT

A. Pre-Admission Treatment Authorization

1. The Plan requires all Inpatient Hospital confinements to be approved by the Medical Coordinator.

2. All non-Emergency confinements must be approved prior to entering the facility. All Emergency admissions must be approved within forty-eight (48) hours of the admission.

3. In compliance with the Newborn and Mother's Health Protection Act of 1996, group health plans generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours as applicable). In addition, a provider is not required to obtain pre-certification authorization unless the length of stay will exceed 48 hours (96 hours as applicable.)

4. The telephone number for contacting the Medical Coordinator is on the Participant's identification card.

5. Benefits will be reduced as specified in the Schedule of Benefits if:

   a. The Participant does not obtain the pre-authorization approval.

   b. The Medical Coordinator does not approve the request for services.

B. Concurrent Utilization Review

The Plan requires a length of confinement be set at the time the treatment is authorized by the Medical Coordinator. If an additional length of stay is requested, the Medical Coordinator must be contacted. The Medical Coordinator will either approve an extension of the Hospital confinement or will advise the patient and attending Physician that Benefits will be reduced if the confinement exceeds the date authorized.

C. Retrospective Review

In the event a retrospective review becomes necessary, and the confinement is deemed Medically Necessary, charges will be considered the same as a pre-authorized confinement.

D. Alternate Care

Alternate plans of medical treatment must be beneficial to both the Participant and this Plan. The Utilization Management organization or case manager shall coordinate and implement a plan by providing guidance and information on available resources and suggest the most appropriate treatment plan. The Claims Administrator, attending Physician, patient and patient's family must all agree to any alternate treatment plan. Once agreement has been reached, the Plan will reimburse for

medical services as stated in the treatment plan, even if these expenses normally would not be covered by this Plan.

Note: Participation in an alternative treatment plan is voluntary. There is no reduction in benefits or penalties that will be applied if the patient chooses not to participate.

XX. HOSPITAL BILL SELF-AUDIT

The Plan will provide a payment to the participating Employee in the amount of 25% of the savings (the total dollar difference between the original bill and the revised bill), not to exceed the Participant's actual out-of-pocket expenses (deductible and Coinsurance) for that claim. The maximum payment is limited to your out-of-pocket expenses to avoid possible taxation of any payment you may receive through this program. The Employee will receive a payment from the Plan for any errors that the Employee identifies and the Hospital corrects.

The Participant must take the following steps before contacting the Claims Administrator:

A. Obtain a copy of the itemized bill before leaving the Hospital or make arrangements for an itemized bill to be sent to you.

B. Review the Hospital bill for overcharges or errors on the bill.

C. If you feel an error has been made, contact the business office of the Hospital to review the possible error(s).

D. Request the business office of the Hospital to satisfactorily explain the possible error(s) or issue a revised bill that contains the credit(s) for the incorrect charge(s).

E. Send the revised bill to the Claims Administrator with a letter outlining your actions, the amount of savings and your request for payment.

XXI. EXCLUSIONS AND LIMITATIONS

Coverage under this Plan is subject to the following exclusions and limitations for which no Benefits shall be paid:

A. Fees in excess of the maximums specified in the Schedule of Benefits or fees in excess of reasonable fees.

B. Any Benefit or service provided after Coverage has been terminated for the group or for the Participant.

C. Treatment, care, services or supplies that are obtained without cost to the Participant.

D. Treatment, care, services or supplies for which the Participant would have no obligation for payment if such Participant were not eligible under this Plan.

E. Professional medical or surgical services rendered by an individual who is related to the Participant by blood or marriage.

F. Benefits payable under this Plan will be limited to services provided and expenses incurred within the United States. However, should a condition arise which necessitates medical attention while traveling outside of the United States benefits shall be payable as specified in the Schedule of Benefits.

G. Services, supplies or Benefits furnished to a Participant or paid under any of the following plans or insurance Coverage:

1. Any group plan, program or insurance policy providing Benefits for Hospital, medical and/or other health care expenses under a group master policy including, but not limited to, policies issued to any health maintenance organization or any entity to which such policies may legally be issued for the purpose of insuring a group of individuals.

2. Any group plan, program or insurance policy, and/or medical payment automobile insurance or Personal Injury Protection (PIP) Coverage as required and defined by Statute where the Participant legally resides, which provides Benefits or makes payments to or on behalf of a Participant for Hospital, medical and/or other health care expenses.

