



CBA Blue

An Independent Licensee of the Blue Cross and Blue Shield Association

SYSTEMSPLUS HEALTH + ***EMPLOYEE HEALTH PLAN***

Summary Plan Description

Effective: May 1, 2010
Revised: May 1, 2011

SYSTEMSPPLUS HEALTH + EMPLOYEE HEALTH PLAN

INTRODUCTION

This is a summary of the SystemsPlus Health + Employee Health Plan adopted by your employer (the "Plan"). The SystemsPlus Health Plan is available only to members of the National Franchisee Association ("NFA").

This booklet is provided to help you understand how the Plan works. It highlights what types of expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan.

Your employer, as a member of the National Franchisee Association, is sponsoring this self-funded ERISA employee health plan which provides medical benefits for all covered employees and their covered dependent(s). Stop loss reinsurance is being purchased from SystemsPlus Mutual Insurance Company to protect the Plan Sponsor from unpredictable claims experience.

Each covered person is entitled to the benefits outlined in this Plan Document. To obtain benefits from the Plan, the covered person must ultimately submit a diagnostic bill to the Contract Administrator, Comprehensive Benefits Administrator, Inc. dba CBA Blue, for processing. This claim submission is required for reimbursement to the employee or direct payment to the service provider by the SystemsPlus Health + Employee Health Plan.

In any event where a question may arise as to a claim for benefits or denial of a claim for benefits, the Employer, the Contract Administrator (the third party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan document, which is also the Summary Plan Description within the meaning of the Employee Retirement Income Security Act of 1974, as amended ("ERISA").

A clerical error will neither invalidate the employee's coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

Comprehensive Benefits Administrator, Inc. dba CBA Blue, an independent licensee of the Blue Cross and Blue Shield Association, provides administrative claims payment services only and does not assume any financial risk or obligation with respect to claims.

TABLE OF CONTENTS

GENERAL INFORMATION	1
SCHEDULE OF BENEFITS	3
GENERAL PROVISIONS	15
PLAN ENROLLMENT	15
PREEXISTING CONDITION LIMITATION	17
COORDINATION OF BENEFITS	18
TERMINATION OF BENEFITS	20
MILITARY LEAVE	20
REINSTATEMENT OF COVERAGE	20
EXTENSION OF BENEFITS (COBRA)	21
PLAN DETAILS	26
MEDICAL COVERED EXPENSES	33
GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS	39
CLAIM FILING PROCEDURES	43
CLAIM REVIEW PROCEDURES	44
MISCELLANEOUS PROVISIONS	51
ERISA STATEMENT OF RIGHTS	58
DEFINITIONS	60

GENERAL INFORMATION

Plan Sponsor:

Federal Tax Identification Number: [PLACE STICKER HERE]

Name of the Plan:

Plan Number:

Plan Administrator: Plan Sponsor, acting through its exclusive agent, Allison Hazen, Trustee of the NFA Member Plan Master Trust and exclusive agent of the Sponsor:
61 Overlook Drive
South Burlington, VT 05403-7887
Phone: 802-865-5291
Cell: 802-922-3548

Group Number: 50704

Benefits Covered: Medical benefits under the SystemsPlus Health + Employee Health Plan

Plan Effective Date: May 1, 2010

Plan Anniversary Date: May 1st

Plan Year Ends: April 30th

Plan Revision Date: May 1, 2011 – This document replaces the previous Employee Health Plan Document in its entirety. All claims incurred prior to May 1, 2011 will be governed by the terms of the Plan in effect prior to this revision date.

Contract Administrator/Pre-Certification Administrator:

Comprehensive Benefits Administrator, Inc. dba CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365
Customer Service & Pre-Certification: (888) 222-9206

Agency for Service of Legal Process: Allison Hazen, Trustee of the NFA Member Plan Master Trust and exclusive agent of the Sponsor
61 Overlook Drive
South Burlington, VT 05403-7887
Phone: 802-865-5291
Cell: 802-922-3548

Contributions: The Plan is contributory.

Eligibility Requirements: All salaried employees and all full-time hourly “non-crew” employees working an average of thirty (30) hours per week.

Dependent Children's Coverage: Married or unmarried dependent children up to twenty-six (26) years of age.

Eligibility Date: First day of the month following sixty (60) days of continuous employment unless the waiting period is waived as a condition of employment.

Termination Date: See "Termination of Benefits" section.



