PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION FOR:

INTEGRITY HOME CARE + HOSPICE
SELECT PLAN
(DENTAL, VISION, SHORT TERM DISABILITY)

AMENDED AND RESTATED EFFECTIVE 01/01/2017

Administered by:

Contents

INTRODUCTION

This document is a description of Integrity Home Care Employee Select Supplemental Plan (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Plan Participants against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Changes in the Plan may occur in any or all parts of the Plan including benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like.

Failure to follow the eligibility or enrollment requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, lack of timely filing of claims or lack of coverage. These provisions are explained in this document.

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated. An expense for a service or supply is incurred on the date the service or supply is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are **not** covered.

Claim Provisions. Explains the rules for filing claims and the claim appeal process.

Coordination of Benefits. Shows the Plan payment order when a person is covered under more than one plan.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained.

Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

Responsibilities for Plan Administration. Explains the responsibilities for the Plan Administrator and includes information about the Plan's obligations with respect to Participants' privacy rights under the Health Insurance Portability and Accountability Act (HIPAA) and the Plan's compliance with the HIPAA Electronic Security Standards. Explains the Plan's structure and the Participants' ERISA rights under the Plan.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.

SCHEDULE OF BENEFITS

VERIFICATION OF ELIGIBILITY: Contact the Claims Supervisor to verify eligibility for Plan benefits **before** the charge is incurred. (Refer to General Plan Information section for contact information.)

Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

TIMELY FILING OF CLAIMS: Claims must be filed with the Claims Supervisor within six months of the date charges for the services were incurred. If the Plan should terminate, all claims must be filed within 90 days of the Plan's termination date. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined. (Refer to the section entitled "How to Submit a Claim".)

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the above.

The meanings of these capitalized terms are in the Defined Terms section of this document.

DENTAL BENEFITS

To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria:

(1) Dentally Necessary;

(2) Ordered by an appropriate Physician;

(3) Not excluded under the Plan; and

(4) Meets the standards of care for the diagnosis.

All benefits described in this Schedule are subject to the exclusions and limitations described more fully herein including, but not limited to, the above. Charges will be allowed at the Usual and Customary Allowance, negotiated rate or billed amount. Notwithstanding these allowances, all charges from all providers will be subject to a review for Reasonable allowance.

PREDETERMINATION OF BENEFITS and ALTERNATIVE TREATMENT: Before starting a dental treatment for which the charge is expected to be $500 or more, a predetermination of benefits form should be submitted. (Please read the sections Alternate Treatment and Predetermination of Benefits in the Dental Plan. You will need to follow these sections or reimbursement from the Plan may be reduced.)

Deductibles payable by Plan Participants

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid by a Covered Person once a Calendar Year. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any Covered Charges. Each January 1st, a new deductible amount is required.

Calendar Year Deductible

Per Covered Person	$50.00
Per Family Unit	$150.00

The deductible applies to these Classes of Service:

Class B Services – Basic

Class C Services – Major

Dental Percentage Payable by Plan

	Year 1	Year 2
Class A Services - Preventive	100%	100%
Class B Services - Basic	50%	80%
Class C Services - Major	25%	50%

Coverage will increase to the next level at the beginning of the second Calendar Year.

Maximum Payable by Plan

Per Covered Person per Calendar Year	$1,250.00

Additional information on Dental Care can be found in the Dental Benefits section of this document.

SHORT TERM DISABILITY BENEFITS

(Amounts payable by the Plan)

Waiting period for eligibility under this benefit. .....six months from effective date

Weekly benefit limit.....60% of covered weekly earnings up to a maximum of $1,000*

Benefits are payable:

For Injury.....15th day of Total Disability

For Sickness.....15th day of Total Disability

Maximum period payable+

Pregnancy, vaginal delivery ..... 6 weeks**
Pregnancy, cesarean delivery.....8 weeks**
Other Non-work related Illness or Injury.....10 weeks

Maximum of 10 weeks payable per 12-month period.

* If the Covered Employee receives compensation under the Employer's workers' compensation plan or unemployment benefits and that compensation is less than the weekly benefit limit above, then this short term disability benefit will pay the difference so that the sum of the two amounts is no more than the maximum listed above.

** Additional time not to exceed the maximum may be paid if due to complications it is deemed Medically Necessary by the Covered Person's treating Physician.

Additional information on Short Term Disability can be found in the Short Term Disability Benefits section of this document.

VISION CARE BENEFITS

(Amounts payable by the Plan)

Eye exam, per person, per Calendar Year.....$50

Only one vision correction option below is payable per 12-month period:

Option 1:

Frame-type lenses, per pair, in a 12 month period:

Single vision lens $50
Bi-focal lens $65
Tri-focal lens $75
Progressive lens.....$100
Frames, per pair, in a 24 month period $75

Option 2:

Contact Lenses, in a 12 month period …….....$150

Additional information on Vision Care can be found in the Vision Care Benefits section of this document.

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

ELIGIBILITY

Eligible Classes of Employees. Active office staff and professional (licensed) field staff of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage once he or she satisfies all of the following (refer to the EFFECTIVE DATE section*)*:

(1) New Employee

(a) Non-variable Hour Employee

(i) is a Full-time, Active Employee of the Employer (has begun working for the Employer). An Employee is considered to be Full-time if he or she works at least 20 Hours of Service/benefit units per week and is on the regular payroll of the Employer for that work.

(ii) is in a class eligible for coverage.

(iii) completes the employment Waiting Period with an average of 20 Hours of Service/benefit units worked per week as an Active Employee. A "Waiting Period" is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the last day of the first full month (as long as remaining eligible). Coverage will begin on the first day of the 2nd calendar month. For example, an Active Employee who has met all eligibility requirements as of the 20th of the month will have coverage beginning on the first day of the 2nd calendar month.

(b) Non-variable Hour Employee experiencing a change in employment status to Variable Hour Employee

(i) Completed the Non-variable Hour Employee employment Waiting Period with an average of 20 Hours of Service/benefit units worked per week as an Active Employee. Coverage will continue until one full standard measurement period has been completed. Retesting for eligibility will be performed at that time. A “Waiting Period” is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends at midnight on the last day of the first full month (as long as remaining eligible). Coverage will begin on the first day of the following calendar month. For example, an Active Employee who has met all eligibility requirements as of the 20th of the month will have coverage beginning on the first day of the 2nd calendar month. If the Non-variable Hour Employee Waiting Period was not completed, eligibility will be determined utilizing the monthly measurement period method until one full standard measurement period is completed.

(ii) is in a class eligible for coverage.

(c) Variable Hour Employee- Professional or Para Professional Hospice Aides

(i) Completes the employment Waiting Period with an average of 20 Hours of Service/benefit units worked per week as an Active Employee. Coverage will continue until one full standard measurement period has been completed. Retesting for eligibility will be performed at that time. Coverage will begin on the first day of the 2nd calendar month thereafter. For example, an Active Employee who has met all eligibility requirements as of the 20th of the month will have coverage beginning on the first of the 2nd calendar month. If the Employee fails to

average 20 or more hours per week during the first two months, they would continue with their initial measurement period, and following its completion you would offer or not based on average hours of service over the initial measurement period. A “Waiting Period” is the time beginning on the first day of employment as an Active Employee eligible for coverage and ends on the last day of the first full month (as long as remaining eligible).

(ii) is in a class eligible for coverage.

(d) Variable Hour Employee-Para Professional (other than Para Professional Hospice Aides), Part-time Employee or Seasonal Employee

(i) during the Initial Measurement Period, based on Hours of Service, the Employee has been determined during the New Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she average 20 or more Hours of Service per week (130 Hours of Service or more in a month) during the Initial Measurement Period.

(ii) is in a class eligible for coverage.

(2) Ongoing Employee

(a) based on Hours of Service during the Standard Measurement Period, has been determined, during the Ongoing Employee Administrative Period to be a Full-time Employee of the Employer. An Employee is considered to be Full-time if he or she averaged 20 or more Hours of Services per week (130 Hours of Service or more in a month) during the Standard Measurement Period.

(b) is in a class eligible for coverage.

Capitalized terms used above that are not included in the Defined Terms section of the Plan Document can be found in the Plan’s Eligibility Appendix. If you wish to review a copy of the Appendix, please contact the Plan Administrator.

Note: Coverage under this Plan is available to Employees age sixty-five (65) and over and to spouses age sixty-five (65) and over of Employees under the same conditions as coverage is available to Employees and their spouses under age sixty-five (65). Nonetheless, Employees over age sixty-five (65) are entitled to select primary coverage under Medicare. To do so, they must decline all coverage under this Plan.

The Employee or spouse must apply for Medicare coverage at their local Social Security office before submitting claims for Medicare benefits. Contact the local Social Security office with any questions about enrollment or eligibility.

If coverage under the Plan lapses because the Employee or spouse elects to decline coverage after reaching age sixty-five (65), they may become covered again only by filling out a request for reinstatement with the Plan Administrator. For dependents, the Employee must successfully re-enroll as well. All other Plan provisions will apply, i.e., open enrollment, etc.).

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage. At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

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

(1) A covered Employee's Spouse.

The term "Spouse" shall mean the person recognized as the covered Employee's husband

or wife under the laws of the state where the covered Employee lives or was married and shall only include a common law marriage if recognized in the state where the covered Employee lives. The person is no longer considered an eligible Spouse if a Legal Separation or Divorce occurs.

The Plan Administrator may require documentation proving a legal marital relationship. Proof of marriage is established by one of the following:

(a) a copy or abstract of the public record of marriage, or a copy of the church record of marriage, containing sufficient data to identify the parties, the date and place of marriage;

(b) an affidavit of the clergyman or magistrate who officiated; or

(c) an original certificate of marriage, if the Plan Administrator is satisfied it is genuine and free from alteration.

In addition, the Spouse will only be eligible for coverage if the Spouse cannot obtain through his/her employer a group medical plan meeting the minimum value standard of benefits as defined under the Affordable Care Act. The Employee must sign a statement indicating that spousal coverage is not available to the spouse through their employer prior to enrollment into the plan and as may be required annually.

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

An Employee's "Child" includes his natural child, stepchild, adopted child, a child placed with the Employee for adoption or a child for whom the Employee is the Legal Guardian. An Employee's Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the last day of the child's birthday month,

However, for Plan Years beginning before January 1, 2014, an Employee's Child is not an eligible Child if the Child is eligible to enroll in an employer-sponsored health plan other than the group health plan of a parent of the Child, i.e., through the employer of the Dependent Child or Dependent Child’s spouse.

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

For Coordination of Benefits purposes, the following must be provided to the Claims Supervisor: Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

Any child of an Employee who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan as of the date of the request on the QMCSO. The Employee may elect coverage if not already covered under this Plan. (Refer to the Special Enrollment section.)

If a covered Employee is the Legal Guardian of a child or children, these children may

be enrolled in this Plan as covered Dependents.

