Certificate Booklet

for the

GBA Insurance Trust Medical Plan

A component of the Group Benefit Plan for Employees of the Participating Employers of the GBA Insurance Trust, Inc.

Effective January 1, 2022

CERTIFICATE OF COVERAGE

BLUE CHOICE PPO PLAN

Underwritten by Blue Cross and Blue Shield of Georgia, Inc.

BCBS

An Independent Licensee of the

Blue Cross and Blue Shield Association

Having issued a

Group Master Contract

To

GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.

Hereby certifies that

1. The persons and their eligible family Members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by Blue Cross and Blue Shield of Georgia, Inc. BCBS. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Group Master Contract for the benefits described herein:
2. Benefits will be paid in accordance with the provisions and limitations of the Group Master Contract; and
3. Blue Cross and Blue Shield of Georgia, Inc. BCBS has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family Members (if any) as Members of this Group program.

The Group Master Contract (which includes this Certificate Booklet, the Summary of Benefits and Coverage, the Trust Adoption Agreement executed by each participating Employer, and any amendments or riders) constitutes the entire Contract. (The Group Master Contract may be referred to as the "Contract" or the "Plan" in this booklet. All rights which may exist arise from and are governed by this Group Master Contract, and this Certificate Booklet does not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all Contracts and/or Certificates which may have been issued previously by Blue Cross and Blue Shield of Georgia, Inc. BCBS through the Plan Administrator.

The words "we", "us", and "our" refer to Blue Cross and Blue Shield of Georgia, Inc. The words "you", and "your" refer to the Member, Subscriber and each Covered Dependent. The term "Plan Administrator" means the Georgia Bankers Association Insurance Trust, Inc.

CERTIFICATE OF COVERAGE

BLUE CHOICE POS PLAN

Underwritten by Blue Cross and Blue Shield of Georgia, Inc.

An Independent Licensee of the

Blue Cross and Blue Shield Association

Having issued a

Group Master Contract

To

GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.

Hereby certifies that

1. The persons and their eligible family Members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by Blue Cross and Blue Shield of Georgia, Inc.. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Group Master Contract for the benefits described herein:
2. Benefits will be paid in accordance with the provisions and limitations of the Group Master Contract; and
3. Blue Cross and Blue Shield of Georgia, Inc. has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family Members (if any) as Members of this Group program.

The Group Master Contract (which includes this Certificate Booklet, the Summary of Benefits and Coverage, the Trust Adoption Agreement executed by each participating Employer, and any amendments or riders) constitutes the entire Contract. (The Group Master Contract may be referred to as the "Contract" or the "Plan" in this booklet. All rights which may exist arise from and are governed by this Group Master Contract, and this Certificate Booklet does not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all Contracts and/or Certificates which may have been issued previously by Blue Cross and Blue Shield of Georgia, Inc. through the Plan Administrator.

The words "we", "us", and "our" refer to Blue Cross and Blue Shield of Georgia, Inc. The words "you", and "your" refer to the Member, Subscriber and each Covered Dependent. The term "Plan Administrator" means the Georgia Bankers Association Insurance Trust, Inc.

CERTIFICATE OF COVERAGE

BLUE CHOICE HEALTHCARE PLAN

(HMO)

Underwritten by Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc.

An Independent Licensee of the

Blue Cross and Blue Shield Association

Having issued a

Group Master Contract

To

GEORGIA BANKERS ASSOCIATION INSURANCE TRUST, INC.

Hereby certifies that

1. The persons and their eligible family Members (if any) whose names are on file at the office of the Plan Administrator as being eligible for coverage, have had the required application for coverage accepted and subscription charge received by Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc.. These persons are covered under and subject to all the exceptions, limitations, and provisions of said Group Master Contract for the benefits described herein:
2. Benefits will be paid in accordance with the provisions and limitations of the Group Master Contract; and
3. Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc. has delivered to the Plan Administrator the Group Master Contract covering certain persons and their eligible family Members (if any) as Members of this Group program.

The Group Master Contract (which includes this Certificate Booklet, the Summary of Benefits and Coverage, the Trust Adoption Agreement executed by each participating Employer, and any amendments or riders) constitutes the entire Contract. (The Group Master Contract may be referred to as the "Contract" or the "Plan" in this booklet. All rights which may exist arise from and are governed by this Group Master Contract, and this Certificate Booklet does not constitute a waiver of any of the terms. The Group Master Contract may be inspected at the office of the Plan Administrator.

Coverage under this Certificate will be effective and will continue in effect in accordance with the terms, provisions and conditions of the Group Master Contract. This Certificate of Coverage replaces and supersedes all Contracts and/or Certificates which may have been issued previously by Blue Cross and Blue Shield of Georgia, Inc. through the Plan Administrator.

The words "we", "us", and "our" refer to Blue Cross and Blue Shield Healthcare Plan of Georgia, Inc. The words "you", and "your" refer to the Member, Subscriber and each Covered Dependent. The term "Plan Administrator" means the Georgia Bankers Association Insurance Trust, Inc.

Summary of Benefits and Coverage

Please see the Summary of Benefits and Coverage (SBC) for a summary of Plan benefits, including:

- **Deductibles**
- **Copayments**
- **Coinsurance**
- **Out-of-pocket limits**
- **Limitations and restrictions on benefits**

For a copy of the Summary of Benefits and Coverage for your Plan option, go to:
http://www.gabankers.com/WCM/Insurance___Retirement/Plan_Info/WCM/Insurance___Retirement/GBA_Insurance_Trust/Medical%20Plans.aspx?hkey=0a614eef-91de-4b49-b6e2-5c739cd29929.

You can also request a copy of the SBC for the Plan from your Human Resources director.

NOTE: You will need to know the number of your Plan option (250, 450, etc.) in order to find the correct SBC. The chart below shows the identifying numbers of all of the options offered under the GBA Insurance Trust plan. However, the options that are available to you will depend on the options selected by your Employer.

	Type of Coverage		
	PPO	POS	HMO
Plan Option Numbers	250,280,290,295, 299, 542,	450, 480, 481, 482, 490, 495,	610, 620, 639
HSA-Compatible High Deductible Health Plans	719, 780, 781	481, 482	
Early Retiree Options	299, 719 (HSA-Compatible HDHP Plan)	N/A	639

If you are not sure of your Plan option, contact your Human Resource Department or call Member Services.

I. INTRODUCTION

This Certificate Booklet describes the benefits provided under the GBA Insurance Trust Medical Plan (the Plan), which is a component plan of the Group Benefit Plan for Employees of the Georgia Bankers Association Insurance Trust, Inc.. These benefits are subject to the terms and conditions that are described in this booklet. This booklet is written in easy-to-read language to help you and your Dependents understand your health care benefits. The Plan's "**Summary of Benefits and Coverage**", or "**SBC**" summarizes, in chart form, your out-of-pocket costs (known as "Cost Sharing") and certain benefit limitations. In addition, certain administrative details and legal rights provisions are included in separate documents which are held by the Plan Administrator. Together, these documents make up the Plan document and govern your Group's coverage.

The Plan also provides wellness benefits under the "When" program. These benefits will be available to you if your Employer elects to participate in the program. The When program benefits are described in the booklet titled "GBA Insurance Trust Health and Wellness Program." That booklet is also included in the documents that make up the Plan document.

A thorough understanding of your coverage will enable you to use your benefits wisely. Please read this Certificate Booklet carefully. If you have any questions about your benefits as presented in this Certificate Booklet, please contact the Member Services Department.

Si necesita ayuda en español para entender este documento, puede solicitarla sin costo adicional, llamando al numero de servicio al cliente: 800-277-9218 opt#3 .
English translation: If you need Spanish-language assistance to understand this document, you may request it at no additional cost by calling the Member Services number: 800-277-9218 opt#3.

Your Plan Options

The Plan offers three different types of coverage. These include coverage under a Preferred Provider Organization option (PPO), Point of Service option (POS) or a Health Maintenance Organization option (HMO). The PPO, POS and HMO options differ primarily on the basis of the network of providers that are available to you. These differences are explained in more detail in Section II. **In order for you to understand your rights under this booklet, you will need to know which of these options you have selected for your coverage.**

The Plan also offers different levels of coverage under each of these three types of coverage. These different levels of coverage will vary on the basis of the cost sharing provisions (such as copayments, deductibles and coinsurance) applicable to you. See the subsection titled "Cost Sharing: The Member's Responsibility" in Section II below for more details.

Your Employer will choose which options to offer to employees. Your Employer will explain the plan options that are available to you when you become eligible for the Plan and at annual enrollment.

Finally, some of the Plan options are designed to be "HSA Compatible High Deductible Health Plans." If you are considering an HSA-compatible high deductible plan option, please be sure you understand that these health plans are designed to be federally qualified High Deductible Health Plans (HDHP) *compatible with* health savings accounts (or "HSAs"), but *they are not health savings accounts/HSAs.* If you are an eligible individual, the HSA Compatible High Deductible Health Plans may allow you to take advantage of income tax benefits when you establish an HSA and use the money you put into the HSA to pay for qualified medical expenses.

If you intend to enroll in one of these Plan options to use with an HSA for tax purposes, you should consult with your tax advisor about whether you are eligible and whether your HSA meets all legal requirements.

Although BCBS believes that the HSA-Compatible HDHP options meet these requirements, the Internal Revenue Service has not ruled on whether they are qualified as HSA compatible high deductible health plans. If the Internal Revenue Service were to rule that this Plan option does not qualify as a High Deductible Health Plan, you may not be eligible for the income tax benefits associated with an HSA. In this instance, you may have adverse income tax consequences with respect to your HSA for all years in which you were not eligible.

NOTICE: The Plan Administrator and Blue Cross and Blue Shield of Georgia do NOT provide tax advice. The Georgia

Insurance Department does NOT in any way warrant that this policy meets the federal requirements.

Important Contact Information. There are many referrals throughout this Plan document to the various companies that are involved in administering your benefits under the Plan. Their names and contact information are listed below. In addition, many of these numbers are shown on your Member ID Card.

Member Services: You may call Member Services for any question concerning your Plan benefits:

Paragon Benefits, Inc.
P.O. Box 12288
Columbus, GA 31917
1-706-321-0209 Phone
1-706-256-4089 Fax
www.paragonbenefits.com

Plan Sponsor: The Georgia Bankers Association Insurance Trust, Inc. is the employee organization that has established and maintains the Plan for the benefit of eligible employees and dependents.

Georgia Bankers Association Insurance Trust, Inc.
50 Hurt Plaza, Suite 1050
Atlanta, Georgia 30303
Attn: Lee Monroe, lmonroe@gabankers.com, 404-420-2013

GBA Insurance Trust is also the **Plan Administrator, COBRA Administrator, Named Fiduciary** and **Agent for Service of Legal Process**

Prior Approval: The **Cost Management Services Provider** assists the Plan Administrator by approving certain medical benefits in advance by evaluating the medical necessity of certain care settings. **Please be sure to read the Prior Approval and Case Management Services section carefully since you are required to take action in some circumstances to make sure that your benefits are not reduced or penalized.** The Cost Management Service Provider is:

American Health Holdings, Inc.
1-877-417-3363 Phone
1-614-818-3236

American Health Holdings, Inc. is the claims fiduciary only for the first level of appeals for pre-service claims (including urgent care claims) that require you to obtain approval of the services before obtaining medical care. See Section VII: Claims and Appeal Procedures

The **Prescription Benefits Manager** administers the prescription drug benefits under the Plan. The Prescription Benefits Manager is:

RxEdo
888-879-7336
CVS Specialty is the **exclusive provider of specialty drugs** under the Plan.

The **Specialized Solutions** provider is

Wellview Health
1-877-293-9355
wellviewhealth.com/concierge
Email: concierge@wellviewhealth.com

24/7 Nurseline

A 7-day-a-week, 24-hour-a-day service is available for all covered family Members. When you or a covered family Member is experiencing health symptoms, you may call 24/7 Nurseline to speak to a registered nurse. The nurse will provide information to help

you decide on the most appropriate treatment or care. You may also listen to a variety of medical audiotapes or request written information on a variety of conditions. Please call the following number:

1-888-724-2583

II. PAYING FOR COVERED SERVICES

This Section describes how the Plan determines how much will be paid for Covered Services. Reimbursement for Covered Services will depend on the network status of the healthcare provider, the Plan's method for calculating the maximum amount payable for a Covered Service and the Member's share of payment responsibilities.

A. Network Status

The Plan is a comprehensive plan that provides Primary and Specialist health care services. It relies on a wide network of healthcare providers who have agreed to provide services at reduced rates and on other favorable terms. This section explains the difference between Network Providers, Non-Preferred Providers and Out-of-Network Providers and what these differences mean for your benefits under the Plan.

A **Network Provider** is a Provider who is in the managed network for your specific plan option or in a special Center of Excellence or other closely managed specialty network, or who has a participation contract with respect to this Plan. Because Network Providers have agreed to charge reduced fees (the Contracted Rate) to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees. Network Providers have agreed to limit their charges to these Contracted Rates and should not send you a bill or collect for amounts above this rate. However, you will need to pay your cost sharing amount as described in Paragraph C below. Please call Member Services for help in finding an In-Network Provider or visit **www.anthem.com**.

Providers who have not signed any contract with us and are not in any of our networks are **Out-of-Network Providers**. Out-of-Network Providers have not agreed to reduced reimbursement rates with BCBS. The Plan sets limits on the amount it will pay Out-of-Network Providers (the Maximum Allowed Amount, as defined in Paragraph B below). This means that they may charge you for the difference between the amount paid by the Plan and the amount they have charged. You must pay the entire difference between the Maximum Allowed Amount and the provider's charge. This is called balance billing and can be a significant expense. This is in addition to your cost sharing amount. There are certain situations where balance billing is not allowed. These exceptions are described in Paragraph B.

A **Non-Preferred Provider** is a Provider who has not contracted for this Plan, but has contracted for other BCBS products. Non-Preferred Providers (which are sometimes called "Participating Providers") are not Network Providers, but they are different from Out-of-Network Providers because they may not send you a bill and collect balance billing for the amount of the Non-Preferred Provider's charge that exceeds the Maximum Allowed Amount for Covered Services. However, for purposes of determining your cost sharing amount, a Non-Preferred Provider will be treated as an Out-of-Network Provider. So, for example, if your responsibility for coinsurance under your plan option is 20% for Network Providers and 40% for Out-of-Network Providers, your coinsurance for using a Non-Preferred Provider will be 40%.

It is always the Member's choice as to which Provider to use, but a Member who uses a Network Provider will receive better benefits from the Plan than when a non-Network Provider is used. Choosing a Network Provider will likely result in lower out of pocket costs to you.

Note: A Member has the right to designate any Network Provider who is available to accept the Member as a primary care provider. For children, a Member may designate a pediatrician as the primary care provider if the pediatrician is a Network Provider and is available to accept the child as a patient. A Member does not need prior authorization from the Plan, a primary care provider, or any other person in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology and who is a Network Provider. However, the health care professional will be required to comply with certain Plan procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

Plan Options.
Your benefits will depend in part on what type of plan option you have. This could be a Preferred Provider Organization option (PPO), Point of Service option (POS) or a Health Maintenance Organization option (HMO). You have direct access to primary and specialty care from Network Physicians under all Plan options. You are not required to get a referral from your Primary Care Physician to see a Network specialist

PPO and POS Options. If you are covered under a PPO or POS option, you can choose whether to use Network or Out-of-Network Providers.

