BROOKSHIRE BROTHERS, INC. EMPLOYEE HEALTH AND DENTAL PLAN PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

INTRODUCTION

Brookshire Brothers, Inc. has retained the services of Nexcaliber ("Nexcaliber"), an independent Third-Party Administrator experienced in claims processing, to handle your health claims.

This booklet is the Plan Document (the "Plan") and Summary Plan Description (SPD) for the **Brookshire Brothers, Inc. Employee Health and Dental Plan** the "**Plan**"). The Plan conforms to the Employee Retirement Income Security Act of 1974 ("**ERISA**"), the Consolidated Omnibus Budget Reconciliation Act of 1985 ("**COBRA**") as amended, the Health Insurance Portability and Accountability Act of 1996 ("**HIPAA**") and The Women's Health and Cancer Rights Act of 1998. This booklet describes the Plan, its organization and rules, and the benefits it provides for employees and their eligible dependents. This booklet and any amendments constitute the entire Plan Document. The Plan is maintained for the exclusive benefit of the employees and their dependents, and their rights under the Plan are legally enforceable. The Employer has the right to amend the Plan, including employee contributions, at any time and will make a good faith effort to timely inform you of changes that may affect your benefits. The Employer also has the legal right and discretion to terminate the Plan at any time.

The requirements for obtaining coverage under the Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including any limitations and exclusions), the procedures to be followed in presenting claims for reimbursement, and the remedies available for redress of claims denied are outlined on the following pages of this booklet.

This is a reimbursement plan, and benefits will be paid directly to the Covered Person unless a proper assignment to receive payment is made by the Covered Person. You are entitled to this coverage if you are eligible in accordance with the provisions of this booklet. The booklet is not applicable to you if you have ceased to be eligible for coverage. No clerical error will invalidate your coverage if it is otherwise validly in force.

The terms of this booklet will govern in the interpretation of questions concerning benefits. The nature and extent of benefits provided by the Plan, the rules governing eligibility, the resolution of any disputed issues of coverage, and all interpretations of the Plan, shall be made by the Employer. Nexcaliber, the Third-Party Administrator, shall have no authority to alter benefits or eligibility rules.

You should read this booklet and familiarize yourself with the Plan's terms, provisions, benefits, and limitations. Read the entire booklet, not just the Schedule of Benefits, so that you will have as complete an understanding as possible of the Plan. Some of the terms used in the booklet begin with a capital letter. These terms have a special meaning under the Plan, and they are listed in the **Definitions** section. When reading the provisions of the Plan, you may find it helpful to refer to the Definitions section. Becoming familiar with the defined terms will help you better understand the procedures and benefits described in the Plan.

ANTI-ASSIGNMENT PROVISION

PLEASE NOTE THAT THE BENEFITS CONTAINED IN THE PLAN, AND ANY RIGHT TO REIMBURSEMENT OR PAYMENT ARISING OUT OF SUCH BENEFITS, ARE PERSONAL TO THE MEMBER AND ARE NOT ASSIGNABLE OR TRANSFERABLE, IN WHOLE OR IN PART, IN ANY MANNER OR TO ANY EXTENT, TO ANY PERSON OR ENTITY, INCLUDING WITH RESPECT TO POTENTIAL FIDUCIARY BREACHES. ALTHOUGH THE PLAN MAY MAKE PAYMENTS DIRECTLY TO PROVIDERS, SUCH PAYMENTS DO NOT MAKE A PROVIDER AN ASSIGNEE OR OTHERWISE CONFER ON THE PROVIDER ANY RIGHTS UNDER THE PLAN OR ERISA, INCLUDING, BUT NOT LIMITED TO ANY RIGHT TO ENFORCE NON-PAYMENT.

BROOKSHIRE BROTHERS, INC. EMPLOYEE HEALTH AND DENTAL PLAN
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GENERAL INFORMATION

The information furnished herein is designed to acquaint you with the benefits of the Plan which are available to you and your covered Dependents.

Name of the Plan:	The Plan shall be known as the Brookshire Brothers, Inc. Employee Health and Dental Plan.
Plan Administrator: Address of Plan:	Brookshire Brothers, Inc. 1201 Ellen Trout Dr. Lufkin, Texas 75901
Plan Number:	501-050101
Type of Plan:	Medical and Dental
Parent Group Number:	BROOK - 220
Federal Identification Number:	75-2692839
Plan Effective Date:	May 1, 2023
Plan Fiscal Year Ends:	April 30th Annually
Third Party Administrator:	Nexcaliber 14800 Quorum Drive, Suite 540 Dallas, Texas 75254
Agent for Service of Legal Process:	Brookshire Brothers, Inc. 1201 Ellen Trout Dr. Lufkin, Texas 75901
Contributions:	
Eligible Employees	Employer and Employee contribute towards the cost of the Plan.
Dependents	Employer and Employee contribute to the cost of the Plan.
COBRA	Continuation benefits for Qualified Beneficiaries under COBRA are provided through contributions by eligible self-contributors.

Effective Date of Coverage for New Employees:	Employees are eligible for coverage on the date of hire provided proper enrollment application is completed within thirty (30) days of the eligibility date. Effective date of coverage is determined by the date proper enrollment application is received. Part-time employees meeting the 30-hour requirement rules will be offered coverage. If elected, coverage will be effective on the first day of the month following enrollment.
Effective Date of Coverage for Late Enrollments:	After receipt of the enrollment form by the Plan Administrator, the first (1st) day of the month following the next open enrollment period subject to any plan limitations in affect at the time the coverage begins and as allowed by HIPAA. Open enrollment periods may be offered each year.
Effective Date of Coverage for Special Enrollments:	The date of an event that allows for a special enrollment form, provided the employee has completed any required waiting period. The special enrollment form must be received by the Plan Administrator within thirty (30) days of the qualifying event (see HIPAA provisions for special enrollment periods).
Waiting Period for New Employees and Special Enrollments:	The date of hire or the date you meet the eligibility requirements.
Termination of Coverage Date:	Weekly employees - Midnight of the Saturday following the date in which termination of employment occurs or employee ceases to meet definition of eligible employee. Monthly employees - Midnight of the last day of the month in which termination of employment occurs or employee ceases to meet definition of eligible employee.

VENDOR LISTING

For Verification of Eligibility and Benefits:
Nexcaliber
(972) 248-1011 or (800) 741-0185

Pre-Certification is Required.
Spectrum Review Services, Inc.
(800) 258-5055

For Preferred Provider Organization (PPO) Information:
HealthSmart Preferred Network II, Inc.
Physician Only
(800) 687-0500

For Prescription Drug Plan Information:
Brookshire Brothers, Inc. Plan
Nexcaliber at:
(972) 248-1011 or (800) 741-0185

Send all claims to:
Nexcaliber
Post Office Box 802422
Dallas, Texas 75380

MEDICAL BENEFITS

DEDUCTIBLES AND OUT-OF-POCKET EXPENSES

Calendar Year Deductible

	In-Network	Out-of-Network
Individual	$1,500	$3,000
Family	$4,500	$9,000

Note: The individual deductible must be satisfied with expenses from one individual. The family deductible can be satisfied when any combination of covered family members has reached the family deductible. Covered Expenses incurred at an Out-of-Network Provider will not be counted towards the In Network Deductible. Covered Expenses incurred at a Network Provider will not accumulate towards the Out of Network Deductible.

Deductible Three Month Carryover: Covered Expenses incurred in, and applied towards the deductible in October, November and December will be applied towards the deductible for the next Calendar Year.

Out of Pocket Maximum

	In-Network	Out-of-Network
Individual	$ 9,100	No limit
Family	$18,200	No limit

The Out of Pocket Maximum **includes** copayments, deductibles, and coinsurance, but **excludes** premiums.

The 100% Benefit Feature: Once a covered individual or a covered family (cumulative) has reached the Out-of-Pocket Maximum (including deductible) during a Calendar Year, then Covered Expenses will be considered at 100% for the remainder of that Calendar Year. The following expenses will not accumulate toward the coinsurance amount:

1. Denied, ineligible or excluded charges;
2. Charges that are not specifically included as Covered Expenses as defined by the Plan;
3. Charges in excess of Plan limitations.

Covered Expenses incurred at an Out-of-Network Provider will not be counted towards the In Network Out of Pocket Maximum. Covered Expenses incurred at a Network Provider will not accumulate towards the Out of Network Out of Pocket Maximum.

For Covered Employees and their Dependents residing outside the network area or more than twenty-five (25) miles from any hospital, the benefit percentage payable shall be 70% except when a higher benefit is stated in the “Schedule of Benefits”.

Failure to Pre-Certify. Penalty payment of $100 if using a Network Provider and $250 if using an Out-of-Network Provider if pre-certification is not acquired prior to a hospital confinement will be applicable to the hospital confinement billing only. It is the responsibility of the Plan Participant to initiate the process to satisfy the requirements of this provision, provided the medical condition of the Covered Person allows such notification. This does not apply to a newborn child for a hospital confinement that begins at birth. This does not apply to Emergency Care if certification is received within forty-eight (48) hours of emergency admission.

Special Network Provision

If a Covered Person is utilizing a Network Facility, either In Patient or Out Patient, and the Network Provider requests that an Out-of-Network Provider consult and / or treat the patient while in the facility, the Out-of-Network Provider will be considered for payment under the Plan as a Network Provider.

If a Specialty and / or services which are determined to be medically necessary to treat a Covered Person is not available by a Network Provider, an Out-of -Network Provider of services could be considered as a Network Provider.

SCHEDULE OF BENEFITS

The Schedule below summarizes the benefits available under this Plan. Specific limitations and conditions may apply, as described elsewhere in this booklet.

	PPO-Network	Out-of-Network
Office Visit		
Co-payment visits – limit 2 per year (Excludes Office Surgery, MRI, EKG, CAT Scans, PET Scans, Chiropractic services, and all wellness services)	$35 then 100%	40%
Applies to first two office visits each year.		
All visits after Co-payment visits and services not included -		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Health Plan Clinic	$10 then 100%	Not applicable
The Health Plan will offer specific clinics for these visits.		
This benefit is not available with any providers other than the specific clinics offered through the Health Plan.		
Clinic patient age requirements will be indicated by each clinic and will apply to the benefits of the covered Participants.		
Referrals from the Health Plan Clinic to other providers will be considered at the benefit level of actual service provider.		
One exception will be laboratory work ordered by the clinic to be performed at the clinic's preferred laboratory company will be included in the co-payment for the clinic fee.		
Injections in Physician Office		
Injections	70%	40%
Deductible	Applies	Applies
Office Surgery		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
All Other Physician Services in Physician Office		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Ambulance		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Chiropractic Services		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Calendar Year Maximum Benefit	30 sessions	30 sessions
Per Day Maximum Benefit	$50	$50

Durable Medical Equipment

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Services performed and billed by an Enhanced Benefit Facility will be considered In Network and allowed at an enhanced benefit co-insurance percentage of 90% paid by the Plan. Inpatient and outpatient deductibles will be waived. Please contact Nexcaliber (800) 741-0185 at the time of service to confirm facilities included.

Emergency Treatment

Including Emergency Room and		
All Related Charges	$100 Co-pay	$100 Co-pay

Waived for facilities of the Enhanced Benefit Facility listing.

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Extended Care Facility
Skilled Nursing Facility
Convalescent Rehabilitation

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Home Health Care

Visit Fee Only -		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Hospice Care

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Anesthesia Services

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Limited to the Usual & Customary charges for one anesthesia billing per incident.

Hospital Facility Expense/ Inpatient

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Per Confinement Co-payment

Each Hospital In Patient Admission	$300	$500

Waived for facilities of the Enhanced Benefit Facility listing.

In-Patient Surgery

Percentage Payable	70%	40%
Deductible	Applies	Applies

Hospital Room & Board Limits

Semi-Private Room	Semi-Private Rate	Semi-Private Rate
Percentage Payable	70%	40%
Deductible	Applies	Applies
Private Room	Semi- Private Rate	Semi-Private Rate
Percentage Payable	70%	40%
Deductible	Applies	Applies
ICU/CCU	Actual Charges	Actual Charges
Percentage Payable	70%	40%
Deductible	Applies	Applies

Please Note: All inpatient confinements must be pre-certified by the Pre-certificationVendor. In the event a Hospital does not contain semi-private rooms, the private room limit is 80% of the Hospital's actual private room rate. If a private room or isolation room is Medically Necessary due to contagious disease, the Hospital's Reasonable and Customary charge for such room will be a Covered Expense.

Diagnostic X-ray and Laboratory		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Lab Card through Quest Diagnostics - Lab services with preferred provider only.		
Percentage Payable	100%	40%
Calendar Year Deductible	Waived	Applies
Medical Supplies		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Orthotics		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Maximum Lifetime Benefit	$500	$500
Outpatient Services and All Related Charges (including surgery and diagnostic services)		
Per Incident Co-payment	$100 Co-pay	$100 Co-pay
Waived for facilities of the Enhanced Benefit Facility listing.		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Physical / Occupational / Speech Therapy		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Routine Wellness Benefit

Percentage Payable	100%	40%
Calendar Year Deductible	Waived	Applies

Includes, but is not limited to, Pap smears, routine mammography, colorectal and prostate tests, hearing tests, vision testing, routine checkups, immunizations, inoculations, related laboratory work, x-rays. Services rated an "A" or "B" by the United States Preventive Task Force (USPTF).

Enhanced Well Women's Benefits

Prenatal visits (routine preventive visits); screening for gestational diabetes; human papillomavirus (HPV) DNA testing from age 30 every 3 years; counseling for sexually transmitted infections (eligible providers only); counseling and screening for human immunodeficiency virus (HIV) (eligible providers only); screening and counseling for interpersonal and domestic violence (eligible providers only); breast feeding support, supplies and counseling; generic formulary contraceptives, certain brand formulary contraceptives, and all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity with a physician issued prescription.

Preadmission Testing

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Transplant Recipient's Transportation and Lodging

Percentage Payable	70%	70%
Calendar Year Deductible	Applies	Applies

Limited to a Lifetime Benefit of $10,000.

Maternity

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

All Other Covered Services

Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

MENTAL AND NERVOUS DISORDERS
ALCOHOL/SUBSTANCE ABUSE

	PPO-Network	Out-of-Network
Mental and Nervous Disorders		
Inpatient Benefits		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Mental and Nervous Disorders		
Outpatient Benefits		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Alcohol / Substance Abuse		
Inpatient Benefits		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies
Alcohol / Substance Abuse		
Outpatient Benefits		
Percentage Payable	70%	40%
Calendar Year Deductible	Applies	Applies

Mental Health Parity and Addiction Equity Act of 2008

The Plan will make all good faith efforts to comply with the regulations of both the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) and interim regulations on the required effective dates of such regulations.

For the purposes of this Plan, the regulations will apply to any benefits considered as Mental and Nervous Disorders or Alcohol/substance Abuse benefits; as well as; Mental Health or Substance Use Disorder.

1) The Plan will comply with new disclosure requirements. Specifically, upon request by a current or potential participant, beneficiary or contracting provider, the Plan will provide the criteria for determining if a claim is Medically Necessary with respect to Mental Health or Substance Use Disorder benefits.
2) Similar to the rules for denied claims under ERISA, the Plan will make available upon request the reason for any denial of reimbursement or payment for services with respect to Mental Health or Substance Use Disorder benefits in the case of any Covered Person.
3) The Plan will ensure claims reimbursement approvals and / or denials for Mental Health and Substance Use Disorder benefits are subject to the same claim review processes utilized for Medical Benefits.
4) In Network and Out of Network Providers will be considered for all Mental

Health and Substance Use Disorders. The Special Network Provision will apply for Mental Health and Substance Use Disorder.

5) Pre-certification requirements for Inpatient admissions will apply to any and all Inpatient admissions for Mental Health and Substance Use Disorders.
6) Prescription drug benefits are applied to Mental Health and Substance Use Disorders in the same manner and with the same benefit levels as the Medical Benefits.

In general, the Plan administrative procedures for Mental Health and Substance Use Disorder benefits will be the same administrative procedures as recognized for Medical Benefits.

Effective May 1, 2011, the Plan will continue to revise the Mental Health and Substance Use Disorder benefits to comply fully with the interim regulations defining the implementation of the MHPAEA. In general, the interim regulations require any plan that provides Mental Health and/or Substance Use Disorder benefits must not impose more restrictive requirements than the Predominant requirements that apply to Substantially All medical and surgical benefits. Restrictive requirements can be financial in nature or a limitation of some manner on treatment, either qualitative or quantitative.

Plans are only permitted to compare the financial requirements and treatment limitations of medical and surgical benefits to Mental Health and/or Substance Use Disorder benefits for the following six specified classifications:

- inpatient, in-network,
- inpatient, out-of-network,
- outpatient, in-network,
- outpatient, out-of-network,
- emergency care, and
- prescription drugs.

PRESCRIPTION DRUG BENEFIT

Prescription Drugs – Brookshire Brothers Pharmacy Network Only

Each 30 day supply requires one co-payment.

Brand Name – No generic available	Co-payment of 50% to $10 minimum
Brand Name – Generic available	Co-payment of retail price minus $10
Generic	Co-payment $10.00

Some prescription drugs will be excluded from coverage under the Plan. Some excluded drugs are:

a. Over- the-counter drugs except Insulin and Insulin syringes
b. Contraceptive drugs or devices, even if ordered for non-contraceptive purposes (This exclusion does not apply to oral contraceptives or depo provera).
c. Fertility drugs.
d. Fluoride products.
e. Rogaine.
f. Smoking cessation programs with the exception of the prescription Chantix – one treatment per lifetime.
g. Appetite suppressants, dietary supplements and vitamin supplements. (This exclusion does not apply to prenatal vitamins which require a prescription and prescription vitamin supplements containing fluoride, which are covered under the Plan).
h. Anabolic steroids.
i. Impotence treatments including, but not limited to, Muse, Edex, Yohimbine, Viagra, etc.
j. Syringes and needles (all except insulin).
k. Prescriptions related to workers' compensation.
l. Drugs which are not Medically Necessary, including any drugs given in connection with a service or supply which is not Medically Necessary.
m. Cosmetic drugs, even if ordered for non-cosmetic purposes.
n. Any refill that is more than the number of refills ordered by the Physician.
o. Prescriptions that are available for a low cost or for free under Patient Assistance Programs or a similar program in the absence of coverage (even though a Participant or Dependent under the Plan).

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

HIPAA amended the Employee Retirement Income Security Act (ERISA), the Public Health Service Act, and the Internal Revenue Code to provide improved portability and continuity of health insurance coverage.

HIPAA, among other things, provides new rights to allow individuals to enroll for health coverage when they lose other health coverage or add a new dependent.