Custody, guardianship and adoption must be established by valid court order or decree entered after the petition for same has been filed. Custodial parent is the parent awarded physical custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the Calendar Year excluding any temporary visitation.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

In all cases, to qualify as an eligible Dependent under the Plan, the child must be a dependent of the Employee. The Plan Administrator may require documentation proving dependency. Proof that a child is your dependent is established by one (1) of the following types of evidence:

(a) For a natural child born to married parents, a copy of the public record of birth showing the Employee was named as parent of the child. For a natural child born to unmarried parents, a copy of the public record of birth showing the Employee was named as parent of the child, as well as any other documentation that the Plan Sponsor may require, including but not limited to DNA testing;

(b) For an adopted child or a child Legally Placed for Adoption, except in jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, evidence of relationship will include a copy of the decree of adoption or as copy of the adoptive placement agreement and such other evidence as may be necessary. In jurisdictions where petition must be made to the court for release of adoption documents or information, or where release of such documents or information is prohibited, a copy of the child's revised birth certificate will be accepted to establish the fact of adoption;

(c) For a step-child, i) evidence of relationship of a step-child will consist of proof of birth as required for a natural child plus proof of marriage of the Employee to the natural parent of the child, and ii) evidence that either the child is a member of the Employee's household or there is a Qualified Medical Child Support Order (provide copy) stipulating that coverage is required by the natural parent and the natural parent;

(d) For Legal Guardianship, a copy of the public record showing the Employee and/or spouse was named as Legal Guardian of the child. In the event there is a change in status of any Employee's Dependent covered under the Plan following the initial eligibility determination, the Employee must inform the Plan Administrator of the change in status and provide documentation to the Plan Administrator that substantiates such a change in status. In the event of death or divorce, a copy of the death certificate or divorce decree will be required. In the event of adoption or placement for adoption, or acquisition of a step-child, documentation described above for each such situation will be required.

(3) A covered Dependent child, who prior to reaching the limiting age, is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. A Dependent child who becomes Totally disabled after reaching the limiting age is not eligible to be enrolled on this Plan. A new Employee will not be able to enroll a Dependent child who is over the limiting age and is Totally Disabled. A terminated Employee who is rehired is considered a new Employee for the purposes of this provision. The Plan Administrator may

require, at reasonable intervals continuing proof of the Total Disability and dependency.

The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; and the Legally Separated or divorced former Spouse of the Employee. (Refer to Continuation of Coverage Rights under COBRA section.)

If a Dependent Child of an Employee is also a Full-Time Employee, the Dependent Child will only be eligible as an Employee. As of the Dependent Child's effective date as an Employee immediately following their Waiting Period, the (Dependent Child) Employee will no longer be eligible as a Dependent of the parent who is an Employee.

In the case of Employees married to one another without Dependents, the Employees will be covered as separate Employees.

In the case of Employees married to one another with Dependents, one of the Employees must be covered as a Dependent of the other Employee along with the Dependent Children.

If both parents of a Dependent Child are not married to each other and are Employees, the Dependent Child will only be enrolled under one of the Employees, not under both.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums depending upon the coverages elected and which Covered Persons elect those coverages.

FUNDING

Cost of the Plan. Integrity Home Care shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and Employee, if any, and reserves the right to change the level of Employee contributions.

Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraphs. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payment.

In the event that the Employer terminates this Plan, then as of the termination date, the Employer and Employees shall have no further obligation to make additional contributions to the Plan.

ELECTION TO DECLINE COVERAGE

This is an advisory statement for those individuals who decline coverage explaining the impact of that decision and the "special events" circumstances that would offer him/her "Special Enrollment Periods" in the future.

If you are declining enrollment for yourself or your dependent(s), which includes your spouse, because of other health insurance coverage (including, but not limited to, Medicare, Medicaid, COBRA, group health plans and some individual policies), you may in the future be able to enroll yourself or your dependents in this plan, provided that you request enrollment within thirty (30) days after your other coverage ends. In addition to the above, if you have a new dependent as a result of marriage, birth, adoption or placement for adoption or Legal Guardianship, you may be able to enroll yourself or your dependents, provided that you request enrollment within thirty (30) days after the marriage, birth, adoption or placement for adoption or Legal Guardianship. If you apply for coverage other than at the above mentioned situations, you will be subject to the Late Enrollment provisions of the Plan.

IF YOU DECLINE COVERAGE UNDER THIS HEALTH PLAN AND DO NOT DIVULGE TO THE PLAN THAT THIS REASON IS DUE TO OTHER HEALTH INSURANCE COVERAGE, AND SUBSEQUENTLY HAVE A HEALTH COVERAGE CHANGE (SEE SPECIAL ENROLLMENT DEFINITIONS), SPECIAL ENROLLMENT PERIODS THAT MIGHT OTHERWISE HAVE BEEN AVAILABLE TO YOU DUE TO THAT HEALTH COVERAGE CHANGE WOULD NOT APPLY. AS A RESULT, YOU AND/OR YOUR DEPENDENT(S) WILL BE SUBJECT TO THE LATE ENROLLEE/ENROLLMENT PROVISIONS OF THE PLAN.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for Employee and Dependent coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. Enrollment can occur at the end of the Waiting Period, following a Special Enrollment event or during the open enrollment period.

Enrollment Requirements for Newborn Children.

A newborn child of a covered Employee will be enrolled as of the date of birth as long as the enrollment form is received by the Plan Administrator within 30 days of the date of birth. If the Covered Employee applies for the newborn's coverage after the initial 30 days, the newborn is considered to be a Late Enrollee. The newborn will be subject to the Late Enrollment provision of this Plan. There will be no payment by the Plan for charges incurred prior to the Enrollment Date. The covered parent will be responsible for all costs.

Such coverage for a newborn includes: routine nursery care (Refer to Routine Well Newborn Nursery/Physician Care in the Schedule of Benefits); or the necessary care or treatment of medically diagnosed congenital defects, birth abnormalities or complications resulting from prematurity (Refer to Hospital Services and Physician Services in the Schedule of Benefits).

Charges for covered Routine Well Newborn Nursery Care will be applied toward the Plan of the newborn child.

Charges for covered Routine Well Newborn Physician Care will be applied toward the Plan of the newborn child.

TIMELY AND LATE ENROLLMENT

(1) Timely Enrollment - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period.

If two Employees (mother and father) are covered under the Plan and the Employee who is covering the Dependent children terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) Late Enrollment/Open Enrollment - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during open enrollment which is for a specific period of time typically in November.

Details about the annual open enrollment period will be announced by the Employer. During this time, Employees and their Dependents who are Late Enrollees will be able to enroll in the Plan. Benefit choices for Late Enrollees made during the open enrollment period will become effective January 1st.

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

The time between the date a Late Enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period. Coverage begins on January 1st.

SPECIAL ENROLLMENT RIGHTS

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

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

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

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

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

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

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

(c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage

(including as a result of Legal Separation, divorce, death, termination of employment or reduction in the number of hours of employment) or because employer contributions towards the coverage were terminated. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received, unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons.

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

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

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

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

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

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

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

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

(3) Dependent beneficiaries. If the Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and:

(a) A person(s) becomes a Dependent of the Employee through marriage, then the new Dependent(s) (Spouse and step-children) and if not otherwise enrolled, the Employee may be enrolled under this Plan as a Covered Person; or

(b) A person becomes a Dependent of the Employee through birth, Legal Guardianship, Qualified Medical Child Support Order (QMCSO), adoption or placement for adoption, then the new Dependents may be enrolled under this Plan as a covered Dependent of the covered Employee. The Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

Eligible Dependents other than those described in (a) or (b) who were not enrolled when first eligible are not eligible to enroll during this Special Enrollment event. They may enroll as Late Enrollees during the open enrollment period.

If the Employee is not enrolled in the Plan, he or she may enroll as a Special Enrollee as a result of the Special Enrollment events listed in (a) and (b) above. The newly eligible Dependents may not enroll if the Employee does not elect coverage.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption or Legal Guardianship or the commencement of the school term. To be eligible for this Special Enrollment Period, the Employee must request enrollment of the Plan Administrator during this period. Otherwise, the person is considered a Late Enrollee and will be subject to the Late Enrollment provisions under this Plan. The exception may be the enrollment of newborns. Refer to the Enrollment Requirements of Newborn Children in this Enrollment section.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective no later than the following unless agreed upon by the Employee and Plan Administrator for financial or payroll reasons:

(a) in the case of marriage, no later than the first day of the first month beginning after the date the completed request for enrollment is received (i.e., marriage occurred on January 10. If enrollment form is received January 10-31, the effective date will be no later than February 1. If enrollment form is received February 1-9, the effective date will be no later than March 1.);

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

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

(4) Medicaid and State Child Health Insurance Programs. An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if:

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

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

EFFECTIVE DATE

Effective Date of Employee Coverage. An Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

(a) The Eligibility Requirement.

(b) The Active Employee Requirement.

(c) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.

TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of Creditable Coverage under this Plan. The Plan maintains written procedures that explain how to request this certificate. Please contact the Plan Administrator for a copy of these procedures and further details.

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

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

(a) The date the Plan is terminated.

(b) The date the covered Employee's Eligible Class is eliminated.

(c) The day the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the section entitled Continuation Coverage Rights under COBRA.)

(d) The date the Employee elects to terminate coverage. (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.) This termination is typically not a COBRA qualifying event.

(e) When applicable, the end of the period for which the Employer and/or the Employee made any required contribution for the coverage if the full premium for the next period is not paid when due. If an Employee no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.

(f) If an Employee commits fraud or makes an intentional misrepresentation of material fact in applying for or obtaining coverage, or obtaining benefits under the Plan, then the

Employer or Plan may either void coverage for the Employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan's discretion, or may immediately terminate coverage. If coverage is to be terminated or voided retroactively for fraud or misrepresentation, the Plan will provide at least 30 days' advance written notice of such action.

Continuation During Periods of Employer-Certified Disability or Leave of Absence. A person may remain eligible for a limited time if Active, full-time work ceases due to disability or leave of absence. The Employer will notify the Employee of any applicable increase in premium contributions. This continuance will end as follows:

For leave of absence: The Employee is responsible for the premium (same rate as when active) if the Employee continues coverage during the FMLA leave. If the Employee does not return to work at the end of the leave, COBRA may be elected. For non-FMLA leave, the Employee is responsible for the premium for the first six weeks of approved medical leave or the first four weeks of approved personal leave. COBRA may be elected beginning with the first day of non-active employment following either of these periods if the Employee has not returned to active status. (See the COBRA Continuation Options.)

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation During Family and Medical Leave. Regardless of the established leave policies mentioned above, if the Employer meets the requirements of the law, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

The Family and Medical Leave Act (FMLA) requires *Employers of fifty (50) or more employees* to provide up to twelve (12) or twenty-six (26) weeks of unpaid, job-protected leave to "eligible" Employees for certain family and medical reasons. Employees are eligible if they have worked for the Employer for at least one (1) year and one thousand two hundred fifty (1,250) hours over the previous twelve (12) months.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

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

Rehiring a Terminated Employee. If a terminated Employee experiences a period without any Hours of Service and resumes Hours of Service and:

(a) if the Employee is rehired following a Break in Service (as defined in the Plan's Eligibility Appendix), the Employee will be treated as a New Employee and be required to satisfy all eligibility and enrollment requirements under the Plan as stated in the "Eligibility Requirements for Employee Coverage" section.

(b) if the Employee is rehired without experiencing a Break in Service, the Employee will be treated as a Continuous Employee and is eligible for coverage under the Plan upon return if they were enrolled in coverage prior to the start of the period with no Hours of

Service. Such coverage will be effective the first day of the month following the date Hours of Service resumes.