HMO Options. If you are covered under an HMO option, the Plan only covers services from Network Providers located in the applicable Service Area except in these limited circumstances:

- In the case of a Medical Emergency or Out-of-Area Urgent Care;
- Where the services are authorized **in advance** due to a lack of qualified providers in your area; or
- Where services are provided by an Out-of-Network Provider and you have no control over the choice of provider (such as when a Network Hospital uses an Out-of-Network anesthesiologist).

The HMO Service Area is defined in the HMO Provider Directory.

When You Are Away From Home

Emergency Care (All Options). If you are away from the Service Area on business or pleasure, you still have coverage for Medical Emergencies. If you have a Medical Emergency, go to the nearest Hospital emergency room for treatment.

Out-of-Area Urgent Care (HMO Option). If you are covered under an HMO option, you still have coverage if you are temporarily absent from the Service Area and you need urgent medical care to prevent serious deterioration of health that results from an unforeseen illness or Accidental Injury, and receipt of the health care service cannot be delayed until you return to the Service Area. Non-urgent and non-emergency care are not covered outside the Service Area.

Out-of-Area Care (PPO and POS Options). If you are receiving care outside of Georgia but within the United States, you will receive benefits at the Network level if you select a Network PPO or POS Provider (as applicable under your plan option) in the state where you are located. You may find PPO or POS Providers by going to the Anthem website, www.anthem.com, or calling Member Services and a representative will assist you. If you are outside the Service Area, you will have to pay the provider directly for any treatment you receive. We will reimburse you for Covered Charges, except for any required Copayment or other Cost Sharing amount. Call Member Services as soon as it's convenient and one of the representatives will tell you what you should do.

Out-of-Country Care. For treatments outside the country, the Plan only pays benefits for medical emergencies or urgent care services. Other services you receive outside the country are not covered. You will have to pay the provider directly for any treatment you receive, and you will need a copy of any bills translated into English. We will reimburse you for Covered Charges, except for any required Copayment or other Cost Sharing amount. Call Member Services as soon as it's convenient and one of the representatives will tell you what you should do.

Consumer Choice Option – (Please note the following applies only if you purchased the Consumer Choice Option at enrollment) The Consumer Choice Option allows you to nominate an Out-of-Network Provider (limited to a Physician, dentist, podiatrist, pharmacist, optometrist, psychologist, clinical social worker, advance practice nurse, registered optician, licensed professional counselor, physical therapist, licensed marriage and family therapist, chiropractor, qualified athletic trainer (per OCGA 43-5-8), occupational therapist, speech language pathologist, audiologist, dietitian, Physician's assistant or Hospital) for specified Coverage Services. Such nominated Providers must be approved in writing by Blue Cross and Blue Shield of Georgia, Inc. and are subject to the normal rules and conditions which apply to a contracted Network Provider. These terms include reimbursement (who we pay and how much), utilization management protocols (pre-certification procedures and our internal procedures enabling us to pay for Covered Services), Prescription Drug Formulary compliance (making sure we pay for drugs on our approved list), Referral to Network or non-Network Providers, and other internal procedures which Blue Cross and Blue Shield of Georgia, Inc. normally follows. All non-Network Providers must be nominated, agree to participate and be approved.

Please remember that, while you may obtain benefits at Network levels from an approved, nominated Provider, these Providers have not gone through Blue Cross and Blue Shield of Georgia, Inc.'s rigorous credentialing process, and they are not subject to Blue Cross and Blue Shield of Georgia, Inc.'s quality assurance standards.

The nominated Provider is not a Network Provider and has not been credentialed by Blue Cross and Blue Shield of Georgia, Inc. The Member alone is responsible for the selection of the nominated Provider and Blue Cross and Blue Shield of Georgia, Inc. has not undertaken any credentialing or quality assurance measures regarding such nominated Provider. Blue Cross and Blue Shield of Georgia, Inc. will not undertake to conduct routine quality assurance measures which are used for Providers. The Member should understand that any and all Physicians, Hospitals and any others who are not Network Providers must be nominated by the Member (patient) and approved Blue Cross and Blue Shield of Georgia, Inc. prior to any services being performed by the Provider in order for the services to become eligible for reimbursement at Network benefit levels. For additional information, please contact your Plan Administrator.

NOTICE: Federal and State laws prohibit insurers from unfairly discriminating against any person based upon his or her status as a victim of family violence.

B. What the Plan Pays

The Plan will pay benefits only for Covered services as defined in Section IV: Plan Benefits. The maximum benefit the Plan will cover for Covered Services is the "Covered Charge."

Maximum Amount Payable. This section describes how we determine the amount of reimbursement for Covered Services.

Providers are compensated using a variety of payment arrangements, including capitation, fee for service, per diem, discounted fees, and global reimbursement. The maximum amount payable under the Plan differs depending on whether the services are provided by a Network Provider, a Non-Preferred Provider or an Out-of-Network Provider.

For services provided by Network Providers, the Plan will pay based on the rate the Provider has agreed with BCBS to accept as reimbursement for the Covered Services (the "Contracted Rate.") Network Providers have agreed to accept the Contracted Rate and will not charge the Participant for amounts over that rate.

As discussed in Paragraph A, the Plan bases its payment for services provided by Out-of-Network Providers on the "Maximum Allowed Amount." The Maximum Allowed Amount for services from Non-Preferred Providers will also be determined based on the factors shown below unless the contract between us and that Provider specifies a different amount.

BCBS determines the Maximum Allowed Amount using the following guidelines:

1. An amount based on our Out-of-Network fee schedule/rate, which we have established at our discretion, and which we reserve the right to modify from time to time, after considering one or more of the following: reimbursement amounts accepted by like/similar Providers contracted with BCBS, reimbursement amounts paid by the Centers for Medicare and Medicaid Services for the same services or supplies, and other industry cost, reimbursement and utilization data; or
2. An amount based on the level and/or method of reimbursement used by the Centers for Medicare and Medicaid Services for the same services or supplies; or
3. An amount based on information provided by a third party vendor, which may reflect one or more of the following factors: (1) the complexity or severity of treatment; (2) level of skill and experience required for the treatment; or (3) comparable Providers' fees and costs to deliver care, or
4. An amount negotiated by us or a third-party vendor which has been agreed to by the Provider. This may include rates for services coordinated through case management; or
5. An amount equal to the total charges billed by the Provider, but only if such charges are less than the Maximum Allowed Amount calculated by using one of the methods described above.

It is important to understand that Out-of-Network Providers have not agreed to accept the Maximum Allowed Amount and you may be required to pay the entire difference between the Maximum Allowed Amount and the provider's charge ("balance billing)." This can be a significant cost to you. However, the following out-of-network services are not subject to balance billing: emergency services, emergency air ambulance services, and certain nonemergency services provided by an out-of-network provider at an in-network facility. For more details on these rules, see "Other Factors Affecting Plan Payments," below.

Member Services is available to assist you in determining your plan's Maximum Allowed Amount for a particular service from an Out-of-Network or Non-Preferred Provider. In order for us to assist you, you will need to obtain from your Provider the specific procedure code(s) and diagnosis code(s) for the services the Provider will render.

You will also be required to pay a portion of these costs. (See Subsection C: "Cost Sharing") Member Services can assist you in determining your share of charges before services are provided, but the final Maximum Allowed Amount for your claim will be based on the actual claim submitted by the Provider.

Also, remember that if you are covered under an HMO option, the Plan will not pay any benefits for services provided by an Out-of-Network or Non-Preferred Provider except as specifically described below.

Other Factors Affecting Plan Payments. The reimbursement rules discussed above are applied differently under certain circumstances.

Certain Out-of-Network Services. In some instances, your out-of-pocket costs for out-of-network services will be different from the rules described above. These special rules will apply to the following services:

- Emergency Room Services at an Out-of-Network Facility
- Emergency Air Ambulance Services from an Out-of-Network Provider
- Certain services provided by an Out-of-Network Provider at an In-Network Facility

Emergency Room Services: Services provided at an out-of-network emergency room will be subject to the same cost sharing that applies to in-network emergency room services under your plan, and balance billing will not be charged to you.

Emergency Air Ambulance Services: Air ambulance charges for emergency services from an out-of-network provider will be subject to the same cost sharing that applies to in-network air ambulance services under your plan, and balance billing will not be charged to you.

Certain services provided by an Out-of-Network Provider at an In-Network Facility:

- The following services provided by an out-of-network provider at an in-network facility will be subject to the same cost sharing that would apply to the same services if provided by an in-network provider, and balance billing will not apply:
  - Emergency medicine
  - Anesthesia
  - Pathology
  - Radiology
  - Laboratory
  - Neonatology
  - Assistant surgeon, hospitalist, or intensivist services
- For other services offered by an out-of-network provider at an in-network facility, your cost sharing will depend on whether the provider gives you notice beforehand that they are out-of-network. If you consent to the services after receiving the notice, you will pay out-of-network cost sharing and any balance billed amounts.

Services Authorized by the Plan. In some circumstances, such as where there is no Network Provider available for the Covered Service, we may authorize the Network cost share amounts (deductible, copayment, and/or coinsurance) to apply to a claim for a Covered Service you receive from an Out-of-Network Provider. In such circumstance, you must contact Member Services **in advance** of obtaining the Covered Service. . If we authorize a Covered Service so that you are responsible for the Network cost share amounts, you may still be liable for the difference between the Maximum Allowed Amount and the Out-of-Network Provider's charge. Please contact Member Services for Authorized Services information or to request authorization.

Example: You require the services of a specialty Provider; but there is no Network Provider for that specialty in your state of residence. You contact us in advance of receiving any Covered Services, and we authorize you to go to an available Out-Of-Network Provider for that Covered Service and we agree that the Network cost share will apply.

Let's say your plan has a $45 Copayment for Out-of-Network Providers and a $25 Copayment for Network Providers for the Covered Service. The Out-of-Network Provider's charge for this service is $500. The Maximum Allowed Amount is $200.

Because we have authorized the Network cost share amount to apply in this situation, you will be responsible for the Network Copayment of $25 and the Plan will be responsible for the remaining $175 of the $200 Maximum Allowed Amount.

Because the Out-of-Network Provider's charge for this service is $500, you may receive a bill from the Out-of-Network Provider for the difference between the $500 charge and the Maximum Allowed Amount of $200. Combined with your Network Copayment of $25, your total out of pocket expense would be $325.

Claims Processing Rules. When you receive Covered Services from an eligible Provider, we will, to the extent applicable, apply claim processing rules to the claim submitted for those Covered Services. These rules evaluate the claim information and, among other things, determine the accuracy and appropriateness of the procedure and diagnosis codes included in the claim. Applying these rules may affect our determination of the Maximum Allowed Amount. Our application of these rules does not mean that the Covered Services you received were not Medically Necessary. It means we have determined that the claim was submitted inconsistent with procedure coding rules and/or reimbursement policies. For example, your Provider may have submitted the claim using several procedure codes when there is a single procedure code that includes all of the procedures that were performed. When this occurs, the Maximum Allowed Amount will be based on the single procedure code rather than a separate Maximum Allowed Amount for each billed code.

Likewise, when multiple procedures are performed on the same day by the same Physician or other healthcare professional, we may reduce the Maximum Allowed Amounts for those secondary and subsequent procedures because reimbursement at the full rate for those procedures would represent duplicative payment for components of the primary procedure that may be considered incidental or inclusive.

C. Cost Sharing: The Member's Responsibility

The Member's share of responsibility for payment is called "Cost Sharing." These Cost Sharing provisions are applied on a calendar year basis. Different Cost Sharing provisions apply to Medical Benefits than to Prescription Drug Benefits. Cost Sharing levels are shown on the SBC.

Deductible. The deductible is the dollar amount that a Member must spend on Covered Charges each year or for a specific service before the Plan pays benefits. For example, if you have a $500 calendar year deductible, the Plan will begin to pay benefits for Covered Services after you have paid $500 for Covered Services. If a deductible applies to you, it will be shown on the SBC. For all Plan options except HSA-compatible high deductible health plans, out-of-pocket costs for Covered Services received in the last three months of a calendar year which are applied to that year's Deductible will carry over and also be applied toward the next year's Deductible.

Copayments. Copayments (or copays) are payments that are paid by the Member at the time services are rendered. Copayments are usually a flat-dollar amount (such as a $50 copay for an office visit) and apply only to Network Providers. Coinsurance payments usually are not required if a copayment applies. Copayments do not count toward the deductible.

Coinsurance. Coinsurance is the percentage the Member must pay on the remaining Covered Charges after deductibles and copays have been paid. (The Plan also pays coinsurance. For example, depending on the terms of the Plan option, the Plan may pay 80% coinsurance and the Member will be responsible for 20% coinsurance.)

Limits on Your Out-of-Pocket Costs. The amount you must pay for Covered Services each year is capped as shown in the SBC. This limit is called the "out-of-pocket limit." Some Plan options may have separate out-of-pocket limits for medical expenses and prescription drug expenses. Once you have paid this amount for this type of Covered Services during the year, the Plan will begin to pay 100% of the Covered Charges for those services for the rest of the year. Your deductibles, coinsurance and Copayments are all counted in determining when you have met the out-of-pocket limit. Bear in mind that you may have some out-of-pocket costs that are not counted toward the out-of-pocket limit. These excluded costs are described on the SBC. When one or more covered family members reach the family out-of-pocket limit for a year, Covered Charges will be payable at 100% for all covered family members for the rest of the year (except for any charges excluded, as shown on the SBC).

Balance Billing. The Plan does not pay any charges in excess of the Covered Charge for a service. If you use an out-of-Network Provider, you will be responsible for 100% of the balance billed amounts in most cases. However, balance billing will not apply to the services described in "Certain Out-of-Network Services" in Paragraph B above.

Here's an example to illustrate how Cost Sharing works and to show the difference in a Member's financial responsibility depending on the type of provider they choose. However, these examples are not based on the No Surprises Act rules. In this example, assume that:

- The Member has a deductible of $500 and has not paid any amount toward that deductible when they receive the services.
- Under the Member's Plan option the Plan's coinsurance is 80% for Network Providers and 60% for non-Network Providers. The Member's coinsurance is 20% for Network Providers and 40% for non-Network Providers.
- Out-of-Network Providers will be paid at out-of-network benefit levels and you will be responsible for any balance billed amounts. Remember that Non-Preferred Providers cannot balance bill, but benefits are paid at Out-of-Network levels. (These rules do not apply to HMO options except in circumstances where out-of-Service Area benefits are permitted. See Section II.B.)