3. Any group contract issued to this Plan.

4. Any Coverage under a group plan or law of any federal, state or local government or any political subdivision thereof, including but not limited to, Coverage under Medicare, and/or any other federal, state or local government sponsored program or programs, unless otherwise provided by law.

A Participant shall have no right to Benefits under this Plan if said Participant elects to waive any entitlement to Benefits provided under any plan described in this paragraph. The Participant shall provide, execute and deliver such information, instruments and papers, and do whatever else is necessary to secure the instruments and papers, and the Plan's rights under this paragraph.

H. Services rendered by any Physician employed by, or rendered in, any Veterans Hospital or other Hospital or health facility operated by the United States Government or any agency thereof, or operated by any other government, for service connected or related conditions.

I. Services for injuries sustained or Sickness contracted while in any military force of any country while such country is engaged in war (whether or not declared) or hostilities of any kind, or while performing police duty as a member of any military organization.

J. Services or supplies for injury or Sickness resulting from suicide or attempted suicide, self-inflicted injury or self-induced Sickness, unless such injury or Sickness is the result of a mental or physical condition as mandated by Federal Law.

K. Services, supplies and any and all expenses resulting from substance abuse, alcohol abuse, intoxication, consumption, and/or injuries resulting from such, except as stated otherwise.

L. Charges in connection with an illness or injury of the Participant resulting from or occurring during the commission or attempted commission of a criminal battery or felony by the Participant or if the Participant is engaged in an illegal occupation if the Participant is charged with such crime.

M. Services and supplies which in the opinion of the Plan are not Medically Necessary for the diagnosis or treatment of Sickness, injury or bodily malfunction. The fact that a Physician may prescribe, order, recommend, or approve a service or supply does not of itself make it Medically Necessary or make the charge a Covered Expense.

N. Charges incurred for services, supplies, devices, treatments, procedures and drugs which are not reasonable and necessary or that are Investigational or Experimental for the diagnosis or treatment of any Illness, disease, or injury for which any of such items are prescribed. Charges excluded are those incurred for such items which:

1. are not accepted as standard medical treatment for the Illness, disease or injury being treated by Physicians practicing the suitable medical specialty;

2. are the subject of scientific or medical research or study to determine the item's effectiveness and safety;

3. have not been granted, at the time services were rendered, any required approval by a federal or state governmental agency, including without limitation, the Federal Department of Health and Human Services Food and Drug Administration, or any comparable state governmental agency, and the Federal Health Care Finance Administration as approved for reimbursement under Medicare Title XVIII; or,

4. are performed subject to the covered person's informed consent under a treatment protocol that explains the treatment or procedure as being conducted under a human subject study or experiment.

O. Hospital Service for a Participant who remains in a Hospital after the attending Physician advises that further Hospital Services are unnecessary.

P. All charges related to a Hospital confinement that was not approved by the Medical Coordinator will be paid at the reduced rate listed in the Schedule of Benefits.

Q. Fees for physical examination or periodic checkups, except as otherwise specifically stated.

R. Eye examinations, refractions, keratotomy, eyeglasses, hearing aids and examinations or the Prescription or fitting thereof, except as stated otherwise.

S. Services or supplies for beautifying or cosmetic purposes or for complications of such surgery unless:

1. Necessitated by accidental injury while covered under this Plan and performed within six (6) months following the date of the Accident.

2. Required to restore a normal bodily function.

T. All services, supplies and surgical procedures for the treatment of weight control and morbid obesity including, but not limited to weight control/loss programs; appetite suppressants and other

medications; dietary regimens; food or food supplements; exercise programs; exercise or other equipment; gastric or stomach bypass or stapling, intestinal bypass, gastric balloons, jaw wiring, jejunal bypass, gastric shunts, and procedures designed to restrict the ability to assimilate food.

U. Services or supplies for surgery for sexual reassignment or reconstruction, reverse sterilization or for complications of all such surgery. This exclusion includes medications, implants, hormone therapy, surgery and medical or psychiatric treatment.

V. Services for any occupational condition, Sickness or injury arising out of or in the course of employment for wage or profit or any other endeavor for potential profit or gain including self-employment. The Participant shall have no right under this Plan to receive Benefits for services for any occupational condition, Sickness or injury described in this paragraph even though he elects to waive his rights under the laws of the United States or any state or political subdivision to such Benefits or services.

W. Services and supplies provided by any custodial institution, rest home, nursing home, sanitarium, health spa, health resort; or place for rest, the aged, drug addicts, alcoholics or for the treatment of pulmonary tuberculosis or mental or nervous disorders.