(c) if the Employee was continuously covered as a COBRA participant of this Plan, a new employment waiting period does not have to be satisfied and coverage will change to Active Employee status as of the first of the month following the date Hours of Service resumes.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act (USERRA). These rights apply only to Employees and their Dependents covered under the Plan immediately before leaving for military service.

In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate at midnight on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(a) The date the Plan or Dependent coverage under the Plan is terminated.

(b) The date that the Employee's coverage under the Plan terminates for any reason including death. (See the section entitled Continuation Coverage Rights under COBRA.)

(c) The date a covered Spouse loses coverage due to loss of dependency status. (See the section entitled Continuation Coverage Rights under COBRA.)

(d) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the section entitled Continuation Coverage Rights under COBRA.)

(e) The date the Employee requests that a Dependent’s coverage be terminated (Voluntary termination may or may not be allowed in certain situations according to State and Federal law.). This termination is typically not a COBRA qualifying event.

(f) The end of the period for which the required contribution has been paid if the full premium for the next period is not paid when due. If a Dependent no longer satisfies the eligibility requirements under the Plan and fails to elect COBRA within the appropriate time period, coverage will be retroactively terminated to the date as stated in the applicable item above. If the Employer or Plan is notified during the COBRA election period, the difference in premium can be paid in order to continue coverage.

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

The Employee shall be responsible for notifying the Plan Administrator of new Eligible Dependents and of any changes in the eligibility status of a Dependent. (Refer to the COBRA section.) Benefits provided to an ineligible Dependent will be recouped by the Plan in

accordance with its rights for reimbursement. Employee contributions paid for a period when the Employee knew or should have known the Dependent was ineligible will not be reimbursed to the Employee.

DEFINED TERMS

The following terms have special meanings and when used in this Plan will be capitalized.

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer with enough Hours of Service during the Initial Measurement Period or Standard Measurement Period, as applicable, to qualify for benefits. For this purpose, an Employee shall be deemed to be actively employed on the date his or her coverage would otherwise commence if the Employee is absent from work due to a medical condition (including both physical and mental Illnesses).

Calendar Year means January 1st through December 31st of the same year.

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

Cosmetic Dentistry means dentally unnecessary procedures.

Cosmetic Surgery means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements. Cosmetic Surgery is typically surgery that changes:

- The texture or appearance of the skin; or
- The relative size or position of any body part

when such surgery is performed primarily for psychological purposes or is not needed to correct or improve a bodily function.

Covered Charge(s) means those Medically Necessary services or supplies that are covered under this Plan.

Covered Person is an Employee, Dependent or COBRA Continuant who is covered under this Plan.

Dentist is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship and meets the eligibility requirements outlined in "Eligibility Requirements for Employee Coverage" section. The following persons are specifically excluded from the Plan: persons employed as leased employees or independent contractors; persons who are classified by the Employer as temporary workers; and persons covered by a collective bargaining agreement unless the Employer and collective bargaining unit have agreed to participation under the Plan. For purposes of the foregoing, the Employer's employment classification of an individual shall be binding and controlling for all purposes and shall apply regardless of any contrary classification of such person by any other person or entity, including without limitation, the Internal Revenue Service, the Department of Labor, or a court of competent jurisdiction.

Employer is Integrity Home Care + Hospice.

Enrollment Date is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

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

Experimental and/or Investigational means services, supplies, care and treatment which does

not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/nonexperimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

(1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

(2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

(3) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trial or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

(4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Family Unit is the covered Employee and the family members who are covered as Dependents under the Plan.

Genetic Information means information about the genetic tests of an individual or his family members, and information about the manifestations of disease or disorder in family members of the individual. A "genetic test" means an analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

Incidental means requiring unplanned treatment, care or services for a non-emergent Illness while outside the network area. For example, requiring Physician services for acute sinusitis while traveling outside the network area.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Institution of Learning means any accredited high school, accredited college or university, including other recognized educational institutions such as nursing schools, trade school, etc., with full-time curricula, regardless of the length of the term.

Late Enrollee means a Plan Participant who enrolls under the Plan other than during the first 30-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period. (see below).

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

Legally Separated (Legal Separation) means, for purposes of this Plan, a husband and wife have successfully petitioned a court to recognize their separation.

Life Threatening is defined as any serious illness or injury that necessitates immediate medical or surgical intervention to preclude permanent impairment of a body function or permanent damage to a body structure. Examples: burns, loss of organs, loss of limbs, blindness, heart attack, stroke and excessive uncontrolled bleeding through open wounds.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medically or Dentally Necessary care and treatment is recommended or approved by a Physician or Dentist; is consistent with the patient's condition or accepted standards of good medical or dental practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical or dental services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

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

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

Physician means a Doctor of Medicine (M.D.) or Doctor of Dental Surgery (D.D.S.).

Plan means Integrity Home Care Employee Select Supplemental Plan, which is a benefits plan for certain Employees of Integrity Home Care and is described in this document.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

Reasonable means not excessive or extreme as determined by the Plan Administrator. See also Usual & Customary Allowance. If it is determined that a charge is not Reasonable, but services are still eligible, the allowance will be based up an estimated 150% of the Medicare allowable, regardless of previously negotiated or contracted rates.

Reasonable and Necessary is a term used to qualify occupational, physical, speech and other rehabilitative therapy programs. To be considered Reasonable and Necessary, the following conditions must be met:

(1) The services must be considered under accepted standards of medical practice to be a specific and effective treatment for the patient's condition.

(2) The services must be of such a level of complexity and sophistication or the condition of the patient must be such that the services required can be safely and effectively performed only by a qualified therapist or under his/her supervision. Services which do not require the performance or supervision of a therapist are not considered reasonable or necessary services, even if they are performed or supervised by a therapist.

(3) The development, implementation, management, and evaluation of a patient care plan constitute skilled therapy services when, because of the patient's condition, those activities require the skills of a therapist to meet the patient's needs, promote recovery, and ensure medical safety. Where the skills of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program because of an identified danger to the patient, those reasonable and necessary management and evaluation services may be covered, even if the skills of a therapist are not needed to carry out the activities performed as part of the maintenance program.

(4) While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, the key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by non-skilled personnel.

(5) There must be an expectation that the patient's condition will improve significantly in a reasonable (and generally predictable) period of time, or the services must be necessary for the establishment of a safe and effective maintenance program required in connection with a specific disease state.

(6) The amount, frequency, and duration of the services must be Reasonable.

Temporomandibular Joint (TMJ) Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. (Refer to Schedule of Benefits and Medical Benefits for what services are covered by this Plan.)

Total Disability (Totally Disabled) means: In the case of an Active Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness. Total Disability will be determined by the Employer in conjunction with the determination by the treating Physician.

In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

In the case of a Dependent, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Usual and Customary Allowance is determined by the Plan Administrator using the following information:

(1) Third Party data;

(2) Contracted allowables;

(3) Medicare data;

(4) Historical data of Claims Supervisor;

(5) Geographic region of provider;

(6) Cross-section of providers in geographic areas other than where the service is provided if the service is performed less frequently or is a newer service;

(7) The nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience; and/or

(8) Any other available data to make the determination.

(9) When the Usual and Customary Allowance cannot be determined with any of the above, the Plan Administrator or its designee has the discretionary authority to decide the Reasonable allowance for the care, treatment or service.

(10) Even though the Usual and Customary Allowance or network/contracted rate can be determined, the Plan Administrator or its designee has the discretionary authority in determining if the established allowance is Reasonable.

For the purposes of this section, "Reasonable" means not excessive or extreme as determined by the Plan Administrator.

The Plan will consider the actual charge billed if it is less than the Usual and Customary Allowance.

Utilization Review Coordinator is the person who evaluates the appropriateness, medical need and efficiency of health care services, procedures and facilities according to established criteria or guidelines (industry, Claims Supervisor or appropriate third party) and under the provisions of this Plan. Typically, the review includes new activities or decisions based upon the analysis of a case. The Coordinator performs proactive procedures (such as discharge planning, concurrent planning, precertification), clinical case appeals, proactive processes (such as concurrent clinical reviews and peer reviews), and reviews appeals introduced by the provider, payer or Covered Person. A separate entity may provide the precertification services. (Refer to General Plan Information section and the health care plan ID card for contact information.).

Waiting Period is the time beginning on the first day of employment as a Non-variable Employee and ends at midnight on the 60th day (as long as remaining eligible). Similarly, for a Variable Hour, Part-time, Seasonal or Ongoing Employee with a change in employment status to 20 or more hours during the Measurement Period or Stability Period, it is the time beginning on the first day of employment meeting these hours and ends at midnight on the 60th day (as long as remaining eligible). If earlier, coverage will be effective the 1st day of the Stability Period, if the Employee averaged 20 Hours of Service or more per week (over a 13 week period) during the Measurement Period.

DENTAL BENEFITS

This benefit applies when covered dental charges are incurred by a person while covered under this Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of dental charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits.

Family Unit Limit. When the dollar amount shown in the Schedule of Benefits has been incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that year.

BENEFIT PAYMENT

Each Calendar Year benefits will be paid to a Covered Person for the dental charges in excess of the deductible amount if applicable. Payment will be made at the rate shown under Dental Percentage Payable in the Schedule of Benefits. The benefit changes according to the service requirements listed in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount.

MAXIMUM BENEFIT AMOUNT

The Maximum dental benefit amount is shown in the Schedule of Benefits.

DENTAL CHARGES

Dental charges are the Usual and Reasonable Charges made by a Dentist or other Physician for necessary care, appliances or other dental material listed as a covered dental service.

A dental charge considered incurred as follows:

a) For an appliance or modification of an appliance, an expense is considered incurred at the time the impression is made.

b) For a crown, bridge or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared.

c) For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened.

d) All other expenses are considered incurred at the time a service is rendered or a supply furnished.

However, there are times when one overall charge is made for all or part of a course of treatment. In this case, the Claims Supervisor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL SERVICES

Class A Services:

Preventive and Diagnostic Dental Procedures

The limits on Class A services are for routine services. If dental need is present, this Plan will consider for reimbursement services performed more frequently than the limits shown.

(1) Routine oral exams. This includes the examination and cleaning of teeth. Limit of 2 per Covered Person each Calendar Year.

(2) Two bitewing x-ray series (up to four bitewings per series) every Calendar Year.

(3) One full mouth x-ray (including panoramic x-rays) every 36 months.

(4) Two fluoride treatments for covered Dependent children under age 16 each Calendar Year.

(5) Emergency palliative treatment for pain.

(6) Sealants on the occlusal surface of a permanent posterior tooth for Dependent children under age 16, once per tooth in any 36 months.

Class B Services:

Basic Dental Procedures

(1) Dental x-rays not included in Class A.

(2) Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.

(3) Periodontics (gum treatments). Only two periodontic maintenance visits are allowed per Calendar Year. Surgical treatment of diseases of the gums and bone supporting the teeth includes muco-gingival surgery, osseous surgery, osseous graft, pedicle soft tissue graft, free soft tissue graft, gingivectomy and gingivoplasty. Allowance includes the treatment plan, local anesthetics and post-surgical care. All periodontal maintenance procedures performed within three months after completion of periodontal surgery will be considered part of the surgical service and are not a separate covered expense. This includes re-evaluation.

(4) Endodontics (root canals). Multi-visit procedures are payable after the final visit in which the procedure is completed (i.e., crowns, dentures, bridges, root canals).