The first chart shows how much the Plan will pay:

Amount Plan Will Pay			
	Network Provider	Out-of-Network Provider	Non-Preferred Provider
Provider's Charge	$2200	$4000	$4000
Maximum Plan Will Pay	$2200	$2600	$2600
Reduced by Member's Deductible ($500)	($2200 - $500) = $1700	($2600 - $500) = $2100	($2600 - $500) = $2100
Plan Coinsurance	80%	60%	60%
Amount Plan Pays	(80% x $1700) = $1360	(60% x $2100) =$1260	(60% x $2100) =$1260
Charges Not Paid by Plan (Provider Charge – Plan Payment)	($2200 - $1360) = $840	($4000 - $1260) = $2740	($4000 - $1260) = $2740

The Member is responsible for the remaining charges as shown below:

Member's Responsibility			
	Network Provider	Out-of-Network Provider	Non-Preferred Provider
Charges Not Paid by Plan (from above)	$840	$2740	$2740
Member's Deductible	$500	$500	$500
Member's Coinsurance	(20% x $1700) = $340	(40% x $2100) =$840	(40% x $2100) =$840
Balance Billing	Not Applicable	$1400	Not Applicable
Amount Member Pays	($500 + $340) = **$840**	($500 + $840 + $1400) = **$2740**	($500 + $840) = **$1340**

III. PRIOR APPROVAL AND CASE MANAGEMENT SERVICES

The Plan requires the Member or Provider to follow certain certification and authorization procedures for many services. The provider, patient or family member must call the Cost Management Services Provider at least 72 hours in advance of services being rendered or within 72 hours after a Medical Emergency. **Failure to follow the procedures outlined in this Section will result in denial of any claim for the services received. This denial may be appealed by following the procedures of Post-Service Claims as outlined in Section VII.**

Any increased costs that the Participant must pay due to failure to follow cost management procedures will not accrue toward the maximum out-of-pocket limit.

A. Prior Approval Requirements. The Plan does not pay benefits for medical services and supplies that are not Medically Necessary or for services and supplies provided in an unapproved manner or setting. In order to make this determination, you must get prior approval for many procedures. This is the only way to find out in advance if your proposed treatment, service or drug will be considered Medically Necessary or provided in an approved setting. Because of rapidly changing medical technology, it is not possible to list all of these procedures. You should call Member Services to find out if prior approval is required if your healthcare Provider recommends any of the following:

1. Inpatient hospitalization
2. Outpatient surgery
3. Outpatient diagnostic procedures, therapies and treatments
4. Durable medical equipment
5. Hospice
6. Home health care
7. Case management
8. Specialty drugs

B. **Inpatient Pre-Admission and Length-of-Stay Certification (PAC).** Prior approval is always required for inpatient hospital admissions. This type of prior approval is called "pre-admission certification" or "PAC." The term PAC also applies to the requirement to obtain approval for a longer stay in the hospital than provided in the initial approval.

1. PAC is required for **ALL** Hospital admissions except emergency or maternity delivery admissions. Please notify the Cost Management Service Provider within 48 hours of an emergency or maternity admission. PAC determinations are available by phone 24 hours a day, seven days a week for urgent/non-elective care that must be performed within 24 hours after the PAC request, without which a significant threat to the patient's health or well-being will be posed. Call the number shown in the Introduction section of this booklet. Non-urgent/elective pre-certifications can be requested during normal business hours (8:30 a.m. – 5:00 p.m. eastern time).
2. The Pre-Admission Certification Process includes the following procedures:
    a. Length-of-Stay Assignment to indicate the number of Inpatient days usually Medically Necessary to treat a condition;
    b. Continued Stay Review/Concurrent Review to determine whether a continued Inpatient stay is Medically Necessary. If your stay exceeds the number of days assigned under this program, the Hospital's charge for additional days beyond the assigned length of stay will not be paid;
    c. Admission Review to determine whether an unscheduled Inpatient admission or admission not subject to pre-certification was Medically Necessary;
    d. Discharge Planning to assess the Member's need for additional treatment after Hospital discharge.
3. The pre-admission certification applies only to services which have been approved in the pre-certification process and only as described in the approval. Such approval does not apply to any other services. Authorization of such a service, or payment of benefits for an authorized service, does not mean that other similar claims at a later date will be authorized or paid, regardless of whether such later claims have the same, similar or related diagnoses.
4. If you receive services from an Out-of-Network Hospital and these prior approval procedures are not followed, you will be responsible for all Ineligible Charges. The Out-of-Network Provider is under no obligation to hold you harmless for these charges.

C. Outpatient Medical Review Requirements. Certain outpatient procedures also require approval before services are rendered. These services include, but are not limited to, outpatient surgical procedures, diagnostic imaging procedures, and Durable Medical Equipment. This outpatient approval process is a requirement for both Network and Out-of-Network benefits. Among others, prior approval is required for the following outpatient procedures:

1. All scans, including CT Scan (Computed Tomography Scan)
2. CTA
3. Dialysis
4. Echocardiography
5. Home Health Care
6. Hospice
7. Hysterectomy (under age 35)
8. MRA
9. MRI
10. Nuclear Cardiology
11. Orthognathic/TMJ
12. PET
13. Photocoagulation of macular drusen
14. Plantar fasciitis and plantar fibroma, cryoablation
15. Reconstructive Surgery
16. Skilled Nursing
17. Sleep Studies
18. Transplant Evaluation UPPP

These lists are subject to change. Please call the number shown in Section I or on your ID card to determine if a particular procedure or item requires prior approval. If you have any questions regarding these prior approval requirements, please contact Member Services at the number listed on your ID card.

D. Prescription Drugs. Certain drugs will require prior authorization. In most cases, you will be informed at the pharmacy that your prescription requires prior authorization and the prior authorization will be performed by the Prescription Benefits Manager. For certain drugs, the Prescription Benefits Manager will refer the prior authorization review to the Case Management Provider. For these drugs, you will need to contact the Prior Authorization/Case Management Provider listed in Section I to make sure they are covered. The prior authorization requirement applies to Specialty Drugs and Non-Formulary Drugs. Because of the constant changes in approved medical treatments for specific diagnoses, the Prescription Benefits Manager maintains a selected list of Specialty drugs and approved diagnoses. If you are not sure whether a drug that has been prescribed for you is a Specialty Drug that requires prior authorization, contact the Prior Authorization/Case Management Provider listed in Section I.

E. Prior Approval is Not a Guarantee of Payment. The pre-certification, prior approval and verification of benefits processes are intended only to determine the appropriateness of the setting for care and/or the Medical Necessity of the proposed treatment. It does not guarantee that benefits are payable for that care. Actual benefit payment is based upon eligibility for coverage, coverage under the Plan when charges are actually incurred, and Plan benefits and exclusions.

F. Individual Case Management

The individual case management program is designed to provide benefits to eligible Members who, with their attending Physician, agree to treatment under an alternative benefit plan intended to provide quality health care under lower cost alternatives. Benefits will be determined on a case-by-case basis, and payment will be made only as agreed to under a written alternative benefit plan for each program participant.

The program includes the identification of potential participants through active case finding; eligibility screening; and preparation of alternative benefit plans, which may include transfer to alternative treatment settings in which quality care will be provided.

Program Eligibility. The Plan Administrator (or its delegate) will determine eligibility for cases to be included in the program.

Potential cases may include but are not limited to:

1. spinal cord Injury;
2. severe head trauma/coma;
3. respiratory dependence;
4. degenerative muscular/neurological disorders;
5. long term IV antibiotics;

6. premature birth;
7. burns;
8. cardiovascular accident;
9. cancer;
10. accidents;
11. terminal illnesses;
12. transplants;
13. conditions requiring Specialty Drugs;
14. other cases at the Plan Administrator's discretion.

The Member – or legal guardian or family member, if applicable – and the attending Physician must consent to explore with the Case Management Provider the possibilities of transfer to an alternative treatment setting and, prior to implementation, agree to the alternative benefit plan.

A Member receiving benefits under an alternative benefit plan may, at any time, elect to discontinue the plan and revert to regular Plan benefits. However, regular Plan benefits may be offset by the value of benefits provided under the alternative benefit plan.

Benefits. Benefits under the program are furnished as an alternative to, and not in addition to, other Plan benefits. Benefits will be determined on a case-specific basis, depending on the plan of treatment. Benefits will be subject to Plan limits and cost sharing provisions unless specifically waived or modified in writing by the Plan Administrator.

Services will be covered and payable as long as the treatment is required as outlined in the alternative benefit plan, and is equal to or less expensive than the original treatment plan which otherwise would have been followed. The Case Management Provider will determine the maximum approved payments allowable under the program.

Any benefits outlined in a treatment program are subject to the following limitations:
1. Services, equipment and supplies must be approved as Medically Necessary for the treatment and care of the Member.
2. Modifications to the home, if any, will be limited to non-structural modifications that are required to meet minimum standards for safe operation of equipment.
3. When necessary for the long-term care of the Member in the home-setting, Respite Care to relieve family Members or other persons caring for the Member at home may be approved. (The Respite Care benefit can be credited at a rate of 24 hours every month of care rendered in the home setting, and may be reimbursed for up to 6 consecutive days at a time. We may approve on an exception basis up to 5 days per month of Respite Care when medical review of the case indicates that such action is appropriate. Payments for Respite Care will be deducted from the Member's remaining available benefits under the program.) The Member must obtain pre-certification from the Case Management Provider regarding the treatment plan and proposed setting to be used during the Respite Care period.

The determination to provide benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Member, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

Covered Services. Services covered under individual case management will be determined on a case-by-case basis. Benefits may be provided for the rehabilitation of a Member on an Inpatient, outpatient, or out-of-Hospital basis, as long as they are Medically Necessary, support the plan of treatment, and ensure quality of care.
1. The program may provide or coordinate any of the types of Covered Services provided pursuant to this Certificate Booklet.
2. In the context of an individual case management program, the Plan Administrator, in consultation with the Case Management Provider, may approve alternative services or extra-contractual benefits which are (i) excluded by this Certificate Booklet; (ii) neither excluded nor defined as Covered Services under this Certificate Booklet, or (iii) exceed the maximum treatment limits for any Covered Service under this Certificate Booklet.
3. A Provider may be any facility or practitioner, including but not limited to an otherwise ineligible Provider, provided that it is licensed or certified to give services or supplies consistent with the plan of treatment and approved by the Case Management Provider.

4. Benefits will be provided only when and for as long as the Case Management Provider deems they are Medically Necessary. The approved alternative benefit plan of treatment will establish which benefits will be provided and for how long, and shall be subject to pre-certification and continuing review for Medical Necessity as set forth in the plan for treatment.
5. The total benefits that may be paid will not exceed those which the Member would otherwise have received in the absence of individual case management benefits.

Exclusions: In addition to any other Plan exclusions that may apply, Rehabilitation, Custodial Care or other services for chronic (recurring) conditions that do not significantly improve in an observable way within a reasonable period of time will not be a covered benefit under the individual case management program.

Termination of Individual Case Management. Services in the alternative benefit plan under individual case management will cease to be Covered Services under this Contract when extra-contractual benefits or alternative services are no longer Medically Necessary.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the Member and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

IV. PLAN BENEFITS

A. Covered Charges, Limitations and Exclusions

Plan benefits are payable only for Covered Charges. To qualify as a Covered Charge, an expense must be listed as a Covered Service below and be:

a. Incurred by an eligible Employee, Spouse or Dependent while covered under the Plan;
b. For healthcare products and services that are determined by the Plan Administrator or its designee to be Medically Necessary;
c. Provided by a properly credentialed healthcare provider acting within the scope of the provider's license and in compliance with applicable State and Federal laws;
d. Not greater than the Contracted Rate for a Network Provider or the Maximum Allowed Amount for a Non-Preferred or Out-of-Network Provider; and
e. Not excluded or limited by a Plan provision.

The benefits payable for a Covered Charge are subject to the Cost Sharing provisions shown in the SBC. Other quantitative limits on these Covered Charges such as day, visit or dollar limits are also shown on the SBC. Coverage may also depend upon whether you meet the prior approval requirements shown in Section III. The broad categories of healthcare products and services that are covered by the Plan are listed below. . (These are the same categories that you will find in the SBC.) However, all of these broad categories are subject to specific and significant exclusions and limitations. A more specific schedule of these exclusions and limitations (the "Schedule of Benefits") is available at no charge upon request by contacting Member Services. *You should not assume that any particular service or product is covered without checking the Schedule of Benefits first.* You may always contact Member Services before you incur expenses to determine whether a service or product is covered.

1. **Primary Care, Office Visits and Other Out-Patient Care**

2. **Preventive Care**

3. **Laboratory and Other Diagnostic Services**

4. **Inpatient or Surgical Services**

5. **Outpatient Surgery and Procedures Performed at Hospitals and Facilities on an Outpatient Basis**

6. **Emergency and Urgent Care Services**

   Note: A Medical Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

   a. Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
   b. Serious impairment to bodily function; or
   c. Serious dysfunction of any bodily organ or part.

   Note: Emergency Services include: (1) an appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department, to evaluate whether an emergency medical condition exists; and (2) such further medical examination and treatment as may be required to stabilize the individual (regardless of the department of the hospital in which the further medical examination and treatment is furnished) within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department.

7. **Mental Health, Substance Abuse and Behavioral Health Services.** Benefits for covered mental health and

substance abuse care and treatment will be paid on the same basis as comparable medical/surgical benefits in accordance with applicable mental health parity laws.

> **NOTE:** The Mental Health Parity and Addiction Equity Act provides for parity in the application of mental health and substance abuse benefits with medical/surgical benefits. In general, group health plans that offer mental health and substance abuse benefits cannot set calendar year dollar limits, lifetime dollar limits, or day/visit limits on mental health or substance abuse benefits that are lower than that for medical and surgical benefits. The Plan may not impose deductibles, copayments, coinsurance or other out of pocket expenses on mental health and substance abuse benefits that are more restrictive than those applicable to other medical and surgical benefits.

8. **Maternity and Newborn Care.** Maternity Care is generally covered. Charges for care and treatment of pregnancy/maternity services for a Covered Dependent daughter as well as charges for abortion or Complications of Pregnancy for a Covered Dependent daughter are excluded. However, ACA Preventive Care services that apply to pregnant women will be covered.

9. **Rehabilitative and Habilitative Services**
   a. **Rehabilitative Care** is generally covered.
   b. **Habilitative Care** is not covered**.**

10. **Pediatric Services (Dental and Eye).** Charges for pediatric dental and eye care except those incurred in connection with ACA Preventive Care or specifically listed under Oral or Eye Care, are not covered.

11. **Prescription Drug Benefits** are generally covered. Benefits payable for covered charges may vary, depending on whether the drugs are obtained through a pharmacy or another type of health care facility (such as a physician's office or hospital.) The SBC shows the cost sharing that applies to drugs obtained through a pharmacy or the Prescription Benefits Manager.

C. GENERAL EXCLUSIONS. The following care, services and treatments are not covered under the Plan:

1. **Complications of non-covered treatments**. The Plan does not cover care, services or treatment required as a result of complications from a treatment, product or service not covered under the Plan are not covered. This exclusion does not apply to complications from a non-covered abortion.

2. **Court-Ordered Services**, or those required by court order as a condition of parole or probation.