HIPAA provides that Employees or Dependents who are otherwise eligible but not enrolled in the Plan and who would be late enrollees may enroll during the special enrollment period, without penalty, when a change in family status or loss of other group coverage occurs. Employees or Dependents are allowed to enroll in a group plan within thirty (30) days following:

1. A loss of eligibility for group coverage under another plan due to:
    a. legal separation;
    b. divorce;
    c. death;
    d. termination of employment;
    e. reduction in work hours;
    f. employer contributions toward coverage have terminated;
    g. termination of COBRA continuation; and

1. A change in family status due to:
    a. marriage;
    b. birth of a child;
    c. adoption or placement for adoption of a child.

Persons who enroll under these special enrollment conditions are not considered late enrollees.

ELIGIBILITY

Enrollment Requirements. An Employee must enroll for coverage by completing enrollment questions either paper or online. The Covered Employee is required to enroll for Dependent coverage also.

Open Enrollment. The Employer may opt to offer an Open Enrollment as announced by the Employer. During that time employees can add, change or drop coverages.

Eligible Classes. The following persons will be eligible to be covered under the Plan:

1. Employees: All Employees employed by the Employer who are regularly scheduled to work the minimum hours as specified in the definition of an Eligible Employee.
2. Dependents: The lawful spouse and each child of the Eligible Employee between the ages indicated in the definition of an eligible Dependent.
   In the event a husband and wife are both eligible to be covered by the Plan as Covered Employees, only one spouse will be eligible to cover any Dependent children they might have. All other persons are excluded.

Eligibility Date

1. Employee Coverage: An Eligible Employee shall be eligible for coverage as indicated in the General Information section.
2. Dependent Coverage: An Eligible Employee will be eligible for Dependent Coverage on whichever of the following dates is first to occur:
   (a) The date the Eligible Employee is eligible for coverage, if on that date he has eligible Dependents; or
   (b) The date the Eligible Employee gains an eligible Dependent.

Effective Date

1. Effective Dates for Contributory Coverage. Employee or Dependent Coverage for which contributions are required from the Employee, must be requested by the Employee on a form furnished by the Plan Administrator. When so requested, such coverage will become effective as follows:
   (a) If the request for coverage is made on or before the eligibility date, coverage will become effective on the eligibility date;
   (b) If the request for coverage is made on or after, but within thirty (30) days of the eligibility date, and any required contributions are made, coverage will become effective on the date proper enrollment application is received; or,
   (c) If the request for coverage is made more than thirty (30) days after the eligibility date, or after the coverage was voluntarily terminated at the Employee's request, coverage will become effective:
      (i) on the first (1st) day of the qualifying event (in the case of a special enrollment provided under HIPAA); or
      (ii) on the first (1st) day of the month following receipt of the enrollment application by the Plan Administrator during an open enrollment (in the case of a late enrollment).

(iii) on the effective date of any plan change that allows the Employee to satisfy the definition of an Eligible Employee earlier than anticipated based on the plan definition at the time of hire.

2. Effective Date for Newborn Coverage. A newborn child born to an Eligible Employee shall automatically be covered for the first thirty (30) days after birth, to the extent of the benefits provided herein (*see* Newborn's Routine Weill Baby Care). Prior to the expiration of such thirty (30) day period, the Employee should enroll the child in writing, and must agree to make the required contributions, if any, for such newborn. If such enrollment is not made within the thirty (30) day period, the child will not be covered under Dependent coverage until actual enrollment (as a late enrollee) and then coverage will begin the first (1st) day of the May following the Plan Administrator's receipt of the late enrollment request at the Employer's next open enrollment.

General Conditions to Eligibility

1. Any reference in this Plan to an Employee's Dependent being covered means that such Employee has elected Dependent Coverage;
2. No Dependent Coverage will become effective unless the Eligible Employee is covered;
3. If an Eligible Employee specifically declines coverage, whether for the Eligible Employee or the Eligible Employee's Dependents, and at a later date a HIPAA qualifying event occurs, such Employee may request coverage hereunder and such coverage will become effective the first (1st) day following receipt of the Employee's special enrollment application by the Plan Administrator, provided such special enrollment application is received by the Plan Administrator within thirty (30) days of the HIPAA qualifying event;
4. If an Eligible Employee specifically declines coverage, whether for the Eligible Employee or the Eligible Employee's Dependents, and at a later date such Employee requests coverage hereunder, after receipt of the Employee's late enrollment application by the Plan Administrator such coverage will become effective on the first (1st) day of the next month following the Employer's next open enrollment period.;
5. If an Eligible Employee specifically declines coverage, Employee or Dependent, and if at a later date a Qualified Medical Child Support Order (QMCSO) is provided to the Plan Administrator, the terms of the QMCSO will be followed, provided the QMCSO is in accordance with the guidelines of the Omnibus Budget Reconciliation Act of 1993 and ERISA. A QMCSO must meet the following conditions:
   (a) state the name and last known mailing address of the Participant and the name and mailing address of each child covered by the Order;
   (b) provide a reasonable description of the type of coverage to be provided by the plan to each child, or the manner in which such coverage is to be determined;
   (c) state the period to which such order applies.

The QMCSO cannot require that this Plan provide any type or form of benefit not otherwise provided under this plan.

Application to enroll or continue coverage for such child(ren) must be made within thirty (30) days of the date of the QMCSO. Such application must be approved by the Plan Administrator. Written notice of such approval or declination will be given to the Employee and child(ren) or child(ren)'s designated representative. If application to enroll or continue coverage is not made within thirty-one days of the QMCSO, the child(ren) will then be considered a late enrollee. After receipt of the late enrollment application by the Plan Administrator, such coverage will become effective on the first (1st) day of the month following the Employer's next open enrollment period.

6. No person will lose medical coverage solely because of the Employer's change to this Plan from the prior plan, provided that the following conditions are met:
   (a) The individual was covered under the prior plan immediately before the effective date of this Plan; and
   (b) The individual is a member of a class eligible for coverage under this Plan on the effective date of the Plan.
7. No person may be simultaneously covered under this Plan as both an Employee and a Dependent.

TERMINATION DATES OF COVERAGE

Termination of Employee Coverage. A Covered Employee's coverage will terminate on the following dates unless otherwise noted:

Weekly employees -	Midnight of the Saturday following the date of the event
Monthly employees -	Midnight of the last day of the month including the date of the event

Termination of coverage will be effective upon the occurrence of the first of the following events:

1. If the Covered Employee fails to remit required contributions for coverage when due, coverage will terminate at the end of the last period for which a contribution is made;
2. Termination of Employment occurs, except as specified below and in the Continuation of Coverage (COBRA) section;
3. The Covered Employee enters the military service of any country or international organization on a full-time active-duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
4. The Covered Employee ceases to be in a class eligible for coverage;
5. The Covered Employee retires; or,
6. Midnight on the termination date of this Plan.

Coverage During Extended Absence from Work.

In the event a Covered Employee is unable to attend work under their normal work schedule they may be eligible to continue coverage under the plan. Examples of such instances of work absence could be approved leave of absence or total disability.

The continuation of benefit option and/or the time period to continue coverage will be governed by the company policies of your employer at the time the leave begins. Any required contributions must be made during the continuation period. Following the completion of any continuation of coverage period, you will be offered additional coverage on the Plan through COBRA. Please see Continuation of Coverage (COBRA) section of this booklet for details.

Termination of Dependent Coverage. Except as described below in the Continuation of Coverage (COBRA) section of this booklet, a covered Dependent's coverage will terminate upon the occurrence of the first of the following events:

1. When the coverage of the Covered Employee is terminated;
2. When the Covered Employee ceases to make the required contributions for the covered Dependent;
3. When the Covered Employee ceases to be in a class of Covered Employees eligible for Dependent Coverage;
4. When the covered Dependent ceases to meet the definition of an Eligible Dependent;

5. When the covered Dependent enters the military service of any country or international organization on a full-time active-duty basis other than scheduled drills or other training not exceeding one month in any Calendar Year;
6. When the covered Dependent qualifies as an Eligible Employee;
7. When Dependent coverage is discontinued under this Plan; or
8. Midnight on the termination date of this Plan.

Coverage for Physically or Intellectually Disabled Dependent Children. If after the attainment of the specified age whereby coverage would otherwise terminate for a Dependent child, the Plan Administrator has received due proof such child is intellectually disabled or physically handicapped and thereby incapable of self-support and is dependent upon the Covered Employee for support, the child's coverage will continue in force so long as that incapacity continues, the Covered Employee continues to be covered for Dependent Coverage, and this Plan remains in full force and effect.

Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to 24 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee and immediate coverage upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

CONTINUATION OF COVERAGE (COBRA)

(Plans with 20 or more Employees)

This provision contains a summary of your health coverage continuation rights under the federal COBRA law. Employees, spouses and dependents covered under the Plan have rights under COBRA. Therefore, all family members should read this information carefully. **This information DOES NOT indicate that you have lost health coverage.** If you are (or become) covered under the Plan as the employee, spouse or dependent child of the employee, you may be eligible for continuation coverage if you would lose coverage due to a qualifying event such as:

1. Voluntary Termination of Employment;
2. Involuntary Termination of Employment;
3. Reduction of Hours;
4. Death of the Employee;
5. Employee's Medicare Entitlement;
6. Divorce or Legal Separation;
7. A Dependent Child ceasing to be a Dependent; or
8. The bankruptcy of the Employer.

Questions. If you have any questions regarding any of the information contained in these pages, it is your responsibility to contact the Employer or the Plan Administrator.

Your Reporting Responsibilities. The employee, spouse or dependent child has the responsibility to inform the Employer of a divorce or legal separation or a dependent child ceasing to be a dependent child within sixty (60) days. The sixty (60) day period would run from the later of the date of the event or the date group medical coverage would be lost due to the event. If the Employer does not become informed of one of these events by the end of the sixty (60) day period, continuation coverage might not have to be offered. The Employer has a COBRA Election form that may be completed and submitted to the Employer if you or a family member would experience one of these events.

COBRA Qualifying Event Notice. If a loss of group health coverage occurs due to a qualifying event, the Employer must notify you of your right to elect continuation coverage (subject in certain instances to you informing the Employer that an event occurred - see previous paragraph).

COBRA Elections. You are allowed sixty (60) days to make an election of continuation coverage sixty (60) days from the later of the date of the notice or the date your group health coverage would end due to the qualifying event. Each employee, spouse and dependent child covered under the Plan at the time of a qualifying event would be qualified beneficiaries and have independent election rights under COBRA. If continuation coverage were elected and paid for within the proper time frames, your coverage will continue without interruption. The Employer reserves the right to verify your eligibility if you elect continuation coverage and if you are not eligible, they reserve the right to terminate that coverage retroactively.

COBRA Qualified Beneficiaries. Each employee, spouse and dependent child covered under the Plan at the time of a qualifying event has independent rights under COBRA. Additionally, effective January 1, 1997, a child born to or placed for adoption with the Covered Employee during the period of continuation coverage will be provided

qualified beneficiary status under COBRA. Incapacitated qualified beneficiaries have special rights. If a qualified beneficiary is incapacitated, certain individuals could elect continuation coverage on his/her behalf.

HMO Information. If you participate in an HMO or a walk-in clinic and you use the provider's services during your COBRA election period, the employer has the right to treat this use as a constructive election (this is the employer's option). In such case, you would be obligated to pay any applicable charge for the coverage. HMOs may provide region specific coverage. For a COBRA qualified beneficiary outside of the region, coverage may be reduced similarly to that of Active Employees outside of the region. In certain instances, coverage may be eliminated or provided for emergency services only.

Signing and Revoking Waivers. If you sign a waiver regarding your continuation coverage, you may revoke the waiver during the election period. Any claims that occur within the waiver period may not be covered.

Premium Payments. If you elect to continue coverage, you have forty-five (45) days to remit the initial/retroactive premium. This forty-five (45) day period begins on the date your election is sent to the Employer. Depending upon when the initial/retroactive premium was paid, additional premiums may be required to bring payments current. After all retroactive premiums are paid, premiums continue to be due on a monthly basis. The employer may charge up to 102% of the regular group premium for continuation coverage. You are allowed a thirty-one (31) day grace period on each monthly premium (longer than thirty-one (31) days if the Employer or an Active Employee has a longer period). Failure to pay any premium (initial, monthly, etc.) can cause your continuation coverage to be retroactively terminated.

Duration of Coverage. If you continue your group health coverage under COBRA, you will be provided the same coverage as similarly situated Active Employees. Under COBRA, health coverage may be continued for eighteen (18) months if the qualifying event was termination or a reduction of hours. The other events (excluding bankruptcy) allow up to thirty-six (36) months of continuation coverage. The continuation coverage time periods run from the date of the qualifying event. Bankruptcy of the Employer has special rules that pertain to the Employer's retirees.

COBRA Extensions. The eighteen (18) month period (following termination or a reduction of hours) may be extended if another qualifying event (termination, reduction of hours, death of the employee, divorce or legal separation, employee's Medicare entitlement or a dependent ceasing to meet the Plan definition of a dependent) occurs during the eighteen (18) month period. You must notify the Employer if you experience any secondary qualifying event and wish to extend your coverage. If you are deemed disabled by the Social Security Administration, back to the date of a termination or a reduction of hours, you may be able to extend your coverage to twenty-nine (29) months. Effective January 1, 1997, if you are deemed to have been disabled before the end of the first sixty (60) days of continuation coverage, you may be eligible to extend your COBRA coverage up to twenty-nine (29) months from the date of the termination or reduction of hours (regardless of whether the qualifying event took place on or before or after January 1, 1997). To receive this additional coverage, you must provide the Employer with the disability determination from the Social Security Administration before the expiration of the eighteen (18) months and within sixty (60)

days of the determination. The Employer must be notified if you are deemed no longer disabled within thirty (30) days of that determination. If deemed no longer disabled, you are no longer eligible for the additional eleven (11) months of continuation coverage. From the nineteenth (19th) month to the twenty-ninth (29th) month, up to 150% of the applicable group health premium for this extension of coverage could be charged.

Reasons Continuation Coverage Could Terminate. The law also provides that your continuation coverage could be terminated before the end of the 18, 29 or 36 months for any of the following reasons:

1. The Employer no longer provides group health coverage to any employees;
2. The premium for your continuation coverage is not paid when due;
3. You become eligible for Medicare; or
4. You become covered under another group health plan which does not contain any exclusion or limitations affecting your coverage effective the first plan year after June 30, 1997. Please contact the Employer or Plan Administrator for information regarding the Plan Year.

Additional Information. If you experience a qualifying event, you are not required to prove that you are insurable in order to continue your coverage under COBRA. **COBRA notifications will be sent to your last known address.** This makes it imperative that you keep the Employer informed of your current address and address changes. Please also notify the Employer if you add a spouse or dependent to your group health coverage.

"You" in this notice refers to the Employee, spouse or dependent child who is (or becomes) covered under this Plan.

Conversion Privilege following Termination Enrolled Employees and eligible Dependents whose coverage terminates under this Plan may not elect to convert to an individual plan of coverage as the Plan Administrator does not currently offer such benefit.

COMPREHENSIVE MEDICAL EXPENSE BENEFIT

Covered Expenses

(a) All eligible expenses which are incurred while covered under this Plan will be reimbursed at the benefit rate stated in the Schedule of Benefits. The applicable Deductible or Copayment must be satisfied before benefits are payable, unless otherwise stated. The benefits will be subject to the maximums listed in the Schedule of Benefits.

(b) Charges for the allowable expenses or services will be covered to the extent that such charges (1) do not exceed the Reasonable and Customary allowance as defined herein and (2) are not excluded (3) and are determined to be Medically Necessary to diagnose or treat an eligible Illness, Injury, or other specified condition, unless otherwise stated and (4) are not provided by one of the patient's immediate family members or member of the patient's household.

(c) The Plan reserves the right to allocate the Deductible amount to any Covered Expenses and to apportion the benefits to the Covered Person and any assignees.

General Covered Expenses The following expenses or services incurred by a Participant or Dependent will be covered, subject to the "General Exclusions and Limitations", while under the care of a Physician, provided such services meet the criteria established in this Plan.

(a) Hospital semi-private room and board up to the limits stated.

(b) Other hospital services required for medical or surgical care or treatment.

(c) Services of physicians and surgeons, including specialists:

1. When two or more surgical procedures occur during the same operation, the Reasonable and Customary Charge is determined as follows:
   (a) When multiple or bilateral (secondary surgical procedures) that increase the time and amount of patient care are performed, the allowed amount is the Reasonable and Customary fee for the major procedure plus the lesser of 50% of the Reasonable and Customary fee for the subsequent procedures or the actual fee charged.
   (b) When an incidental procedure is performed, the Eligible Expense is the Reasonable and Customary fee for the major surgical procedure only.
2. When an assistant surgeon is required, the Covered Expenses shall be limited to twenty percent (20%) of the surgeon's allowable charge for the surgery. An assistant surgeon must be a Physician, a Physician Assistant, or Certified Surgical First Assistant (CSFA).

(d) Anesthetics and the administration thereof

(e) Diagnostic x-rays, laboratory and test procedures including interpretations.

(f) X-ray and radium treatments and treatments with other radioactive or chemotherapy substances.

(g) Speech therapy by a qualified speech therapist to restore or rehabilitate speech loss or impairment caused by an injury, sickness or surgery. However, speech therapy for a developmental, psycho-neurotic or

personality disorder is not covered. Speech disturbances and delays in children possibly resulting from chronic or repeated infection are not covered. The 1977 Education for All Handicapped Children Act, Public Law 94-142 may provide some assistance with public assistance for this type of treatment.

(h) Oxygen and its administration.

(i) Blood transfusions, including the cost of blood and plasma, unless such blood is replaced.

(j) Drugs and medicines which require a physician's prescription to obtain and which are dispensed by a licensed network pharmacist or physician to treat a covered condition. Copayments for drugs filled through another Prescription Drug Program are eligible.

(k) Any ground transportation furnished by a professional ambulance service to the nearest hospital where medically necessary care and treatment is available, or air ambulance where air transportation is medically indicated to transport a Covered Person to the nearest facility qualified to render treatment, or "CARE" and "LIFE" flights in a life threatening situation only. Transportation by regularly scheduled airline, railroad or air ambulance, to the nearest medical facility qualified to give the treatment. These services must be given within the United States, Puerto Rico or Canada.

(l) Rental of Durable Medical Equipment which is customarily used only for medical therapeutic purposes and would not be useful in the absence of the injury or illness. Such equipment includes, but not limited to, crutches, equipment for the administration of oxygen, a standard wheelchair meeting the patient's minimum medical requirements, a hospital type bed, an iron lung or other mechanical equipment for the treatment of respiratory paralysis. *The Plan reserves the right to approve the purchase of Durable Medical Equipment.* In no event will the total expense covered for rental exceed the actual purchase price.

(m) Replacement prostheses are not covered unless required because of significant growth and development, or substantial pathologic change. Replacements needed primarily because of normal wear or aging of the prosthesis, or technologic advance, are not covered.