(5) Extractions. This service includes local anesthesia and routine post-operative care. (If the Covered Person is covered under the Major Medical Plan, coverage for extractions of impacted teeth will be considered under the Medical Benefits of that Plan *instead of* the Dental Benefits of this Plan.)

(6) Recementing bridges, crowns or inlays.

(7) Repair of crowns, bridgework and removable dentures. Repair (including recementing) of crowns, inlays, bridgework and removable dentures. Repair or replacement of a crown will be covered only once in five years beginning with the date of placement, except for accidental injuries.

(8) Rebasing or relining of removable dentures. Rebasing or relining of removable dentures once per 24 months, but never in the first six months after the dentures are received.

(9) Fillings, other than gold. Limited to one direct restoration on the same tooth surface every six months excluding sedative fillings (see below). Multiple restorations on one tooth surface are considered to be one restoration.

(10) Sedative Fillings. This temporary restoration service which is intended to relieve pain is limited to two fillings per tooth prior to a permanent filling or other restoration.

(11) Installation of stainless steel crown, prefabricated resin crown, and resin based composite crown, limited to once per tooth in any 24-month period. These are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration (Also refer to Class C Services.)

(12) General anesthetics, upon demonstration of Medical Necessity.

(13) Antibiotic drugs administered by Physician.

(14) Consultation with another Physician or Dentist for an opinion or advice but not for treatment.

Class C Services:

Major Dental Procedures

(1) Gold restorations, including inlays, onlays and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.

(2) Installation of crowns. Separate benefits are not available for a gingivectomy or other tissue management procedures performed when placing a crown because they are considered part of the complete procedure. Multi-visit procedures are payable after the final visit in which the procedure is completed (i.e., crowns, dentures, bridges, root canals).

(3) Installing precision attachments for removable dentures.

(4) Oral surgeries not listed in Class B Services. Follow-up procedures performed due to complications of a surgical procedure are not payable as a separate benefit. Periodontal procedures to implant antibiotic-impregnated materials are not covered.

(5) Installing partial, full or removable dentures to replace one or more natural teeth which were extracted while the person was covered for this benefit. This service also includes all adjustments made during 6 months following the installation. Multi-visit procedures are payable after the final visit in which the procedure is completed (i.e., crowns, dentures, bridges, root canals).

(6) Addition of clasp or rest to existing partial removable dentures.

(7) Initial installation of fixed bridgework to replace one or more natural teeth which were extracted while the person was covered for this benefit. Only one pontic is allowed for each missing numbered tooth. Multi-visit procedures are payable after the final visit in

which the procedure is completed (i.e., crowns, dentures, bridges, root canals).

(8) Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will apply only if one of these tests is met:

(a) The replacement or addition of teeth is required because of one or more natural teeth being extracted after the person is covered under these benefits;

(b) The existing denture or bridgework was installed at least five years prior to its replacement and cannot currently be made serviceable.

(c) The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within 12 months from the date the temporary denture was installed.

(9) Oral surgeries other than tooth extractions and periodontal surgeries in Class B Services.

Follow-up procedures performed due to complications of a surgical procedure are not payable as a separate benefit. Periodontal procedures to implant antibiotic-impregnated materials are not covered.

PREDETERMINATION OF BENEFITS

Before starting a dental treatment for which the charge is expected to be $500 or more, a predetermination of benefits form should be submitted.

A pretreatment plan helps reduce your out-of-pocket dental costs. Unlike medical care and treatment, many dental procedures are entirely elective and can be treated in several ways. It's important that you ask your Dentist, dental surgeon or Physician to help you or your dependents choose the most effective and economical course of treatment. By doing so, you can reduce your own out-of-pocket expenses for treatments that may not be covered by the Plan or are covered only to a limited extent.

A regular dental claim form is used for the predetermination of benefits. This form can be obtained from the human resources office or Claims Supervisor. The covered Employee fills out the Employee section of the form and then gives the form to the Dentist.

The Dentist must itemize all recommended services and costs and attach all supporting x-rays to the form.

The Dentist should send the form to the Claims Supervisor at this address:

Mercy Benefit Administrators
PO Box 14230
Springfield, MO 65814
(877) 875-7700

The Claims Supervisor will notify the Dentist of the benefits payable under the Plan. The Covered Person and the Dentist can then decide on the course of treatment, knowing in advance how much the Plan will pay.

If a description of the procedures to be performed, x-rays and an estimate of the Dentist's fees are not submitted in advance, the Plan reserves the right to make a determination of benefits

payable taking into account alternative procedures, services or courses of treatment, based on accepted standards of dental practice. If verification of necessity of dental services cannot reasonably be made, the benefits may be for a lesser amount than would otherwise have been payable.

ALTERNATE TREATMENT

Many covered dental conditions can be treated in more than one way. This Plan has an "alternate treatment" clause which governs the amount of benefits the Plan will pay for treatments. If a patient chooses a more expensive treatment than is needed to correct a dental problem according to accepted standards of dental practice, the benefit payment will be based on the cost of the treatment which provides professionally satisfactory results at the most cost-effective level.

For example, if a regular amalgam filling is sufficient to restore a tooth to health, and the patient and the Dentist decide to use a gold filling, the Plan will base its reimbursement on the Usual and Reasonable Charge for an amalgam filling. The patient will pay the difference in cost.

EXCLUSIONS

A charge for the following is not covered:

(1) **Administrative costs.** Administrative costs of completing claim forms or reports or for providing dental records.

(2) **Broken appointments and other charges.** Charges for broken or missed dental appointments, completion of claim forms or late payment charges.

(3) **Bruxism.** Services, procedures or appliances that treat/prevent bruxism (teeth grinding or clenching).

(4) **Cancer screenings.** Cancer screenings are considered part of the routine oral exam and are not consider a Covered Charge when billed separately.

(5) **Cosmetic.** Services, procedures or appliances that are cosmetic in nature, i.e., veneer facings or similar properties of crowns or pontics placed on or replacing teeth in back of the second bicuspid; teeth whitening processes and characterizing and personalizing prosthetic devices.

(6) **Coverage after termination.** Any procedure begun after coverage under the Plan terminates; or for any prosthetic dental appliance or crown finally installed or delivered more than thirty (30) days after the Covered Person's coverage terminates.

(7) **Crowns.** Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting.

(8) **Excluded under Medical.** Services that are excluded under Medical Plan Exclusions (included in the Medical Benefits of the Employer) unless stated otherwise, or provided as a separate service to the Employee through a dental or medical department maintained by an Employer, a mutual benefit association, labor organization, trustee or similar type of group.

(9) **Hygiene.** Oral hygiene, plaque control programs or dietary instructions.

(10) **Implants.** Implants, including any appliances and/or crowns and the surgical insertion or removal of implants.

(11) **No listing.** Services which are not included in the list of covered dental services.

(12) **Non-prescription drugs.** Charges for non-prescription drugs.

(13) **Orthodontia.** Orthodontic treatment or repair of orthodontic devices.

(14) **Orthognathic surgery.** Surgery to correct malpositions in the bones of the jaw.

(15) **Other charges.** Charges in connection with failing to keep a schedule dental visit, duplicating records, copying of x-rays and dental records and mailing any records.

(16) **Other coverage available.** Charges covered under a terminal liability, extension of benefits, or similar provision of a program replaced by this Plan.

(17) **Other services.** Hypnotism, hypnotic anesthesia, acupuncture and acupressure.

(18) **Periodontal procedures** such as guided tissue regeneration and bone grafting that are performed in preparation for a procedure that is not covered under this Plan.

(19) **Personalization.** Personalization of dentures.

(20) **Replacement.** Replacement of lost or stolen prosthetic appliance or a prosthetic/orthodontic appliance, crown, inlay or onlay restoration or fixed bridge within five years of the date of the last placement of these items. But if a replacement is required because of an accidental bodily Injury sustained while the person is covered under this section, it will be considered a covered expense.

(21) **Splinting.** Crowns, fillings or appliances that are used to connect (splint) teeth, or change or alter the way the teeth meet, including altering the vertical dimension, restoring the bite (occlusion) or are cosmetic.

(22) **Temporary appliances.** Temporary or treatment crowns, bridges or dentures.

(23) **Temporomandibular joint.** Surgically treating a disturbance of the temporomandibular joint. (Refer to the Medical Benefits of this Plan.)

(24) **Usual and Reasonable Charge.** Charges will be allowed at the Usual and Reasonable Charge, contracted rate or billed amount, whichever is less unless specifically stated otherwise in the contract with that provider.

SHORT TERM DISABILITY BENEFITS

This benefit applies when an Employee has a Total Disability that meets all of these tests:

(1) Total Disability starts while the Employee is covered for this benefit.

(2) Total Disability is being continuously treated by a Physician. (For the purposes of Short Term Disability benefits, the Physician must be an M.D. or D.O.)

(3) Total Disability is due to an Injury or Sickness that, in either case, is nonoccupational -- that is, not arising from work for wage or profit.

(4) Total Disability (Totally Disabled) means the complete inability to perform any and every duty of the Employer's occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Sickness.

The Employer shall reserve the option of requesting periodic physical examinations from either the current Physician on the case or a Physician of the Employer's choice. Failure to provide requested Physicians' statements will result in termination of benefits. Employees will be responsible for providing the following information in a clearly understandable format, if requested:

• History regarding when symptoms first appeared or accident happened;	• Progress;
• Diagnosis;	• Prognosis;
• Dates of treatment;	• Suitability for rehabilitation;
• Nature of treatment;	• Physician's signature and tax

Additional information may be required based upon the individual Illness or Injury.

BENEFIT PAYMENT

Benefits will be paid for a Total Disability up to a Weekly Benefit Limit as described in the Schedule of Benefits. Medical recertification will be required in accordance with the Employer's leave policy.

Benefits are payable as described in the Schedule of Benefits. Benefits terminate if employment terminates.

The waiting period begins once the person is Totally Disabled and unable to be Actively Working. If the Employee is absent from work sporadically due to the Illness or Injury, the waiting period will begin once the Employee can no longer return to work. This benefit is not related to the Medical Benefits Integrity Home Care offers separately. Contact the Plan Administrator or Human Resource office for further information.

PERIOD OF TOTAL DISABILITY

Period of Total Disability is the period of time that an Employee is Totally Disabled. The event must have occurred on or after the effective date of coverage for this benefit. The following are descriptions of Periods: 1) New periods due to the same or related causes separated by a return to Active Work for at least two consecutive weeks. A new waiting period (for an Illness) will begin on the first day missed thereafter. For example, the initial period was for a shoulder Injury. Later, the Employee required time off following shoulder surgery. This second period is considered Illness-related; 2) If a return to Active Work is less than two weeks, the Employee will continue with benefits under the initial period. No new waiting period will apply. The time returned to Active Work will be counted in the "Maximum period eligible". 3) New periods due to different causes must be separated by a return to Active Work for at least one day. A New waiting period will apply. **The Plan covers up to 10 weeks of STD within a 12 month period.**

SHORT TERM DISABILITY CLAIMS PROCEDURE

A claim for disability benefits must be filed in writing with the Plan Administrator. The Plan Administrator or its designee will review the claim and make a decision within 45 days unless special circumstances require an extension of up to 30 additional days. Written notice of the decision on such claim shall be furnished promptly to the claimant. If the claim is wholly or partially denied, such written notice will (1) set forth an explanation of the specific findings and conclusions on which such denial is based, making reference to the pertinent provisions of the Plan documents; (2) describe any additional information or material needed to support the claim and explain why such information or material, if any, is necessary; (3) describe any additional information necessary for the claimant to perfect the claim and an explanation why such information is necessary; (4) the review procedures available to the claimant (including a statement of the claimant's right to bring a civil action under ERISA); and (5) upon request and free of charge, a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the appeal, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

A claimant may appeal a denied claim by filing a written request for review with the Plan Administrator within 180 days after receipt of the initial claims denial. As part of the review, the claimant may submit written comments, documents, records and other information relating to the claim (regardless of whether such information was considered as part of the original claim). The claimant may receive copies of all pertinent documents (free of charge) relevant to the claimant's claim.