3. **Criminal Acts.** Disease or Injury received while or caused by committing a crime. This includes, but is not limited to illegal use of alcohol and/or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. The Plan Administrator may rely upon the arresting officer's determination, if any, of inebriation, intoxication or other illegal act; a formal charge or conviction is not required. This exclusion does not apply if the Disease or Injury resulted from an act of domestic violence by a person other than the injured person or a medical (including both physical and mental health) condition.

4. **Custodial care**. Services or supplies provided mainly as a rest cure, maintenance, domiciliary or Custodial Care.

5. **Educational or vocational testing**. Services for educational or vocational testing or training.

6. **Employer-Provided Care**. The Plan does not cover care, treatment or supplies given by a medical department or clinic run for the benefit of employees and/or their dependents by the Member's employer or the employer of the Member's Spouse or other Dependent.

7. **Excess charges**. The part of an expense for care and treatment of an Injury or Illness that is in excess of the Contracted Rate or Maximum Allowed Amount.

8. **Experimental or Investigational.** Care, treatment and supplies, including prescription drugs, which are Experimental/Investigational. This exclusion shall not apply to the extent provided under covered Clinical Trials.

9. **Failure to Keep a Scheduled Visit.** Charges for failure to keep a scheduled visit or for completion of claim forms; for Physician or Hospital's stand-by services; for holiday or overtime rates.

10. **Free Services.** Services and supplies for which the Member has no legal obligation to pay, or for which no charge has been made or would be made if he or she had no health insurance coverage.

11. **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the primary purpose of obtaining medical services.

12. **Government Programs.** Treatment for which payment is made by any local, state, or federal government (except Medicaid), or for which payment would be made if the Participant had applied for such benefits. Services that can be provided through a government program for which the Member is a member of the community are eligible for participation. Such programs include, but are not limited to, school speech and reading programs.

13. **Hazardous Hobby or Activity.** Care and treatment of an Injury or Illness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, jet ski operating and bungee jumping.

14. **Hospital employees**. Professional services billed by a Physician or nurse who is an employee of a Hospital or other facility and paid by the Hospital or facility for the service.

15. **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

16. **Personal comfort items.** Items and services that are furnished primarily for personal comfort or convenience.

17. **Relative giving services.** Professional services performed by a person who is a member of the Member's household or is related to the Member as a spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

18. **Safe Surrounding.** Care furnished to provide a safe surrounding, including charges for providing a surrounding free from exposure that can worsen the Disease or Injury.

19. **Self-Inflicted**. Any care, service or supply required to treat an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence by another person or a medical (including both physical and mental health) condition.

20. **Services before or after coverage**. Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan, after coverage ceased under this Plan or while coverage was in place but the person was not eligible for coverage.

21. **Technology.** No service or supply will be covered under the Plan unless the underlying technology meets all of the following criteria: it must have final approval from the appropriate government regulatory bodies; the scientific evidence permits conclusions concerning the effect of the technology on health outcomes; the technology must improve the net health outcome; the technology must be as beneficial as any established alternative; and the technology must be beneficial in practice.

22. **Transportation** provided by other than a state licensed professional ambulance service is not covered.

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

24. **Treatment (Outside U.S.).** Non-emergency treatment received outside the United States performed without authorization is not covered. Medical tourism is specifically excluded.

25. **Waived Fees**. Any portion of a Provider's fee or charge which is ordinarily due from a Participant but which has been waived. If a Provider waives (does not require the Participant to pay) any cost sharing or balance billing amount, BCBS

will calculate the actual Provider fee or charge by reducing the fee or charge by the amount waived. A fee or charge will be deemed waived if there is no bona fide, documented attempt by the Provider to obtain payment in full from the Participant.

26. **War.** Any Disease or Injury resulting from a war, declared or not, or any military duty or any release of nuclear energy. Also excluded are charges for services directly related to military service provided or available from the Veterans' Administration or military medical facilities as required by law.

27. **Workers' Compensation.** Care of any condition or injury recognized or allowed as a compensable loss through any Workers' Compensation, occupational disease or similar law, whether or not insurance (including self-insured) coverage is in place. Exception: Benefits are provided for actively employed partners and small business owners not covered under a Workers' Compensation Act or similar law, if elected by the Group and additional Premium is paid.

DEFINITIONS

Cosmetic and Reconstructive Surgery and Procedures

Services provided to beautify or alter appearance, including but not limited to, surgery to correct gynecomastia, breast augmentation or reduction, otoplasties, and services provided as a result of or to correct previous Cosmetic Surgery or Procedures, including re-implantation.

Custodial Care

Any type of care, including room and board, that (a) does not require the skills of professional or technical personnel; (b) is not furnished by or under the supervision of such personnel or does not otherwise meet the requirements of post-Hospital Skilled Nursing Facility care; (c) is a level such that the Member has reached the maximum level of physical or mental function and is not likely to make further significant improvement. Custodial Care includes, but is not limited to, any type of care the primary purpose of which is to attend to the Member's activities of daily living which do not entail or require the continuing attention of trained medical or paramedical personnel. Examples of Custodial Care include, but are not limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, changes of dressings of non-infected, post-operative or chronic conditions, preparation of special diets, supervision of medication that can be self-administered by the Member, general maintenance care of colostomy or ileostomy, routine services to maintain other service which, in the sole determination of the Plan Administrator can be safely and adequately self-administered or performed by the average non-medical person without the direct supervision of trained medical and paramedical personnel, regardless of who actually provides the service, residential care and adult day care, protective and supportive care including educational services, rest care and convalescent care.

Drug Formulary

The Drug Formulary is a list of drugs that includes drugs that are covered under the Prescription Drug Program; drugs that are not covered; drugs that must be authorized in advance in order to be covered. A Member or prospective Member shall be entitled upon request, to a copy of the Drug Formulary Guide, available on the Pharmacy Benefit Manager's website shown in the Introduction section of this booklet, or as a separate reprint. The Pharmacy Benefit Manager may modify the Drug Formulary from time to time to add or remove drugs, or to reclassify drugs as generic, preferred, non-preferred or not covered.

Durable Medical Equipment

Equipment which is (a) made to withstand prolonged use; (b) solely made for and used in the treatment of Illness or Injury; (c) suited for use while not confined as an Inpatient at a Hospital; (d) not normally of use to persons who do not have an Illness or Injury; (e) not for exercise or training; and (f) ordered by a Physician.

Experimental or Investigational

Services which are considered Experimental or Investigational include services which (1) have not been approved by the Federal Food and Drug Administration or (2) for which medical and scientific evidence does not demonstrate that the expected benefits of the proposed treatment would be greater than the benefits of any available standard treatment and that adverse risks of the proposed treatment will not be substantially increased over those standard treatments. Such determination must result from prudent professional practices and be supported by at least two documents of medical and scientific evidence. Medical and scientific evidence means:

- Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff;
- Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National

Institute of Health's National Library of Medicine for indexing in Index Medicus, Excerpta Medikus (EMBASE), Medline, and MEDLARS data base or Health Services Technology Assessment Research (HSTAR);

- Medical journals recognized by the United States Secretary of Health and Human Services, under Section 18961 (t)(2) of the Social Security Act;
- The following standard reference compendia: the American Hospital Formulary Service-Drug Information, the American Medical Association Drug Evaluation, the American Dental Association Accepted Dental Therapeutics, and the United States Pharmacopoeia-Drug Information;
- Findings, studies, or research conducted by or under the auspices of federal government agencies and nationally recognized federal research institutes including the Federal Agency for Health Care Policy and Research, National Institute of Health, National Cancer Institute, National Academy of Sciences, Health Care Financing Administration, and any National board recognized by the National Institutes of Health for the purpose of evaluating the medical value of health services; or
- It meets the Technology Assessment Criteria as determined by BCBS as outlined in the "Definitions" Section of this Certificate Booklet.

Home Health Care
Care, by a state-licensed program or Provider, for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's Physician.

Home Health Care Agency
A Provider which renders care through a program for the treatment of a patient in the patient's home, consisting of required intermittent skilled care, which may include observation, evaluation, teaching and nursing services consistent with the diagnosis, established and approved in writing by the patient's attending Physician. It must be licensed by the appropriate state agency.

Hospice
A Provider which provides care for terminally ill patients and their families, either directly or on a consulting basis with the patient's Physician. It must be licensed by the appropriate state agency.

Hospice Care
A coordinated, interdisciplinary program that is recognized by BCBS as an approved Hospice Program and designed to meet the special physical, psychological, spiritual and social needs of the terminally ill Member and his or her covered family Members, by providing palliative and supportive medical, nursing and other services through at-home or inpatient care. The Hospice must be licensed by the appropriate state agency and must be funded as a Hospice as defined by those laws. It must provide a program of treatment for at least two unrelated individuals who have been medically diagnosed as having no reasonable prospect for cure for their illness.

Medical Emergency.
A Medical Emergency is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in one of the following conditions:

- Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;
- Serious impairment to bodily function; or
- Serious dysfunction of any bodily organ or part.

Specialty Drugs.
Specialty Drugs are typically high-cost drugs that may be administered orally, by injection or infusion, or which may require special handling such as temperature-controlled packaging and expedited delivery. Specialty Drugs may include (but are not limited to):biotechnology products; orphan drugs used to treat rare diseases; high cost drugs that total greater than $4000 per prescription per month; injectable medications including infusions in any outpatient setting—physician's office, home, or clinic; drugs requiring ongoing frequent management or monitoring of the patient by clinician, such as dose adjustment, or drugs used to treat chronic and potentially life threatening diseases; and drugs which require specialized coordination, handling and distribution services to ensure appropriate medication administration.

V. ELIGIBILITY

A. Eligible Classes of Employees. These employees are eligible to participate in the Plan:

1) Regular Full-Time Employees.

2) Regular Part-Time Employees who have worked at least 600 Hours of Service can be eligible if the Employee's participating Employer offers coverage to regular Part-Time employees. If your Employer offers this coverage, the eligibility rules will be described in your Employer's Offer of Coverage.

3) ACA Qualifying Employees. Special eligibility rules apply to ACA Qualifying Employees. They are described below.

4) Early Retirees who are enrolled in the Plan on the day immediately preceding retirement are eligible to enroll in certain plan options. References to Employees will generally include Early Retirees, except that active employment and hours of service rules will not apply. Other special rules applicable to Early Retirees will be specifically noted below.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

1) A covered Employee's Spouse.

2) A covered Employee's Child(ren).

3) A covered Employee's Totally Disabled Child who is enrolled in the Plan on the day immediately preceding his or her 26th birthday.

4) An Early Retiree's Spouse who is enrolled in the Plan on the day immediately preceding the Early Retiree's retirement.

5) A Retired Employee's Child(ren) who is (are) enrolled in the Plan on the day immediately preceding the Early Retiree's retirement.

The following do not qualify as Dependents: any person who is on active duty in any military service of any country; any person who permanently resides outside the United States; or any person who is covered under the Plan as an Employee.

Multiple Eligibility. An eligible person may be covered under this Plan as an Employee or a Dependent, but not both. If both parents are Employees, their children may be covered as Dependents of one parent, but not of both. If the Employee who is covering the Dependent child(ren) terminates coverage, the Dependent coverage may be continued by the other covered Employee without a break in coverage. If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for all cost sharing amounts applied to maximums.

Special Rules Applicable to ACA Qualifying Employees. The special rules that apply in determining whether or not an Employee works sufficient hours to qualify as an ACA Qualifying Employee are described in this section. The capitalized terms used in this section are also described below.

New Employees: An ACA Qualifying Employee is an Employee who is not a Regular Full-Time Employee but who averages at least 30 Hours of Service per week over the Employee's Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee's Initial Stability Period, subject to completion of enrollment requirements. An ACA Qualifying Employee will remain eligible throughout the Initial Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules.

Note: if there is a gap between the end of the Qualifying Employee's Initial Stability Period and the start of the Qualifying Employee's first Standard Stability Period (see below), the Qualifying Employee will remain eligible under the Plan until the

day preceding the start of the Standard Stability Period (to the extent the employee remains employed, and subject to the Plan's Break in Service rules.)

If a Qualifying Employee transfers to a Regular Full-Time Employee position prior to the start of the Qualifying Employee's Initial Stability Period, the Employee will become eligible for coverage under the rules applicable to Regular Full-Time Employees.

Ongoing Employees: Once an Employee has completed the Plan's Initial Measurement Period, eligibility will be based solely on the Employee's Hours of Service during the Plan's Standard Measurement Period. Any Employee who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Employees") will be eligible for coverage under the Plan during the Plan's next Standard Stability Period, provided that the Ongoing Employee remains employed, and subject to the Plan's Break in Service rules. Coverage will be effective on the first day of the Standard Stability Period, subject to completion of the enrollment requirements.

> This example illustrates these rules. For purposes of the example, let's say:
>
> An Employee is hired as a part-time employee with variable hours. He is hired on September 15, 2015. His Initial Measurement Period starts October 1, 2015 and ends September 30, 2016. His Initial Stability Period is the one-year period beginning on November 1, 2016. The Standard Measurement Period begins on November 1 and ends the following October 31. The Standard Stability Period is the calendar year.
>
> The Employee works an average of 32 hours per week from October 1, 2015 through September 30, 2016 (his Initial Measurement Period). Since he worked at least 30 hours per week during his Initial Measurement Period, he will become eligible for coverage starting on November 1, 2016, the first day of his Initial Stability Period. He remains eligible for coverage until October 31, 2017. However, since the Plan's Standard Stability Period does not begin until January 1, 2018, he will also be allowed to continue coverage until December 31, 2017. From now on, his eligibility for coverage will be based on the rules that apply to ongoing employees. He will be eligible for coverage beginning on January 1, 2018 only if he has worked an average of at least 30 hours per week during the Standard Measurement Period. (That is, from November 1, 2016 until October 31, 2017.)

The capitalized terms used in this section have the meanings below:

ACA Qualifying Employee means an Employee who is not a Regular Full-Time Employee but who averages at least 30 Hours of Service per week over the Employee's Initial Measurement Period. Coverage will be effective on the first day of the Qualifying Employee's Initial Stability Period, subject to completion of enrollment requirements.

Initial Measurement Period means the 12-calendar month period beginning on the first day of the calendar month coinciding with or next following the Employee's Date of Hire. Notwithstanding the foregoing, the Employer may make adjustments to the Initial Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Initial Stability Period means the 12-calendar month period means that begins on the first day of the calendar month following the calendar month that begins on or after the Employee's anniversary date. By way of example, if an Employee's anniversary date is July 15, the Initial Stability Period would begin on September 1.

Standard Measurement Period means the 12-calendar month period that begins on the first day of November of one calendar year and ends on the last day of October of the following calendar year. By way of example, the Standard Measurement Period to determine an Employee's average weekly hours in 2016 would begin on November 1, 2015 and end on October 31, 2016. However, the Employer may make adjustments to the Standard Measurement Period with respect to Employees on payroll periods that are weekly, bi-weekly or semi-monthly in duration, as set forth herein.

Standard Stability Period means the calendar year.