(n) The first pair of eyeglasses or contact lenses prescribed as part of postoperative treatment for medically necessary interocular surgery or due to accidental injury to the eye that the patient was covered by the Plan at the time of the surgery or injury. Prosthetics primarily for cosmetic rather than functional improvement are not covered.

(o) Services of a qualified licensed physiotherapist or occupational therapist, when for the therapeutic care of acute symptoms and conditions. Maintenance care is not covered.

(p) Expenses for services rendered in an ambulatory surgical center or outpatient facility of a hospital.

(q) Pre-admission laboratory and x-ray testing expenses incurred in connection with a scheduled hospital confinement prior to the date the confinement commences with such tests being medically valid at the time confinement is scheduled to commence.

(r) Injury to or care of mouth, teeth and gums. Charges for injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Expenses under Medical Benefits only if that care is for the following oral surgical procedures.
    1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
    2. Emergency repair due to injury to sound natural teeth. This repair must be made within twelve (12) months from the date of the accident.
    3. Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
    4. Excision of benign bony growths of the jaw and hard palate.
    5. External incision and drainage for cellulites.
    6. Removal of impacted wisdom teeth.
    7. No charge will be covered under the Medical Benefits for dental and oral surgical procedures involving orthodontic care of teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

(s) Private duty nursing care given on an inpatient basis by a licensed nurse (R.N., L.P.N., or L.V.N.) shall be considered an eligible expense if the service rendered is otherwise covered. Such private duty nursing services must be Medically Necessary.

(t) Charges for the following medical supplies: colostomy bags, catheters, diabetic lancets, diabetic glucose testing strips, glucose monitors and oxygen. Also, surgical dressings, splints, plaster casts and sterile supplies applied by a physician or Home Health Care agency. Upon prior plan approval, other medical supplies may be eligible.

(u) Charges for electrocardiograms, electroencephalograms and similar type testing to diagnose conditions for which symptoms or clinical findings exist.

(v) Charges for bone stimulators upon prior approval by the Plan.

(w) TENS units.

(x) Charges for one (1) wig per Lifetime for hair loss as a result of chemotherapy or radiation therapy or as a result of an accidental Injury while covered under the Plan.

(y) Charges for circumcision.

(z) Sterilization procedures (Benefits may be considered as any other illness if they are not approved for the Routine Wellness Benefits or Enhanced Well Women's Benefits outlined on the Schedule of Benefits.)

(aa) Chantix for smoking cessation treatments – one treatment per lifetime.

Special Covered Expenses

(a) Home Health Care - Expenses furnished to a Participant or Dependent for the sole purpose of treating a disability, provided that a Home Health Care Plan has been:

    1. established and recommended in writing by the attending physician;
    2. certified by the attending physician that the proper treatment of the disability would require continued confinement as an inpatient in a hospital in the absence of the services and supplies provided as part of the home health care plan.

Home Health Care Expenses shall not include:

1. transportation services, or
2. expenses during any period in which the Covered Person was not under the care of a Physician.

(b) Extended Care Facility - Expenses incurred for services furnished by an Extended Care Facility, provided they are:

1. in lieu of a hospital confinement,
2. recommended by a physician,
3. medically necessary for the treatment of or leading to the recovery or rehabilitation from an accident or Illness, and
4. not primarily for custodial care.

(c) Hospice Care - Hospice Care Services approved by the Pre-certification vendor may include, but are not limited to:

1. medical treatment given by a physician;
2. intermittent nursing care by a registered nurse or by a licensed practical nurse under the supervision of a registered nurse;
3. physical therapy, occupational therapy and speech therapy;
4. nutritional guidance given by a registered nutritionist;
5. drugs and medicines lawfully obtainable only upon the written prescription of a physician;
6. transfusions and blood which is not donated or replaced;
7. oxygen and other gases and their administration;
8. dressing;
9. rental of durable medical equipment;
10. Medical Social Services;
11. bereavement counseling; services of a licensed social worker or licensed pastoral counselor for members of the immediate family;
12. Hospice facility expenses;
13. assessment of the social, psychological and family problems related to or arising out of the terminally ill individual's illness and treatment;
14. appropriate action and utilization of community resources to assist in resolving such problems;
15. participation in the development of treatment for the terminally ill individual.

(d) Rehabilitation Expenses - Expenses which meet the following prerequisites:

1. confinement is in lieu of an acute care hospital confinement,
2. the confinement to the Rehabilitation Hospital is determined to be a medically necessary part of a written rehabilitation plan, and
3. the confinement requires technical skills not available on an Outpatient Setting.

(e) Preventive Care Benefit - Benefit includes, but is not limited to: mammograms, Pap smears, prostate testing, diagnostic tests, hearing testing, vision testing, immunizations, inoculations, and the office visit or examination fees for performing same, providing the claim documentation does not indicate the presence of an Illness or Injury, or symptoms suggesting the medical need for the testing. Such expenses shall be reimbursed as listed in the Schedule of Benefits. Charges are not an eligible Preventive Care

Benefit if the charges are incurred are for treatment of documented conditions, symptoms, or physician findings, unless the office encounter includes charges for both Preventive Care Benefit(s) and medically necessary eligible care. When Preventive Care Benefit charges are incurred during the same office encounter as charges to treat documented conditions, symptoms or physician findings, the charges will be considered eligible for the Preventive Care Benefit. Once the maximum for the Preventive Care Benefit, as stated in the Schedule of Benefits, has been reached, Preventive Care charges will be excluded for the remainder of the Calendar Year.

(f) Second Surgical Opinion - Expenses for the services of a Physician and related testing in connection with a second or third opinion to determine the need for a surgical procedure are payable as any other illness for both Plan options. Such second or third opinion must be given by a board-certified surgeon or a board-certified specialist in the appropriate specialty. **No benefits** will be paid for a second or third surgical opinion if the physician who gives the opinion also performs the surgery.

Mental Health Care Charges for the outpatient diagnosis, care and treatment of a Mental Illness or Nervous Disorder are available to the extent listed in the Schedule of Benefits. Facility, Physician Care and/or necessary laboratory work or other testing performed to prescribe or regulate drug therapy, however, will be considered under this benefit. Day Facility treatment programs will be covered if determined to be necessary for the care of the patient. This benefit also covers Individual, Group and Intensive Day Therapy. Residential Care is not covered by this Plan.

Pregnancy will be covered as any other Illness under this Plan for Covered Employees and their Dependent Spouses, EXCLUDING elective abortions or complications thereof. Dependent daughters are not eligible for pregnancy benefits or any benefits for complications as a result of pregnancy. Eligible hospitalization is automatically authorized for up to forty-eight (48) hours from the date of a vaginal delivery or up to ninety-six (96) hours from the date of a Cesarean Section delivery. Medical complications requiring longer stays will be reviewed for necessity upon documentation by the attending physician. Expenses for a hospital stay following a normal vaginal delivery will not be limited to less than forty-eight (48) hours for both the mother (if a Covered Person) and the newborn child. Coverage for a hospital stay in connection with childbirth following a Cesarean section will not be limited to less than ninety-six (96) hours for both the mother (if a Covered Person) and the newborn child. Notwithstanding any language to the contrary, the Plan will at all times comply with the Newborns' and Mothers' Health Protection Act of 1996, as promulgated.

These Covered Services and Supplies are subject to the same requirements as any other Covered Services and Supplies.

(a) Nurse-Midwife's services. Services of a licensed or certified Nurse-Midwife. Benefits are payable on the same basis as services given by a Physician.

(b) Birthing Center Services.
   1. Room and board;
   2. Other services and supplies; and
   3. Anesthetics.

Newborn's Routine Well Baby Care The following applies to newborn's:

(a) Facility and physician care for healthy newborns are covered under the Plan for the first thirty (30) days, provided the newborn is eligible for coverage under the Plan.

(b) **You must add your newborn child to the Plan within the first thirty (30) days following birth for coverage to continue**.

(c) Charges for routine circumcision of a newborn will be covered only if performed within the first thirty (30) days and prior to discharge from the Hospital.

(d) Charges for other than routine newborn care will not be covered under the Plan unless the child is added to the Plan within thirty (30) days following birth.

(e) Newborn medical expenses incurred for the treatment of a diagnosed illness, injury, congenital defect or birth abnormality shall be covered as any other Illness providing such newborn is eligible for coverage **and** properly enrolled in the Plan within thirty (30) days from the date of birth.

(f) Expenses for newborn children born to Dependent children are not eligible.

Managed Care Program The Managed Care Program will be administered by the vendors specified on the Vendor Listing as a means of controlling the increase of health care costs. Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charges to a Reasonable and Customary charge in accordance with the terms of this Plan Document. In the event there is a conflict between this Plan Document and any other agreement, this Plan Document will prevail over and supersede all conflicting contractual obligations set forth in the other agreements.

(a) Preferred Provider Network - Certain providers have been identified to participate in the preferred provider network. By using one of these providers, Covered Persons, and the Plan are expected to achieve lower medical care costs.

(b) Pre-Admission Notification
   1. The pre-admission certification vendor will review, all hospital admissions prospectively, the medical necessity of all hospitalizations and the appropriateness of lengths of stay. As soon as a Covered Person is told by a doctor that hospitalization is planned, the Hospital Pre-certification Vendor must be notified. In the event of an emergency admission, the Hospital Pre-certification Administrator must be notified within forty-eight (48) hours after admission to the hospital.
   2. **IT IS THE EMPLOYEE'S RESPONSIBILITY TO BE SURE THAT THE PRE-CERTIFICATION VENDOR IS CALLED OR NOTIFIED WITHIN THE TIME LIMITS REQUIRED. THE EMPLOYEE OR ANY MEMBER OF THE FAMILY CAN MAKE**

THE INITIAL TELEPHONE CALL TO THE PRE-CERTIFICATION COMPANY TO BEGIN THE NOTIFICATION PROCESS.

3. **IF THE PRE-CERTIFICATION VENDOR IS NOT NOTIFIED PRIOR TO ADMISSION (OR WITHIN FORTY-EIGHT (48) HOURS OF AN EMERGENCY ADMISSION), RETROSPECTIVE REVIEW WILL BE PERFORMED AND THE NON-COMPLIANCE PENALTY WILL APPLY TO ALL SERVICES DETERMINED TO BE COVERED BY THE PLAN. CHARGES DETERMINED NOT TO BE MEDICALLY NECESSARY WILL BE DENIED.**

Case Management Services When indicated, the Plan Administrator will arrange for review and/or Case Management services from a professional qualified to perform such services. The Plan Administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care. Decisions will be made with the understanding and agreement of the affected Participant. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability, with respect to that Covered Person or any other Covered Person.

ORGAN/TISSUE TRANSPLANTS EXPENSES INCURRED IN PREPARATION FOR A COVERED TRANSPLANT PROCEDURE WILL BE ELIGIBLE BY THE PLAN, PROVIDED THAT THE LIKELIHOOD OF A TRANSPLANT WITHIN TWO (2) YEARS IS ESTABLISHED. THIS PROVISION WILL APPLY TO PATIENTS IN REMISSION AT THE TIME THE PREPARATION EXPENSES ARE INCURRED.

(a) The Utilization Review vendor must be notified at least seven (7) working days before the scheduled date of any of the following, or as soon as reasonably possible:
    1. The evaluation;
    2. The donor search;
    3. The organ procurement/tissue harvest; and
    4. The transplant procedure

    Services and supplies for Medically Necessary organ or tissue transplants are payable under this Plan.

(b) In the case of an organ or tissue transplant, donor charges are considered Covered Expenses ONLY if the recipient is a Covered Person under this Plan. If the recipient is not a Covered Person, no benefits are payable for donor charges.

(c) The search for bone marrow/stem cell from a donor who is not biologically related to the patient is not considered a Covered Service UNLESS the search is made in connection with a transplant procedure arranged by a designated transplant facility.

(d) If a Qualified Procedure, listed below, is Medically Necessary and performed at a Designated Transplant Facility, the Medical Care and Treatment and transportation and lodging provisions described below apply.

1. Qualified Procedures:
   i. Heart transplants
   ii. Lung transplants
   iii. Heart/lung transplants
   iv. Liver transplants
   v. Kidney transplants
   vi. Pancreas transplants
   vii. Kidney/pancreas transplants
   viii. Bone marrow/stem cell transplants
   ix. Other transplant procedures when the Plan Administrator determines that it is Medically Necessary to perform the procedure at a Designated Transplant Facility.

2. Medical care and treatment. The Covered Expenses for services provided in connection with the transplant procedure include:
   i. Pre-transplant evaluation for one of the Qualified Procedures listed above.
   ii. Organ acquisition and procurement.
   iii. Hospital and Physician fees.
   iv. Transplant procedures.
   v. Follow-up care for a period up to one (1) year after the transplant.
   vi. Search for bone marrow/stem cell from a donor who is not biologically related to the patient provided that benefits to the donor are not provided under any other form of coverage.

3. Transportation and lodging. The Utilization Review vendor will assist the patient and family with travel and lodging arrangements. Expenses for travel, lodging and meals for the transplant recipient and a companion are available under this Plan, up to the amount specified in the Schedule of Benefits, as follows:
   i. Transportation of the patient and one companion who is traveling on the same day(s) to and/or from the site of the transplant for the purposes of an evaluation, the transplant procedure or necessary post-discharge follow-up.
   ii. Reasonable and necessary expenses for lodging and meals for the patient (while not confined) and one companion.
   iii. Travel and lodging expenses are only available if the transplant recipient resides more than 50 miles from the Designated Transplant Facility.

There is a combined overall lifetime maximum of $10,000 per Covered Person for all transportation, lodging and meal expenses incurred by the transplant recipient and

companion and will be reimbursed under this Plan in connection with all transplant procedures.

Cosmetic or Reconstructive Surgery.

(a) Cosmetic or reconstructive surgery, for treatment of accidental Injury which was sustained while covered under this Plan, provided such treatment is received within twelve (12) months of the Injury, or for the correction of a congenital anomaly in a Covered Person under the age of nineteen (19) years or for reconstructive surgery that follows surgery for deformities which result from an Illness that commenced while that person was covered under this Plan.

(b) Reconstructive surgery to remove scar tissue on the neck, face, or head if the scar tissue is due to Illness or accidental Injury which happens while the person is covered under this Plan.

Such Benefits are subject to any appropriate Plan requirements, exclusions, Calendar Year Deductibles, and coinsurance provisions as outlined by the Plan.

Breast Surgery.

(a) **Breast Reconstruction After Mastectomy.** Reasonable and Customary Charges for breast reconstructive surgery "in connection with" Medically Necessary mastectomies are covered and may include the following:

1. Reconstruction of the diseased breast on which the mastectomy has been performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;

3. Coverage for prostheses directly connected to the mastectomy (such as implants or special bras limited to two (2) bras per Calendar Year); and

4. Physical complications of all stages of mastectomy, including lymphedemas as recommended by the attending Physician of the patient.

(b) **Breast Implant Removal After Mastectomy.** Reasonable and Customary Charges for removal of breast implants from a Medically Necessary mastectomy may be covered for any of the below listed scenarios when Plan requirements are met. However, insertion of a new implant or other surgery to restore appearance after such removal are considered cosmetic surgery and are not covered.

1. Implant rupture, failure, exposure, or extrusion; or

2. Infection or inflammatory reaction to a breast prosthesis including siliconoma, granuloma; or

3. Painful Baker Class IV capsular contracture with disfigurement if (i) daily functioning is significantly affected; (ii) interferes with adequate mammography screening; and (iii) no equally effective course of treatment is available that is more conservative or less costly; or

4. Interference with diagnosis or treatment of breast cancer.

(c) **Breast Cosmetic Surgery.** Except as provided above in connection with Medically Necessary mastectomies, services provided directly for or relative to cosmetic surgery or reconstructive surgery of the breast are not covered except when the surgical procedure is one of the following:

1. Cosmetic or reconstructive repair of accidental Injury, which was sustained while covered under this Plan, provided such treatment is received within twelve (12) months of the Injury; or

2. Reconstructive and related services that are performed on structures of the body to improve / restore impairments of bodily function resulting from disease, trauma, congenital or developmental anomalies or previous therapeutic processes.

(d) **Breast Implant Removal After Cosmetic Surgery.** – Reasonable and Customary Charges for removal of breast implants inserted for cosmetic purposes may be covered for painful Grade IV Baker capsular contracture with disfigurement when Plan requirements are met if (i) daily functioning is significantly affected; (ii) interferes with adequate mammography screening; and (iii) no equally effective course of treatment is available that is more conservative or less costly.

Such Benefits are subject to any appropriate Plan requirements, exclusions, Calendar Year Deductibles, and coinsurance provisions as outlined by the Plan.

CONTINUITY OF CARE

Continuity of Care. Protections apply for continuing care patients who are receiving Covered Services or items from a treating provider or health care facility, and their treating provider or health care facility experiences a change in network status due to one of the following:

1. The provider or health care facility's contractual relationship with the Plan is terminated;
2. The provider or health care facility's terms of participation in the Plan or coverage change, resulting in a termination of benefits with respect to the provider or health care facility;
3. A group health plan's contract with a health insurance issuer offering health insurance coverage in connection with the Plan is terminated, resulting in a loss of benefits provided under the Plan with respect to the provider or health care facility.

Definitions As used in this Continuity of Care section, the following terms shall have the meanings indicated.

(a) **Continuing care patient** means an individual who, with respect to a provider of facility,
   1. Is undergoing a course of treatment for a serious and complex condition from the provider or facility;
   2. Is undergoing a course of institutional or inpatient care from the provider or facility;
   3. Is scheduled to undergo nonelective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
   4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; of
   5. Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

(b) **Cost Sharing** means the amount a participant, beneficiary, or enrollee is responsible for paying for a covered item or service under the terms of the Plan. Cost sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance billing by Out-of-Network Providers, or the cost of items or services that aren't covered under the Plan.

(c) **Emergency department of a hospital** includes a hospital outpatient department that provides emergency services.

(d) **Health care facility** means, in the context of non-emergency services, each of the following:
   1. A hospital (as defined in section 1861€ of the Social Security Act);
   2. A hospital outpatient department;
   3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
   4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

(e) **Independent freestanding emergency department** means a health care facility (not limited to those described in the definition of health care facility with respect to non-emergency services) that:
   1. Is geographically separate and distinct and licensed separately from a hospital under applicable State law; and
   2. Provides any emergency services as described in 45 CFR §149.110(c)(2)(i).

(f) **Out-of-network emergency facility** means an emergency department of a hospital, or an independent freestanding emergency department (or a hospital, with respect to services that pursuant to 45 CFR §149.110(c)(2)(ii) are included as emergency services, that doesn't have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

(g) **Out-of-Network Provider** means any physician or other health care provider who doesn't have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

(h) **Physician or health care provider** means a physician or other health care provider who is acting within the scope of practice of that provider's license or certification under applicable state law but doesn't include a provider of air ambulance services.