The Plan Administrator's review on appeal will not afford deference to the initial adverse benefit determination and will be decided by an appropriate named fiduciary who is neither the individual who made the initial adverse benefit determination nor a subordinate of such individual. A written notice of the decision on review shall be furnished to the claimant within 45 days following the receipt of the request for review (unless special circumstances require an extension of up to 45 additional days). The written notice of the Plan Administrator's decision shall include specific reasons for the decision and shall refer to the pertinent provisions of the Plan on which the decision is based.

The Plan Administrator's decision on appeal will be conclusive and binding on the claimant and all other parties.

COVERED WEEKLY EARNINGS

Covered weekly earnings are the based upon the Employee's average rate of weekly earnings during the most recent 13 week-period preceding the start of Total Disability benefits.

VISION CARE BENEFITS

Vision care benefits apply when vision care charges are incurred by a Covered Person for services that are recommended and approved by a Physician or Optometrist.

BENEFIT PAYMENT

Benefit payment for a Covered Person will be made as described in the Schedule of Benefits.

VISION CARE CHARGES

Vision care charges are the Usual and Reasonable Charges for the vision care services and supplies shown in the Schedule of Benefits. Benefits for these charges are payable up to the maximum benefit amounts shown in the Schedule of Benefits for each vision care service or supply.

LIMITS

No benefits will be payable for the following:

(1) **Before covered.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan.

(2) **Excluded.** Charges excluded or limited by the Plan design as stated in this document.

(3) **Health plan.** Any charges that are covered under a health plan that reimburses a greater amount than this Plan.

(4) **No prescription.** Charges for lenses ordered without a prescription.

(5) **Orthoptics.** Charges for orthoptics (eye muscle exercises).

(6) **Replacements.** Charges for replacement of lost, stolen or broken lenses or frames.

(7) **Sunglasses.** Charges for safety goggles or sunglasses, including prescription type.

(8) **Training.** Charges for vision training or subnormal vision aids.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Process for Filing Claims

Typically, the claim is submitted by the provider to the Claims Supervisor or a PPO network. The contract rates are applied to the claim and, if all other required information is provided, the "Clean Claim" is processed by the Claims Supervisor. An Explanation Of Benefits (EOB) is returned to the provider and/or the Employee (or covered dependent if directed to do so) explaining any patient responsibility and/or reimbursement to the appropriate party. Occasionally the Claims Supervisor must pend a claim to the provider or Covered Person if not enough initial information is received in order to process the charges. This can cause delays in processing.

If you do not receive timely notice of the determination of your health claim, please contact the Claims Supervisor directly at the phone number listed on your ID card to verify receipt of the claim. You may also contact the provider to make sure the claim was filed correctly.

Providers *may* collect any applicable co-payments, deductibles or co-insurance amounts for covered services, or for services not covered by the Plan, at the time service is rendered. Billing and payment arrangements are between the Covered Person and the provider.

"Clean Claim" means a claim void of any material errors, omissions of pertinent information, coordination of benefits issues, and any liability issues, as determined by the Plan Administrator. Where not otherwise specified, this Plan follows National Correct Coding Initiative for coding modifiers, bundling/unbundling, and payment parameters. Other guidelines may be applicable where NCCI is silent. The Plan Administrator has full discretionary authority to select guidelines and/or vendors to assist in determinations.

How does the Covered Person file a claim when the provider does not do so on their behalf?

(1) Obtain a Claim form from the Personnel Office, Human Resources, the Plan Administrator or www.mercyoptions.net.

(2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.

(3) If a claim or bill from the provider is not available with all the information below, have the Physician complete the provider's portion of the form.

(4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:

- Name of Plan
- Employee's name
- Name of patient
- Name, address, telephone number of the provider of care
- Diagnosis (ICD-9 codes)
- Type of services rendered, with diagnosis and/or procedure codes (CPT codes)
- Date of services
- Charges

(5) Send the above to the **address on the ID card** or Claims Supervisor at this address (if the address on the ID card is different, sending claims to the Claims Supervisor may cause a delay in the processing of the claim):

Mercy Benefit Administrators
PO Box 14230
Springfield, MO 65814
(877) 875-7700

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Claims Supervisor within six months of the date charges for the service were incurred. The following additional filing limitations apply:

(1) Charges that were not previously submitted but related to a processed claim are considered a new claim and must be filed in the time limit above.

(2) Corrected information submitted on a processed claim is considered an appeal and not a newly filed claim. The filing limit will follow the appeal limit. Refer to the Grievance and Appeal Processed and Procedures section below.

(3) If it is not reasonably possible to submit the claim in the time limit above (i.e., if the person has primary insurance with another plan and this plan is the secondary plan, if the person is not capable of submitting the claim due to Illness, etc.), the filing period will be 12 months from the date of service. The Claims Supervisor will determine if it was or was not reasonably possible for the claim to be submitted within the time limit above.

(4) If the Plan should terminate, all claims must be filed within 90 days of the Plan's termination date.

Benefits are based on the Plan's provisions at the time the charges were incurred.

CLAIMS PROCEDURE

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

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

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan. If a Claim is denied, in whole or in part, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination."

Both the Claims and the Appeal procedures are intended to provide a full and fair review.

A claimant must follow all Claims and Appeal procedures, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

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

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

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

Concurrent Care Claims

A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination.

In the case of a Concurrent Care Claim, the following timetable applies:

(1)	Notification to claimant of Adverse Benefit Determination	30 days
(2)	Extension due to matters beyond the control of the Plan	15 days
(3)	Extension due to insufficient information on the Claim	15 days
(4)	Response by claimant following notice of insufficient information	45 days
(5)	Notification of Adverse Benefit Determination on Appeal	60 days

Pre-Service Claim

A Pre-Service Claim means any Claim for a benefit under this Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care. These are, for example, Claims subject to Pre-certification. Please see the Cost Management section of this booklet for further information about Pre-Service Claims.

(1)	Notification to claimant of Adverse Benefit Determination	15 days
(2)	Extension due to matters beyond the control of the Plan	15 days
(3)	Insufficient information on the Claim:	

a.	Notification of	15 days
b.	Respond by claimant	45 days
c.	Notification, orally or in writing, of failure to follow the Plans' procedures for filling a Claim	5 days
d.	Notification of Adverse Benefit Determination on Appeal	30 days
e.	Reduction of termination before the end of the treatment	15 days
f.	Request to extend course of treatment	15 days

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care or a Pre-Service Claim; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.

Notification to claimant of benefit reduction	Sufficiently prior to scheduled termination of course of treatment to allow claimant to appeal
Notification to claimant of rescission	30 days
Notification of determination on Appeal of Urgent Care Claims	24 hours (provided claimant files Appeal more than 24 hours prior to scheduled termination of course of treatment)
Notification of Adverse Benefit Determination on Appeal for non-Urgent Claims	15 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state (as required by Federal Law) in a manner calculated to be understood by the claimant:

(1) The specific reason or reasons for the adverse determination.

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

(3) 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.

(4) A description of the Plan's internal Appeal procedures. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of

ERISA following a Final Adverse Benefit Determination.

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

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

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment.

There are two levels of internal appeal available to a Covered Person (or his/her authorized representative). Both must be requested prior to the end of the initial appeal period. They are as follows:

(1) The first level is the appeal process directed to the Claims Supervisor.

(2) The second level is the appeal process directed to the Plan Administrator.

Both the Claims Supervisor and the Plan Administrator will follow the review guidelines outlined in this section in making their determinations.

A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all do a document, record, or other information shall be considered relevant to a Claim if it:

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

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

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

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

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.

The review shall take into account all comments, documents, records, and other information

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

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

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

(1) The specific reason or reasons for the adverse determination.

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

(3) A description of the Plan's review procedures and the time limits applicable to such procedures.

(4) This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

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

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

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

COORDINATION OF BENEFITS

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

The plan that pays first according to the COB rules (Refer to Benefit Plan Payment Order that follows) will pay as if there were no other plans involved. As a subsequent plan, this Plan will consider the allowable amount to be the lesser of:

(1) what this Plan would have allowed as the primary plan; or

(2) the lesser amount allowed by any preceding plan(s).

The Total payment by this Plan may be reduced so as not to exceed 100% of this total allowable amount when added to any preceding plan's reimbursement and any responsibility of the Covered Person. Should the reimbursement(s) by any preceding plan(s) exceed this total allowable, no payment will be made by this Plan.

If the primary or any other preceding plan denies a claim due to the Covered Person or provider's failure to respond to a request for more information, this Plan will not consider the charges as eligible.

If the primary or any other preceding plan denies a claim for lack of Medical Necessity, this Plan will not consider the charges as eligible. The appeals procedures under the prior plan(s) must be exhausted and the results provided to this Plan before charges will be reviewed for consideration under this Plan's benefits.

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

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

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

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

Allowable Charge. To be considered a Covered Charge under this Plan, treatment, services and/or supplies must meet all of the following criteria: **(1)** Medically Necessary; **(2)** Ordered by an appropriate Physician; **(3)** Not excluded under the Plan; and **(4)** Meets the standards of care for the diagnosis.

Automobile limitations. When medical payments are available under vehicle insurance which insures the Covered Person, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. (For purposes of this section, "available" means that the insured has personal injury coverage under his/her personal automobile insurance, and applies whether the

coverage is provided directly or indirectly (i.e., under a spouse's or parent's auto policy). This Plan is secondary even if no claim is filed with the auto carrier. Accident claims filed with this Plan will not be considered pending receipt of the auto policy information. If the information is not provided within the requested period, the claim(s) will be denied. (Refer to the Claims Procedure section.)

This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier (only available in some states).

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

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

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

(a) The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan which covers the person as a dependent ("Plan B").

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

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

(d) When a child is covered as a Dependent and the parents are married, are living together whether or not they have ever been married or not separated or divorced, these rules will apply:

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

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

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

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

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be

considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

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

(iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a Dependent and the parents are not separated or divorced.

(v) If there is no court decree allocating responsibility for child's health care expenses or health coverage or for parents who were never married to each other and not living together, the rules apply as follows as long as paternity has been established:

1. The Plan of the Custodial Parent;
2. The Plan of the spouse of the Custodial Parent;
3. The Plan of the non-custodial parent; and then
4. The Plan of the spouse of the non-custodial parent.

If a court decree states that one of the parents is responsible for the Dependent Child's health care expenses or health insurance coverage, that Plan is primary. This rule applies to Claim Determination Periods or Plan Years commencing after the Plan is given notice of the court decree.

If a court decree states that both parents are responsible for the Dependent Child's health care expense or health insurance coverage, the provisions of subparagraph (d) of this section shall determine the order of benefits.