B. Effective Date of Coverage. Once an Employee becomes eligible for coverage, coverage will become effective as of the first day of the calendar month following the date the eligibility requirements are met. Coverage of his or her eligible dependents will become effective on the later of the date the Employee becomes covered or the first day of the calendar month following the date the dependent meets the requirements for dependent eligibility. However, these rules do not apply if the Plan

Administrator does not receive all required enrollment materials in a timely fashion. If an eligible Employee or dependent is not enrolled on a timely basis, he or she may not be enrolled until the next Annual Enrollment Period or a Special Enrollment Period.

An Employee must be an active employee for this coverage to take effect. If an Employee is not actively at work on the date his or her coverage is to become effective, the coverage effective date will be postponed until the date the Employee returns to active status. However, if the Employee is not actively at work due to health status, this delay in effective date will not apply.

On occasion, when an Employer begins to offer coverage under this Plan, if an Employee or Dependent had coverage under a prior carrier and is covered under an extension of benefits provision, the Employee or Dependent (if otherwise eligible) will be enrolled in this Plan but the prior carrier will be responsible for payment of benefits and services related to disabilities in accordance with the terms of that carrier's coverage and applicable state law. To the extent these expenses are not covered under the prior carrier's coverage, this Plan will pay benefits in accordance with its own terms and conditions.

At any time, the Plan Administrator may require proof that an Employee or Dependent qualifies or continues to qualify for coverage under this Plan. This may include documentation including birth certificates, marriage certificates, tax records, proof of residency, or legal proceedings regarding guardianship or parental rights. Failure to provide such documentation is grounds for denial or termination of coverage.

C. Termination of Coverage

The Plan Administrator has the right to rescind any coverage of the Employee and/or Dependents for cause, making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage or benefits under the Plan, or failing to notify the Plan Administrator that he or she has become ineligible for coverage. The Employer or Plan Administrator may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan Administrator will provide at least 30 days' advance written notice of such action. The Employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The Plan Administrator reserves the right to collect additional monies if claims are paid in excess of the Employer's, Employee's and/or Dependent's paid contributions.

Employee Coverage**.** Employee coverage will terminate on the earliest of the following dates. (However, in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA). Coverage will terminate on the earliest of the following:

(1) The date the Plan is terminated or amended to eliminate the Employee's Eligible Class.

(2) The date the covered Employee's Employer ceases to be a participating Employer.

(3) The last day of the month in which a covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of active employment of the covered Employee (unless a terminated Employee is eligible as an Early Retiree.) It also includes an Employee on disability, leave of absence or other leave of absence, except as the Plan specifically provides for continuation during these periods.

(4) The end of the month for which any required contribution has been paid if the charge for the next month is not paid when due.

(5) For Early Retirees, the last day of the month in which occurs the Early Retiree's 65th birthday.

<u>Continuation During Periods of Employer-Certified Leave of Absence</u>**.** A covered Employee and his or her covered Dependents may remain eligible for coverage under the Plan for a limited time if the Employee's active work ceases due to disability or medical leave of absence. This continuance will extend for a period not to exceed twelve weeks following the last day of active work, or until the period of authorized absence ends, if sooner. While continued, coverage will be that which was in force on the last day worked as an active Employee. However, if benefits change for others in the class, they will change in the same manner for the continued person.

<u>Continuation During Family and Medical Leave</u>**.** Regardless of the established leave policies mentioned above, 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 and 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.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

<u>Rehiring a Terminated Employee</u>**.** A terminated Employee who is rehired after a Break in Service will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements. However, if the Employee is returning to work directly from the Employer's COBRA coverage, this Employee does not have to satisfy any Waiting Period.

A terminated Employee who is rehired before incurring a Break in Service will be treated as a continuous employee, as follows:

1. An Employee who had satisfied any Waiting Period prior to termination is not required to satisfy a new Waiting Period. If the Employee was enrolled in the Plan on the day before the Break in Service began, the Employee will be eligible for coverage under the Plan upon return. Coverage will be effective on the first day of the month that coincides with or follows the date the Employee resumes Hours of Service, subject to completion of enrollment requirements.

2. An Employee who had not satisfied any Waiting Period prior to termination will be credited with service prior to the termination for purposes of satisfying the Waiting Period following rehire.

<u>Employees on Military Leave</u>**.** 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) under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

(1) The maximum period of coverage of an Employee and the Employee's covered Dependents under such an election shall be the lesser of:

  (a) The 24-month period beginning on the date on which the Employee's absence begins; or

  (b) The day after the date on which the Employee was required to apply for or return to a position of employment and fails to do so.

(2) A person who elects to continue health plan coverage must pay 102% of the full contribution under the Plan, except an Employee on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

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

If the Employee wishes to elect this coverage or to obtain more detailed information, contact the Plan Administrator. The Employee may also have continuation rights under COBRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent with COBRA, not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their covered Dependents, but Dependents do not have any independent right to elect USERRA health plan continuation. -

Dependent Coverage**.** A Dependent's coverage will terminate on the earliest of the dates described below. However, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA).

(1) The date the Plan or Dependent coverage under the Plan is terminated or amended to eliminate coverage for the Dependent's Eligible Class.

(2) The date that the Employee's coverage under the Plan terminates for any reason. However, coverage may be extended if a covered Employee dies while still employed by the Group. In that case, coverage for the Employee's Spouse, if covered at the time of Employee's death, may continue until the beginning of the month in which he or she reaches age 65, or if earlier, at the end of the month in which he or she remarries. Coverage for the Employee's covered Dependent children will terminate at the end of the month in which the child ceases to meet the eligibility requirements for a Dependent child as described above. Continuation of coverage will be subject to timely payment of any required premium contributions. The Spouse or Dependent Child must notify the Plan Administrator at the time of the death, as different coverage options may apply. COBRA coverage may also be available at that time.

(3) The last day of the month in which the Dependent ceases to meet the applicable eligibility requirements.

(4) The last day of the month for which any required contribution has been paid if the charge for the next month is not paid when due.

If a Dependent commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage or benefits under the Plan, or fails to notify the Plan Administrator that he or she has become ineligible for coverage, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Group Coverage. The Plan Administrator may cancel the Employer's participation (and the coverage of all Employees and Dependents) in the Plan in the event of any of the following:

(1) The Employer fails to pay premiums in accordance with the terms of this Plan.

(2) The Employer ceases to meet the eligibility requirements to participate in the Plan.

(3) The Employer performs an act or practice that constitutes fraud or intentional misrepresentation of material fact in applying for or procuring coverage.

(4) The Employer has fallen below the minimum employer contribution or employer participation rules. We will submit a written notice to the Employer and provide 60 days to comply with these rules.

(5) We terminate, cancel, or do not renew all coverage under a particular policy form, provided that: we provide at least 180 days' notice of the termination; we offer the Employer and all other small Group or large Group policies, depending on the size of the Group, currently being offered or renewed by us for which you are otherwise eligible; and we act uniformly without regard to the claims experience or any health status related factor of the individuals insured or eligible to be insured.

Continuation of Hospital Benefits. If a covered Employee or covered Spouse or Dependent Child is receiving care in the Hospital at the time coverage is terminated for reasons other than the termination of Employer's participation in the Plan or for failure to timely pay premium contributions, benefits for Hospital Inpatient care will be provided only to the extent available for that Hospital stay.

D. Definitions: Below are terms that are used frequently in this Eligibility section.

Break in Service means a period of at least 13 consecutive weeks during which the Employee has no Hours of Service. A Break in Service may also include any period for which the Employee has no Hours of Service that is at least four (4) consecutive weeks in duration and longer than the prior period of employment (determined after application of the procedures applicable to Special Unpaid Leaves.)

Child means an Employee's natural child, adopted child, a child placed with the Employee for adoption, stepchild, foster child, or a child for whom the Employee or Spouse is legal guardian. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26 without regard to student status, marital status, financial dependency or residency status with the Employee or any other person, except that the eligibility of a Child for whom an Employee or Spouse is legal guardian will end on the last day of the month in which the Employee or Spouses ceases to be a legal guardian. When a Child reaches the limiting age of 26, coverage will end on the last day of the Child's birthday month.

A foster child is not eligible if one or both of the child's natural or adoptive parents lives with the Employee, or if the foster child has been placed with the Employee under a welfare arrangement and the welfare agency pays all or part of the child's support.

The phrase "placed for adoption" refers to a child whom a person intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by such person of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

Any eligible Child of a Plan Participant who is an alternate recipient under a qualified medical child support order that requires the Employee to provide coverage shall be considered eligible for Dependent coverage under this Plan. A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

Coverage Effective Date means the first day of the month following completion of the Waiting Period and satisfaction of all enrollment requirements.

Coverage Termination Date means the last day of the month in which a Covered Employee's or Covered Dependent's eligibility ends.

Early Retiree means a former Employee who (1) has attained at least 55 years of age and less than 65 years of age, (2) with at least ten years of service with a participating Employer, and (3) is covered under the Plan on the date he retires from service, (4) with an Employer that offers Early Retiree coverage. An Early Retiree who disenrolls from the Plan following retirement is not eligible to re-enroll at any time.

Hours of Service means each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following, consistent with 29 C.F.R. 2530.200b-2(a)(i):

- Vacation
- Holiday
- Illness or incapacity
- Layoff
- Jury duty
- Military duty or leave of absence

Regular Full Time Employee means an active employee who is designated by the Employer as being regularly scheduled to work for the Employer at least 30 hours per week.

Regular Part-Time Employee means an active employee who is designated by the Employer as being regularly scheduled to work for the Employer fewer than 30 hours per week. The Employer may establish a minimum number of daily, weekly or monthly hours required to be eligible for benefits as a Regular Part-Time Employer. These requirements will be described in the Employer's Offer of Coverage.

Special Unpaid Leave of Absence means any of the following types of unpaid leaves of absence that do not constitute a Break in Service: (i) Leave protected by the Family and Medical Leave Act, (ii) leave protected by the Uniformed Services Employment and Reemployment Rights Act or (iii) Jury Duty (as reasonably defined by the Employer).

Spouse means the person with whom a covered Employee has established a valid marriage under the laws of the State or other jurisdiction in which the couple were married. The term Spouse includes same sex spouses but does not include a spouse who is married under a common law marriage.

Totally Disabled Child means a covered Dependent Child who is totally disabled on the date of his 26th birthday. A child is considered to be totally disabled if he is incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The covered Employee must notify the Plan Administrator and give evidence of the disability within 30 days of the Child attaining age 26. The Plan Administrator may require annually, continuing proof of the total disability and dependency, and may require the Dependent to be examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity. Eligibility will end if the Dependent ceases to be totally disabled.

Waiting Period means the period established by a participating Employer which begins on the first day of an Employee's employment in an eligible class and ending not later than 90 consecutive days later. The Waiting Period chosen by an Employer will be set out in the Offer of Coverage.

VI. ENROLLMENT REQUIREMENTS

Eligible Employees and their eligible Dependents must be enrolled on a timely basis in order for coverage to become effective. This Section describes when enrollment is allowed.

A. INITIAL ENROLLMENT

Eligible Employees must enroll by completing, signing (or electronically authorizing) and submitting an enrollment application within 30 days after first becoming eligible for coverage. If enrollment materials are submitted in a timely manner, coverage will become effective retroactive to the first day of the calendar month following satisfaction of all eligibility requirements. The Employee must enroll any eligible Dependents at the same time. If all the required enrollment materials are not received by the Plan Administrator by that time, the Employee and/or his or her eligible Dependents will not be eligible to enroll until the next Open Enrollment period or upon the occurrence of a Special Enrollment Event.

If an eligible Employee acquires a new Dependent after his initial enrollment, the new Dependent must be enrolled under the Special Enrollment rules described below. However, a special rule applies with regard to newborn children. A newborn child of a covered Employee is automatically enrolled in the Plan for 31 days. Coverage will terminate at the end of this period unless the Employee enrolls the child and pays all required premiums within the 31 days.

B. OPEN ENROLLMENT

Eligible Employees and their eligible Dependents may enroll each year for the following Plan. The open enrollment period begins each year when the Employer distributes the SBC and provides information about any required contributions toward coverage. The enrollment period ends no sooner than 30 days after the date the enrollment period begins.

Benefit choices made during the open enrollment period will become effective on the first day of the next Plan Year and remain in effect until the last day of that Plan Year unless there is a Special Enrollment event or a change in family status during the year. If an Employee who is already enrolled in the Plan fails to make an election during open enrollment, his or her present coverage will automatically continue into the next Plan Year.

C. SPECIAL ENROLLMENT

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or herself or his or her dependents (including his or her spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days of the birth, marriage, adoption or placement for adoption.

The Special Enrollment rules are described in more detail below. To request Special Enrollment or obtain more detailed information of these portability provisions, contact the Plan Administrator.

Special Enrollment Periods. The events described below may create a right to enroll in the Plan under a Special Enrollment Period.

(1) **Losing other coverage may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if the individual loses eligibility for other coverage and loss of eligibility for coverage meets all of the following conditions:

(a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.

(b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.

(c) Either (i) the other coverage was COBRA coverage and the COBRA coverage was exhausted, or (ii) the other coverage was not COBRA coverage, and the coverage was terminated as a result of loss of eligibility for the coverage or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(d) The Employee or Dependent requests enrollment in this Plan not later than 30 days after the date of exhaustion of COBRA coverage or the termination of non-COBRA coverage due to loss of eligibility or termination of employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

(2) For purposes of these rules, a loss of eligibility occurs if one of the following occurs:

(a) The Employee or Dependent has a loss of eligibility due to the plan no longer offering any benefits to a class of similarly situated individuals (for example: part-time employees).

(b) The Employee or Dependent has a loss of eligibility as a result [of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the plan), death, termination of employment, or reduction in the number of hours of employment or contributions towards the coverage were terminated.

(c) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual).

(d) The Employee or Dependent has a loss of eligibility when coverage is offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area, (whether or not within the choice of the individual), and no other benefit package is available to the individual.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the plan), that individual does not have a Special Enrollment right.

(3) **Acquiring a newly eligible Dependent may create a Special Enrollment right.** If:

(a) The Employee is a participant under this Plan (or has met any Waiting Period applicable to becoming a participant under this Plan is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent may be enrolled under this Plan. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Special Enrollment Period for newly eligible Dependents is a period of 30 days that begins after the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent and/or Employee enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(4) **Eligibility changes in Medicaid or State Child Health Insurance Programs may create a Special Enrollment right.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

(a) The Employee or Dependent is covered under a Medicaid plan under Title XIX of the Social Security Act or a State child health plan (CHIP) under Title XXI of such Act, and coverage of the Employee s terminated due to loss of eligibility for such coverage, and the Employee or Dependent requests enrollment in this Plan within 60 days after such Medicaid or CHIP coverage is terminated.

(b) The Employee or Dependent becomes eligible for assistance with payment of Employee contributions to this Plan through a Medicaid or CHIP plan (including any waiver or demonstration project conducted with respect to such plan), and the Employee or Dependent requests enrollment in this Plan within 60 days after the date the Employee or Dependent is determined to be eligible for such assistance.

If a Dependent becomes eligible to enroll under this provision and the Employee is not then enrolled, the Employee must enroll in order for the Dependent to enroll.

Coverage will become effective as of the first day of the first calendar month following both the date the Special Enrollment Event occurs and the date the completed enrollment form is received unless an earlier date is established by the Employer or by regulation.