X. Any service to a Participant hospitalized primarily for rest, rest/cure, or primarily for observation.

Y. Rehabilitative services, such as recreational therapy, or any similar services by whatever name, except as otherwise stated.

Z. Diagnosis, care and treatment of developmental delays and learning disabilities.

AA. Biofeedback.

BB. Personal comfort or convenience items, services or supplies not directly related to the Participant's care, including, but not limited to: admission kit, guest meals, accommodations, telephone charges, communications, travel or travel time even if prescribed by a Physician.

CC. Air conditioners, dehumidifiers, air purifiers, home exercise or rehabilitative equipment, or any non-Durable Medical Equipment.

DD. Treatment, care, services or supplies for maintenance care.

EE. Transplants of any type, except as stated otherwise.

FF. All Maternity and pregnancy related charges, including any complications of such pregnancy, incurred by a covered Participant serving as a surrogate mother shall not be considered an eligible Plan expense. For the purpose of this plan, the child of a surrogate mother will not be considered a Dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which she relinquishes the child following its birth.

GG. In-vitro fertilization or any other form of artificial impregnation (except artificial insemination), and any treatment, testing, care, services, supplies or complications related to the artificial impregnation.

HH. Infertility related treatment and services, unless specifically stated otherwise.

II. Elective abortions unless carrying the fetus to term would endanger the life of the mother.

JJ. Over-the-counter medications including vitamins (except pre-natal vitamins) and minerals dispensed on an Outpatient basis are not eligible for reimbursement even though prescribed by a Physician.

KK. Prescriptions purchased from Non-Participating Pharmacies.

LL. Routine foot care, including the paring and removing of corns and calluses or trimming of nails. However, services associated with foot care for diabetes and peripheral vascular disease are covered when Medically Necessary.

MM. Treatment of flat feet or subluxation of the foot including but not limited to shoes, shoe orthotics, shoe inserts and arch supports.

NN. Dentist, Physician or Hospital charges for dental care and treatment including treatment or removal of teeth and immediately adjacent structures, (i.e., gingival) and any services for orthodontia, prosthodontia, periodontia and preparation for dentures unless, as a result of an Accident, natural teeth have been damaged or a fractured or dislocated jaw requires setting and then only if such dental treatment is begun within ninety (90) days from the date of Accident.

OO. Services for procedures, appliances or restorations necessary to increase vertical dimension in the oral cavity, to restore occlusion or for purposes of splinting to include craniomandibular orthopedic repositioning, orthotics, or interdental wiring, except as stated otherwise.

PP. Acupuncture or acupressure treatment.

QQ. Massage Therapy, unless performed by a Registered Physical Therapist or M.D, in conjunction with physical therapy.

RR. Travel or accommodations, whether or not recommended by a Physician.

SS. Hypnosis.

TT. Charges for nicotine addiction except specific treatment mandated by the Affordable Care Act (ACA).

UU. Diet control and/or diet supplements.

VV. Services rendered by an assistant surgeon, when Medically Necessary, will be limited to a maximum of 25% of the surgeons allowable fee.

WW. Amount of charge in excess of Reasonable and Customary. In the case of multiple surgical procedures performed in a single surgical episode, reasonable charges for the services of the Physician shall be based on the following schedule:

- 100% of Reasonable and Customary for the first or primary procedure.
- 50% of Reasonable and Customary for the second and tertiary procedure.
- 25% of Reasonable and Customary for any additional procedures.
- Bilateral procedures shall be considered at 150% of Reasonable and Customary charges.

XXII. COORDINATION OF BENEFITS

Some persons have medical Coverage in addition to Coverage under this Plan. When this is the case the Benefits from "other plans" will be taken into account. This may mean a reduction in Benefits under this Plan.

A. All Benefits provided under this Plan are subject to Coordination of Benefits. When a Participant is covered by an "other plan", the order of Benefit determination in Paragraph B of this Section outlines which plan is primary and which plan is secondary. The primary plan pays Benefits first without any consideration of the "other plan". The secondary plan then pays the difference between all allowable expense and the Benefits paid by the primary plan, not to exceed the Benefits available under this Plan. An allowable expense means any Medically Necessary, Reasonable and Customary item of expense, at least a part of which is covered under one of the plans. At no time should the total Benefits paid exceed 100% of all allowable expenses.