For the purposes of this section: **Custodial Parent** means the parent awarded custody by a court decree; or in the absence of a court decree, is the parent with whom the child resides more than one-half of the Calendar Year excluding any temporary visitation. In the case where the parents are not married but are living together, absent any court decree directing otherwise, the Custodial Parent shall be deemed to be the mother of the child and her plan shall be the primary plan.

Claim Determination Period means a Calendar Year. Claim Determination Period does not include any part of the Calendar Year during which a claimant has no coverage under this Plan, or before the date this COB provision or a similar provision takes effect.

(f) If there is still a conflict after these rules (a) – (c) have been applied, the benefit

plan which has covered the Covered Person for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of Allowable Charges when paying secondary.

(g) This Plan will follow the adopted NAIC rules for how to coordinate benefits when a Dependent Child is covered under their own or their spouse's insurance plan and either or both of his/her parents.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon the benefit determination by Medicare under Parts A, B and D or this Plan, if the benefit would be less. The Covered Person must exhaust all option Medicare benefits such as reserved inpatient days before this Plan will be considered the primary payer. This Plan will always follow the standard Medicare Secondary Payer rules as may be revised from time to time.

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

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

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

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

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

While the Covered Person may receive payment of such claims pursuant to the terms of the Plan, the Covered Person shall be required to refund to the Plan all medical or dental expenses paid if the Covered Person Recovers from any other party.

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

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

Payment Prior to Determination of Responsibility of a Third Party

The Plan does not cover nor is it liable for any expenses for services or supplies incurred by a Covered Person for which a third party is required to pay because of the negligence or other tortuous or wrongful act of that third party.

However, subject to the terms and conditions of this Section, the Plan may advance payment after receipt of a properly executed reimbursement agreement and consent to lien, and pay claims in accordance with the Plan of Benefits, until it is determined whether or not a third party is required to pay for those services or supplies.

By accepting an advance of benefits paid by the Plan the Covered Person jointly and severally agrees that:

(1) the Plan has a priority lien against the proceeds of any such settlement, judgment, arbitration, or recovery to assure that reimbursement is promptly made; and

(2) the Plan will be subrogated to every Covered Person's right of recovery from that third party or that third party's insurer to the extent of the Fund's advances any benefit payments; and

(3) the Covered Person(s) will, jointly and severally, reimburse the Plan out of any and all amounts paid or payable to any or all of them by any third party or that third party's insurer to the extent of the entire amount advanced for related claims to the accident or injury by the Plan.

The Plan's reimbursement and/or subrogation rights will include all claims, demands, actions and rights of recovery of all Covered Persons against any third party or insurer, including any Workers' Compensation insurer or governmental agency, and will apply to the extent of any and all advance payments made or to be made by the Plan. This means that the Covered Person recognizes the Plan's rights to 100%, first dollar priority over any and all Recoveries and/or funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, whether by judgment, settlement, arbitration award or otherwise and shall not be limited by any other characterization of the nature or purpose of the amounts recovered or by the identity of the party from which recovery is obtained. This priority is over any claims, including medical, non- medical or dental charges, attorney fees, or other costs and expenses associated with the enforcement of the Plan's rights under this Right of Recovery/Subrogation benefit.

The Plan shall be Subrogated, and shall be entitled to Reimbursement, for any payment by a Third Party to a Covered Person for future medical expenses paid pursuant to a judgment, settlement or contract on the following bases:

(1) If any amount is awarded by means of a verdict after a full and complete trial and the judgment or verdict form itemizes by separate finding or special amount awarded for future medical expenses, such amount shall be binding on the Plan and the Covered Person as the amount of future medical expenses to which the Plan is subrogated and entitled to reimbursement.

(2) If there exists any contract or policy of insurance by which future medical expenses are paid (other than a policy or contract of health care, hospitalization or disability insurance issued to and in the name of such Covered Person), the Plan shall be subrogated to and entitled to reimbursement and deemed secondary or excess insurance to such contract or policy and amounts paid thereby.

(3) If any amount is paid to a Covered Person by means of a settlement or general judgment or verdict which does not itemize components of damage, the Plan Administrator and the Covered Person shall agree on the amount which is attributable to future medical and dental expenses. In the event that the Plan Administrator and the Covered Person cannot agree on the amount attributable to future medical expenses, the Plan Administrator, in its sole and absolute discretion, shall determine the amount attributable to future medical expenses

If any amount awarded under subsection (1), the total amount of future medical expenses to which the Plan is Subrogated and entitled to reimbursement shall be reduced by and, in determining the amount to which the Plan is Subrogated and entitled to reimbursement under subsection (3), consideration may be given to:

(a) the amount of proportionate or comparative fault assessed against the Covered Person which reduces the amount of total future medical expenses which are paid by the other;

(b) the amount not collectible.

In addition, in determining the amount of future medical expenses paid under subsection (3) above, consideration shall be given to the percentage of total future medical expenses paid by the one who is jointly liable with another, the other remaining liable, any discount for present value of future expenses and any discount for possibilities of incurring the claimed future medical expenses.

When any amount is paid or payable pursuant to Subsections (1), (2) or (3) above, the Covered Person shall pay all medical expenses incurred in the future for treatment of the injuries sustained for which the payments under (1), (2) or (3) were made or agreed to be made, and the Plan shall have no responsibility or liability to pay any such future medical expenses, nor shall the amount of any such payment be considered to represent a Covered Expense incurred under this Plan for purposes of satisfying any of the provisions of this Plan with respect to the Deductible or co-payment requirements, until the amount under subsection (1), (2) or (3) is fully used.

The Plan may, at its discretion, start any legal action or administrative proceeding it deems necessary to protect its right to recover any amount it advanced in accordance with the Plan of Benefits, and may try or settle any such action or proceeding in the name of and with the full cooperation of the Covered Persons.

However, in doing so, the Plan will not represent, or provide legal representation for, any covered individual with respect to that Covered Person's damages to the extent those damages exceed any advance on account of the Plan of Benefits.

The Plan may, at its discretion, intervene in any claim, legal action, or administrative proceeding started by any Covered Person against any third party or that third party's insurer on account of any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person's injury or illness that resulted in the advance by the Plan.

Reimbursement and/or Subrogation Agreement

The Covered Person (or his/her representative in the case of minor child(ren) or an incapacitated Covered Person), recognizes that compliance with this section of the Plan is a condition of participating in and having payments made under this Plan, and that as such the Covered Person agrees to the provisions of this section. The Plan's standard administrative procedure will be to ascertain the nature of any injury to determine whether a third party could be held liable. Claims will not be paid until this determination is made. If it is determined that the claim may be the result of a third party's negligence, the Plan will not process any claims without a properly signed Reimbursement Agreement and Consent to Lien.

Every Covered Person on whose behalf an advance may be payable must execute and deliver any and all agreements, instruments and papers requested by or on behalf of the Plan (including but not limited to the reimbursement agreement and consent to lien), and must do whatever is necessary to protect the Plan in obtaining reimbursement and/or subrogation rights. As a condition precedent to the advance payment of related claims by the Plan, all Covered Persons will, upon written request, execute a Reimbursement Agreement or Consent to Lien in a form provided by or on behalf of the Plan.

If any Covered Person does not execute any such Reimbursement Agreement or Consent to Lien for any reason, it will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan reimbursement and/or subrogation rights if the Plan, at its discretion, makes an advance and inadvertently pays benefits in the absence of a reimbursement and/or subrogation agreement.

Cooperation with the Plan by All Covered Persons

By accepting an advance for related claim payment, every Covered Person agrees to do nothing that will waive, compromise, diminish, release or otherwise prejudice the Plan's Reimbursement and/or Subrogation rights.

By accepting an advance payment for related claims to an injury, every Covered Person agrees to notify and consult with the Plan Administrator or its designee before:

(1) starting any legal action or administrative proceeding against a third party based on

any alleged negligent, intentional or otherwise wrongful action that may have caused or contributed to the Covered Person's injury that resulted in the Plan advance payment of claims; or

(2) entering into any settlement agreement with that third party or that third party's insurer that may be related to any actions by that third party that may have caused or contributed to the Covered Person's injury that resulted in the Plan's advance for claims related to such injury.

By accepting an advance in claim payments, every Covered Person agrees to keep the Plan Administrator and Claims Supervisor informed of all material developments with respect to all such claims, actions or proceedings.

All Recovered Proceeds Are to Be Applied to Reimbursement of the Fund

The Covered Person agrees to automatically assign his/her rights against any Third Party or insurer when this provision applies. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered' Person's Third Party Claims.

By accepting an advance payment of claims for an injury, every Covered Person agrees to reimburse Plan for all such advances by applying **any and all** amounts paid or payable to them by any third party or that third party's insurer by way of settlement or in satisfaction of any judgment or agreement, regardless of whether those proceeds are characterized in the settlement or judgment as being paid on account of the medical expenses for which any advance has been made by the Health Fund. In such event the Plan must be fully reimbursed within 31 days, or the claimant will have additional liability for interest and all costs of collection, including reasonable attorney's fees.

If the Covered Person fails to take action against a responsible Third Party to recover damages within one year or within thirty (30) days of a request by the Plan, the Plan shall be deemed to have acquired, by assignment or Subrogation, a portion of the Covered Person's claim equal to its prior payments. The Plan may thereafter commence proceedings directly against any responsible Third Party. The Plan shall not be deemed to waive its rights to commence action against a Third Party if it fails to act after the expiration of one (1) year, nor shall the Plan's failure to act be deemed a waiver or discharge of the Lien described in this section.

The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to Recover payment for medical or dental expenses from the Covered Person.

Also, The Plan's right to Subrogation and reimbursement still applies if the Recovery received by the Covered Person is less than the claimed damage, and as a result, the claimant is not made whole.

If any Covered Person fails to reimburse the Plan as required by this section, the Plan may deny payment of claims and treat prior paid claims (related to the accident/injury) as overpayments recoverable by offset against any and all future claims for benefits that may become payable on behalf of all Covered Persons within the injured Covered Person's immediate family to the amount not reimbursed.

Once the claim is settled, the Plan will not pay future benefits for claims related to that Injury or accident unless it is determined by the Plan Administrator or Claims Supervisor that the original settlement was reasonable and the subsequent claims were not recognized in the settlement.

The Plan shall have no obligation whatsoever to pay medical or dental benefits incurred by a

Covered Person if a Covered Person refuses to cooperate with the Plan's Reimbursement and/or Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its Reimbursement and Subrogation rights.

No Fault Insurance Coverage

If you are required to have no-fault insurance coverage, the automobile No-Fault Insurance carrier will initially be liable for lost wages, medical, surgical, hospital, and related charges and expenses up to the greater of:

(1) the maximum amount of basic reparation benefit required by applicable law: or

(2) the maximum amount of the applicable No-Fault Insurance coverage in effect.

The Plan will, thereafter, consider any excess charges and expenses under the applicable provisions of the respective Plan in which you are provided health coverage. Before related claims will be paid through this Fund, the Covered Person or his dependent will be required to sign a Reimbursement Agreement.

If the Participant or his dependent fails to secure No-Fault Insurance as required by state law, the Participant or dependent is considered as being self-insured and must pay the amount of the basic medical reparation expenses for himself and/or his dependents arising out of the accident.