(i) **Provider of air ambulance services** means an entity that is licensed under applicable state and federal law to provide air ambulance services.

(j) **Serious and complex condition** means, with respect to a participant, beneficiary, or enrollee under the Plan
   1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or
   2. In the case of a chronic illness or condition, a condition that is [i] life-threatening, degenerative, potentially disabling or congenial; and [ii] requires specialized medical care over a prolonged period of time;

(k) **Terminated** means, with respect to a contract, the expiration or nonrenewal of the contract, but doesn't include a termination of the contract for failure to meet applicable quality standards or for fraud.

MEDICAL GENERAL EXCLUSIONS AND LIMITATIONS

Unless specified otherwise in this Plan, **no benefits** shall be paid for expenses incurred for or due to:

4. Services rendered to the Participant or Dependent prior to the date his/her coverage becomes effective. For the purposes of the coverage, an expense shall be deemed to have been incurred on the date the service or supply for which the charge is made was received.
5. Dental services of any kind except expenses specifically covered herein.
6. Cosmetic surgery or treatment and any related expenses except those expenses for cosmetic surgery or treatment described in this Plan. Expenses related to complications of cosmetic procedures shall not be covered, unless the original cosmetic procedure was covered by the Plan.
7. Eyeglasses, eye exercises, contact lenses, hearing aids, or examinations for the prescription or fitting of eyeglasses or hearing aids unless required due to interocular surgery, or to an accidental bodily injury to the eye or ear performed or sustained while the person is covered under this Plan. This Plan does not cover refractive surgical procedures or treatment of the eye, e.g., Radial Keratotomy (RK) or Photorefractive Keratotomy (PRK) conditions. The Plan also does not cover treatments for eye alignment problems, e.g., Strabismus, Esotropia or Exotropia, by corrective lens, surgery, vision training or any other means;
8. Services received for any condition, illness, injury or complication thereof arising out of or in the course of any employment (including self-employment) or occupation for compensation or profit.
9. Expenses for services furnished the Covered Person in any Veteran's Hospital or Military Hospital (except for non-service related disabilities not otherwise excluded hereunder), institution or facility operated by the United States government, or by any state government, or by any agency or instrumentality of such government. This provision is subject to any governmental provision or regulation which requires that benefits of this Plan be utilized before benefits are available thereunder. The provisions of the immediately preceding exclusion do not apply to benefits available under the Health Insurance for the Aged and Disabled provisions of the United States Social Security Act as now or hereafter amended.
10. Services received as a result of injury or sickness while the Covered Person was participating in an act of war, declared or undeclared, or any type of military conflict.
11. Services for which neither the Participant nor the Dependent incurs a legal obligation to pay including services provided by a family member, (spouse, son, daughter, brother, sister or parent). or fees or portions of fees which have been or will be discounted or reduced, or for which no charge would have been made in the absence of coverage.
12. Service expenses in excess of the Reasonable and Customary charge for such services.
10. Expenses related to intentionally self-inflicted injury or attempted suicide committed while sane or insane.
11. Charges for genetic testing;

12. Expenses incurred for or related to the reversal of sterilization.
13. Contraceptive services other than any Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity with a physician issued prescription.
14. Expenses incurred to treat infertility or to affect the inducement of pregnancy by artificial means, i.e. artificial insemination or in vitro fertilization or any surgery or treatment to induce pregnancy.
15. Services in connection with elective abortions.
16. Charges related to or in connection with pregnancy or complications of pregnancy of a Dependent child including expenses for a newborn child born to a Dependent child;
17. Wigs or toupees (except as specifically stated under Covered Expenses), hair transplants, hair weaving or any drug if such drug is used in connection with the treatment of baldness;
18. Charges for nutritional counseling, special foods, food supplements, liquids, diet plans or any related products;
19. Membership costs for health clubs, weight loss clinics and similar programs.
20. Charges for services in connection with treatment of obesity or weight reduction.
21. Charges related to hypnotherapy, except as part of a physician's outpatient treatment of a mental illness or when hypnosis is used in lieu of an anesthetic.
22. Charges for acupuncture treatment (meridian therapy).
23. Charges for Biofeedback;
24. Charges for treatment of sexual dysfunctions or inadequacies;
25. Charges for penile implants or treatment of impotency;
26. For charges related to sexual surgery, gender reassignment or disturbances of gender identification;
27. Charges for services or supplies for custodial or sanitarium care or rest cures.
28. Education, training and bed and board while confined in an institution which is mainly a school or other institution for training, a place of rest, a place for the aged or a nursing home.
29. Charges for expenses for treatment related to an Illness or Injury caused by the Covered Person's commission or attempted commission of a felony or being engaged in an illegal act, riot or insurrection.
30. Charges for expenses for treatment not actually rendered.
31. Charges for surgery or treatment which is experimental including drugs, research studies or for any services or supplies not considered legal in the United States.
32. Charges for educational, vocational, or other non-medical or non-illness related counseling, self-help training or other training services, unless specifically included in this Plan. Care and treatment of mental health conditions shall be limited to those specified as Covered Expenses.
33. Charges for expenses incurred more than twelve (12) months prior to the date the claim for benefits is received by the Third-Party Administrator;
34. Charges for services of the clergy who would normally not make a charge for services that are rendered during the course of their normal practice as a member of the clergy.

35. Expenses for travel or accommodations or other non-medical expense, whether or not recommended by a physician or necessary to obtain medical care, unless specifically covered under this Plan.
36. Expenses not specifically listed as a Covered Expense.
37. Expenses for devices, supports or braces or any other supply, treatment or equipment necessary to allow participation in athletics or fitness activities but are not Medically Necessary.
38. For the services related to: (a) Weak, strained, flat, unstable or unbalanced feet, or metatarsalgia, except open cutting operations; or (b) Corns, calluses or toenails, except the removal of nail roots and necessary services for the treatment of metabolic or peripheral vascular diseases; or (c) Orthotics in excess of the amount specified in the Schedule of Benefits.
39. Chelation therapy, except to treat heavy metal poisoning.
40. Ecological or environmental medicine, diagnosis and/or treatment.
41. Herbal medicines, holistic or homeopathic care, including drugs.
42. Examinations or treatment ordered by a court in connection with legal proceedings unless such examinations or treatments otherwise qualify as Covered Expenses.
43. Personal convenience or comfort items including, but not limited to, such items as admission kits, televisions, telephones, first aid kits, exercise equipment, air conditioners, humidifiers, saunas and hot tubs.
44. For standby Physicians or other medical practitioners except where the services are Medically Necessary and satisfactory evidence documenting Medical Necessity has been received.
45. Completion of claim forms or missed appointments.
46. Smoking cessation programs with the exception of the prescription Chantix.
47. Treatment for Temporomandibular Joint Disorder (TMJ) unless specifically stated as covered.

DENTAL BENEFITS

SCHEDULE OF BENEFITS

Calendar Year Maximum	$1,000
Applicable to plan members as of age 18 years	
Calendar Year Deductible	
Individual	$50
Family	$150
Benefit Percentage Payable	
Preventive Care Services	
(Calendar Year Deductible waived)	100%
Basic Services	
(Calendar Year Deductible applies)	80%
Major Services	
(Calendar Year deductible applies)	50%

DETAILED DENTAL PROVISIONS

If you or any one of your Dependents incurs Covered Expenses, the Plan will:

1. deduct any Dental Deductible that applies from the Covered Expenses first incurred in a Calendar Year for a person; and
2. pay for the other Covered Expenses incurred in that Calendar Year up to the Maximum Covered Expense determined from the Dental Services Schedule for each dental service subject to the Alternate Benefit Provision.

The Dental Deductible which must be satisfied by Covered Expenses is shown in the Schedule.

Maximum Benefit Provision. The total amount payable for all expenses incurred for a person in a Calendar Year will not be more than the Maximum Benefit shown in the Schedule. This maximum does not apply to Covered Dependents under age 18 years.

Covered Expenses. The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a dentist for the performance of a dental service listed in the Dental Services Schedule.

Covered Expenses will include only those expenses incurred for such charges when the dental service:

1. is performed by or under the direction of a Dentist;
2. is essential for the necessary care of the teeth; and,
3. starts and is completed while the person is covered.

Any portion of charges for a dental service that exceeds the Maximum Covered Expense shown for that service in the Dental Services Schedule is not included in determining any benefits payable under the Plan.

A dental service is deemed to start when the actual performance of the service starts except for:

1. fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared.
2. a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
3. root canal therapy, it starts when the pulp chamber of the tooth is opened.

Alternate Benefit Provision. When more than one dental service could provide suitable treatment based on common dental standards, the Plan will determine the dental service on which payment will be based and the expenses that will be included as Covered Expenses.

Pre-determination of Benefits. The term *Predetermination of Benefits* means a review by the Plan Administrator of Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. It is recommended whenever extensive dental work is proposed. The information should be sent to the Plan Administrator before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to the Plan Administrator.

The expenses that will be included as Covered Expenses will be determined by the Plan Administrator and are subject to the Alternate Benefit Provision and the Reasonable and Customary limits. When there has not been a Predetermination of Benefits, the Plan Administrator will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of Benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

COVERED DENTAL EXPENSES

Covered Dental Expenses will include expenses incurred for dental services listed in this Schedule. The Plan may agree to accept, as Covered Dental Expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to This Plan.

The Plan will determine the Maximum Covered Expense for services that it accepts. The Maximum Covered Expense so determined will be consistent with the maximums listed.

A temporary dental service is included in the allowance for the final dental service and is not a separate dental service.

Preventive Care Services – Class I Services – Diagnostic and Preventive

The Maximum Covered Expense for any Preventive Care Service, is the Reasonable and Customary Charge for the following services:

1. Periodic Oral Examination. Limited to two (2) per Covered Person per Calendar Year.
2. Emergency palliative treatment to relieve dental pain when no other definitive dental services are performed. (Any x-ray taken in connection with such treatment is a separate dental service.)
3. Full mouth x-rays consisting of a complete series (with or without bitewings) including panoramic film, limited to one (1) per Covered Person, in any three (3) year period.
4. Bitewing x-rays - limited to two (2) charge or series per Covered Person per every one (1) Calendar Year.
5. Prophylaxis or Periodontal Prophylaxis (Cleaning). Limited to two (2) per Covered Person per Calendar Year.
6. Topical application of acid fluoride phosphate - Limited to one (1) application per Calendar Year for Covered Persons under nineteen (19) years of age.
7. Topical application of sealant per tooth. Limited to one (1) application during any three-year period (3) for Covered Persons under fourteen (14) years of age.
8. Space Maintainers fixed unilateral - Limited to non-orthodontic treatment.

Basic Services - Restorations, Endodontics, Periodontics, Prosthodontics Maintenance and Oral Surgery

The Maximum Covered Expense for any Basic Service is a percentage of the Reasonable and Customary Charge for the following services:

1. Amalgam restorations
2. Composite restorations
3. Root canal therapy
4. Crowns / Inlays / Onlays (including steel crowns, post and core buildup excluding abutments)
5. Osseous surgery
6. Periodontal scaling and root planing
7. Recement bridge, crowns, onlays or inlays
8. Oral surgery
9. Endodontic treatment / therapy

10. Periodontics treatment / therapy
11. Repairs / adjustments to bridges, partials or crowns
12. Anesthesia, local anesthetic, analgesic and desensitizing medications
13. Occlusal adjustments
14. Thumb sucking appliances

Major Services - Restorations, Dentures and Bridgework

The Maximum Covered Expense for any Major Service is a percentage of the Reasonable and Customary Charge for the following services:

1. Fixed or removable appliances
2. Bridge pontics
3. Abutment crowns
4. Adjustments - complete denture. Any adjustment of or repair or relining to a denture within six (6) months of its installation is not a dental service
5. Addition of teeth to an existing partial

DENTAL GENERAL LIMITATIONS AND EXCLUSIONS

Covered Expenses **will not** include, and no payment will be made for expenses incurred for:

1. Charges for services performed solely for cosmetic reasons including labial veneers;
2. Charges for replacement of a lost or stolen appliance;
3. Charges for replacement of a bridge, crown or denture within five (5) years of the date it was originally installed unless:
    (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth;
    (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered under this Plan;
4. Charges for any replacement of a bridge, crown or denture while it is or can be made serviceable according to common dental standards;
5. Charges for procedures, appliances or restoration (except full dentures) whose main purpose is to diagnose or treat conditions or dysfunction of the temporomandibular joint including maxillofacial prosthetic appliances;
6. Charges for bite registration, precision or semi-precision attachments or splinting;
7. Charges for surgical implant of any type including any prosthetic device attached to it;
8. Charges for instruction for plaque control, oral hygiene and diet;
9. Charges for dental services that do not meet common dental standards;
10. Charges for services that are deemed to be medical services;
11. Charges for services and supplies received from a hospital;
12. Charges for or in connection with an Injury arising out of, or in the course of, any employment for wage or profit;
13. Charges as a result of war, declared or undeclared, or any act of war;
14. Charges for or in connection with an Illness or Injury which is covered under any

workers' compensation or similar law;

15. Charges made by a Hospital owned or operated by, or which provides care or performs services for, the United States Government, if such charges are directly related to a military service-connected Illness or Injury;
16. Charges for any payment which is unlawful where you or any one of your Dependents resides when the expenses are incurred;
17. Charges for more than Reasonable and Customary Charges;
18. Charges for expenses incurred prior to becoming covered under the Plan;
19. Charges for orthodontic treatment, except to the extent benefits are provided specifically for such expenses;
20. Charges for unnecessary care, treatment or surgery;
21. Charges for or in connection with custodial care, education or training;
22. Charges for fees that you or any one of your Dependents is in any way paid or entitled to payment for those expenses by or through a public program, other than Medicaid;
23. Charges for drugs and/or medications of any kind other than a therapeutic drug injection administered by a Dentist;
24. Charges for or in connection with experimental procedures or treatment methods not approved by the American Medical Association, the American Dental Association or the appropriate medical or dental specialty society;
25. Charges for infection control, sterilization and waste disposal; or
26. Charges for appointments not kept, or for completion of claims forms or pre-treatment forms.

COORDINATION OF BENEFITS

Coordination of Benefits When Covered Persons are covered under more than one group "Plan" as defined below, the combined benefits payable by this Plan and all other group plans will not exceed 100% of the eligible expenses incurred by the covered individual. The Plan assuming the primary payor position by the order of benefit determination stated in this section will determine benefits first, without regard to the benefits provided under any other group plan. When this Plan is the secondary payor it **will consider all Eligible Expenses, apply all Plan provisions, and reimburse the difference between the Eligible charge and the primary carrier's payment, or the Plan's normal liability, whichever is less.** When there are more than two plans, this Plan may be primary to one and secondary to another.

Definitions As used in this Coordination of Benefits section, the following terms shall have the meanings indicated.

(a) **Plan** means any of the following providing medical benefits or services:
   6. any group, blanket or franchise insurance coverage;
   7. a group hospital service prepayment plan, group medical service prepayment plans, group practice, or other prepayment coverage providing benefits or services for members of a group;
   8. any coverage under labor management trustee plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans whether insured or self-insured;
   9. any coverage under governmental programs, and any coverage required or provided by any statute, other than the Medical Assistance Plan or any state in implementation of Title XIX of the Social Security Act of 1965;
   10. any mandatory coverage under a state auto reparation or indemnity act, commonly known as "no fault auto insurance", or individual automobile coverage, except when prohibited by law or regulation of the state in which this Plan is written; and
   11. this Plan.

   This term shall not include individual or family plans, or contracts, or public medical assistance programs.

(b) **Eligible Expense** means any Reasonable and Customary charge considered by this Plan.

(c) **Parent** means natural parent, adoptive parent, legal guardian, or person(s) legally responsible for the medical expenses of the Dependent Child.

Order of Benefit Determination

(a) The Plan(s) which does not coordinate with other plans is the primary plan.

(b) The benefits of a plan which covers the person for whom a claim is made as an Employee shall be determined before the benefits of a plan which covers such person as a Dependent.

(c) For a covered dependent child, the plan covering the parent with the earliest birth date (excluding year of birth) will be primary.

(d) For a covered dependent child whose parents are divorced or legally separated, then:

1. The Plan covering the parent with custody will be primary over the Plan covering the parent without custody; or
2. If the parent with custody has remarried, then the custodial parent's plan is primary, the custodial stepparent's plan pays second, the non-custodial parent's plan pays third; and the non-custodial step-parent's plan pays fourth.
3. If there is a court decree that establishes financial responsibility for the health care expenses with respect to the child, the benefits are determined to be primary in agreement with the court decree.

(e) when rules a, b, c or d above do not establish an order of benefit determination, the plan which has covered the person for whom the claim is made for the longer period of time shall be primary to the plan covering the patient for a shorter period of time with the following exception: When one plan covers the claimant as a COBRA participant, or a laid off or retired employee (or dependent of such employee) and the other plan has adopted this provision, then the plan which covers the claimant as other than a COBRA participant, or a laid off or retired employee (or dependent of such employee) will pay first.

(f) **This Plan will automatically be amended to comply with any future legislative changes effecting Medicare entitlement and the Coordination of Benefits between Medicare and ERISA Group Health Plan Participants.**

Effect on Health Maintenance Organization (HMO) Coverage. This Plan will not consider as an allowable expense any charge which would have been covered by an HMO had a Covered Person, for whom the HMO would be primary payor, used the services of an HMO participating provider. Nor will this Plan consider as an allowable expense any charge in excess of what an HMO participating provider has agreed to accept as payment in full.

Rights to Receive and Release Necessary Information For the purposes of determining the applicability of and implementing the terms of this Plan, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which appears to be necessary for such purposes, with respect to any person claiming benefits under this plan. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement this provision. Failure to furnish requested information may result in a reduction of benefits otherwise available. The Plan reserves the right to withhold payment if information required to evaluate the appropriateness of the claim - or the applicability of any benefit provision or limitation - is not provided when requested by the Plan Sponsor or its designee.

Facility of Payment A payment made under another Plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. We will not have to pay that amount again. The term “payment made” includes providing benefits in the forms of services. In such a case “payment made” means reasonable cash value of the benefits provided in the form of services.

Rights of Recovery Whenever payments made by the Plan exceed the maximum amount of payment necessary to satisfy the intent of this provision, irrespective of the payee, the Plan shall have the right to recover the excessive payments, from one or more of the following:

(a) Any individual to or with respect to whom such payment was made, or
(b) Any insurance company, or
(c) Any other organization or person.

ADDITIONAL PROVISIONS AS A RESULT OF MEDICARE
Applicable to Covered Persons Age Sixty-five (65) or Over

(This provision applies to Employers with at least 20 Employees)

All Employees age sixty-five (65) and over, who are eligible for coverage under this Plan, and the eligible spouse of any Employee, if spouse is under age sixty-five (65), will be provided with coverage under this Plan on the same basis as those Employees under the age of sixty-five (65), unless such Employee rejects the Plan and elects to treat Medicare as his only coverage.