B. The following determines which plan is primary when the claim is for the Employee or for a covered spouse:

1. The group plan that has no coordination of Benefits.

2. The group plan that covers the Participant as an Employee.

3. When (1) or (2) of this paragraph do not establish which group plan is primary, the Benefits of the group plan which has covered the Participant for the longer period of time shall be determined before the Benefits of a group plan which has covered the Participant the shorter period of time, provided the Benefits of the group plan covering the Participant as a non-active Employee shall be determined after the Benefits of any other group plan covering the Participant as an active Employee.

4. The group plan that covers the individual as an Employee (or as that person's Dependent) when that individual has elected to continue Coverage with COBRA on another group plan.

C. The following determines which group plan is primary when the claim is for a covered Dependent child:

1. The group plan that has no coordination of Benefits.

2. When the parents are legally married, the group plan covering the parent whose birthday falls earlier in the year.

3. When the parents are divorced, and a court of law has decreed financial responsibility for health care costs, the group plan of that parent is primary.

4. When the parents are divorced, and the parent with custody has not remarried, that parent's group plan is primary. If the parents are subject to joint custody and neither is designated in the divorce decree as being specifically responsible for health care costs, the parent whose birthday falls earlier in the year is primary.

5. When the parents are divorced, and the parent with custody has remarried, the following order will apply:

   a. The group plan of the parent who has custody.

   b. The group plan of the step-parent.

   c. The group plan of the parent who does not have custody.

   d. If the parents are subject to joint custody and neither is designated in the divorce decree as being specifically responsible for health care costs, the parent whose birthday falls earlier in the year is primary.

6. The group plan that covers the individual as an Employee (or as that person's Dependent) when that individual has elected to continue Coverage with COBRA on another group plan.

7. If the primary group plan cannot be determined by items 1 through 6, the plan which has continuously covered the child longer will be primary.

D. "**Other plan**" means the following plans or insurance Coverage:

1. Any group plan, program or insurance policy providing Benefits for Hospital, medical and/or other health care expenses under a group master policy including, but not limited to, policies issued to any health maintenance organization or any entity to which such policies may legally be issued for the purpose of insuring a group of individuals.

2. Any plan, program or insurance policy and/or medical payment automobile insurance or Personal Injury Protection (PIP) Coverage as required and defined by statute where the Participant legally resides, which provides Benefits or make payments to or on behalf of a Participant for Hospital, medical and/or other health care expenses.

3. Any group contract issued to this Plan.

4. Any homeowners' policy that provides Coverage for medical expenses.

5. Any Coverage under a group plan or law of any federal, state or local government or any political subdivision thereof, including but not limited to, Coverage under Medicare and/or other federal, state or local government sponsored program or programs, unless otherwise provided by law.

   Medicare will be primary or secondary to the extent stated in Federal Law.

E. A Participant shall have no right to Benefits under this Plan if the Participant elects to waive any entitlement to Benefits provided under any plan described in paragraph D. The Participant shall provide any information, execute and deliver any legal instruments or papers, and do whatever else is necessary to secure the Plan's rights under this Section.

XXIII. HOW TO SUBMIT A CLAIM

In most circumstances, the medical provider of service will file claims on a Participants behalf with the Claims Administrator. However, in the event a Participant pays the medical provider at the time of service, the Participant may file a claim directly with the Claims Administrator for reimbursement. In order to avoid a delay in processing, the Participant should follow the steps outlined below:

A. Review the medical claim to be sure the Employee name, patient name, member ID number and group number appear on the bill.

B. Verify that the medical provider name, address and Tax ID number appear on the bill.

C. Verify that the bill you are submitting is an actual claim with dates of service, procedure codes and corresponding charges on it. Balance due bills from providers usually do not contain this pertinent information on them.

D. Keep a copy for your own records and mail all claims to:

Preferred Benefit Administrators, Inc.
PO Box 916188
Longwood, FL 32791-6188

XXIV. WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Claims filed later than that date may be declined or reduced **unless**:

A. it is not reasonably possible to submit the claim in that time; and

B. the claim is submitted within one year from the date incurred. This one-year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If additional information is requested by the Claims Administrator, the medical provider and/or Participant shall be required to submit the necessary requested information in a timely manner in order for the claim to be properly evaluated. Additional information requested from medical provider(s) and/or a Participant must be submitted within one year from the date services were incurred. Failure to submit necessary information within one year from the date of service will result in a denial of the claim(s).

Note: The Employer has no responsibility to fund claims that are submitted after the above filing deadline.