Refund of Overpayment of Benefits - Right of Recovery

If the Fund pays benefits for expenses incurred on account of you or your Eligible Dependent, you or any other person or organization that was paid must make a refund to the Fund if:

(1) all or some of the expenses were not paid, or did not legally have to be paid by you or your Eligible Dependents.

(2) all or some of the payment made by the Fund exceeds the benefits under the Plan.

(3) all or some of the expenses were recovered from or paid by a source other than this Plan including another Plan to which this Plan has secondary liability under the Coordination of Benefits provisions.

This may include payments made as a result of claims against a third party for negligence, wrongful acts or omissions. The refund shall equal the amount the Fund paid in excess of the amount it should have paid under the Plan. In the case of recovery from or payment by a source other than this Plan, the refund equals the amount of the recovery or payment up to the amount the Fund paid.

If you or any person or organization that was paid does not promptly refund the full amount, the Fund may reduce the amount of any future benefits that are payable under the Plan. The reductions will equal the amount of the required refund. The Fund may have other rights in addition to the right to reduce future benefits.

RIGHT OF RECOVERY

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

If the Covered Person's total Recovery from all sources does not adequately reimburse him for his expenses and injuries, the Plan Administrator, in its sole and absolute discretion, may accept a lesser amount in full satisfaction of its rights. The Plan Administrator shall have sole authority to determine whether a Covered Person has been adequately reimbursed and whether to accept a lesser amount.

Waiver of Subrogation Rights. The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan's Subrogation rights. Such waiver shall not automatically occur in any matter. Waivers of the Subrogation and reimbursement interest of the Plan may be granted when the expected administrative costs exceed the expected reimbursement or savings to the Plan. Waivers of Subrogation and reimbursement interests will generally not be granted if the past medical expenses are greater than $500 or if the total judgment or settlement exceeds $5,000.

Conflict Within the Plan. If any portion of this Section on Subrogation and reimbursement is deemed to conflict with any other provision of the Plan on coordination of benefits of primary-secondary insurance coverage, the other portion of the Plan shall control and the provisions of this section shall supplement such other provisions to the extent that they are not inconsistent.

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

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and Subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and Subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible Third Party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and Subrogation rights on all Recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Defined terms:

"Covered Person" means anyone covered under the Plan, including minor dependents.

"Lien" is a right created by law to obtain Reimbursement from monies paid by a Third Party in compensation for a loss. This means the Plan retains the right to repayment for the value of all benefits provided by the Plan that are associated with the Injury or Illness for which the Third Party is or may be responsible, plus the costs to perfect the Lien. To prevent a double Recovery on the payment of medical expenses, a Lien is created in favor of this Plan in providing payment of medical expenses for the injured Covered Person.

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

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

"Reimbursement" means that the Plan has a right to be paid a Recovery received by the participant or to the extent not contrary to law, to offset all or any part of the Plan's Recovery against any

amount the Plan or the Employer owes to the Covered Person or owes as benefits for the Covered Person.

"Subrogation" means the right of the Health Fund to be substituted in place of any Covered Person with respect to that Covered Person's lawful claim, demand, or right of action against a third party who may have wrongfully caused the Covered Person's injury or illness that resulted in a payment of benefits by the Plan.

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

CONTINUATION COVERAGE RIGHTS UNDER COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under The Larson Group/Larson Farm & Lawn Employee Health Care Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

Complete instructions on COBRA, as well as election forms and other information, will be provided by the COBRA Administrator to Plan Participants who become Qualified Beneficiaries under COBRA. (Refer to General Plan Information section for contact information.)

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., common-law employees (full or part-time), self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United

States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

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

What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(1) The death of a covered Employee.

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

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

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

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

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied by other group health plans if there is more than a 63-day gap in health coverage and election of COBRA continuation coverage may help you avoid such a gap. Second, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the

maximum time available to you, you will lose the right to convert to an individual health insurance policy, which does not impose such pre-existing condition exclusions. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

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

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

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. Recent changes in the law increased this assistance temporarily to 80%, and temporarily extended the period of COBRA continuation coverage for eligible individuals. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628- 4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

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

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

(2) death of the employee,

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

(4) enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.

NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the Plan Administrator.

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

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

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

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

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

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

Is COBRA coverage available if a Qualified Beneficiary has other group health plan

coverage or Medicare? Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

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

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

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

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

(4) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(5) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).

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

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

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

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

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

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

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

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

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

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

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

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

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

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

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

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

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

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

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

IF YOU HAVE QUESTIONS

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

KEEP YOUR PLAN ADMINISTRATOR INFORMED OF ADDRESS CHANGES

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

RESPONSIBILITIES FOR PLAN ADMINISTRATION

PLAN ADMINISTRATOR. Integrity Home Care Employee Select Supplemental Plan is the benefit plan of Integrity Home Care, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or committee may be appointed by Integrity Home Care to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator or a committee member resigns, dies or is otherwise removed from the position, Integrity Home Care shall appoint a new Plan Administrator as soon as reasonably possible.

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

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR

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

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

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

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

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

(6) To appoint a Claims Supervisor to pay claims.

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

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

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

(10) To maintain the Plan in accordance with all applicable State and Federal laws. If this Plan has not been amended according to a required change, the administration of the Plan will comply with the change until such time that the Plan is amended.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves **without** compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

(1) with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;

(2) by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and

(3) in accordance with the Plan documents to the extent that they agree with ERISA.

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

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIMS SUPERVISOR IS NOT A FIDUCIARY. A Claims Supervisor is **not** a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

DELAY OF DUTIES OF PLAN ADMINISTRATOR OR CLAIMS SUPERVISOR DUE TO FORCE MAJEURE. Force Majeure is a circumstance not within a person's control, including but not limited to: fire, flood, war, civil disturbance/riot, court order, strike, partial or complete destruction of facilities, etc. No suit or action in law or equity may be taken against them on account of any of these events. The Plan Administrator and Claims Supervisor will have no liability or obligation if their respective services are delayed or not provided; or if medical care is delayed, not provided, or covered as non-network care due to Force Majeure. The Plan Administrator and Claims Supervisor will, however, make a good-faith effort to provide services during and subsequent to any of these events.

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

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

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

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

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

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

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

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

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

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

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

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

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

(a) Not use or further disclose the Protected Health Information other than as

permitted or required by the Plan documents or as required by law;

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

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

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

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

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

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

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

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

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

The following members of Integrity Home Care's workforce are designated as authorized to receive Protected Health Information from Integrity Home Care Employee Select Supplemental Plan ("the Plan") in order to perform their duties with respect to the Plan: Privacy Officer and others as authorized by the Employer.

COMPLIANCE WITH HIPAA ELECTRONIC SECURITY STANDARDS. Under the Security Standards for the Protection of Electronic Protected Health Information (45 CFR Part 164.300 et. seq., the "Security Standards"), the Employer agrees to the following:

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

mean Protected Health Information that is transmitted by or maintained in electronic media.

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Supervisor.

Assignment and Non-Alienation of Benefits: Amounts payable at any time may be used to make direct payments to health care providers. Except as applicable law may otherwise require, no benefit, right or interest of any member hereunder shall at any time be used or be subject in any manner to alienation by anticipation, sale, transfer, assignment, bankruptcy, pledge, attachment, charge or encumbrance of any kind. Any attempt to alienate, sell, transfer, assign, pledge, attach, charge or otherwise encumber any such amount, whether presently or hereafter payable, shall be void. The Plan shall not be liable for or subject to the debts or liabilities of any person entitled to any amount payable under the Plan, or any part thereof.

Assignment means, for purposes of this Plan, that the Plan may pay any benefits due under this Plan directly to the Provider. The rights of a participant and the benefits to which he is entitled or for which he applies under the Plan are not assignable, except for assignment of payments directly to a provider, or in accordance with the subrogation provisions of the Plan. The Plan has full discretionary authority to accept or reject an assignment. The provisions of this Plan shall supersede any and all other assignment or alienation provisions, under whatever terms that may be used, that a member may make with a provider of health care services. Moreover, this Plan has priority lien against any and all proceeds that may be due the plan.

THE TRUST AGREEMENT

If this Plan is established under a Trust agreement, that agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

(1) A copy of the Trust agreement.

(2) A complete list of employers and employee organizations sponsoring the Plan. Service of legal process may be made upon a Plan trustee or Plan Administrator.

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

The Plan Administrator will have final determination of benefits if there are typographical or grammatical errors that appear in this document. Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

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

PHYSICAL EXAM

The Plan has the right and opportunity to examine any Covered Person with respect to a claim for benefits that is pending under the Plan when and as often as it may reasonably require and at the Plan's expense. A Covered Person is required by the Plan to submit to such examination as a condition of coverage. This may be required to assist the Plan Administrator/Claims Supervisor in determination of non-covered services (i.e., malpractice claim, suspected felony, or other non-covered service).

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).

MATERIAL MODIFICATIONS

Material Modifications to the Plan will be provided to all Covered Persons within sixty (60) days following the effective date of the change.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

As a Plan Participant in this 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:

Receive Information About Your Plan and Benefits:

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as Pension and Welfare Benefits Administration).

Obtain, upon written request to the Plan Administrator, copies of Plan documents and other Plan

information. The Plan Administrator may make a reasonable charge for the copies.

Continue Group Health Plan Coverage:

Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

Enforce Your Rights:

If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

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

In addition, if a Plan Participant disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, he or she may file suit in federal court if resolution of the dispute is not otherwise resolved.

Note: As per this Plan’s provisions, the right to file suit in state or federal court may be initiated only following exhaustion of the grievance and appeals processes as outlined in this Plan document. In addition, you will lose your right to file suit should you fail to follow this Plan’s grievance and appeals processes as outlined in this Plan document.

Prudent Actions by Plan Fiduciaries:

In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of this Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

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

Assistance with Your Questions:

If the Plan Participant has any questions about the Plan, he or she should contact the Plan

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

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees.

PLAN NAME: Integrity Home Care Employee Select Supplemental Plan

PLAN NUMBER: 502

GROUP NUMBER: 0117IHC

TAX ID NUMBER: 43-1875357

PLAN EFFECTIVE DATE: January 1, 2008. Herein revised January 1, 2017.

PLAN YEAR ENDS: December 31st

EMPLOYER INFORMATION

Integrity Home Care
2960 North Eastgate
Springfield, Missouri 65803
(417) 889-9773

PLAN ADMINISTRATOR

Co-Owner
Integrity Home Care
2960 North Eastgate
Springfield, Missouri 65803
(417) 889-9773

NAMED FIDUCIARY

Co-Owner
Integrity Home Care
2960 North Eastgate
Springfield, Missouri 65803

AGENT FOR SERVICE OF LEGAL PROCESS

Co-Owner
Integrity Home Care
2960 North Eastgate
Springfield, Missouri 65803

CLAIMS SUPERVISOR

Mercy Benefit Administrators
PO Box 14230
Springfield, MO 65814
(877) 875-7700

UTILIZATION REVIEW COORDINATOR

Mercy Care Management
4520 S National Ave
Springfield, Missouri 65810

TRUSTEE(S)

Co-Owner
2960 North Eastgate
Springfield, Missouri 65803

BY THIS AGREEMENT, Integrity Home Care Employee Select Plan for Dental, Vision and Short Term Disability, is hereby adopted as shown.

IN WITNESS WHEREOF, this instrument is executed for Integrity Home Care on or as of the day and year first below written.