VII. CLAIMS AND APPEAL PROCEDURES

Benefits under this Plan shall be paid only if claims are properly submitted and the Plan Administrator decides that a Member is entitled to them.

A. How to Submit a Claim

Claims should be filed with the Claims Administrator within 90 days after the date of service or, if greater, within the time period described in a provider's contract with Anthem. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless it's not reasonably possible to submit the claim in that time, and the claim is submitted within one year from the date incurred. If the claimant is not legally capable of submitting the claim, it must be filed as soon as reasonably possible and in no event later than one year following the date an authorized representative is appointed for the claimant.

Network and Participating Providers will usually file claims on your behalf. When they do, the Plan will send the Provider's share of any reimbursements directly to the Provider. An Out-of-Network Provider may file directly on your behalf, but any claims reimbursements will be sent to you and you will need to reimburse the Provider. You may not assign your right to reimbursement to these Out-of-Network Providers.

To submit a Claim, you will need to:

(1) Obtain a Claim form from Member Services.
(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
(3) Have the health care provider complete the provider's portion of the form.
(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis
- Type of services rendered, with diagnosis and/or procedure codes
- Date of services
- Charges

(5) Send the above to the Claims Administrator at the address shown in Section I.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to require a Plan Participant to seek a second medical opinion.

B. How the Claim Review Process Works

1. In General. Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for payment of a Plan benefit, made by a claimant or by an authorized representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan or a request for prior approval of medical or prescription drug services unless the Plan imposes a reduction in benefits or a financial penalty for failure to obtain prior approval.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as the "Initial Adverse Benefit Determination."

A claimant has the right to request a review of the Initial Adverse Benefit Determination. This request is an "Appeal."

Post-Service Claims: If the Initial Adverse Benefit Determination on a Post-Service Claim is upheld on the first Appeal, the claimant may request a second Appeal. If the Initial Adverse Benefit Determination is again upheld, the Plan's final decision is known as a "Final Adverse Benefit Determination."

Pre-Service Claims: One level of appeal is allowed for Pre-Service Claims. If the Initial Adverse Benefit Determination of a Pre-Service Claim is upheld on the appeal, this is the "Final Adverse Benefit Determination."

For certain types of Claims, if the claimant receives notice of a Final Adverse Benefit Determination, the claimant then has the right to request an independent external review. The External Review procedures are described below.

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

A claimant must follow all claims and appeal procedures, both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within one (1) year after the date of the Final Adverse Benefit Determination. If the Plan Administrator has not complied with the procedures described in this Section, the claimant may have the right to file a lawsuit before these procedures are exhausted. In that case, the lawsuit must be filed within two years of the initial claim denial.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. The types of Claims and the timeframes that apply to each are described later in this section.

2. Initial Decisions on a Claim.

Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. Except with Urgent Care Claims (which are described below in Paragraph 4) when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator will provide written or electronic notification of the Initial Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the claim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(b) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(c) Reference to the specific Plan provisions on which the determination was based.

(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(e) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. Where applicable, this will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

(f) If the Initial Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Initial Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(g) If the Initial Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

The Plan Administrator's notification to the claimant of its Initial Adverse Benefit Determination will be made as soon as practical and not later than the time shown in the timetables below.

3. Appealing a Claim. If a claimant receives an Initial Adverse Benefit Determination, the claimant has the right to file a written request for an Appeal of the decision. The claimant may submit written comments, documents, records, and other information relating to the Claim.

If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

(a) was relied upon in making the benefit determination;

(b) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

(c) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

(d) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

(a) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, and the cl aim amount, if applicable), and a statement that the diagnosis code and treatment code and their corresponding meanings will be provided to the claimant as soon as feasible upon request.

(b) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

(c) Reference to the specific Plan provisions on which the determination was based.

(d) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

(e) A description of the Plan's internal and external review procedures and the time limits applicable to such procedures. Where applicable, this will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

(f) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

(g) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

(h) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

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

If the claimant requests two Appeals and the second Appeal upholds the Initial Adverse Benefit Decision, this notice is the Final Adverse Benefit Determination.

4. Time Frames.

This section describes the time periods for the various stages of the appeal process. These time periods depend on the type of the initial clam, as described below.

The definitions of the different types of Claims are:

Post-Service Claim: A Post-Service Claim means any Claim for a Plan benefit that is not a Pre-Service Claim, an Urgent Care Claim, or a Concurrent Care Claim, as described below; in other words, a Post-Service Claim is a request for payment under the Plan for medical services already provided to the claimant.

Pre-Service Claim: A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to precertification or prior approval requirements, and they must be submitted, in writing, before the claim is incurred.

Urgent Care Claim: A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim. Urgent Care Claims are a type of Pre-Service Claim because the rules only apply if benefits are conditioned on prior approval. The Urgent Care Claim rules do not apply to claims involving urgent care where Plan benefits are not conditioned on prior approval. These claims are subject to the rules on Post-Service Claims.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. The Claims Administrator will defer to the attending provider's determination that the Claim involves Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

Concurrent Care Claims: A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is

to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

The timetable below sets out the maximum time periods for each step in the claims and appeal process. The period of time within which a benefit determination is required to be made shall begin at the time the Claim or appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown below. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

ACTION	TYPE OF CLAIM		
	Post-Service	Pre-Service/ Urgent Care	Concurrent Care/ Rescission Claims
Initial Decision on Claim			
Plan must notify claimant of Initial Adverse Benefit Determination (IABD) within	30 days	15 days. For urgent care, 72 hours (or within 24 hours if additional information is needed)	For concurrent care, prior to scheduled termination of course of treatment with sufficient time for claimant to appeal. For rescission, 30 days prior to termination of coverage
Extension may be permitted for a period	Up to 15 days	Up to 15 days. Extension not permitted for urgent care	N/A
Claimant must provide additional information if requested within	45 days	45 days. For urgent care, 48 hours	N/A
If claim is denied, request for review must be filed within	180 days after date of IABD	180 days after date of IABD	Prior to scheduled termination of course of treatment
Decision on Review (Appeal)			
1. First Level Appeal	Post-Service	Pre-Service/ Urgent Care	Concurrent Care/ Rescission Claims
a. Plan must notify claimant of ABD on First Level Appeal within	30 days	30 days For urgent care, 24 hours	30 days. For concurrent care involving urgent care, 24 hours (provided claimant files appeal more than 24 hours prior to scheduled termination)
b. Extension may be permitted for a period	Up to 60 days	Up to 60 days Extension not permitted for urgent care	N/A
c. Claimant must provide additional information if requested within	45 days	45 days. For urgent care, 48 hours	N/A
d. If second level appeal is requested, request must be filed within	90 days after date of ABD on First Level Appeal		

2. **Second Level Appeal**	Post-Service	Pre-Service/ Urgent Care	Concurrent Care/ Rescission Claims
a. Plan must notify claimant of ABD (the "Final Adverse Benefit Determination") within	30 days	N/A	30 days. For concurrent care involving urgent care, 24 hours (provided claimant files appeal more than 24 hours prior to scheduled termination)
b. Extension may be permitted for a period	Up to 60 days	N/A	N/A
c. Claimant must provide additional information if requested within	45 days	N/A	N/A

EXTERNAL REVIEW PROCESS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process. The External Review process is available only where the Final Adverse Benefit Determination is denied on the basis of (1) a medical judgment (which includes but is not limited to, Plan requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit), (2) a determination that a treatment is experimental or investigational, or (3) a rescission of coverage. The request for External Review must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.

The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on the criteria described above and whether: The claimant is or was covered under the Plan at the time the Claim was made or incurred; the denial relates to the claimant's failure to meet the Plan's eligibility requirements; the claimant has exhausted the Plan's internal Claims and Appeal Procedures; and the claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866-444-3272).

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4-month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

(1) The claimant's medical records;

(2) The attending health care professional's recommendation;

(3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;

(4) The terms of the Plan;

(5) Appropriate practice guidelines;

(6) Any applicable clinical review criteria developed and used by the Plan; and

(7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

(1) A general description of the reason for the External Review, including information sufficient to identify the claim;

(2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;

(3) References to the evidence or documentation the IRO considered in reaching its decision;

(4) A discussion of the principal reason(s) for the IRO's decision;

(5) A statement that the determination is binding and that judicial review may be available to the claimant; and

(6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the PPACA.

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

(1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

(2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the Plan.

VIII. CONTINUATION COVERAGE RIGHTS

Continuation of Coverage

A. Continuation of Coverage (Georgia Law)

Any Employee insured in Georgia under a company welfare benefit plan whose employment is terminated other than for cause, may be entitled to certain continuation benefits. If you have been continuously enrolled for at least six months under this Contract, or this and its immediately preceding health insurance Contract, you may elect to continue Group health coverage for yourself and your enrolled family Members for the rest of the month of termination and three additional months by paying the appropriate Premium.

This benefit entitles each Member of your family who is enrolled in the company's Employee welfare benefit plan to elect continuation independently.

<u>Cost</u>
These continuation benefits are available without proof of insurability at the same Premium rate charged for similarly insured Employees. The Premium rate is calculated without regard to any amounts paid by your Employer for active employees. To elect this benefit, you must notify the Group's Plan Administrator within 30 days of the date your coverage would otherwise cease that you wish to continue your coverage and you must pay the required monthly Premiums in advance.

This continuation benefit is not available if:

- your employment is terminated for cause; or
- your health plan enrollment was terminated for your failure to pay a Premium or Premium contribution; or
- your health plan enrollment is terminated and replaced without interruption by another Group Contract; or
- health insurance is terminated for the entire class of Employees to which you belong; or
- the Group terminates health insurance for all Employees

<u>Termination of Benefits</u>
Continuation coverage terminates if you do not pay the required Premium on time or you enroll for other Group insurance or Medicare.

B. Continuation of Coverage (Federal Law – COBRA)

Under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under the Plan will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform you, in summary fashion, of your rights and obligations under COBRA. This notice is intended to reflect the law and does not grant or take away any rights under the law.

If your coverage ends under the Plan, you may be entitled to elect continuation coverage under COBRA. If your employer normally employs 20 or more people, and your employment is terminated for any reason other than gross misconduct, instead of the three months continuation benefit described above, you may elect from 18-36 months of continuation benefits under COBRA coverage.

There may be options other than COBRA coverage available when you lose your Group coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

<u>Qualifying events for Continuation Coverage under Federal Law (COBRA)</u>

COBRA continuation coverage is available when your Plan coverage would otherwise end because of certain "qualifying events." A Qualifying Event is any of the following if the Plan eligibility requirements would cause you to lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA coverage:

(1) The death of a covered Employee.

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

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation.

(4) A covered Employee's enrollment in any part of the Medicare program.

(5) A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

(6) For members with retiree coverage, a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment the covered Employee retired at any time.

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

For non-FMLA leaves of absence, the COBRA Qualifying Event date will be the day the leave ends, if the Employee does not return to work in an Eligible Class. However, COBRA coverage will not be available if coverage lapses prior to the end of the leave of absence because of failure to pay premiums.

Qualified Beneficiaries.

After a qualifying event, COBRA continuation coverage must be offered to each person who is a "Qualified Beneficiary." A person is a "Qualified Beneficiary" if (1) the person is an Employee, Spouse or Dependent Child of an Employee, (2) is covered under the Plan on the day before the Qualifying Event, and (3) the Qualifying Event causes the Employee, Spouse or Dependent Child to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences). For example, any increase in Premium that must be paid by the Employee, Spouse, or Dependent Child as a result of the occurrence of one of the Qualifying Events listed above is a loss of coverage.

Although a person must be covered under the Plan on the day before the Qualifying Event in order to be a Qualified Beneficiary, an exception may be made if coverage is denied or not offered under circumstances in which the denial or failure to offer constitutes a violation of applicable law. In that case, the person will be considered to have had the Plan coverage on the date before the Qualifying Event.

If the Employee elects COBRA continuation coverage and a child is born to or placed for adoption with the covered Employee during the time COBRA continuation coverage is in effect, the newborn or adopted child will also be a Qualified Beneficiary. In addition, a person who is covered by the Plan as an alternate recipient under a qualified medical support order who would otherwise lose coverage as a result of a Qualifying Event will be a Qualified Beneficiary.

A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was covered under the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

Each Qualified Beneficiary (including a child who is eligible as a Dependent Child and who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualified beneficiaries who elect COBRA must pay for this COBRA continuation coverage.

There may be other options available when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

What factors should be considered when determining to elect COBRA continuation coverage? When considering options for health coverage, Qualified Beneficiaries should consider:

- **Premiums:** This plan can charge up to 102% of total plan premiums for COBRA coverage. Other options, like coverage on a spouse's plan or through the Marketplace, may be less expensive. Qualified Beneficiaries have special enrollment rights under federal law (HIPAA). They have the right to request special enrollment in another group health plan for which they are otherwise eligible (such as a plan sponsored by a spouse's employer) within 30 days after Plan coverage ends due to one of the Qualifying Events listed above.

- **Provider Networks:** If a Qualified Beneficiary is currently getting care or treatment for a condition, a change in health coverage may affect access to a particular health care provider. You may want to check to see if your current health care providers participate in a network in considering options for health coverage.

- **Drug Formularies:** For Qualified Beneficiaries taking medication, a change in health coverage may affect costs for medication – and in some cases, the medication may not be covered by another plan. Qualified beneficiaries should check to see if current medications are listed in drug formularies for other health coverage.

- **Severance payments:** If COBRA rights arise because the Employee has lost his job and there is a severance package available from the employer, the former employer may have offered to pay some or all of the Employee's COBRA payments for a period of time. This can affect the timing of coverage available in the Marketplace. In this scenario, the Employee may want to contact the Department of Labor at 1-866-444-3272 to discuss options.

- **Medicare Eligibility:** If your COBRA Qualifying Event results from termination of employment, you should be aware of how COBRA coverage coordinates with Medicare eligibility. If you are eligible for Medicare at the time of the Qualifying Event, or if you will become eligible soon after the Qualifying Event, you should know that you have 8 months to enroll in Medicare after the later of your termination of employment or your becoming eligible for Medicare to avoid Medicare late enrollment penalties. Electing COBRA coverage does not extend this 8-month period. For more information, see medicare.gov/sign-up-change-plans.

- **Service Areas:** If benefits under the Plan are limited to specific service or coverage areas, benefits may not be

available to a Qualified Beneficiary who moves out of the area.

- **Other Cost-Sharing:** In addition to premiums or contributions for health coverage, the Plan requires participants to pay copayments, deductibles, coinsurance, or other amounts as benefits are used. Qualified beneficiaries should check to see what the cost-sharing requirements are for other health coverage options. For example, one option may have much lower monthly premiums, but a much higher deductible and higher copayments.

Are there other coverage options besides COBRA Continuation Coverage? Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for Qualified Beneficiaries through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

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

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

(1) the end of employment or reduction of hours of employment,

(2) death of the Employee,

(3) commencement of a proceeding in bankruptcy with respect to the employer, or

(4) entitlement of the employee to any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the Employee and Spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you or someone on your behalf must notify the person or company identified in Section I about this initial Qualifying Event within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing during the 60-day notice period, any Spouse or Dependent child who loses coverage will not be offered the option to elect continuation coverage.