If such Employee elects to retain his coverage under this Plan, then the benefits of this Plan shall be determined before any benefits provided by Medicare. In the absence of any written election, this Plan will be primary.

Applicable to Medicare - Services Furnished to E.S.R.D. (End Stage Renal Disease) Beneficiaries Who Are Covered Under Employer Group Health Plans. If a Covered Person becomes eligible for benefits under Medicare as a result of disability due to End Stage Renal Disease and chooses to remain covered under this Plan, this Plan will pay its benefits first and Medicare will be the secondary payor for the first thirty (30) months of disability. *After the initial thirty (30) months, Medicare will be the primary payor.*

All Other Persons Eligible for Medicare - Not in Full-Time Service. If a Covered Employee or covered Dependent who is not in active employment is eligible for (has made application and is paying premium) Medicare benefits, such person shall be considered as having "full Medicare coverage." The term "full Medicare coverage" means coverage for all the benefits provided under Medicare Part A and the voluntary portion of Medicare Part B.

When a Covered Person becomes eligible for Medicare, benefits will be provided, as described under Coordination of Benefits, for that portion of the Covered Expenses which are not covered by Medicare unless any nonpayment by Medicare is due to a failure to enroll for Medicare coverage or to apply for Medicare benefits.

Medicare shall be considered a "Plan" as defined under the "Coordination of Benefits" section of this Plan, and benefits for Medicare shall be determined before the benefits of this Plan.

SUBROGATION

Plan's Right to Subrogation and Reimbursement. In the event of any Benefit payments made under the Plan to or on behalf of any Covered Person, the Plan shall, to the extent of such payments, be fully subrogated to all the rights of recovery and other rights of the Covered Person arising out of any claim or cause of action that may accrue because of the alleged accidental, negligent, intentional, or tortious conduct, act or omission, of another person or entity (hereinafter all such persons or entities shall be individually and collectively referred to as a "third party"). The Covered Person, by participation in the Plan, agrees that he and his estate, and the legal representatives of his estate, shall be obligated and that the Plan shall be fully subrogated to any recovery or right of recovery that he or the estate may have against any third party, including without limitation, any wrongful death claim. The Covered Person, or the legal representative or beneficiaries of the Covered Person or his estate, shall notify the Plan Administrator of any claim or lawsuit against a third party or insurance carrier within thirty-one (31) days of the date that the claim is made or the lawsuit is filed. The Plan Administrator, on behalf of the Plan, also has the right to pursue any action to enforce its subrogation rights against a third party or insurance carrier. If no legal actions have been pursued during a one-year period from date of accident and/or illness, then the plan has the right to pursue such actions on the plan's behalf at their discretion.

The Covered Person's Agreement to Subrogation and Reimbursement. The Covered Person, on behalf of himself and each beneficiary of a payment made on the Covered Person's behalf, by accepting Benefits under the Plan, consents and agrees (a) that the Plan shall be promptly reimbursed for any payments made to or on the Covered Person's behalf under the Plan out of any monies recovered as the result of any lawsuit, judgment, order, award, settlement, compromise, arbitration or other arrangement, (b) to include all Benefits paid or payable under the Plan in any liability or other claim against a third party or its insurance carrier, (c) the "make whole" doctrine, the "fund" doctrine, the "common fund" doctrine, comparative/contributory negligence, "collateral source" rule, the "attorney's fund" doctrine, regulatory diligence or any other defenses or doctrines that may affect the Plan's rights of subrogation and reimbursement do not apply to the Plan; and (d) the Plan's rights of reimbursement and subrogation are for the full amount of all related Benefits' payments, up to the amount of the recovery; this amount **shall not** be offset by legal costs, attorneys' fees or other expenses incurred by the Covered Person, on behalf of himself and each beneficiary in obtaining recovery. Furthermore, the Covered Person and said beneficiaries promise and agree to take such action, to furnish such information and assistance, to execute and deliver any assignments, reimbursement agreements and other instruments as the Plan Administrator may require to facilitate enforcement of the Plan's subrogation and reimbursement rights, and not to prejudice, or in any way detrimentally affect, such rights. The Plan's subrogation and reimbursement rights shall extend to all conceivable sources of recovery, other than the Plan itself, including, by way of example and not limitation, any and all automobile insurance coverage (including uninsured/underinsured motorist coverage and no-fault coverage), medical insurance coverage, school insurance coverage, disability coverage, personal injury awards and settlements and malpractice awards and settlements.

Limitation to the Plan's Subrogation and Reimbursement Rights. The Plan's subrogation and reimbursement rights shall extend only to the recovery by the Plan of

(a) the Benefits that it has paid or will pay to or on behalf of the Covered Person and (b) the cost of prosecuting the claim including reasonable attorneys' fees and court and collection costs incurred by the Plan.

Subrogation and Reimbursement Rights Not Affected By Payment. The Plan's subrogation and reimbursement rights shall not be affected if Benefits are paid before the Plan Administrator or its agent obtains any additional agreement from the Covered Person (or from any other payee) or if the Plan Administrator does not request any such agreement. In addition, the failure or refusal of a Covered Person (or other payee, if applicable) to sign an agreement at the request of the Plan Administrator or its agent recognizing the Plan's subrogation and reimbursement rights shall result in a forfeiture of all Benefits payable to that Covered Person (or other payee) even if such Benefits have already been paid, and the Plan Administrator shall retain a right to recover paid Benefits which are forfeited in such a manner; moreover, any such failure or refusal shall not affect the Plan's rights which shall remain in full force and effect.

Lien on Proceeds. The Plan Administrator, on behalf of the Plan, shall have a first and primary lien against the proceeds of any settlement, award or judgment that results from a claim or lawsuit by or on behalf of a Covered Person who received Benefits under the Plan. Notice of the lien is sufficient to establish the Plan's lien against the third party or insurance carrier. The Plan Administrator shall be entitled to:

(a) deduct the amount of the lien from any future claims payable to or on behalf of the Covered Person if:
    1. the lien is not repaid or otherwise recovered by the Plan Administrator, or
    2. the Covered Person or other claimant fails to promptly notify the Plan Administrator of a payment received from a third party or insurance carrier that is subject to the Plan's subrogation and reimbursement rights, and
(b) to otherwise take any action that the Plan Administrator deems to be necessary or appropriate to enforce the Plan's rights.

Coordination with Automobile Insurance Coverage. The Plan's liability for expenses arising out of an automobile accident is based on the type of automobile insurance law enacted by the Covered Person's state. Currently there are three types of state automobile insurance laws: (1) no-fault automobile insurance laws; (2) financial responsibility laws; and (3) other automobile liability insurance laws. It is the Plan's general intent not to pay medical expenses resulting from automobile accidents, and the Plan should be so interpreted.

(a) An individual is considered to be covered under any automobile insurance policy if he or she is either:
    1. an owner or principal named insured of the policy, or
    2. a family member of a person insured under the policy, or
    3. a person who would be eligible for medical expense benefits under an automobile insurance policy if this Plan did not exist.

(b) Coordination Under No-fault Automobile Coverage - Except as required by law, the Plan is secondary to any no-fault automobile coverage. It is not intended to reduce the level of coverage that would otherwise be available through a no-fault automobile insurance policy, nor does it intend to be

primary in order to reduce the premiums or costs of no-fault automobile coverage. If the Covered Person incurs Covered Expenses as a result of an automobile accident (either as a driver, passenger or pedestrian), the amount of Covered Expenses that the Plan will pay is limited to:

1. any Deductible under the automobile coverage; and,
2. any Copayment under the automobile coverage, and,
3. any expense properly excluded by the automobile coverage that is an Eligible Charge; and,
4. any expense that the Plan is required to pay by law.

(c) Coordination Under Financial Responsibility Law - The Plan is secondary to automobile coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile accident. If Covered Person's state has a "financial responsibility" law which does not allow the Plan to pay benefits as secondary or which does not allow the Plan to advance payments with the intent of subrogating or recovering the payment, the Plan will not pay any benefits related to an automobile accident for the Covered Person.

(d) Coordination Under Other Automobile Liability Insurance - If the Covered Person's state does not have a no-fault automobile insurance law or a "financial responsibility" law, this Plan is secondary to their automobile insurance coverage or to any other party who may be liable for the Covered Person's medical expenses resulting from the automobile accident.

DEFINITIONS

Where the following quoted terms appear in this Plan document, they shall have the meanings set forth in this Section unless the context clearly indicates to the contrary.

Accident shall mean a bodily injury sustained independently of all other causes, that is sudden, direct and unforeseen and is exact as to time and place.

Active Employee is an Employee who performs all of the duties of his or her job with the Employer on a full-time basis.

Acquired Secondary Immunodeficiency shall mean an impairment to the immune system occurring in individuals with previously normal immune systems as the result of illness.

All Benefits Plan Maximum Amount shall mean the maximum amount payable for all Covered Expenses incurred during the specific time period indicated for the maximum. The word "Lifetime" as used herein, means the duration of participation in this Plan.

All Expenses/All Other Expenses For the purposes of this Plan, "All Expenses" shall refer to all Covered Expenses except those specifically listed in the Schedule of Benefits as having unique benefit calculation, accumulation, or limits.

Ambulatory Surgical Center shall mean a facility that:

(a) an institution or facility, either free standing or as a part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures; and
(b) to which a patient is admitted to and discharged from within a twenty-four (24) hour period.

An office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an ambulatory surgical center.

Ambulatory / Outpatient Surgery means surgical treatment or service for sickness or injury provided in a physician's office, hospital outpatient department, neighborhood health center, clinic or freestanding surgical center.

Amendment shall mean a formal document that changes the provisions of the Plan Document, duly signed by the authorized person or persons as designated by the Plan Administrator.

Audiologist means a person who has received a master's or doctorate degree in audiology from an accredited college or university and is certified by the American Speech-language and Hearing Association.

Benefit shall mean the *payment* or *reimbursement* of a Covered Expense incurred by Plan Participants or eligible Dependents. The term "Benefit" includes reimbursements or payments by this Plan along with any other payments, whether made by federal or state governments or by the plan of another employer or any other insurance with which this Plan coordinates under the appropriate coordination of benefits rules.

Benefit Percentage shall mean that portion of eligible expenses to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It is the basis used to determine any out-of-pocket expenses in excess of the Calendar Year Deductible which are to be paid by the Employee.

Benefit Period shall mean the twelve-month period ending each December 31st. Such benefit period will terminate on the earliest of the following dates:

(a) The last day of the period so established; or
(b) The day the Maximum Lifetime Benefit applicable to the Covered Person becomes payable; or
(c) The day the Covered Person ceases to be covered for medical expense benefits.

Birthing Center shall mean a facility, staffed by Physicians, which is licensed as a Birthing Center in the jurisdiction where it is located.

Calendar Year shall mean January 1 through December 31st.

Certified Social Worker - Advanced Clinical Practitioner means a person certified by your state Department of Human Services as a Social Worker with the order of recognition of Advanced Clinical Practitioner.

Claim shall mean proof of loss filed by the provider of benefits or the Covered Person.

CMS shall mean the Centers for Medicare * Medicaid Services.

Coinsurance. The Covered Person's percentage share of health care costs in addition to the deductible, if any.

Copayment shall mean the fee required to be paid by a Covered Person in connection with receiving benefits for certain services, prescriptions or supplies covered by this Plan. A Copayment may be specified in the Schedule of Benefits as a fixed dollar amount. Copayments are in addition to deductibles, if any, and are not included in the calculation of out-of-pocket expenses. Providers may or may not accept a Copayment and may require the Covered Person to pay the entire fee for the services, prescriptions or supplies. The Covered Person may then submit a claim for reimbursement for the eligible expenses less any Copayments and deductibles, if applicable.

Complication of Pregnancy shall mean (1) conditions requiring hospital confinement (when the pregnancy is not voluntarily terminated) whose diagnoses are distinct from pregnancy but are adversely affected by pregnancy or are caused by pregnancy. Missed abortion and similar medical and surgical conditions of comparable severity are considered complications. False labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness, hyperemesis gravidarum, preeclampsia and similar conditions associated with the management of a difficult pregnancy do not constitute a complication of pregnancy as defined by this plan; and (2) non-elective Cesarean sections for ectopic pregnancy are also considered complications of pregnancy.

Convalescent Center shall mean Extended Care Facility.

Cosmetic Services shall mean services desired or provided for the primary purpose of altering appearance. Services are considered to be cosmetic even when there is a secondary functional improvement, if the medical condition or symptoms could have been alleviated or treated more conservatively with adequate result.

Covered Expenses shall mean the eligible expenses as defined by this document to include the terms "Charges", "Fees", and "Expenses" and will not include:

(a) the amount, if any, in excess of what is Reasonable and Customary, or
(b) any amount for service, supply or treatment not recognized in generally accepted medical practice as necessary for the diagnosis or treatment of the condition of the patient, or
(c) any amount for the unnecessary repetition of tests, as determined by the Plan.

For purposes of reimbursement under any aggregate excess loss reinsurance and specific excess loss reinsurance coverage only, and for no other purposes under this Plan, Covered Expenses shall include professional negotiation and re-pricing service fees paid by the Plan.

To identify covered expenses, the Plan may consult a professional review organization or peer review committee regarding the extent to which the service, supplies, procedures and tests are necessary for the diagnosis and treatment of the condition of the patient.

Covered Person or Covered Employee shall mean a person who is actually covered under the Plan and is thus eligible for benefits hereunder.

Custodial Care shall mean care or service designed primarily to assist a Participant in the activities of daily living which could reasonably and safely be provided by people without professional skills or training. Such activities do not include the regular services of a trained medical professional and include, but are not limited to: bathing,

feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Day Hospital Treatment Program shall mean an outpatient program or facility providing medical or behavioral health treatment and/or therapy within or on the immediate campus of a licensed and accredited hospital during the hours of treatment/therapy.

Deductible (Calendar Year) The Deductible amount is the amount of Covered Expense which must be incurred in a Calendar Year before benefits are payable for some Covered Expenses. The Calendar Year Deductible may be satisfied only once in any one calendar year for any one Covered Person. The family limit will be satisfied when the total applied to the individual calendar year Deductibles equals the family limit stated in the Schedule of Benefits.

Designated Transplant Facility shall mean a Hospital, named as such by the Plan Administrator, which has entered into an agreement with or on behalf of the Plan to render Medically Necessary and medically appropriate Covered Services and Supplies for transplants covered under this Plan.

Dentist shall mean a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

Dependent shall have the meanings set forth in IRS Code Section 152, however, for the purposes receiving medical, dental or vision benefits under this Plan, dependent shall mean:

(a) An Employee's lawful spouse, including a separated spouse. The person to whom the Employee is married, and whose marriage has been licensed, solemnized and registered in accordance with the statutory law of the jurisdiction in which the marriage occurred.
(b) In the case of a common law spouse, the Plan Administrator requires a "Declaration and Registration of Informal Marriage" issued by a county clerk in the resident county, and signed by the eligible Covered Employee and the dependent spouse attesting to the fact that a common law marriage relationship exists.
(c) An Employee’s dependent children under age nineteen (19), including legally adopted children, stepchildren, and/or other children for whom the Employee is designated by the courts to be legal guardian or under the terms of an approved Qualified Medical Child Support Order. In the event of adoption, the date the child is placed for adoption shall be the date of dependency recognized by this Plan. Placed for adoption means the assumption and retention by the Participant of a legal obligation for total or partial support of such child in anticipation of such adoption.
(d) The Employee’s children who are at least age nineteen (19) but under age twenty-six (26) regardless of employment status. However, if the Dependent is enrolled in their employer’s health coverage options, this Plan would always provide secondary coverage for benefits provided under the primary health policy.
(e) A child that met the qualifications of the previous plan and was covered by the previous plan on the effective date of this plan.

(f) The Employee's children, regardless of age, who are totally and permanently disabled prior to age twenty-six (26) years are eligible provided that such child is dependent upon the Participant for financial support and maintenance. Totally and permanently disabled means a medically determinable physical or mental condition which prevents the Dependent from engaging in self-supporting activity and which can be expected to result in death or to be of long continued or indefinite duration. If after the attainment of the age of twenty-six (26) years, whereby coverage would otherwise terminate for a Dependent child, the Plan Administrator has received due proof such child is intellectually or physically handicapped and is incapable of self-support and is dependent upon the Covered Employee for support, the child's coverage will continue in force so long as that incapacity continues, the Covered Employee continues to be covered for Dependent Coverage, and this Plan remains in full force and effect. The Plan reserves the right to request continuing proof of disability as deemed necessary. Non-compliance with such request may cause termination of Dependent child's coverage at the end of such month the request is made.

(g) A legally adopted child or child to whom the Employee has formally committed to provide full financial support and custody for the duration of the child's dependent years. Such child shall be considered to be an eligible dependent on the earliest of the following dates:
    1. the date of birth if adoption (or formal commitment to adopt) and proper enrollment occur within thirty (30) days of birth, or
    2. the actual date of the child's adoption or placement for adoption (as defined in Section 609(c)(3)(b) of ERISA) is finalized if such date is more than thirty (30) days after the child's date of birth. Enrollment must take place within thirty (30) days of such acquisition date.

(h) Other Dependent Provisions/Requirements:
    1. If enrollment does not take place within thirty (30) days of acquisition, coverage will be effective on the 1st day of the month after late entrant approval is granted as set forth in the Plan.
    2. All other standard eligibility and effective date Plan provisions shall also apply.
    3. Dependent shall not include anyone who is eligible for Coverage under the Plan as an Employee.
    4. No person may be covered as a dependent of more than one (1) Employee.
    5. The Plan also retains the right to request whatever documentation is necessary to affirm that dependents enrolled in the Plan meet the Plan's definition of Dependent.

Durable Medical Equipment is equipment which (a) can withstand repeated use, (b) is primarily and customarily used only to serve a medical and therapeutic purpose, (c) is not useful in the absence of an Illness or Injury, and (d) must be prescribed or ordered by the attending physician. All requirements of this definition must be met before an item can be considered to be durable medical equipment.

Elective Surgical Procedure and Elective Surgery shall mean a non-emergency surgical procedure which is scheduled at the Covered Person's convenience without

endangering the Patient's life or without causing serious impairment to the Patient's bodily functions.

Eligible Employee: A person who is a regular employee of the Employer, regularly scheduled to work for the Employer in an employee-employer relationship. Such a person must be scheduled to work for the Employer regularly and be in an employee classification that is eligible for benefits. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the Employee to travel, and for which he/she receives regular earnings from the Employer.