By: _____
Plan Administrator
Integrity Home Care

Date: 2/17/17

Witness: _____

Date: 2/17/17

ELIGIBILITY APPENDIX

INTEGRITY HOME CARE

Integrity Home Care Employee Major Medical Health Care Plan

Integrity Home Care will utilize the Look Back Measurement Period Method to determine the Full-time status of Ongoing Employees and New Variable Hour, Part-time or Seasonal Employees for purpose of Plan eligibility under the Employer Shared Responsibility provisions of the Affordable Care Act. Full-Time Employee status will be based on the average Hours of Service during a Standard Measurement Period (Ongoing Employees) or an Initial Measurement Period (New Variable Hour, Part-time or Seasonal Employees). Employee eligibility (or lack thereof) for coverage under the Plan will extend through the Ongoing Employee Stability Period or New Employee Stability Periods established by the Plan, as applicable. Set forth below is a detailed description of the Look Back Measurement Period Method.

Measurement Periods

All Integrity Home Care Employees will fall under one of two Measurement Period options - the Standard Measurement Period for Ongoing Employees and Initial Measurement Periods for New Variable Hour, Part-time or Seasonal Employees. All Employee categories are treated the same for purpose of the Look Back Measurement Period Method, including hourly and non-hourly. For the first year of applicability of the Standard Measurement Period, Integrity Home Care will use the Transitional Relief for 2015 (detailed below).

Ongoing Employees

For Ongoing Employees, a 12 Calendar Month Standard Measurement Period will be utilized to determine which Employees are eligible for coverage beginning at each plan year anniversary of January 1. If, during the Standard Measurement Period, an Employee is determined to have worked, on average 30 or more Hours of Service per week (130 Hours of Service or more in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] they will be offered coverage for the 12 Calendar Month Ongoing Employee Stability Period beginning on the plan year anniversary.

An Ongoing Employee Administrative Period, never to exceed 90 calendar days, will follow the Standard Measurement Period. During this Ongoing Employee Administrative Period, the Plan will make eligibility determinations for the Ongoing Employee Stability Period. If an Employee is determined to be eligible for coverage for the Ongoing Employee Stability Period, they will be eligible for the entire 12 Calendar Month duration as long as they remain in a class eligible for coverage and do not experience a Break in Service. If an Employee is not determined to be eligible for coverage for the Ongoing Employee Stability Period, they will be ineligible for the entire 12 Calendar Month duration. The timing of the Standard Measurement Period and associated Ongoing Employee Administrative Period and Ongoing Employee Stability Period will be static from year to year.

The following will apply for ongoing employees:

Standard Measurement Period	11/01-10/31 (12 Calendar Months)
Ongoing Employee Administrative Period	11/01-12/31 (2 Calendar Months)
Ongoing Employee Stabilization Period	01/01-12/31 (12 Calendar Months)

New Variable Hour Employee, Part-time Employee or Seasonal Employee

A New Variable Hour, Part-time or Seasonal Employees will complete a 12 Calendar Month Initial Measurement Period to determine eligibility for coverage. The 12 Calendar Month Initial Measurement Period will begin on the first day of the Calendar Month following date of hire (if date of hire is the first day of the Calendar Month, the Initial Measurement Period will begin on the date of hire). During the Initial Measurement Period, if an Employee is determined to have worked, on average 30 or more Hours of Service per week (130 Hours of Service or more in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] they will be offered coverage for a subsequent 12 Calendar Month New Employee Stability Period.

A New Employee Administrative Period, never to exceed 90 days or extend beyond the last day of the Calendar Month that begins on or after an Employee's anniversary date, will follow the Initial Measurement Period. During this New Employee Administrative Period, the Plan will make an eligibility determination for the New Employee Stability Period. If an Employee is determined to be eligible for coverage during a New Employee Stability Period, they will be eligible for the entire 12 Calendar Month duration as long as they remain in a class eligible for coverage and do not experience a Break in Service. If an Employee is determined to be ineligible for coverage during a New Employee Stability Period, they will be ineligible for the entire 12 Calendar Month New Employee Stability Period. The timing of the Initial Measurement Period, New Employee Administrative Period and New Employee Stability Period will vary from Employee to Employee, but Initial Measurement Periods will always commence on one of 12 monthly periods.

For purposes of determining whether an employee is a New Variable Hour, Part-time or Seasonal Employee, the Employer will not take into account the likelihood that the Employee may terminate employment with the Employer (including any member of the Employer) before the end of the Initial Measurement Period.

Standard Measurement Period	12 Calendar Months
New Employee Administrative Period	1 Partial Month, if any plus 1 Calendar Month
New Employee Stabilization Period	12 Calendar Months

New Variable Hour Employee, Part-time Employee or Seasonal Employee experiencing a Change in Employment Status during the Initial Measurement Period

If a Variable, Part-time or Seasonal Employee experiences a change in employment status before the end of the Initial Measurement Period such that the Employee, if hired into that new position, would reasonably be expected to be employed on average at least 30 Hours of Service per week (130 Hours of Service in a Month), [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] they will be offered coverage following completion of the waiting period applicable to New Non-variable Hour Employees or, if earlier, the first day of the New Employee Stability Period, if the Employee averaged 30 Hours of Service or more per week (130 Hours of Service or more in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] during the Initial Measurement Period.

Tracking Hours of Service
Each Employee's Hours of Service will be determined in a manner consistent with Internal Revenue Code Section 4980H and the regulations issued thereunder.

Break in Service Rules
If an Employee experiences a Break in Service during a Measurement Period or Stability Period, they will be treated as a New Employee upon the date that the Employee resumes Hours of Service for the Employer.

Alternatively, an Employee who does not experience a Break in Service, but does have a period during

which they are not credited with any Hours of Service, will be considered a Continuous Employee. The Continuous Employee will resume their associated Measurement Period and Stability Period upon resuming Hours of Service for the Employer. They will be credited no Hours of Service for the time missed during the Measurement Period. If they were enrolled in coverage prior to the start of the period with no Hours of Service, the Continuous Employee's coverage will be effective the first day of the month following the date Hours of Service resume.

Special Unpaid Leave of Absence Rules

If the Employee takes a Special Unpaid Leave of Absence during which no Hours of Service are credited to the Employee, and the Employee resumes service as a Continuous Employee, special treatment is required for purposes of the Measurement Period.

The Employer will disregard the period that such Employee was on a Special Unpaid Leave when calculating the Hours of Service for the Employee during the applicable Measurement Period (i.e., the Measurement Period for such an Employee will be reduced by the period the Employee is on a Special Unpaid Leave).

Defined terms

Break in Service - a period of at least 13 consecutive weeks during which the Employee has no Hours of Services, as defined herein. Using the rule of parity, a Break in Service may also include a period with no credited Hours of Service (of less than 13 weeks) that is at least four consecutive weeks in duration and is longer than the Employee's period of employment immediately preceding that period with no credited Hours of Service (determined after application of the procedures applicable to Special Unpaid Leaves of Absence prescribed herein).

Calendar Month - one of the 12 months named in the calendar (i.e. January, February, etc.).

Continuous Employee - an employee who has a period during which they are credited with no Hours or Service, but the period is not sufficient enough in length to be considered a Break in Service.

Full time Employee - an Employee is considered to be Full-Time if he or she works an average of at least 30 Hours of Service per week with an Employer (130 Hours of Service in a Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] and is on the regular payroll of the Employer for that work.

Hours of Service - each hour for which the Employee is paid or entitled to payment for performance of services for the Employer AND any hour for which the Employee is paid or entitled to payment by the Employer for a period of time during which no duties are performed due to any of the following (i.e., paid leave): vacation; holiday; illness or incapacity to the extent such coverage is provided by the Employer; layoff; jury duty; military duty or leave of absence.

Initial Measurement Period - for a New Variable Hour, Part-time or Seasonal Employee, the 12 Calendar Month period beginning on the first day of the Calendar Month following date of hire (if date of hire is the first day of the Calendar Month, the Initial Measurement Period will begin on date of hire). Average Hours of Service are tracked during this period to determine eligibility for coverage during the subsequent New Employee Stability Period.

Measurement Period - the Initial Measurement Period or the Standard Measurement Period, as applicable.

Month - the period that begins on any date following the first day of a calendar month and that ends on the immediately preceding date in the immediately following calendar month (for example, from February 2 to March 1 or from December 15 to January 14).

New Employee - an employee who has been employed by an applicable large employer for less than one complete Standard Measurement Period.

New Employee Administrative Period - the partial month, if any, preceding the Initial Measurement Period and the two Calendar Months following the Initial Measurement Period. During this time, the Employer will determine if the New Employee qualifies as a Full-time Employee for purpose of eligibility for coverage during the subsequent New Employee Stability Period.

New Employee Stability Period - 12 Calendar Months following the Initial Measurement Period and New Employee Administrative Period. If determined Full-time during the Initial Measurement Period, coverage will be offered for the duration of this period, barring a Break in Service. If determined not to be Full-time, coverage will not be offered for the duration of this period.

Non-variable Hour Employee - a New Employee for whom it can be determined on the start date that the Employee is reasonably expected to work, on average, 30 Hours of Service or more per week (130 Hours of Service per Month) [or 20 or more Hours of Service over 13 weeks for the Select Supplemental Plan] during each Month of employment during the Initial Measurement Period. The determination whether an employee is non-variable or not is based on the facts and circumstances that exist at the time of employment. An inclusive list of factors that may be used for this determination are: whether the Employee is replacing an Employee who is or was full-time; the extent to which Hours of Service for Ongoing Employees in comparable positions vary above or •below the 30 Hours of Service threshold during recent Measurement Periods; or whether the job was advertised as full-time or not.

Ongoing Employee - an employee who has been employed by an applicable large employer for at least one complete Standard Measurement Period.

Ongoing Employee Administrative Period - the two Calendar Months following the Standard Measurement Period. During this time, the Employer will determine which Ongoing Employees qualify as Full-time Employees for purpose of eligibility for coverage during the subsequent Ongoing Employee Stability Period.

Ongoing Employee Stability Period - 12 Calendar Months following the Standard Measurement Period and Ongoing Employee Administrative Period. If an Ongoing Employee is determined to be Full-time during the Standard Measurement Period, coverage will be offered for the duration of this period, barring a Break in Service. If determined not to be Full-time, coverage will not be offered for the duration of this period.

Part-time Employee - a New Employee who the applicable large employer member reasonably expects to be employed on average less than 30 Hours of Service per week. Whether an Employer's determination that a New Employee is a Part-time Employee is reasonable is based on the facts and circumstances at the Employee's start date.

Seasonal Employee - a New Employee who is hired into a position for which the customary employment is 6 months or less (although it can be longer under unusual circumstances) and the period of employment customarily begins during the same time of year each year.

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

Stability Period - the New Employee Stability Period or the Ongoing Employee Stability Period, as applicable. Standard Measurement Period- for Ongoing Employees, the 12 Calendar Month period from November 1 - October 31. Average Hours of Service are tracked during this period to determine eligibility for coverage during the subsequent Ongoing Employee Stability Period.

Variable Hour Employee - a New Employee who, based on the facts and circumstances at the

Employee's start date, the applicable large employer member cannot reasonably determine whether the employee is expected to be employed on average at least 30 Hours of Service per week because the Employee's hours are variable or otherwise uncertain.