XXV. CLAIM DETERMINATION

A. Urgent Care Claims:

Determination for any pre-service Urgent Care Claims (whether adverse or not) must take place as soon as possible but no longer than seventy-two (72) hours, unless the Participant fails to provide sufficient information to determine whether, or to what extent, Benefits are covered or payable under this Plan. In the case of such failure, the Claims Administrator shall notify the Participant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The Participant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. The Claims Administrator shall notify the Participant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of the Plan's receipt of the specified information or the end of the period afforded by the Participant to provide the additional information.

Urgent Care Claims must be decided within seventy-two (72) hours. There is no extension of time allowed for claims involving urgent care.

B. Pre-Service Claims:

Pre-Service Claims must be decided within a maximum of fifteen (15) days at the initial level and up to thirty (30) days following and Adverse Benefit Determination. In the case of a failure by a Participant or and Authorized Representative of a Participant to follow the Plan's procedures for filing a Pre-Service Claim, the Participant or representative shall be notified of the failure and the proper procedures to be followed in filing a claim for Benefits. This notification shall be provided to the Participant or Authorized Representative, as appropriate, as soon as possible, but not later than five (5) days following the failure. Notification may be oral, unless written notification is requested by the Participant or Authorized Representative.

C. Post-Service Claims:

Post-Service Claims must be decided within thirty (30) days for the initial decision and a maximum of sixty (60) days on review.

D. Filing Extensions:

The Plan may extend determination on both Pre-Service and Post-Service claims for one additional period of fifteen (15) days after expiration of the relevant initial period, if the Claims Administrator determines that such an extension is necessary for reasons beyond the control of the Plan. Delays caused by cyclical or seasonal fluctuations in claims volume are not considered to be matters beyond the control of the Plan that would justify an extension.

If the reason for taking the extension is the failure of the Participant to provide necessary information, the time period for making the determination is tolled from the date on which notice of the necessary information is sent to the Participant until the date on which the Participant responds to the notice. The time periods for making a decision are considered to commence to run when a claim is filed in accordance with the reasonable filing procedures of the Plan, without regard to whether all the information necessary to decide the claim accompanies the filing.

E. Concurrent Care Decisions:

If a plan has approved an ongoing course of treatment to be provided over a period of time, or a number of treatments, any reduction or termination by the Plan (other than by plan amendments or termination) before the end of such period of time or number of treatments shall be considered an Adverse Benefit Determination. The Claims Administrator shall notify the Participant of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments for a claim involving urgent care, shall be decided as soon as possible, taking into account the medical exigencies, and the Claims Administrator shall notify the Participant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments.

F. Adverse Benefit Determination:

The notice of an Adverse Benefit Determination will either include the protocol in which it was based upon or a statement that a protocol was relied upon and that a copy is available free of charge upon receipt by the Participant.

Notification of an Adverse Benefit Determination (at both the initial level and on review) based on medical necessity, experimental treatment, or other similar exclusion or limit will be explained as to the scientific or clinical judgment of the Plan to the Participant's medical circumstances, or an explanation will be provided free of charge to the Participant upon request.

Where the Plan utilizes a special internal rule or protocol, it must furnish the protocol to the Participant or their Authorized Representative upon request.

G. The Plan will recognize an Authorized Representative, including a health care provider, acting on behalf of a Participant. The Plan will recognize a Health Care Professional with knowledge of a Participant's medical condition as the Claimant's representative in connection with an Urgent Care Claim. Procedures will be established by the Plan for verifying that an individual has been authorized to act on behalf of a Participant.

XXVI. RIGHT OF REVIEW AND APPEAL

A Participant has up to one hundred eighty (180) days to file an appeal of an Adverse Benefit Determination. As part of the appeal process, a Participant has the right to (a) review this Plan and other relevant documents, (b) argue against the denial in writing, and (c) have a representative act on behalf of the Participant in the appeal. All relevant documents will be provided free of charge, upon request by the Participant, after receiving an Adverse Benefit Determination. A document, record or other information is considered relevant if it was relied upon in making the benefit determination, if it demonstrates compliance with the administrative processes, or if it constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Participant's diagnosis, without regard to whether such advice or statement was relied upon in making the determination.

If the Participant or Authorized Representative appeals an Adverse Benefit Determination, the Claims Administrator will respond to the appeal within seventy-two (72) hours for an Urgent Care Claim, thirty (30) days for a Pre-Service Claim, and sixty (60) days for a Post-Service Claim. The notice will specify the reason for the denial or describe the additional information required to process the claim. Written denial will include the specific reasons for the denial with reference to this Plan Document, a description and need for any other material pertinent to the claim and an explanation of this Plan's review procedures with the names of any medical professionals consulted as part of the claims process.