NOTICE PROCEDURES:

Any notice that you provide under this Continuation of Coverage under COBRA section must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person listed and the address shown in the Introduction section.

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

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

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

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

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

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage.

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

(1) The last day of the applicable maximum coverage period.

(2) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.

(3) The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee.

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes entitled to Medicare (either part A or part B, whichever occurs earlier).

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

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

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

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.

(2) In the case of a covered Employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program. This extension does not apply to the covered Employee; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the covered retiree ends on the date of the retiree's death. The maximum coverage period for a Qualified Beneficiary who is the covered Spouse, surviving Spouse or Dependent child of the retiree ends on the earlier of the Qualified Beneficiary's death or 36 months after the death of the retiree.

(4) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(5) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months,

but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice of a second Qualifying Event must be sent to the person or company identified in the Introduction section in accordance with the procedures above.

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

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified Beneficiaries will pay 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

IF YOU HAVE QUESTIONS

If you have questions about your COBRA continuation coverage, you should contact the COBRA Administrator in accordance with the procedures above. For more information about your rights under COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

IX. COORDINATION OF BENEFITS

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Member is covered by this Plan and another plan, or the Member's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance up to each one's plan formula minus whatever the primary plan paid. This is called non-duplication of benefits. The total reimbursement will never be more than the amount that would have been paid if the secondary plan had been the primary plan -- 50% or 80% or 100% -- whatever it may be. The balance due, if any, is the responsibility of the Member.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term benefit plan means this Plan or any one of the following plans:

(1) Group or group-type plans, including dental, franchise or blanket benefit plans.

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes, but is not limited to, Medicare and Tricare.

(5) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.

(6) No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable it must be a Usual and Reasonable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Member does not use an HMO or network provider, this Plan will not consider as an Allowable Charge any charge that would have been covered by the HMO or network plan had the Member used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the Allowable Charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules:

(1) Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.

(2) Plans with a coordination provision will pay their benefits up to the Allowable Charge:

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B"). Where a person is covered as a dependent child under one plan and as a spouse under the other plan, the benefits of the plan that covers the person as a spouse are determined before those of the plan which covers the person as a dependent child.

(b) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or Retired Employee. The benefits of a benefit plan which covers a person as a Dependent of an Employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a Dependent of a laid off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(c) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired are determined before those benefits of a benefit plan which covers that person as a laid-off or Retired Employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.

(d) The benefits of a benefit plan which covers a person as an Employee who is neither laid off nor retired or a Dependent of an Employee who is neither laid off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.

(e) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

(i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;

(ii) If both parents have the same birthday, the benefits of the benefit plan which has covered the parent for the longer time are determined before those of the benefit plan which covers the other parent.

(f) When a child's parents are divorced or legally separated, these rules will apply:

(i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

(iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a Dependent.

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the

plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.

(g) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare would be the primary payer if the person had enrolled in Medicare, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B regardless of whether or not the person was enrolled under any of these parts. The Plan reserves the right to coordinate benefits with respect to Medicare Part D. The Plan Administrator will make this determination based on the information available through CMS. If CMS does not provide sufficient information to determine the amount Medicare would pay, the Plan Administrator will make reasonable assumptions based on published Medicare fee schedules.

(4) If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

(5) The Plan will pay primary to Tricare and a State child health plan to the extent required by federal law.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the claims determination period.

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Member will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case this Plan may recover the amount paid from the other benefit plan or the Member. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

Exception for Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Member under the Plan.

X. THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

When this provision applies. The Member may incur medical or dental charges due to Injuries or Sickness which may be caused by the act or omission of a Third Party, or for which a Third Party may be responsible for payment. In such circumstances, the Member may have a claim against that Third Party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Member may have to Recover payments from any Third Party or insurer, including but not limited to the Member's insurer. This Subrogation right allows the Plan to pursue (1) any claim which the Member has against any Third Party, or insurer, whether or not the Member chooses to pursue that claim; and (2) reimbursement from the Member from any amounts Recovered. The Plan may make a claim directly against the Third Party or insurer, but in any event, the Plan has a lien on any amount Recovered by or on behalf of the Member whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The payment for benefits received by a Member under the Plan shall be made in accordance with the assignment of rights by or on behalf of the Member as required by Medicaid.

In any case in which the Plan has a legal liability to make payments for benefits received by a Member, to the extent that payment has been made through Medicaid, the payment for benefits under the Plan shall be made in accordance with any state law that has provided that the state has acquired the rights of the Member to the payments of those benefits.

The Member:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

Amount subject to Subrogation or Refund. The Member agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over any and all Recoveries and funds paid by a Third Party to a Member relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. This provision expressly abrogates the "make whole" and "common fund" doctrines and similar defenses to the Plan's claims. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Member may have to recover payments from any responsible third party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Member's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Member. Also, the Plan's right to Subrogation still applies if the Recovery received by the Member is less than the claimed damage, and, as a result, the claimant is not made whole.

When a right of Recovery exists, the Member will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Member will do nothing to prejudice the right of the Plan to Subrogate.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Member if a Member refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Member is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Member or his authorized legal representative

obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms: "Member" means anyone covered under the Plan, including minor dependents.

"Recover," "Recovered," "Recovery" or "Recoveries" means all monies paid to the Member or his designee by way of judgment, settlement, or otherwise to compensate for any losses caused by the Injury or Sickness, whether or not said losses include medical or dental charges covered by the Plan. The term "Recoveries" further includes, but is not limited to, recoveries for medical or dental expenses, attorneys' fees, costs and expenses, pain and suffering, loss of consortium, wrongful death, lost wages and any other recovery of any form of damages or compensation whatsoever.

"Refund" means reimbursement to the Plan for medical or dental benefits that it has paid toward care and treatment of the Injury or Sickness.

"Subrogation" means the Plan's right to pursue the Member's claims for medical or dental charges against a third party or to place a lien against any proceeds Recovered by or on behalf of the Member with respect to such claims.

"Third Party" means any Third Party including another person or a business entity.

Recovery from another plan under which the Member is covered. This right of Refund also applies when a Member Recovers under an uninsured or underinsured motorist plan (which will be treated as Third Party coverage when reimbursement or Subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

Rights of Plan Administrator. The Plan Administrator has a right to request reports on and approve of all settlements.

XI. MISCELLANEOUS PROVISIONS

A. Duties of the Plan Administrator. The Plan shall be administered by the Plan Administrator in accordance with the provisions of ERISA and other applicable law. The Plan Administrator serves at the convenience of the Plan Sponsor. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties. The Plan Administrator has the right and authority:

(1) To administer the Plan in accordance with its terms.

(2) To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.

(3) To decide disputes which may arise relative to a Plan Participant's rights.

(4) To prescribe procedures for filing a claim for benefits and to review claim denials.

(5) To keep and maintain the Plan documents and all other records pertaining to the Plan.

(6) To appoint a claims administrator, utilization manager, prescription benefit manager and such other entities as may be helpful for the administration and operation of the Plan.

(7) To perform all necessary reporting as required by ERISA.

(8) To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.

(9) To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

Individual board members who serve as the Plan Administrative committee shall serve without compensation; however, all expenses for plan administration, including compensation for hired services, may be paid by the Plan.

B. Claims Administrator Is Not A Fiduciary. A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan. The Claims Administrator does not perform these functions.

C. Compliance With HIPAA Privacy Standards. Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health

Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including genetic information and information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities. However, Protected Health Information that consists of genetic information will not be used or disclosed for underwriting purposes.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach, may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.

(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

D. Compliance With HIPAA Electronic Security Standards. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

(1) The Employer agrees to implement reasonable and appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of Electronic Protected Health Information that the Employer creates, maintains or transmits on behalf of the Plan. "Electronic Protected Health Information" shall have the same definition as set out in the Security Standards, but generally shall mean Protected Health Information that is transmitted by or maintained in electronic media.

(2) The Employer shall ensure that any agent or subcontractor to whom it provides Electronic Protected Health Information shall agree, in writing, to implement reasonable and appropriate security measures to protect the Electronic Protected Health Information.

(3) The Employer shall ensure that reasonable and appropriate security measures are implemented to comply with the conditions and requirements set forth in Compliance With HIPAA Privacy Standards provisions (3) Authorized Employees and (4) Certification of Employers described above.

E. Funding The Plan And Payment Of Benefits

The cost of Plan benefits are covered by a combination of contributions from covered Employees and/or the Employer. The level of any required Employee contributions will be established by the Employer and communicated to Employees at the time of enrollment.

F. Plan Is Not An Employment Contract

The Plan is not to be construed as a contract for or of employment.

G. Clerical Error

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 an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, the amount of overpayment may be deducted from future benefits payable.

H. Amending and Terminating The Plan

If the Plan is terminated, the rights of covered Employees and beneficiaries are limited to expenses incurred before termination.

The Plan Sponsor reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any). Each participating Employer reserves the right to suspend or terminate the Plan in whole or in part with respect to its own employees.

I. Assignment Not Permitted

A Member may not assign or transfer any benefits or rights that arise under the Plan or applicable law to any other person, including a healthcare provider, and any purported assignment or transfer is invalid and void. This includes (but is not limited to) an attempted assignment or transfer of claims for payment of benefits, breach of fiduciary duty, penalties or any other claim or remedy. For convenience, the Plan may pay any undisputed benefit directly to the healthcare provider, but this is not a waiver of this anti-assignment provision and does not make the healthcare provider an assignee or confer any other rights on the provider. Similarly, the Plan recognizes an authorized representative for purposes of the Plan's claims and appeal procedures, but the authorized representative is not an assignee and has no derivative rights with respect to the claim. However, this anti-assignment provision will not apply (1) to a Member's assignment pursuant to Section X: Third Party Recovery Provision; or (2) to the extent required under Medicaid laws.

J. Certain Rights Under ERISA

Members in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Members shall be entitled to:

- Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance certificates and a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain copies of all Plan documents, including insurance certificates, the latest annual report and updated summary plan description upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Obtain a complete list of the employers sponsoring the Plan upon written request to the Plan Administrator.

- Obtain information as to whether a particular employer is a sponsor of the Plan and, if that employer is a Plan sponsor, the sponsor's address.

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

- Continue health care coverage under certain circumstances for a covered Employee, Spouse, or other Dependents. See Section VII: Continuation of Coverage. Employees, Spouses and Dependents must pay for such coverage.

- If a Member's claim for a benefit is denied or ignored, in whole or in part, the Member has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. These rules are described in Section VI: Claims and Appeal Procedures.

Under ERISA, there are steps a Member can take to enforce the above rights. For instance, if a Member requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Member up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Member has a claim for benefits which is denied or ignored, in whole or in part, and the member has followed all of the procedures described in Section VI: Claims and Appeal Procedures, the Member may file suit in state or federal court.

In addition, if a Member disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

In addition to creating rights for Members, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. Plan fiduciaries have a duty to do so prudently and in the best interest of the Members. No one, including the Employer or any other person, may fire a Member employee or otherwise discriminate against a Member in any way to prevent the Member from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

If Plan fiduciaries misuse the Plan's money, or if a Member is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Member is successful, the court may order the person sued to pay these costs and fees. If the Member loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

If the Member has any questions about the Plan, he or she should contact the Plan Administrator. If the Member has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Member should contact either the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

XII. PLAN INFORMATION

The purpose of this notice is to furnish you with certain information regarding this plan as required by the Employee Retirement Income Security Act of 1974. If this notice fails to answer your questions regarding any aspect of this plan, please contact the Plan Administrator named below. This person will help you understand fully your rights and obligations under the plan.

- **Plan Name:** Group Benefits Plan for Employees of the Participating Employers of the Georgia Bankers Association Insurance Trust, Inc.

- **Plan Sponsor:** Georgia Bankers Association Insurance Trust, Inc. Participants may receive information about whether a particular employer participates in the Plan (including the address of the employer if it is a participating employer) by submitting a written request to the Plan Administrator at the address shown below.

- **Plan Number: 501**

- **Employer I.D. Number:** 58-2241094

- **Type of Plan:** The Plan provides health, dental, life, and disability coverage. This booklet describes the terms of coverage and benefits under the health and life insurance coverage.

- **Plan Year Ends:** December 31st

- **Plan Administrator, Named Fiduciary and Agent for Service of Legal Process:**
  Georgia Bankers Association Insurance Trust, Inc.
  50 Hurt Plaza, Suite 1050
  Atlanta, GA 30303
  (404) 522-1501

- **Loss of Benefits; Modification of the Plan.**
  This booklet describes the events which may cause all or part of the coverage under the plan to terminate, and any rights you may have at such termination.

  One such event is termination of Blue Cross and Blue Shield of Georgia, Inc. Contracts which will result in the following:

  > Termination of that part of the Plan's healthcare expense coverage for which BCBS has liability in accordance with the Group Contract Terms.

  If the Group Contract terminates, the Plan's benefits, to the extent they were provided under it, will also terminate unless the Plan Administrator modifies the Plan to provide those benefits from another source.

  The BCBS Contract will terminate at the end of the grace period for an unpaid Premium, at any earlier date requested by the Plan Administrator, or (at BCBS's Option) when the number of covered Employees falls below any minimums in the Group Contract. In the case of the Group's Contract's health care expenses coverage, the part of the Group Contract providing that coverage will end if the benefits provided directly by the Employer end or are substantially changed.

  Georgia Bankers Association Insurance Trust, Inc. expects to continue the Plan indefinitely, but reserves the right to amend or terminate the Plan, or any part of it, at any time without the consent of persons covered under it. Amendment or termination of the Plan shall be made by the Directors of the Georgia Bankers Association Insurance Trust, Inc. However, any part of the Plan provided under the Group Contract issued by BCBS cannot be changed without BCBS's consent. Upon an amendment eliminating a Plan benefit or upon termination of the Plan, neither BCBS, Georgia Bankers Association Insurance Trust, Inc. nor any Employer shall be liable for the payment of any claim incurred for any benefit terminated or eliminated pursuant to such amendment or termination. Any assets remaining following termination of the Plan shall be disposed of in accordance with the Articles of Incorporation of the Georgia Bankers Association Insurance Trust, Inc.

The plan shall not give any Employee or any Dependent of any Employee, any right or claim except to the extent that such right or claim specifically fixed under the terms of the plan. The establishment of the plan shall not be construed to give any Employee a right to be continued in the employ of the employer or as interfering with the right of the employer to terminate the employment of any Employee at any time.

Greater Georgia Life Insurance Company

This booklet-Certificate is not a policy Contract or a part of the Group policy. It merely describes in general terms the benefits provided by the Group life insurance policy issued to Georgia Bankers Association Insurance Trust. The Policy is on file at the office of the Policyholder and may be inspected there.

Greater Georgia Life Insurance Company

GENERAL INFORMATION

Home Office: Atlanta, Georgia

Group Term Life Insurance

Your Certificate Schedule shows the specific benefits and amounts of coverage you have. Your coverage amount may be based on a multiple of your annual salary (up to a maximum coverage amount of $350,000) or a flat dollar amount (such as $10,000, $25,000 or $50,000.)