An Employee's eligibility status will be reviewed on a regular basis by the Employer to meet the regulations to verify that the hourly requirements are met for the previous measurement period. A part-time employee that does not average 30 hours per week will not be considered eligible as of the last day of the previous stability period in which the hourly requirements were not satisfied. If the hourly requirements were met in the previous measurement period, then the Employee would be allowed to enroll into the Plan for the next stability period.

Eligibility will not be affected by health status. A director of a corporate Employer shall not be deemed an Employee solely because of such directorship. An independent contractor or other such person not in an employee-employer relationship with the Employer under applicable law or government regulation shall not be deemed an Employee for the purpose of this Plan, unless otherwise specifically noted in the Plan Document. An Employer may or may not elect to include such person as an Employee in this Plan.

A consultant and Board of Director members of the Employer shall be deemed an Employee for the purpose of this Plan without any requirements as to hours per week to be scheduled or worked. Such consultants receiving coverage hereunder are limited to the individuals listed in the Plan Document.

Emergency Care shall mean professional services required to treat a condition, which, if treatment was delayed or not provided immediately, would be significantly life, limb or health threatening, or substantially increase the patient's discomfort or future disability. Emergency Care shall include care provided because it reasonably appeared that the patient's health was in danger. Emergency criteria includes but is not limited to:

(a) Severe pain, sudden onset, (e.g. chest pain, headache with neurological changes, acute severe abdominal pain),
(b) Severe hemorrhage;
(c) Respiratory distress;
(d) Accidental injuries (e.g. 2nd & 3rd degree burns, lacerations requiring suturing, fractures),
(e) Obvious severe emotional distress requiring treatment with I.M. or I.V. medications,
(f) Unconsciousness and / or convulsions,
(g) High body temperatures of an unusual or dangerous nature.

Employee shall mean Eligible Employee.

Employer shall mean Brookshire Brothers, Inc. and any subsidiaries.

Enrollment Date shall mean date of the enrollment of the individual in this ERISA Plan is the first day of the individual's "Waiting Period" for such enrollment. For late enrollments and special enrollments, the Enrollment Date is the first day of Coverage.

ERISA shall mean the Employee Retirement Income Security Act of 1974, as enacted and as it may be amended from time to time, together with its related rules and regulations. References to any Section of ERISA shall include any successor provision.

Experimental or Investigative shall mean a treatment, procedure, device or drug which the Plan Administrator, in the exercise of its discretion, determines does not constitute generally accepted medical or dental practice under the standards of a reasonably substantial, qualified, responsible and relevant segment of the medical community after taking into account the requirements for Medically Necessary care and treatment. The Plan Administrator shall make an evaluation of the experimental or investigational standing of a specific treatment, procedure, device or drug. The decision of the Plan Administrator shall be rendered following a review of the case and the proposed treatment and, in this regard, the Plan Administrator shall be guided by the following principles or such other procedures as the Plan Administrator, in its sole discretion, shall deem appropriate under the circumstances then existing:

(a) Approval of the U.S. Food and Drug Administration for marketing a drug or device has been given at the time it is furnished, if such approval is required by law; and

(b) Reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy compared with the standard means of treatment or diagnosis; and

(c) Reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device or drug is that further studies or clinical trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with the standard means of treatment or diagnosis; and

(d) Reliable evidence includes anything determined to be such by the Plan Administrator, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical or dental professional community.

If a treatment, procedure, device or drug does not meet the above criteria, it will be deemed experimental or investigational. The decision of the Plan Administrator in this regard shall be made in its discretion, in accordance with this definition, and shall be final and binding on the Covered Person and all other interested persons and entities.

Extended Care Facility or Convalescent Facility or Skilled Nursing Facility shall mean an institution or a distinct part thereof, operating pursuant to law which meets the conditions of participation for an extended care facility under Medicare, Title XVIII, of the Federal Social Security Act, as enacted and amended. This term shall also apply to an institution referring to itself as a skilled nursing facility or any other similar nomenclature. The facility must provide skilled nursing or skilled rehabilitation

services on a daily basis by appropriately licensed personnel and may not be a place for rest, the aged, drug addicts, alcoholics, the mentally incapacitated or for the care of mental health disorders. The facility may not be primarily intended for custodial care.

Family Medical Leave Act (FMLA). Applicable to employers with fifty (50) or more employees, the FMLA provides at least twelve (12) weeks of unpaid leave to eligible employees for the birth and newborn care of a child, adoption of a child, or serious illness of the employee or the employee's spouse, child, or parent. In the case of the birth or adoption of a child, the twelve (12) weeks must be taken within the twelve (12) months following the birth or adoption.

An employee is an Eligible Employee if he or she meets the following three criteria:

1. Has been employed by the employer for at least twelve (12) months (not necessarily consecutively);
2. Has worked a minimum of 1,250 hours during the last year; and
3. Has done the work at a work site that has 50 or more employees (or employs 50 or more people within the seventy-five (75) miles using surface transportation).

Family Status Change or Change in Family Status means a marriage, divorce, birth, adoption or placement of a child for adoption, death of a spouse or dependent, a dependent ceasing to meet the definition of dependent, loss of a dependent or loss of a spouse's employment or reduction in hours due to voluntary of involuntary circumstances.

General Provisions shall mean Covered Expenses other than those listed as Special Plan Provisions.

Home Health Care means services provided by a Home Health Care Agency for necessary services and supplies furnished for the sole purpose of treating a disability, in accordance with a home health care plan and takes the place of a hospital confinement. Home Health Care Agency means an organization which is licensed by the Community Health Accreditation Program (CHAP) and:

(a) is primarily engaged in providing skilled nursing and other therapeutic services for, and in the private residences of, persons recovering from a sickness or injury,
(b) has a full-time administrator,
(c) provides supervision of its services by a professional group associated with the agency or organization. The professional group must include at least one physician and one registered nurse and maintains clinical records on all of its patients, and
(d) is not, other than incidentally, engaged in providing care or treatment of the mentally ill or custodial type case.

Hospice Care shall mean a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel which includes at least one physician and one registered nurse, and it must maintain central clinical records on all patients. A hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital shall mean an accredited institution which is approved as a Hospital by the Joint Commission on the Accreditation of Health Care Organizations (JCAHO) or the American Osteopathic Association, and which meets all of the following criteria:

(a) it is primarily engaged in providing, for compensation from its patients and on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment, and care of injured and sick persons by or under the supervision of a staff of Physicians. If primarily a facility for the treatment of mental and/or nervous conditions, or substance abuse, such facility must have a bona fide arrangement by contract or otherwise with a Hospital to perform such surgical procedures as may be required;
(b) it continuously provides twenty-four (24) hours per day nursing service by registered nurses under the supervision of Physicians; and
(c) it is not, other than incidentally, a place for rest, the aged, or a nursing home, a hotel or the like.

Illness shall mean physical sickness, mental illness or functional nervous disorder, stress or adjustment reactions, or substance abuse disorder which requires treatment by a Physician. This term shall not include any condition which is related to any employment or occupation for compensation or profit.

Injury shall mean all bodily injuries sustained by an individual accidentally and independently of all other causes, by an outside traumatic event or due to exposure to the elements. Such injury must require treatment by a Physician and must not arise out of, be caused by or contributed to, or exist as a consequence of, any injury which arises out of or in the course of any employment or occupation for compensation or profit.

In Network Deductible (Calendar Year) The amount is the amount of Covered Expense which must be incurred with a Network Provider in a Calendar Year before benefits are payable for some Covered Expenses.

Inpatient shall mean a person who is a resident patient using and being charged for a room and board in a facility, but not to include any day on which such person is on leave or otherwise absent from the facility, irrespective of whether a room and board charge is made.

Intensive Care Unit shall mean that part of a hospital which is equipped and staffed to provide care for critically ill or injured patients other than that available in other standard hospital rooms or wards, such care to include constant observation by trained and qualified personnel whose duties are confined to such part of the hospital.

Late Enrollee An Eligible Employee or Eligible Dependent, covered under this Plan, who enrolled on a date other than either (a) the first date he or she could have enrolled in this Plan, or (b) during a "special enrollment period" (see HIPAA provisions for explanation of special enrollment periods).

Medical Benefits shall mean the benefits included in the Schedule of Benefits which may include but are not limited to all medically and surgically related benefits; excluding all Mental Health and Substance Use Disorder benefits.

Medically Necessary shall be, determined by the Plan Administrator in its sole discretion, any confinement, treatment, service or item that is:

(a) prescribed by a Physician or other approved health care provider;

(b) necessary and appropriate to the diagnosis;
(c) not experimental or investigational;
(d) consistent with professionally recognized national standards of quality;
(e) customarily employed nationwide for treatment, taking the Covered Person's condition into account; and
(f) not be solely for the convenience of the patient, Physician or supplier; and
(g) could not have been omitted without adversely affecting the patient's condition.

Medicaid Plan shall mean a state plan for medical assistance approved under Title XIX of the Social Security Act, as amended.

Medical Social Services shall mean services rendered, under the direction of a physician or an advanced practice registered nurse, by a qualified social worker holding a master's degree from an accredited school of social work, including, but not limited to, (a) assessment of the social, psychological and family problems related to or arising out of such covered person's illness and treatment, (b) appropriate action and utilization of community resources to assist in resolving such problems, and (c) participation in the development of the overall plan of treatment for such covered person.

Medicare shall mean the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965 as enacted and amended.

MedPAC shall mean the Medicare Payment Advisory Counsel.

Mental Health for purposes of this Plan shall mean the services for mental health conditions subject to all terms of the Plan and in accordance with applicable Federal and State laws.

Mental Illness shall mean an Illness so labeled or defined by the standards set forth by the American Psychiatric Association in the Diagnostic and Statistical Manual of Mental Disorders (DSM) and/or the International Classification of Diseases (ICD-9). Included are all neuroses, psychoneurosis, psychopathy, psychosis, mental or emotional disease, behavior disorders, or adjustment, stress or depressive reactions.

Morbid Obesity shall mean an Illness so labeled or defined by the standards set forth by the American Medical Association (AMA) whereby Medical Necessity is documented as follows:

(a) The Covered Person must be twice his/her ideal weight or greater than 100 pounds overweight.
(b) The Covered Person must suffer from a documented separate condition which is aggravated by obesity (e.g., severe diabetes mellitus, hypertension, alveolar hypoventilation, a chronic back condition, varicose veins, etc). This must be documented by objective evidence provided by the physician who is treating the claimant for the condition aggravated by obesity.

Charges for the treatment of Morbid Obesity are not covered by the Plan.

Necessary Services and Supplies shall mean any item for which a charge is made by an eligible provider for necessary medical or dental services and supplies actually administered and which are generally accepted in medical or dental practice as necessary for the diagnosis and/or treatment of the condition of the patient.

Network Provider shall mean the physician and hospital network, specified on the Vendor page of this booklet, which the Plan Administrator has contracted with for Participants to utilize for treatment.

Nominated Provider shall mean the physician or facility that is not currently a Network Provider, but an employee has made a formal request in writing to have the provider contacted to join the network. The first ninety (90) days following the original effective date of the Plan will allow any provider nominated prior to the effective date to be considered as a Network Provider (benefits would be payable at the in network percentage and Reasonable and Customary parameters will not be applicable.

Out-of-Network Provider shall mean a physician, hospital, facility, or any other medical professional who does not have a contract with the Plan Administrator.

Nurse Midwife means a person:

(a) certified to practice as a Nurse Midwife;
(b) licensed by a board of nurses as a Registered Nurse (RN); and
(c) who has completed a program for the preparation of Nurse Midwife that is approved by the state in which the person is practicing.

Occupational Therapy shall mean a program of care which focuses on the physical, cognitive and perceptual disabilities that influence the patient's ability to perform functional tasks. The therapist evaluates the patient's ability to use his fingers and hands, (fine motor skills), perceptual skills, cognitive functioning and eye-hand coordination. Therapy sessions may also involve physical movement exercises. Functional tasks also may be used. The therapist may also perform splinting of the patient's arms or hands and may provide the patient with special equipment.

Open Enrollment Period shall mean the time period during which employees can add, change or drop coverages without approved family status events. The exact time period will be announced by the Employer. An Open Enrollment period is not required by the Plan.

Out of Network Deductible (Calendar Year) The amount is the amount of Covered Expense which must be incurred with an Out-of-Network Provider in a Calendar Year before benefits are payable for some Covered Expenses.

Outpatient shall mean a person who receives medical services and treatments but is not an inpatient.

Participant shall mean an eligible Employee of the Plan Sponsor who elects to participate in the Plan. All eligible Employees who were enrolled prior to the date this Plan is adopted by each division shall be given the option to elect coverage by this Plan. Participant shall also mean any individual who is enrolled in this Plan under the Continuation of Coverage provisions of this Plan or the immediately preceding plan.

Physical Therapy shall mean a plan of care provided to return a patient to the highest level of motor functioning possible. The physical therapist extensively evaluates the patient's muscle tone, movement, balance, endurance, ability to ambulate, ability to plan motor movements, strength and coordination. If the patient requires special equipment (such as a wheelchair, walker or splint) the therapist evaluates the patient's ability to use the equipment and determines the correct size and type of equipment for

the specific patient. The therapist constructs a program of exercises and movements to maximize the patient's motor skills.

Physician/Practitioner shall mean a physician or person (**providing a treatment which is covered under this Plan)** acting within the scope of applicable state licensure/certification requirements including, but not limited to, the degree of Doctor of medicine (M.D.), Doctor of chiropractic medicine (D.C.), Doctor of dental medicine (D.M.D.), Doctor of dental surgery (D.D.S.), Doctor of optometry (O.D.), Doctor of osteopathy (D.O.), Doctor of podiatry medicine (D.P.M.), Physician Assistant (P.A.), Certified Surgical First Assistant (CSFA), Psychologist (Ph.D., Ed.D., Psy.D), Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Family Nurse Practitioner (F.N.P.), Registered Nurse Certified Specialty (R.N.C.S.), Registered Physical Therapist (R.P.T.), Registered Respiratory Therapist (R.R.T.), Occupational Therapist, Speech Therapist, Licensed Clinical Social Worker (L.C.S.W.), Licensed Professional Counselor (L.P.C.), Master of Social Work (M.S.W.), Marriage, Family, Child Counselor (M.F.C.C.).

Placement for Adoption Placement, or being placed, for adoption means the assumption and retention by the Covered Employee of the legal obligation for total or partial support of a child in anticipation of the legal adoption of the child. Once the Covered Employee no longer has this obligation, the child's placement for adoption ceases.

Plan shall mean the Plan established and maintained pursuant to this document or any predecessor documents which set forth the rights and obligations of the persons entitled to benefits under the Plan and the procedures by which Plan fiduciaries may be identified.

Plan Administrator shall mean Brookshire Brothers, Inc.

Plan Lifetime shall mean the accumulation of all periods of time during which an individual meets the Plan definition of Covered Person.

Plan Participant shall mean a person who is actually covered under the Plan and is thus eligible for benefits hereunder.

Plan Sponsor shall mean Brookshire Brothers, Inc.

Plan Year shall mean the Plan's fiscal year.

Preadmission Testing shall mean routine laboratory and x-ray tests performed in connection with a scheduled hospital confinement prior to the date the confinement commences, with such tests being considered medically valid at the time the confinement begins, provided:

(a) such tests are related to the performance of scheduled surgery;
(b) such tests have been ordered by a duly qualified physician after a condition requiring such surgery has been diagnosed and hospital admission for such surgery has been requested by the physician and confirmed by the hospital; and
(c) a Participant or Dependent is subsequently admitted to the hospital, or the confinement is canceled or postponed because a hospital bed is unavailable or because there is a change in the Participant's or Dependent's condition which precludes the surgery.

Predominant shall mean the level that applies to more than one-half of medical/surgical benefits in a particular class of benefits subject to the financial requirement or quantitative treatment limitation.

Preferred Provider Organization (PPO) means an organization that has contracted with hospitals, doctors and other providers who have agreed to provide their services under a negotiated or reduced fee arrangement. This term is equivalent of Network Provider.

Prescription Drugs shall mean:

(a) Federal Legend Drugs (which are limited to any medicinal substance the label of which is required under the Federal Food, Drug and Cosmetic Act to bear the legend "Caution: Federal Law prohibits dispensing without prescription");
(b) drugs which require a prescription under State but not under Federal Law;
(c) compound drugs which contain at least one ingredient that constitutes a Federal Legend Drug or a drug requiring a prescription under State Law; and,
(d) injectable Insulin.

Qualified Beneficiary shall mean an individual who is entitled to elect to receive continuation coverage under COBRA as a result of a loss of employer-provided group health coverage. To be eligible to elect continuation coverage, an individual must have been covered by the Plan on the day before the qualifying event occurred. In addition, only Active Employees, former employees, and spouses and dependent children of Active Employees and former employees can become qualified beneficiaries.

Qualified Medical Child Support Order means a medical child support order issued by a court of competent jurisdiction which:

(a) creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant is eligible under this Plan, and
(b) is approved by the Plan Administrator as required by the Plan.
(c) Definition of:
    1. Alternate Recipient - The term "alternate recipient" means any child of a Participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such Participant.
    2. Medical Child Support Order - The term "medical child support order" means any judgment, decree, or order (including approval of a settlement agreement) issued by a court of competent jurisdiction which:
        a. provides for child support with respect to a child of a Participant under a group health plan or provides for health benefit coverage to such a child, is made pursuant to a State domestic relations law (including a community property law), and relates to benefits under such plan,
        b. or, enforces a law relating to medical child support described in section 1908 of the Social Security Act (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan.

Qualifying Event shall mean any of the following events which result in the loss of coverage of a qualified beneficiary:

(a) Voluntary Termination of Employment;
(b) Involuntary Termination of Employment (except for gross misconduct);
(c) Reduction of Hours;
(d) Death of the Employee;
(e) Employee's Medicare Entitlement;
(f) Divorce or Legal Separation;
(g) A Dependent Child ceasing to be a Dependent; or
(h) The bankruptcy of the Employer.

Reasonable and Customary shall mean charges for medical services or supplies essential to the care of the individual and the lesser of the:

(a) actual charges for such services and/or supplies; or
(b) For facility claims, 140% of the CMS/MedPAC rate, excluding any outliers either contractual or through Medicare allowable calculations, under the Acute Inpatient Prospective Payment System ("IPPS") or the Hospital Outpatient Prospective Payment System ("OPPS") applicable as of the date such services and/or supplies were rendered; or
(c) For physician and ancillary claims, 110% of the CMS/MedPAC rate, excluding any outliers either contractual or through Medicare allowable calculations, under the Acute Inpatient Prospective Payment System ("IPPS") or the Hospital Outpatient Prospective Payment System ("OPPS") applicable as of the date such services and/or supplies were rendered; or
(d) amount normally charged and accepted as payment by the provider for similar services and supplies not to exceed the amount ordinarily charged and accepted as payment by most providers for comparable services and supplies in the locality where the services or supplies are received.