A full and fair review of an Adverse Benefit Determination will be performed by an appropriate named fiduciary, which is neither the party who made the initial adverse determination, nor the subordinate of such person. The review will not defer to the initial Adverse Benefit Determination. The review will take into account all comments, documents, records and other information submitted by the Participant, without regard to whether such information was previously submitted or considered in the initial determination.

If the review results in another Adverse Benefit Determination, it shall include specific reasons for denial, written in a manner understandable to the Participant, and will contain specific reference to the pertinent Plan provisions upon which the decision was based.

A Participant must follow the Right of Review and Appeal procedures listed above before initiating any legal actions. These are the Participant's administrative remedies, which must be exhausted before legal action may be pursued.

If the Plan fails to provide procedures in compliance with the regulation, or the required procedures, the Participant is deemed to have exhausted the administrative remedies and is free to pursue legal action as provided in ERISA on the basis that the Plan has failed to provide a reasonable claim procedure that would yield a decision on the merits of the claim.

XXVII. PROVIDER APPEAL PROCESS

When a claim is denied, Plan Participants have the option to Appeal the determination, as described in the "RIGHT OF REVIEW AND APPEAL" section of this Plan. The Plan Participant may appoint their Provider as their Authorized Representative for appeal purposes. **Note: this selection of an Authorized Representative is entirely separate from an Assignment of Benefits. Being named an Authorized Representative does not confer an Assignment of Benefits, and receiving an Assignment of Benefits does not make the recipient an Authorized Representative.**

In the interests of fairness and transparency, and in special consideration of the desires of Providers, the Plan will consider an Appeal from a Provider in the same manner that it will consider an Appeal from the Plan Participant, even if the service provider has not attained Authorized Representative status. Furthermore, the Plan will supply the Provider with the results of that Appeal, just as it would to the Plan Participant. In order to avail itself of this service, the Provider in question must comply with the rules and timelines for filing an Appeal in the same way that a Plan Participant would have to, as detailed in the "RIGHT OF REVIEW AND APPEAL" section of this Plan. By availing themselves of this special Appeal service, Providers agree to comply with the conditions of the Appeal set out above, and also agree to seek reimbursement of the claim in question exclusively from the Plan, voluntarily waiving all right to recover, from the Plan or Plan Participant, any amount in excess of the Allowable Charge. Nothing in this paragraph shall be construed to prevent Provider from recovering the Plan Participant's responsibilities under the terms of this Plan, which are limited to: a) Co-payments; b) Deductibles; c) Coinsurance; d) Plan non-compliance penalty fees; e) Services and Supplies that were not covered under the terms of the plan; and f) Charges beyond the limits described in this Plan Document.

For the purposes of the Appeals Process in this section, a provider's representation that it has received an Assignment of Benefits on a Form UB or Form HCFA (or other claim form of roughly equivalent function) will be sufficient proof for the Plan that benefits are legally assigned to that provider, and the Plan will require no additional documentation in order to proceed.

For more information, please contact the Claims Administrator.

XXVIII. PAYMENT OF BENEFITS, ASSIGNMENT

Benefits provided under this Plan for a specified injury or Sickness may be paid to the Participant or to the institution or person who has provided or paid for such services or supplies for which such Benefits are payable. Such Benefits may be assigned by the Participant to such institution or persons and will be paid according to the Participant's designation on the claim form, but only to the extent such institution or person's interest shall appear; otherwise this Plan and such Benefits are non-assignable. If Benefits are paid prior to the receipt and acceptance by the Claims Administrator of any assignment of such Benefits, the assignment shall be null and void and unenforceable against the Plan.

In the event an Employee or Dependent dies, or is physically, mentally or otherwise incapable of making payments due to a Provider, Plan Benefits may be paid directly to the Provider or to any person or institution appearing to assume responsibility for the expense. This payment shall discharge the Plan's obligation for such expense.

XXIX. SUBROGATION AND RIGHT OF RECOVERY

A. In the event any payment is made to or on behalf of a Participant covered under this Plan, the Plan, to the extent of such payments, shall be subrogated to all causes of action and rights of recovery such Participant has against any person or organization. Such subrogation rights shall extend and apply to any settlement of a claim, irrespective of whether litigation has been initiated. The Participant shall execute and deliver such instruments and papers as requested by the Claims Administrator. Further, the Participant or the Participant's legal representative shall promptly notify the Claims Administrator of any settlement negotiations prior to entering into a settlement agreement. No waiver, release of liability, or other documents executed by you without such notice to the Claims Administrator shall be binding upon the Plan, and failure to so notify the Claims Administrator will not prejudice the Plan's first right to recover such payment from any person or organization to the fullest extent permitted by law.