Definitions

"We", "our", and "us" refer to Greater Georgia Life Insurance Company. We may use "he", "his", or "him" to refer to an insured person, male or female.

An "insured person" means:

- You, and
- Your eligible Dependents for whom enrollment requirements have been met, and for whom all the Premiums have been paid.

"Active" means:

- For you, that you are actively at work at your normal place of employment;
- For a Dependent, that he is not confined in a Hospital and that he is able to carry on regular activities customary of a person in good health of the same age and sex.

"Employer" or "Participating Employer" means a Member of the Georgia Bankers Association (or certain affiliates of the Georgia Bankers Association), who has adopted this Plan of Insurance. Each Employer that adopts this Plan of Insurance selects a specific Benefit Schedule that applies to its respective eligible Employees. However, any provisions that are based on service with an Employer, such as eligibility provisions, limitations, etc., are based on service with all Employers who have adopted the Plan.

"Retired Employee" means for insurance purposes a former Active Full-Time Employee who has completed at least 10 years of service and is at least 55 years of age.

N/A means "not applicable".

Who Is An Eligible Employee

If you are an active full-time Employee who is regularly scheduled to work at least 30 hours per week, you are eligible for insurance on the first day of the month following your Employer's length-of-service requirement.

Who Are Eligible Dependents

Your Dependents become eligible at the same time you become insured.

Eligible Dependents are:

- Your spouse, provided you are not legally separated,
- Your children who are
    - Age 14 days to 26 years. You will be required to provide: a copy of the birth certificate naming you the parent or for a step-child naming your spouse as a parent. For an adopted or foster child you will need to provide a

copy of the amended birth certificate or a copy of the adoption decree naming you as the parent/foster parent and a copy of a legal document showing the child's age.

Children include:

- Your children
- Step-children
- Legally adopted children
- Foster children

The term "Dependent" does not include any person who:

- is eligible as an Employee;
- is an active Member of the armed forces of any country; or
- is permanently residing outside the United States and Canada

If both you and your spouse can be insured as Employees, only one of you may insure eligible children as Dependents.

When Insurance Begins

Your insurance and the insurance for each Dependent becomes effective on the Effective Date shown on your personalized Summary of Benefits, provided the person to be insured has applied for it and is "active" on that date. Otherwise, the person's insurance will become effective on the date the person becomes "active".

An employee may elect both basic and optional dependent life without providing proof of insurability if he enrolls within 31 days of first becoming eligible. If the employee elects dependent medical coverage, the basic dependent life coverage is mandatory and will automatically be provided. Optional dependent life will be issued only if the employee elects it.

If the employee does not elect dependent life when he first becomes eligible, evidence of insurability must be provided, except that basic dependent life will be issued without proof of insurability at any time the employee elects dependent medical coverage.

If you are required to pay all or part of the cost of insurance, evidence of insurability will be required if the application for the person to become insured is received more than 31 days after becoming eligible. When evidence is required, insurance will become effective on the first day of the month following approval.

Scheduled Reduction

As of the first day of the month following the date an active Employee attains age 70, the amount of Life and AD&D insurance showing in your personalized Summary of Benefits will be reduced to 30% of that amount. Coverage amounts will be rounded to the nearest $1000 of coverage.

For example, if your coverage amount is $60,000, the reduced coverage amount will be $18,000. If the amount of coverage prior to reduction is greater than $250,000, that amount will be reduced to $75,000. This benefit will not be further reduced unless you elect to reduce your coverage to $15,000 (see "Continuation after Retirement" below.)

When Increases or Decreases in Amounts of Insurance Are Effective

Increases in amounts of insurance are effective on the first day of the month on or next following the date of the change. An insured person must be active on the date any increase in insurance is to become effective. Otherwise, that person's increase will become effective on the date he becomes active. Evidence of insurability may be required as outlined in the Group policy.

When evidence is required, the date the increase becomes effective for such person will be subject to our approval of the evidence.

Decreases in amounts of insurance occur on the first day of the month on or next following the date of the change. The Effective Date of a scheduled reduction upon attainment of a stated age is January 1 coincident with or next following the event.

When Insurance Terminates

Your insurance will terminate the end of the month following the earliest of:

- the date the Group policy ends;
- the date you end your employment or retire (unless the Group policy provides continuation of coverage for retired Employees and you are a qualified retiree);
- the date you cease to meet the definition of "insured person";
- the date your employment classification is deleted from the Group policy or you cease to be eligible under any Employee classification;
- the date you stop making a contribution, if contributions are required;
- the date your employer's business ceases to be eligible for any reason.

Your Dependent's insurance will terminate the end of the month following the date below which occurs first:

- the date you cease to be an insured person, unless insurance is continued temporarily as outlined in the section on "Continuance Due to Sick Leave or Leave of Absence" that follows;
- the date your Dependent ceases to meet the definition of "Dependent" or "insured person".

Continuance Because of Total Disability – Waiver of Premium

If you become totally disabled, you may be entitled to continue your Group term life insurance as provided in the Group Policy if you:

- are less than 60 years of age;
- are unable to engage in any business or perform any work for pay or profit; and
- furnish proof of your disability after you have been disabled at least nine months and not later than one year after your active employment was terminated.

After we acknowledge your disability, We will:

- continue your Term Life Insurance (does not include Supplemental Life Insurance, AD&D or Dependent Life);
- waive Premiums for your Term Life Insurance; and
- require periodic evidence of your continuing disability.

Insurance continued under this provision is subject to "Scheduled Reductions" and terminates upon attainment of age 70.

Continuance Due to Sick Leave or Leave of Absence

If Premiums are paid and the Group policy remains in force, Insurance may be continued for:

- up to three months if you are granted an authorized leave of absence; or
- up to three months if you are temporarily laid off; or
- up to three months if you are temporarily placed on a part time employment basis; or
- up to a maximum of twelve months if you are unable to work due to disability which results from illness or Accidental Injury.

Continuance After Retirement

As a qualified retiree, you may be eligible for Term Life Insurance continuation after retirement. A Retired Employee for life insurance purposes is a former Active Full-Time Employee of the Employer who:

- has completed at least 10 years of service;
- is at least 55 years of age; and
- is covered by this Term Life benefit on the date of retirement.

The amount of Life Insurance will depend on whether your coverage amount is based on a multiple of your salary or a flat dollar amount.

Coverage Amount Based on Salary. Beginning on the first of the month after you retire, the amount of Life Insurance will be equal to thirty (30) percent of the amount in effect on the day before the date of retirement. (If the amount of coverage in place on the day before retirement is greater than $250,000, then the amount of coverage following retirement will be reduced to $75,000.) You have the option to elect reduced coverage in the amount of $15,000 if you prefer.

Flat Dollar Coverage. Beginning on the first of the month after you retire, the amount of Life Insurance will be equal to thirty (30) percent of the amount in effect on the day before the date of retirement. For example, if your coverage amount is $60,000, the reduced coverage amount will be $18,000.

Coverage amounts will be rounded to the nearest $1000 of coverage.

Accidental death and dismemberment benefits terminate on the last day of the month in which you retire.

Termination of Dependent insurance continued under this provision is concurrent with the termination of a Retired Employee's Insurance.

Check with your employer for more detailed information regarding retirement benefits and eligibility.

GROUP TERM LIFE BENEFITS

If an insured person dies while insured under the Group policy, we will pay the beneficiary the amount of Group term life insurance then in effect. We can require proof of eligibility for coverage before making claim payments; this information will be requested if needed. Benefits for suicide during the first two years may be limited.

Assignment of Benefits

You may not make a valid assignment of life insurance unless it is in writing and filed with and approved by us. To be valid, an assignment must be absolute and irrevocable. We assume no liability for its sufficiency.

Conversion Privilege

You or your Dependents (if insured) may apply, without evidence, for an individual policy of life insurance to replace all or part of term life insurance that ceases because;

- your employment has terminated;
- eligibility for term life insurance has ended;
- of your death.

If you have been insured for five continuous years or more, you or your Dependents (if insured) will also have this right if term life insurance ceases because of:

- termination of the Group policy;
- amendment of the policy as to terminate your class.

Schedule reductions in the amount of insurance when you reach a stated age are not convertible.

The individual policy may be a plan we offer for sale at the time it is applied for. It cannot be a preferred risk plan or a policy containing term insurance or disability insurance.

The individual policy will go into effect at the end of the 31 day conversion period.

Conversion Period

You or your Dependents (if insured) must make written application for the individual policy and pay the first Premium within 31 days after insurance under this policy ceases. If insurance is continued under any provision of the Group policy, application and Premium payment must be made within31 days after the period of continuance ends.

If any insured person dies within the 31 day conversion period, we will pay the amount of insurance that he was entitled to convert. We will pay that amount whether or not an application has been made. But a claim cannot be made under both the Group policy and under the individual policy.

Amount Which May Be Converted

1. If insurance ends for a reason other than policy termination or amendment, the full amount may be converted.
2. If the Group policy terminates or is amended to terminate insurance, the amount convertible will be the amount terminated less the amount of any life insurance for which the insured person becomes eligible under any Group policy within 31 days after termination. The maximum is $2,000.
3. If the Group policy terminates within 31 days following your termination, the amount which may be converted will be determined by 2 rather than 1 above.

Beneficiary Designation

You are the beneficiary for all benefits payable except for benefits payable upon your death.

You name your beneficiary at the time you complete your enrollment form. Unless there is a legal restriction, you may change your beneficiary at any time by filing a written request with us or your employer. Subject to any payment or action taken prior to our receiving the change or notice of the change from your employer in our home office, the change will become effective as of the date of the request.

If there are two or more beneficiaries at your death and the share for each is not shown, we will pay them in equal shares.

If there is no legally appointed beneficiary living at the time of your death, your estate will be the beneficiary.

Accelerated Death Benefit

This Group Policy provides for an accelerated payment of a portion of your life insurance benefit amount if you are diagnosed with “terminal illness”. To be eligible for such an accelerated payment, your life insurance amount must be equal to or greater than $15,000.

If you are diagnosed with a “terminal illness”, you may request an accelerated payment of a portion of your life insurance benefits. The life insurance benefit amount will be determined as the date “Notice of Claim” is received by the Insurer. The maximum accelerated death benefit payable is limited to fifty percent (50%) of the life insurance amount, not to exceed $100,000 for all policies or Certificates issued by “us”.

To apply for this benefit:

- A written request must be made by you (“we” will provide proper forms and instructions upon request);
- Acceptable proof of your “terminal illness” must be provided. Proof will include, but is not limited to, a written Physician certification documenting the nature and extent of the condition(s) involved and stating that it will, in the medical judgment of the Physician, directly result in a life expectancy of 12 months or less. “We”, Greater Georgia Life, may at our expense, require an independent examination by a Physician of “our” choice; and

- A signed acknowledgment and agreement from any assignee or irrevocable beneficiary, if any, as to payment of the accelerated death benefit must be provided.

An accelerated death benefit will be paid only if you are living at the time of payment. The benefit will be paid in one lump sum and is subject to a $200 administrative fee. Upon your death, the beneficiary will receive the life insurance amount in effect as of the time of death, less the amount of any accelerated death benefit paid to the Employee. Only one accelerated death benefit will be paid to an Employee.

This benefit will not apply:

- to any intentionally self-inflicted Injury or suicide attempt for a period of two (2) years from your Effective Date of coverage;
- if diagnosis was made and disability began on or after insured's 60th birthday;
- if the Premium is due and unpaid beyond the 31 day grace period;
- if you are required by law to use this benefit to meet the claims of creditors, whether related to bankruptcy or otherwise;
- to any insurance amount of less than $15,000, unless a signed acknowledgment and agreement of assignee or irrevocable beneficiary is received;
- when all or a portion of your life insurance amount is assigned;
- if prognosis of your terminal illness was made prior to the Effective Date of your coverage.

This benefit may or may not be taxable. You are advised to seek the advice of a professional tax advisor in this matter.

EMPLOYEE ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

(Refer to your personalized Summary of Benefits to determine if applicable to you)

You are insured for loss of life, limbs, or sight as a result of accidental bodily Injury. Accidental bodily Injury means an Injury caused to the body by accident, directly and independently of any other cause. The loss must occur within 90 days after the accident.

The amount payable, known as the Principal Sum, is shown in the personalized Summary of Benefits and is the maximum that we will pay for all your injuries, as outlined below, whenever they occur.

Loss Of	Amount Payable
Life	The Principal Sum
More than one Member	The Principal Sum
One Member	½ The Principal Sum

Loss is defined as:

- severance of the hand at or above the wrist;
- severance of the foot at or above the ankle joint;
- the permanent loss of the entire sight of an eye.

We will not pay for any loss caused by:

- disease or bodily or mental infirmity, or any kind of treatment for those conditions;
- suicide, attempted suicide or intentional, self-inflicted Injury;
- aeronautic operations as a pilot or crew member;
- war, declared or undeclared;

- Injury while you are in military service;
- committing, or attempting to commit, a felony or assault;
- being under the influence of alcohol; voluntarily taking any hallucinogen, narcotic, or drug unless prescribed for the Employee by a Physician; voluntarily inhaling gas or fumes or voluntarily taking poison.

Benefit Payments

Submitting a Claim

Your employer has the necessary forms and can assist in submitting life, disability, or other claim to us.

When Benefits Are Paid

We will pay benefits as soon as possible once we receive satisfactory proof of loss.

To Whom and How Benefits Are Paid

Benefits for the loss of life will be paid as set out in the beneficiary provision.

You may instruct us to make payment in one of these ways;

-in one single payment,

-in equal monthly installments over a fixed period of time,

-in any other method of payment to which we agree.

- If you die without choosing a method of payment, your beneficiary may choose the method of payment. If no method of payment is chosen, we will pay the amount in one single payment. Installments include guaranteed interest at a compound annual rate of 3.5%. We may pay additional interest from time to time.
- Interest will be added to the single payment only if we do not make the payment within 30 days after we receive proof of death. If payment is made more than 30 days after date of death, we will pay interest from the date of death to the date of payment, except that no interest will be paid if the amount is less than five dollars. Interest will not be less than 6% a year nor less than required by state law.

Benefits due at your death will be paid to the beneficiary as designated by you for your Group Term Life Insurance.

All other benefits will be paid to you.

Review of Claim Denial.

If your claim for life insurance benefits is denied, you or your authorized representative will receive a written notice stating the basis for the denial. You will then be entitled, upon written request, to review of claim decision. If you are not notified at all within 90 days after you submit the claim, this may be considered a claim denial and you may request a review as described above. Your request for a review must be submitted within 60 days after the claim is denied. The request should be accompanied by any documents or records in support of your appeal. A decision on the request will be made in writing within 60 days after it is received, except that if special circumstances require an extension of time, you will be so notified. In no event will a final decision on your claim be rendered more than 120 days after the request for review. The final decision should be in writing to the claimant, with reference to the relevant plan provision on which the decision was based. The insurance company has the right to interpret the plan provisions, so its decision is conclusive and binding.

More information regarding this review procedure can be obtained from Greater Georgia Life, Blue Cross and Blue Shield of Georgia, Inc., or the employer.