The Plan Administrator has the discretionary authority to decide whether a charge is Reasonable and Customary.

Notwithstanding the foregoing, to the extent the Plan has entered into a direct contract with a Provider, the terms of such contract shall control the determination of Reasonable and Customary.

Rehabilitation Facility shall mean a legally operating institution or distinct part of an institution which has a transfer agreement with one or more Hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute Hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services. It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental disorders or tuberculosis except if such facility is licensed, certified or approved as a Rehabilitation Facility for the treatment of medical conditions in the jurisdiction where it is located, or is accredited as such a facility by the Commission for the Accreditation on Rehabilitation Facilities (CARF) or the Joint Commission on the Accreditation of Health Care Organizations (JCAHCO).

Registered Graduate Nurse shall mean a professional nurse who has the right to use the Title "Registered Nurse" and the abbreviation "R.N." and who is licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Semi-Private Room shall mean the actual semi-private rate charged by the Hospital for such accommodations. In the absence of semi-private rooms this shall mean eighty percent (80%) of the lowest priced private room of such hospital.

Skilled Nursing Facility shall mean an Extended Care Facility.

Social Worker is described under the definition of Physician/Practitioner.

Specialty Drugs means high-cost prescription drugs used to treat complex, chronic conditions like cancer, arthritis, and multiple sclerosis. Often require special handling.

Speech-language Pathologist means a person who has received a master's or doctorate degree in speech-language pathology from an accredited college or university and is certified by the American Speech-language and Hearing Association to restore speech loss or correct a speech impairment.

Speech Therapy and Pathology shall mean a program of care which evaluates the patient's motor-speech skills, expressive and receptive language skills, writing and reading skills, and determines if the patient requires an extensive hearing evaluation by an audiologist. The therapist also evaluates the patient's cognitive functioning, as well as his social interaction skills such as the ability to maintain eye contact and initiate conversation. Therapy may also involve developing the patient's speech, listening and conversational skills, and higher-level cognitive skills such as understanding abstract thought, making decisions, sequencing etc. Therapy may be recommended for patients without apparent speech problems, but who do have deficits in higher-level language functioning as a result of trauma or identifiable organic disease process.

Substance Abuse shall be considered an Illness and shall mean the excessive use of alcohol and/or drugs that results in physiological or psychological dependency upon such substance, as defined by the standards set forth by the American Psychiatric Association (DSM) and the US Department of Health and Human Services (ICD). Dependence upon tobacco, nicotine and caffeine are not included in this definition.

Substance Use Disorder for purposes of this Plan shall mean the services for conditions relating to the use or abuse of substances which may or may not be illegally obtained subject to all terms of the Plan and in accordance with applicable Federal and State laws.

Substantially All will be defined as applying to at least two-thirds of all medical/surgical benefits in a particular class of benefits.

Third Party Administrator: The person/organization providing consulting and administrative services to the Employer in connection with the operation of the Plan and performing such routine and non-discretionary functions, including administering the processing and payment of claims, as may be delegated to it.

Totally Disabled and Total Disability under this Plan means:

(a) for a Covered Employee, unless otherwise specifically defined, a disability resulting solely from an Illness or accidental bodily Injury which prevents an Employee from engaging in the occupation or employment for compensation or profit which the Employee performed prior to the commencement of such disability, or

(b) for any covered Dependent, COBRA beneficiary, or Eligible Retiree, any confinement or disability resulting solely from an Illness or Injury which prevents such person from engaging in any of the normal occupational, domestic or social activities of a person of like age or gender in good health. A Dependent, COBRA beneficiary, or Eligible Retiree, whose social activities or activities of daily living are restricted but who is otherwise in good health shall not be considered to be Totally Disabled unless such Dependent, COBRA beneficiary, or Eligible Retiree, is confined to a facility.

Waiting Period shall mean the period of time during which an employee must be in continuous full-time service in an eligible class before becoming covered under this Plan. Any required waiting period is not applicable for any employee classified as a monthly employee.

The Women's Health and Cancer Rights Act of 1998 ("WHCRA) is a federal legislation that states "under WHCRA, group health plans, insurance companies, and health maintenance organizations (HMSs) offering mastectomy coverage, must also provide coverage for certain services related to the mastectomy in a manner determined in consultation with the attending physician and the patient. Required coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, protheses and treatment of physical compilations of the mastectomy, including lymphedema." **WHCRA does not require coverage for additional surgery to revise or improve the result of the breast reconstruction and/or replace implants. Refer to the Covered Expenses of this Plan for guidelines as to coverage.**

Year means a Calendar Year (January 1 through December 31).

You and Your refers to You and means the Covered Employee.

RIGHTS OF COVERED EMPLOYEES

As a Participant in your Employer's Health Benefits Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

1. Examine, without charge, at the Plan Administrator's Office all Plan documents, including insurance contracts, bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of Labor, such as annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report (if applicable). The Plan Administrator is required by law to furnish each Participant with a copy of this summary financial report.
4. File suit in a federal court, if any materials requested are not received within thirty-one (31) days of the Participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to $100 for each day's delay until the materials are received.

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Health Benefits Plan. These persons are referred to as "fiduciaries" in the law. Fiduciaries must act solely in the interest of the Plan Participants, and they must exercise prudence in the performance of their Plan duties. Fiduciaries who violate ERISA may be removed and required to make good any losses they have caused the Plan.

Your Employer may not fire you or discriminate against you to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan Administrator review and reconsider your claim. If you are improperly denied a benefit in full or in part, you have a right to file suit in a federal or state court. If Plan fiduciaries are misusing the Plan's money, you have a right to file suit in a federal court or request assistance from the U.S. Department of Labor. If you are successful in your lawsuit, the court may, if it so decides, require the other party to pay your legal costs, including attorneys' fees. If you lose, the court may order you to pay the other side's legal costs, including attorney's fees, for example, if it finds your claim is frivolous.

If you have any questions about this statement of your rights under ERISA, you should contact the nearest office of the Pension & Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Pension & Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

Genetic Information Nondiscrimination Act of 2008 (GINA) Not withstanding anything in the Plan to the contrary, the Plan will comply with the Genetic Information

Nondiscrimination Act of 2008 and the mandates of the Act's implementing regulations.

Health Information Technology for Economic and Clinical Health Act (HITECH)

The Plan recognizes the requirements of HITECH and will conform to all federal requirements from this Act. Participation in this Plan is an agreement to allow all requirements of the Act to be performed by the Plan for any and all claim and medical history obtained during your enrollment period. The Plan will comply with standardized electronic reporting methods which could include trading of medical information with your providers or other required parties through electronic means.

The Plan and 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 Plan or Employer creates, maintains or transmits. 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. In order to maintain your privacy and security for your claim and medical data, the Plan will do the following:

a.) Establish a federal breach notification requirement for health information that is not encrypted or otherwise made indecipherable;

b.) Provide proper notification of such breach to the Plan Participant as described below;

c.) 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 and to immediately notify the Plan of any breach of confidentiality with regard to such information;

d.) Provide transparency to patients by allowing them to request an audit trail showing all disclosures of their health information made through an electronic record;

e.) The Plan and Employer agree to not solicit or receive any remuneration in exchange for a Covered Employee's protected health information unless expressly authorized by the Covered Employee or permitted by HITECH Act or its accompanying regulations. The Plan and Employer also agree to not utilize the protected health information in marketing efforts unless such communications are explicitly permitted by the Security Standards.

Notification in the event of a breach of protected health information

In the event of a breach of protected health information, the Plan shall notify the Plan Participant whose unsecured information has been, or is reasonably believed by the Plan or Employer to have been accessed, acquired or disclosed as a result of such breach and the Plan and Employer reasonably believes that such breach poses a significant risk of financial, reputational, or other harm. All notification required under this paragraph shall be made without unreasonable delay and in no case later than sixty (60) calendar days after the discovery of the breach. Notice under this paragraph shall be provided in the following form: (1) written notification by first-class mail to the

Covered Employee or Dependent (or next of kin if the Covered Employee is deceased) at the last known address of the Covered Employee or the next of kin, respectively; (2) in the case in which there is insufficient, or out of date contact information that precludes direct written notification, a substitute form of notice shall be provided, including in the case that there are ten (10) or more Covered Employees involved in the breach of information, then a conspicuous posting for a period determined by the Department of Health and Human Services on the home page of the website of the Employer or notice in major print or broadcast media, including major media in geographic areas where the Covered Employees affected by the breach will likely reside. Such a notice in media or web posting will include a toll-free telephone number to learn whether or not the Covered Employee information is possibly included in the breach; (3) in any case deemed by the Plan or Employer to require urgency because of possible imminent misuse of unsecured protected health information, notification may be provided by telephone, or other means, as appropriate, including e-mail notifications. The Plan shall also provide notice to prominent media outlets following the discovery of a breach involving unsecured information of more than 500 Covered Employees.

Regardless of the method by which notice is provided to the Covered Employee, the notice shall include, to the extent possible, the following information:

a) a brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known;

b) a description of the types of unsecured information involved in the breach (such as full name, Social Security number, date of birth, home address, account numbers, or disability codes);

c) the steps the Covered Employee should take to protect themselves from potential harm resulting from the breach;

d) a brief description of what the Plan and Employer is doing to investigate the breach, to mitigate the losses, and to protect against any further breaches;

e) contact procedures for the Covered Employee to ask questions or learn additional information which shall include toll free telephone number, an e-mail address, web site, or postal address;

f) provide notice to the Secretary of the Department of Health and Human Services.

CLAIMS FILING PROCEDURES

You should complete claim forms for the Plan which are available at your place of employment. The claim form submitted must include a HCFA 1500 or UB-04 claim form obtained from the Provider, which complies with the Plan's reasonable procedure for filing Claims and making benefit Claims' determinations.

To expedite Claims payment, be sure the bills submitted include all of the following:

1. Employee's name, social security number and date of birth.
2. If Claim is made for a Dependent, Dependent's name, SSN, date of birth, and Dependent's employer.
3. Employer's name: Brookshire Brothers, Inc.
4. Physician or Hospital's name, tax identification number, National Provider Identifier (NPI) and address.
5. Place if service and date if service.
6. Physician's diagnosis.
7. Itemization of charges which should include ICD 10 modifiers as appropriate, charge amount, service quantity, DPT code for professional claims, DRG code, CPT code and Revenue Code for facility claims.
8. Date of occurrence of the Injury or Illness.
9. Other insurance providers.

These items are REQUIRED in order to accurately pay claims. Certain claims may require additional information before being processed.

Mail all claims to: Nexcaliber
Attention: Claims Department
Post Office Box 802422
Dallas, TX 75380

Third Party Administrator The Third Party Administrator is responsible for receiving claims from Plan Participants, making reasonable efforts to verify the validity and accuracy of claims, determining the amount payable in accordance with the Plan, causing payments to be made to Plan Participants or other eligible payees as instructed by the Plan Participant, and keeping the necessary records and correspondence related to these activities. The Plan Administrator may contract with outside parties to provide these services.

Claims Review and Appeal Procedures

The following is a description of how the Plan processes Claims for benefits and reviews the Appeal of any Adverse Benefit Determination received. The terms used in this section are defined below. Any defined term used in this section that is not defined below shall have the meaning set forth in the Definition section of the Plan document.

"Adverse Benefit Determination" is defined as a denial of a Claim, in whole or in part, a reduction in or termination of benefits, or a failure to provide payment for a benefit, and any rescission of coverage (cancellation or discontinuance of coverage that has a retroactive effect whether or not the rescission has an adverse effect on any particular benefit at that time).
"Appeal" is defined as a Claimant's right to request a review of an Adverse Benefit Determination, in accordance with the Appeal Procedures outlined in the Plan.

"Authorized Representative" is defined as the individual a Claimant has appointed to act on their behalf with respect to a Claim or Appeal of an Adverse Benefit Determination by completing, executing and submitting the Authorization Form to the Plan Administrator or Third Party Administrator. For an appointment of an Authorized Representative to be valid, the Plan's Authorization Form, which can be obtained from the Plan Administrator or Third-Party Administrator, free of charge, upon request, must be utilized. An appointment of an Authorized Representative cannot be irrevocable. The Plan has the right to disregard appointments that are determined to be defective, fraudulent or otherwise invalid. The Plan cannot disclose a Claimant's protected health information (PHI) to the Authorized Representative unless the Claimant also completes, executes and submits the Authorization to Disclose Protected Health Information Form ("PHI Authorization Form") to the Plan Administrator or Third Party Administrator.

"Claim" is defined as any request for a Plan benefit, made by a Claimant using HCFA 1500 or UB-04 claim form obtained from the provider, which complies with the Plan´s reasonable procedure for filing Claims and making benefit Claims determinations. A Claim does not include a request for determination of an individual´s eligibility to participate in the Plan.

"Claimant" is defined as a Covered Person, or an Authorized Representative of a Covered Person, that asserts a Claim.

"Claims Reviewer" is defined as an appropriate named fiduciary of the Plan, or a person(s) designated by a named fiduciary to carry out fiduciary responsibilities under the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of such individual.

"Concurrent Care Claim" is defined as any Claim that occurs when the Plan approves an ongoing course of treatment for a fixed period of time or a fixed number of treatments, and (i) reconsideration results in a reduction or termination of treatment; or (ii) an extension is requested beyond the initially approved time or number of treatments.

"External Review" is defined as the Claimant's right to request a review by an Independent Review Organization in accordance with the External Review Procedures outlined in the Plan, in the event the Claimant receives notice of an Adverse Benefit Determination, including a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal Procedures properly.

"Final Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the Plan Claim at the end of the Appeal Procedures outlined in the Plan.

"Independent Review Organization" is defined as an entity that is (i) accredited by URAC or by a similar nationally-recognized accrediting organization to conduct an External Review; (ii) is not biased and is independent; (iii) not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits; and (iv) may not impose any costs, including filing fees, on the Claimant requesting the External Review.

"PHI Authorization Form" is defined as a Claimant's authorization to release the Claimant's protected health information (PHI) to a duly appointed Authorized Representative. A PHI Authorization Form can be obtained from the Plan Administrator or Third-Party Administrator, free of charge, upon request.

"*Post-Service Claim"* is defined as any Claim that is filed for payment of benefits after care has been received and that is not a Pre-Service Claim.

"*Pre-Service Claim"* is defined as any Claim that requires approval in advance of receiving medical care.

"Relevant Information" is defined as any document, record or other information which (i) was relied upon in making the benefit determination; (ii) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; (iii) demonstrates compliance with the administrative processes and safeguards required by federal law in making the benefit determination; or (iv) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the Claimant's diagnosis without regard to whether such advice or statement was relied upon in making the benefit determination.

"*Urgent Care Claim"* is defined as 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 (i) could seriously jeopardize the life or health of the Claimant or the ability of the Claimant to regain maximum function; or (ii) in the opinion of a physician with knowledge of the Claimant's medical condition, 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. The Urgent Care Claim rules do not apply to Claims involving urgent care where Plan benefits are not conditioned upon prior approval. These Claims are subject to the rules on Post-Service Claims described herein.

A Physician with knowledge of the Claimant's medical condition may determine if a Claim is one involving urgent care and the Plan shall defer to such determination. 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.

Initial Benefit Determination

A Claimant may make a Claim under the Plan by filing a written Claim, identified as a Claim, with the Third-Party Administrator.

There are different types of Claims as defined in the Plan, and each one has a specific timetable for each step in the review process.

Upon receipt of the Claim, the Third-Party Administrator must decide whether to approve or deny the Claim, in whole or in part. The Third-Party Administrator´s notification to the Claimant of its decision must be made as shown in the timetable. However, if the Claim has not been properly filed, or if it is incomplete, or if there are other matters beyond the control of the Third Party 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 Third-Party Administrator needs more information from the Claimant, the Claimant must provide the requested information within the time shown on the timetable. Once the Claim is complete, the Third-Party Administrator must make its decision as shown in the timetable.

The period of time within which a benefit determination is required to be made shall begin at the time a Claim is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a benefit determination accompanies the filing.

In the event a period of time is extended due to a Claimant's failure to submit information necessary to decide a Claim, the period for making the benefit determination is tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

IN NO EVENT WILL A CLAIM SUBMITTED TWELVE (12) MONTHS AFTER THE DATE OF RECEIVING MEDICAL, DENTAL OR VISION CARE BE CONSIDERED AN ELIGIBLE EXPENSE.

Adverse Benefit Determination

The Third-Party Administrator will provide written or electronic notification of any Adverse Benefit Determination. Adverse Benefit Determination of Urgent Care Claims may be oral, followed by written or electronic notification within three (3) days of the oral notification. The notice will set forth:

1. Information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare provider, and the amount of the Claim, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, which will be provided as soon as practical after such request).

2. The specific reason or reasons for the Adverse Benefit Determination, including the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used to deny the claim.

3. Reference to the specific Plan provisions on which the determination was based.

4. 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.

5. A description of the Plan's Appeal Procedures (both Internal Appeal Procedures and External Review), 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.

6. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion; either the specific rule, guideline, protocol, or similar criterion; or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request.

7. If the Adverse Benefit Determination is based on the Medical Necessity or treatment that is Experimental or Investigative 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.

8. If the Adverse Benefit Determination involves an Urgent Care Claim, a description of the expedited review process applicable to such claim.

9. 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 Appeals Procedures or External Review**.**

If you receive notification of an Adverse Benefit Determination, the Claimant shall have a reasonable opportunity to Appeal if done in accordance with the timelines and procedures outlined in the Plan, and which there will be a full and fair review of the Claim and the Adverse Benefit Determination.

Notification Timelines

You will receive written notification from the Third-Party Administrator of a benefit determination (adverse or not), within a reasonable period of time after receipt of the Claim, but not later than the following:

Type of Claim	Time Limit for Adverse Benefit Determination	Extension Permitted
Urgent Care Claims	As soon as possible, not later than 72 hours	None
Pre-Service Claims	15 days	15 days
Post Service Claims	30 days	15 days
Concurrent Care Claims	Prior to termination of care (if sufficient notice)	None

If the Third-Party Administrator needs more information to make a determination on the Claim, the Claimant will be notified within a reasonable period of time and the notice will describe the required information. Notification may be oral unless written notification is requested by the Claimant.