B. The Plan may recover overpayments from the covered Participant, Provider of medical services, any insurance company or other organization, and from future claims of the covered Employee, covered Dependents, or any combination thereof.

C. The Plan's subrogation rights shall be considered a first priority claim and shall be paid before any other claims for the Participant as the result of the Illness or injury, regardless if the Participant is made whole.

D. The Plan further reserves the right of first reimbursement without regard to the expressed allocation of the amount recovered by or on behalf of the covered Participant including but not limited to attorney fees or costs, comparative negligence, limits of collectability or responsibility, or otherwise, and without regard to whether or not the covered Participant has been or will be made whole by said recovered amounts.

E. Benefit payments are made on the condition that the Plan will be reimbursed by the Participant to the extent of, but not exceeding, the amount received by the individual from such third party by way of settlement or in satisfaction of any judgment.

F. By accepting any Plan payment of Benefits arising out of illness, injury or medical condition, a Participant agrees that the Plan shall be subrogated to all claims, demands, actions and rights of recovery of the Participant against any third party or any insurer to the extent of any and all payments made or to be made by the Plan.

G. Should legal action be required to recover overpayments made as a result of fraudulent statements or omissions on the application or claim form or any part thereof, the defendant will be responsible for attorney's fees, court costs and legal interest from date of judicial demand until paid.

XXX. EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

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

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a (pension, welfare) Benefit or exercising your rights under ERISA.

If your claim for a (pension, welfare) Benefit is denied in whole or in part you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in 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 a reason beyond the control of the administrator.

If you have a claim for Benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court.

The court will decide who should pay the 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. If you have any questions about your Plan, you should contact the Plan Administrator.

If you have any questions about this statement or about your rights under ERISA and the Health Insurance Portability & Accountability Act of 1996 (HIPAA), you should contact either the nearest Area Office of the U.S. Pension and Welfare Benefits Administration, Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

XXXI. USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION

This Plan will use Protected Health Information (PHI) to the extent and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

A. Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibilities for coverage and provision of plan benefits that relate to an individual whom health care is provided. These activities include but are not limited to the following:

1. Determination of eligibility;
2. Coverage and cost sharing amounts (for example, cost of a Benefit, plan maximums and Co-payments as determined for a Participant's claim;
3. Coordination of Benefits;
4. Adjudication of health benefit claims (including appeals and other payment disputes);
5. Establishing Employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related health care data processing including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
10. Medical Necessity reviews or reviews of appropriateness of care or justification of charges;
11. Utilization review, including pre-authorization, concurrent review and retrospective review;
12. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name, address, date of birth, social security number, payment history, account number and name and address of the provider and/or health plan); and
13. Reimbursement to the Plan.

B. Health care operations include, but are not limited to the following activities:

1. Quality assessment;
2. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
3. Rating provider and plan performance, including certification, licensing or credentialing activities;
4. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
5. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
6. Business planning and development, such as conducting cost-management and planning related analysis related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
7. Business management and general administrative activities of the Plan, including, but not limited to:
    a. Management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
    b. Customer service, including the provision of data analysis for Participants, Plan Sponsors or other customers.
8. Resolution of internal grievances; and
9. Due diligence in connection with the sale or transfer of assets to a potential successor or in interest, if the potential successor in interest is a covered entity under HIPAA or, following completion of the sale or transfer, will become a covered entity.

C. The Plan will use and disclose PHI as required by law and as permitted by authorization of the Participant or beneficiary. With an authorization, the Plan will disclose PHI to the benefit plan of the Employer.

D. The Plan may disclose PHI to the Plan Administrator and the Plan Administrator agrees:

1. Not to use or further disclose PHI other than as permitted or required by the plan document or as required by law;
2. To ensure that any agents, including a subcontractor and the Claims Administrator, 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. Not to use or disclose PHI for employment related actions and decisions unless authorized by the Employee;
4. Not to use or disclose PHI in connection with any other benefit or Employee benefit plan of the Plan Administrator unless authorized by the Employee;
5. To report to the Plan any PHI use or disclosure that is inconsistent with the uses and disclosures provided for of which it becomes aware;
6. To make PHI available to an individual in accordance with HIPAA's access requirements.
7. To make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
8. To make available the information required to provide an account of disclosures;
9. To make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and
10. 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 (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

E. Adequate separation between the Plan and the Plan Administrator must be maintained. In accordance with HIPAA, only the following Employees or classes of Employees may be given access to PHI:

1. The Benefits Manager or other authorized representative of the Plan; and/or
2. Staff designated by the Benefits Manager or other authorized representative of the Plan.

F. The persons described in this section may only have access to and use and disclose PHI for Plan administration functions that the Plan Administrator performs for the Plan.

G. If the persons described in this section do not comply with this Plan document, the Plan Administrator shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

XXXII. GENERAL PROVISIONS

A. The Claims Administrator will issue to the Employer for delivery to each Participating Employee covered hereunder a Plan Document and Summary Plan Description and an identification card, which the Employee or his eligible covered Dependents can present to a Hospital and/or Physician in claiming Benefits due under this Plan.

It shall be the Employer's responsibility to disseminate to the Employees the Plan Document and Summary Plan Description and the Employee identification card. The Employee's Benefits are non-assignable prior to a claim. If any amendment to this Plan shall materially affect any Benefits, Summary Plan Descriptions, or Schedules of Benefits as required by law shall be delivered to the participating Employer to be distributed to Employees. The Plan shall provide Benefits that are designed to meet the needs of the Participants and that are based on actuarial soundness. The Plan may be modified or discontinued by the Plan Administrator at any time. Notices of modification or discontinuance must be given to the Participants and all parties of interest as required by law.

B. All statements made by the Employer or the Employees of such Employer shall be deemed representations and not warranties, and no such statement made for the purpose of effecting Coverage shall void such Coverage or reduce Benefits unless contained in a written instrument signed by the Employer or Employee of such Employer and a copy furnished to such Employer or Employee as the case may be.

Any material misrepresentations or omissions on any written instrument to obtain insurance Coverage within three (3) years from the date Coverage continuously began shall be reason for the Plan to void any such Coverage or to deny a claim for loss.

C. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate Coverage otherwise validly in force or continue Coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future Benefits payable.

D. No reduction in Benefits shall be made by reason of change in the occupation of any Employee while in the employ of the Employer or by reason of the Employee's doing any act or thing pertaining to any other occupations.

E. No representative has authority to change this Plan or waive any of its provisions. No change in this Plan shall be valid unless approved by the Plan Administrator.

F. Benefits provided in this Plan will be payable to the Hospital or Physician rendering service under this Plan or to the Participant upon receipt, by the Claims Administrator, of paid Hospital or Physician bills in acceptable form.

G. No action at law or in equity shall be brought to recover under this Plan prior to the expiration of sixty (60) days written notice to the Plan. No such action shall be brought after the expiration of the specified statute of limitations on such action.

H. Except as otherwise provided herein, the Plan waives a physical examination of the Participant as a condition of participation in the Plan and, in consideration of such waiver, the Participant and/or each Dependent of the Participant agrees that any Physician or Hospital that has made or may hereafter make a diagnosis, render service, attendance or treatment of or to a Participant may furnish and is authorized to furnish to the Claims Administrator at any time upon its request a report containing all information and records or copies of records pertaining to diagnosis, attendance, service or treatment. The Participant and/or each Dependent of the Participant agrees to execute a medical authorization as may be required by the Claims Administrator.

I. The Claims Administrator shall not be responsible for the payment of any charge for Hospital or medical services not covered by this Plan or any amounts in excess of the maximum Benefits allowed by this Plan.

J. Eligible new Participants may be added to the Plan in accordance with the terms and conditions of this Plan Document and Summary Plan Description.

K. No Employee shall be refused Coverage or be charged an unfairly discriminatory rate for participation solely because such Employee is mentally or physically handicapped; provided, however, this Section shall not be construed as requiring the Plan to provide Coverage against a handicap which the applicant or policyholder has already sustained.

L. Benefit Payments are paid directly from the funds of the Employer. The Claims Administrator does not contribute funds to pay benefits, nor does the Claims Administrator have any liability to do so. Benefit payment checks issued to providers or Participants are paid out of the Employer funds. The Claims Administrator's name may appear on the check, however, in no way should this be construed as any financial obligation on the part of the Claims Administrator.

M. This Plan is not a "grandfathered health plan" under Health Care Reform, Questions regarding the Plan's status can be directed to the Plan Administrator or Claims Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272, or visit www.dol.gov/ebsa/healthreform.

N. If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of the law.