Type of Claim	Notification to Claimant of Additional Information Required	Claimant Must Provide Additional Information	Time Limit for Adverse Benefit Determination
Urgent Care Claims	Within 24 hours of Claim filing	Within 48 hours from receipt of notice	No later than 48 hours after the earlier of: (i) Plan's receipt of specified information or (ii) 48 hours from Claimants receipt of notice
Pre-Service Claims	Within 5 days of Claim filing	Within 45 days from receipt of notice	10 days from receipt of specified information*
Post Service Claims	Prior to 30 days of Claim filing	Within 45 days from receipt of notice	No more than 30 days from receipt of specified information*

*Taking into consideration the tolling of the time period (Refer to tolling provision under Initial Benefit Determination section)

Appeal Procedures

Internal Appeals Procedure -One Level of Appeal

If the Claimant receives an Adverse Benefit Determination, the Claimant may submit an Appeal, in writing, to the Third Party Administrator, requesting reconsideration of the Claim, provide an explanation as to why the Claim should have been processed differently and provide any additional material or information necessary to support the Claim. The Appeal must be received by the Third-Party Administrator within the following timeframes:

Type of Claim	Appeal Notification	Time Limit for Appeal
Urgent Care Claims	Request expedited appeal process, either orally or in writing	180 days following receipt of Adverse Benefit Determination
Pre-Service Claims	Written appeal	180 days following receipt of Adverse Benefit Determination
Post Service Claims	Written appeal	180 days following receipt of Adverse Benefit Determination
Concurrent Care Claims	Written appeal	180 days following receipt of Adverse Benefit Determination

Determination on Appeal

The Claims Reviewer will respond to Appeals within a reasonable period of time, but not later than the following.

Type of Claim	Time Limit for Appeal Denial	Extension Permitted
Urgent Care Claims	As soon as possible, not later than 72 hours	None
Pre-Service Claims	15 days	None
Post Service Claims	60 days	None
Concurrent Care Claims	Prior to termination of care (if sufficient notice)	None

Review Procedures on Appeal

The Review Procedures are intended to provide a full and fair review of the Claim on Appeal. In the conduct of any review, the following will apply:

1. No deference will be afforded to the initial Adverse Benefit Determination.

2. The review will be conducted by the Claims Reviewer.

3. In deciding an appeal that is based in whole or in part on a medical judgment, including determination with regard to whether a particular treatment, drug, or other item is Experimental or Investigative or not Medically Necessary or appropriate, the Claims Reviewer shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

4. Any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination will be identified, without regard to whether the advice was relied upon in making the determination.

5. Any health care professional consulted in making a medical judgment shall be an individual who was neither consulted with in connection with the Adverse Benefit Determination that is the subject of the Appeal, nor the subordinate of any such individual.

6. In the case of a claim involving an Urgent Care Claim, an expedited review process will be available pursuant to which (i) a request for an expedited appeal may be submitted orally or in writing by the Claimant, and (ii) all necessary information, including the Plan's determination on review, shall be submitted between the Plan and the Claimant by telephone, facsimile or other available similarly expeditious method.

7. The Claimant will be provided with any new or additional evidence considered, relied upon, or generated by the Plan in connection with the Claim, as well as any new or additional rationale for denial. The Claimant will have a reasonable opportunity to respond to such new evidence or rationale.

Notice of Benefit Determination on Appeal

The Claims Reviewer will provide written or electronic notification of any determination on appeal within the time period shown on the timetable. If such determination is an Adverse Benefit Determination, the notification will include:

1. Information sufficient to allow the Claimant to identify the Claim involved (including date of service, the healthcare provider, and the amount of the Claim, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, which will be provided as soon as practical after such request).

2. The specific reason or reasons for the Adverse Benefit Determination including a discussion of the decision.

3. Reference to the specific Plan provisions on which the determination was based.

4. If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion; either the specific rule, guideline, protocol, or similar criterion; or a statement that such a rule, guideline, protocol, or similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request.

5. A statement that the individual is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other Relevant Information.

6. A description of the Plan's External Review Procedures, incorporating any voluntary appeal procedures offered by the Plan. This will include a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following a Final Adverse Benefit Determination.

7. 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 Appeals or External Review Procedure**.**

General Claim and Appeals Procedures

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.

The time periods shown on the timetables 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 timetable herein. Unless otherwise noted "days" means calendar days.

The Claimant must follow all Claims and Appeals Procedures both internal and external before he or she can file a lawsuit. However, this rule may not apply if the Third-Party Administrator has not complied with the procedures described in this Section. **If a lawsuit is brought, it must be filed within one year after the final determination of an Appeal. Any lawsuit must be filed in the federal district court in which the Plan is administered.**

Any of the authority and responsibilities of the Third-Party Administrator or Claims Reviewer under the Claims and Appeals Procedures or the External Review, 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 Third-Party Administrator.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an 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.

External Review Procedures

If a Claimant receives an Adverse Benefit Determination (including 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 Procedures.

An External Review is available only where the Adverse Benefit Determination or Final Adverse Benefit Determination is denied on the basis of (i) 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); (ii) a determination that a treatment is Experimental or Investigative; or (iii) a rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time). The request for External Review must be filed in writing within four (4) months after receipt of the Adverse Benefit Determination or Final Adverse Benefit Determination.

The Third-Party Administrator, within five (5) business days following the date of receipt of the External Review request, shall complete a preliminary review of the request to determine whether the Claim is eligible for External Review. This determination is based on the criteria described above and whether:

1. The Claimant is or was covered under the Plan at the time the Claim was made or incurred;

2. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to the Claimant's failure to meet the Plan's eligibility requirements;

3. The Claimant has exhausted the Plan's internal Claims and Appeal Procedures; and

4. The Claimant has provided all the information required to process an External Review.

Within one (1) business day after completion of this preliminary review, the Third Party Administrator shall 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 Third Party 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 the request. The Claimant will have forty-eight (48) hours following the receipt of the notification or until the last day of the four (4) month filing period, whichever is later, to submit the additional information.

If the request is eligible for External Review, the Plan will assign it to one (1) of three (3) qualified Independent Review Organization's ("IRO"). Within five (5) business days after the date of assignment to the IRO, the Plan must provide the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final Adverse Benefit Determination.

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 ten (10) business days from receipt of the notice, additional information the IRO must consider when conducting the review. The IRO must share with the Plan any additional information submitted by the Claimant within one (1) business day of receipt. The Plan may consider this information and decide to reverse its denial of the Claim. One (1) business day after making such decision, the Plan must provide written notice to the Clamant and the assigned IRO. If the denial is reversed, the IRO will terminate the External Review.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of a *de novo* review of all of the information in the record, as well as additional information timely submitted by the Claimant, 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 forty-five (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 (including date of service, the healthcare provider, and the amount of the Claim, if applicable, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, which will be provided as soon as practical after such request and the reason for the Plan's denial);

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, including the rationale for its decision and any evidence-based standards that were relied on in making its 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 PHS Act section 2793

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7. Upon receipt of a notice of a External Review decision reversing the Adverse Benefit Determination or Final Adverse Benefit Determination, the Plan shall immediately provide coverage or payment for the Claim.

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 seventy-two (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 forty-eight (48) hours to both the Claimant and the Plan.

GENERAL PROVISIONS

Entire Plan. This document, and any amendments thereto, constitute the entire plan of coverage under this Plan between the Plan Administrator and the Covered Persons. The Plan Administrator shall have the right to alter or waive the normal provisions of This Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of patient care. Decisions will be made with the understanding and agreement of the affected Participant. Alternative care will be determined on the merits of each individual case and any care or treatment provided will not be considered as setting any precedent or creating any future liability, with respect to that Covered Person or any other Covered Person.

Plan Description. The Plan Administrator shall provide to Employees who are Covered Persons a copy of this booklet containing the benefits of this Plan and the rights and obligations of Covered Persons under this Plan.

Effect of Changes. All changes to this Plan shall become effective as of a date established by the Plan Administrator, EXCEPT that:

1. No increase or reduction in benefits shall be effective with respect to Covered Expenses incurred prior to the date a change was adopted by the Plan Administrator, regardless of the effective date of the change; and
2. No change shall become effective with respect to any Covered Person who was disabled on the effective date of such change until the date such person ceases to be disabled.

Termination of the Plan. The Plan Administrator may terminate this Plan at any time by providing written notice to the Covered Employees. Such termination will become effective on the date set forth in such notice.

Written Notice. Any written notice required under this Plan shall be deemed "received" by a Covered Employee if sent by regular mail, postage prepaid, to the last address of such Covered Employee on the records of the Plan Administrator.

Law. This Plan is governed by ERISA. Any provision of this Plan which is in conflict with the law of any governmental body or agency which has jurisdiction over this Plan, shall be interpreted to conform to the minimum requirements of such law.

Waiver. The failure of the Plan Administrator to strictly enforce any provision of this Plan shall not be construed as a waiver of the provision. Rather, the Plan Administrator reserves the right to strictly enforce each and every provision of this Plan at any time regardless of the prior conduct of the Plan Administrator and regardless of the similarity of the circumstances or the number of prior occurrences.

Clerical Error/Delay. Clerical errors made on the records of the Plan Administrator and delays in making entries on such records shall not invalidate coverage or cause coverage to be in force or to continue in force which would otherwise not exist. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Gender. The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise.

Headings. The headings used in this Plan are for the purposes of convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading. In all cases, the full text of the Plan will be in control.

Free Choice of Physician. Any Employee or Dependent covered hereunder will have free choice of his Physician.

STATEMENTS

Not Warranties. Statements made by or on behalf of any person to obtain coverage under this Plan shall be deemed representations and not warranties.

Misstatements on Application. If any relevant fact has been misstated by or on behalf of any person to obtain coverage under this Plan, the true facts shall be used to determine whether coverage is in force and the extent, if any, of such coverage. Upon the discovery of any such misstatement, an equitable adjustment of any contributions will be made.

Time Limit for Misstatement. No misstatement made to obtain coverage under this Plan shall be used to void the coverage of any person which has been in force for a period of two (2) years or to deny a claim for a loss incurred or disability commencing after the expiration of such two (2) year period. The provisions of this paragraph shall not apply if any such misstatement has been made fraudulently.

Use of Statements. No statement made by or on behalf of any person shall be used in any context unless a copy of the written instrument containing such statement has been or is furnished to such person or to any person claiming a right to receive benefits with respect to such person.

NOTES

SIGNATURE PAGE

IN WITNESS WHEREOF, Brookshire Brothers, Inc., as Plan Administrator, has executed this Plan on this the ____ day of May, 2023, to be effective as of May 1, 2023.

BROOKSHIRE BROTHERS, INC.

X
By: _____
Name (Print): ERIN PARKER
Title: Vice President of Human Resources

Affordable Act Coverage

United States Preventive Task Force (USPSTF) guidelines for preventive services, which most insurance companies use as procedures to cover under the Affordable Act.

Abdominal Aortic Aneurysm Screening: (USPSTF)
One time screenig for abdominal aortic aneurysm (AAA) by ultrasonography in men aged 65 to 75 who have ever smoked. Women included.

Anemia, Iron Dificiency Anemia Screening: (USPSTF)

Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 week's gestation or at the first prenatal visit.

Autism screening:
For children at 18 and 24 months.

Breast Feeding Support:
Breastfeeding support, supplies, and counseling: Comprehensive lactation support and counseling, from a trained provider, during pregnancy and/or in the postpartum period, and costs for renting or purchase breastfeeding equipment.

Chlamydia Infection Screen: (USPSTF)
Cover as part of a wellness office visit.

Depression Screening for adolscents:
Ages 12-18

Dietary Nutrition:
Affordable act covers intensive behavioral dietary counseling for adult patients with hyperlipidemia and other know factors for cardiovascular and diet-related chronic disease. Nutritionist and dietitians are covered. Includes but not limited to Diabetes, Obesity, Heart disease, Kidney failure and high risk pregnancy. Procedure code 97802

Gonorrhea Screening: (USPSTF)
Cover as part of a wellness office visit.

Hepatitis B Virus Infection Screening: (USPSTF)
Screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.

HIV- Human Immunodeficiency Virus Screening for Adolescents and Adults: (USPSTF)
HIV all adolescents and adults at increased risk for HIV infection. Screen all pregnant women.
We consider this as part of any routine wellness visit.

RH Incompatibility Screening: (USPSTF)
Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care. Repeat Rh (D) for all unsensitized Rh (D) negative women at 24-28 weeks gestation .

Syphilis Screen: (USPSTF)
Screen persons at increased risk for syphilis infection. Screen all pregnant women for syphilis infection.
We consider this as part of any routine wellness visit.

Genetic Counseling and Evaluation for BRCA Testing: (USPSTF)
Women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes be referred for genetic counseling and evaluation for BRCA testing.

Diabetes Screening: (USPSTF)
Screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or Untreated) greater than 135/80 mm Hg.
We cover this as part of any routine wellness visit or first prenatal visit. (part of Expanded Women's Preventive Care)

Rubella Screening: (USPSTF)
B Screening for rubella susceptibility by history of vaccination or by serology is recommended for all Women of childbearing age .

Screening Mammography: (USPSTF)
With or without clinical breast examination (CBE), every 1-2 years for women aged 40 and older.
We use age 35 or older, unless personal or family history of breast cancer.

Cervical Cancer Screening, Pap Smear: (USPSTF)
Screening for cervical cancer in women ages 21 to 65 years with cytology (Pap smear) every 3 years
Or, for women ages 30 to 65 years who want to lengthen the screening interval, screening with
Combination of cytology and human papillomavirus (HPV) testing every 5 years.
We consider one per calendar year with a wellness visit.

Cholesterol Screening (Lipid Disorders Screening): (USPSTF)
Screening men aged 35 and older for lipid disorders. Screening men aged 20 to 35 for lipid disorders
If they are at increased risk for coronary heart disease.

Contraception Coverage under the Affordable Care Act (women only)
Required coverage: Sterilization, contraception requiring a prescription.
Not covered: Condoms and spermicidal agents.
If in-patient for delivery and a tubal ligation is done, related service for the tubal is considered at 100%.

Screening Women at increased Risk: (USPSTF)
Screening women aged 45 and older for lipid disorders if they are at increased risk for coronary heart disease . Screening women aged 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease. We consider this as part of a routine wellness visit.

Colorectal Cancer Screening: (USPSTF)
Fecal Occult Blood Testing Sigmoidoscopy or Colonoscopy.
Screening for colorectal cancer using fecal occult blood testing, sigmoidoscopy, or colonoscopy,in adults, beginning at age 50 years and continuing until age 75 years.

Computed Tomographic Colonography (Virtual Colonoscopy): (USPSTF)
The USPSTF concludes that the evidence is insufficient to assess the benefits and harms of Computed Tomographic Colongraphy as a screening modality for colorectal cancer.
United Healthcare covers this as a preventive service. (will have to look into this before we decide we will cover.)

Folic Acid supplements:
For women who may become pregnant.

Gestational Diabetes Screening:
Under the law, gestational diabetes screening is required for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
We cover gestational diabetes screening for all pregnant women.

Wellness Examinations (well baby, well child, well adult) (USPSTF)
This also includes: Breastfeeding support and counseling
Contraceptive methods counseling
Domestic violence screening
Annual HIV counseling
Sexually Transmitted infections counseling
Well-woman visits.

Immunizations:
We use CDC's recommendation immunization schedule. Attached is copy.

Newborn Screenings: (USPSTF)
Hearing Screening for hearing loss in all newborn infants. Hypothyroidism Screening, screening for congenital hypothyroidism in newborns. Phenylketonuria Screening for phyenylketonuria (PKU) in newborns. Sickle Cell screening-screening for sickle cell disease newborn.

Obesity screening and counseling: (USPSTF)
The USPSTF recommends screening all adults for obesity. Clinicians should offer or refer patients with a body mass index of 30 kg/m^2 or higher to intensive, multicomponent behavioral interventions.
Children age 6 years and older for obesity and offer them or refer them to comprehensive, intensive behavioral interventions to promote improvement in weight status.
Covered: Medical Nutrition :Therapy 970802,97803,97804
Preventive Medicine Individual Counseling : 99401,99402,99403
Behavioral Counseling Therapy: G0446,G0447

Osteoporosis Screening: (USPSTF)
Screening for osteoporosis in women age 65 and older, and in younger women whose fracture risk is greater than a 65 year old woman.
We use age 50 or older.

Prenatal services: Include routine prenatal obstetrical office visits, all lab services explicitly immunizations. Screening for asymptomatic bacteriuria with urine culture for pregnant women at 12 to 16 week's gestation or at the first prenatal visit.
Prenatal services **not covered under the women's preventive coverage include,** but are not limited to, radiology (i.e., obstetrical ultrasounds), delivery and high-risk prenatal services. **Postnatal care is not covered without cost-share under the health reform act.**

Prostate Cancer Screen: (USPSTF)
USPSTF recommends testing men age 75 and older.
We consider men ages 50 and older.

Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse:(USPSTF)
Screening and behavioral counseling interventions to reduce alcohol misuse by adults, including Pregnant women, in primary care setting. Codes 99408 and 99409.

Aspirin for the Prevention of Cardiovascular Disease (Counseling): (USPSTF)
Aspirin for men age 45 to 79 years when the potential benefit due a reduction in myocardial infarctions Outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
Aspirin for women age 55 to 79 years when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.

Tobacco Use Screening:
All adults and cessation interventions for tobacco users.
Covered: 99406,99407 G0436 G0437 99401,99402,99403,99404

✅ 100% Payable Services

- **Female Sterilization: Diagnosis Code:** Z30.2 – Female sterilization
  Payment: 100% Payable by Plan

- **Routine/Wellness Services**

  - **Payment:** 100% Payable by Plan
  - **Diagnosis Codes:**
    - Z00 to Z00.8 - Routine health checkups and General medical exams
    - Z01.41 to Z01.419 – Encounter for Gynaecological Examination
    - Z12.11 – Encounter for screening for malignant neoplasm of colon
    - Z12.31 – Encounter for screening for malignant neoplasm of breast
    - Z78.0 – Asymptomatic menopausal state
  - **CPT Codes:**
    - **77080** → Bone Density
    - **99244**, **99243** → Consults

- **Routine Eye Exam (PPO Provider)**

  - **Diagnosis Codes:** H52 to H52.4**, Procedure Codes:** 92002 to 92015
    Payment: 100% Payable by Plan

- **Maternity Care – Office Visit & Lab Only**

  - Z34.90 to Z34.93 - Supervision of Normal Pregnancy, Unspecified
  - Z34.81 to Z34.82 - Supervision of Other Normal Pregnancy, 1st and 2nd Trimesters
  - **Note:** 100% Payable by Plan **only** for Office Visits & Lab, not payable at 100% for: **X-ray, Ultrasound, Inpatient**

- **Mammography**

  - **Diagnosis Code:** Z13.81 - Encounter for screening for digestive system disorders
  - **Payment:** 100% Payable by Plan

- **Antenatal Screening**

  - **Diagnosis Code:** Z36.85 - An encounter for antenatal screening for Streptococcus B
    Payment: 100% Payable by Plan

- **CPT Code 81162 – DNA Testing (BRCA1 (BRCA1, DNA repair associated) and BRCA2 (BRCA2, DNA repair associated) gene analysis)**

  - **Default Policy: Not Covered,**
  - **Exception:** If billed with **Diagnosis Code: Z80.3 -** Family history of malignant neoplasm of breast
    Payment: 100% Payable by Plan