SystemsPlus Health + Employee Health Plan Schedule of Medical Benefits Plan 1-A

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	\$500 per individual \$1,000 per family	\$1,000 per individual \$2,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year.	\$1,000 per individual \$2,000 per family	\$2,000 per individual \$4,000 per family
Preventive Services:	100%	60%
Physician's Office Visits: One copayment per physician per day.	\$20 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of \$3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	100% to a maximum of \$3,000 per plan year; then deductible and 80%	60% to a maximum of \$3,000 per plan year; then deductible and 60%
Chiropractic Care: Maximum of \$1,000 per plan year.	\$20 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	80%	80%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	\$40 copayment	Deductible; 60%



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 1-A**

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	\$100 copayment, deductible; then 80%	\$100 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	In-Network deductible, then 80%
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 80%	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	In-Network deductible, then 80%
Dialysis Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 60%
Outpatient Mental Health/Substance Abuse:	\$20 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 30 for a list of these services)	\$500 non-compliance penalty	\$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$10 \$25 \$50	Not Covered



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 1-A**

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$20 \$50 \$100	N/A
Lifetime Benefit Maximum Per individual.	Unlimited	
Annual Benefit Maximum Per individual.	\$2,000,000	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are combined.
6. Copayments and precertification penalties are not applied to the deductible or out-of-pocket maximum.
7. The annual benefit maximum applies only to essential benefits, as defined herein.



SystemsPlus Health + Employee Health Plan Schedule of Medical Benefits Plan 2-A

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	\$1,000 per individual \$2,000 per family	\$2,000 per individual \$4,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (excludes deductible).	\$3,000 per individual \$6,000 per family	\$6,000 per individual \$12,000 per family
Preventive Services:	100%	60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: \$20 copayment Specialist: \$40 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of \$3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	100% to a maximum of \$3,000 per plan year; then deductible and 80%	60% to a maximum of \$3,000 per plan year; then deductible and 60%
Chiropractic Care: Maximum of \$1,000 per plan year.	\$40 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	80%	80%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	\$40 copayment	Deductible; 60%



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 2-A**

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	\$100 copayment, deductible; then 80%	\$100 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 80%	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 60%
Outpatient Mental Health/Substance Abuse:	\$20 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 30 for a list of these services)	\$500 non-compliance penalty	\$500 non-compliance penalty
Prescription Drug Benefit (Retail- 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$10 \$35 \$60	Not Covered



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 2-A**

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$20 \$70 \$120	N/A
Lifetime Benefit Maximum Per individual.	Unlimited	
Annual Benefit Maximum Per individual.	\$2,000,000	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are combined.
6. Copayments and precertification penalties are not applied to the deductible or out-of-pocket maximum.
7. The annual benefit maximum applies only to essential benefits, as defined herein.



SystemsPlus Health + Employee Health Plan Schedule of Medical Benefits Plan 3-A

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	\$2,000 per individual \$4,000 per family	\$4,000 per individual \$8,000 per family
Plan Coinsurance:	80%	60%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (excludes deductible).	\$6,000 per individual \$12,000 per family	\$12,000 per individual \$24,000 per family
Preventive Services:	100%	60%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: \$20 copayment Specialist: \$40 copayment	Deductible; 60%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	60% to a maximum of \$3,000 per plan year; then deductible and 60%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	100% to a maximum of \$3,000 per plan year; then deductible and 80%	60% to a maximum of \$3,000 per plan year; then deductible and 60%
Chiropractic Care: Maximum of \$1,000 per plan year.	\$40 copayment	Deductible; 60%
Outpatient Diagnostic Laboratory Services:	80%	80%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 80%	Deductible; 60%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 80%	Deductible; 60%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 80%	Deductible; 60%
Outpatient Private Duty Nursing:	Deductible; 80%	Deductible; 60%
Urgent Care Services:	\$40 copayment	Deductible; 60%



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 3-A**

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	\$100 copayment, deductible; then 80%	\$100 copayment, in-network deductible; then 80%
Ambulance Services:	Deductible; 80%	In-Network deductible, then 80%
Anesthesiology Services:	Deductible; 80%	Deductible; 60%
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 80%	Deductible; 60%
Hospice Facility/Home Hospice:	Deductible; 80%	Deductible; 60%
Durable Medical Equipment:	Deductible; 80%	Deductible; 60%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 80%	Deductible; 60%
Dialysis Maximum of 40 visits per plan year.	Deductible; 80%	Deductible; 60%
Inpatient Mental Health/Substance Abuse:	Deductible; 80%	Deductible; 60%
Outpatient Mental Health/Substance Abuse:	\$20 copayment	Deductible; 60%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 30 for a list of these services)	\$500 non-compliance penalty	\$500 non-compliance penalty
Prescription Drug Benefit (Retail– 30 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$15 \$40 \$60	Not Covered



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 3-A**

Benefit	In-Network	Out-of-Network
Prescription Drug Benefit (Mail Order – 90 Day Supply) Generic Drug Preferred Brand Drug Non-Preferred Brand Drug	\$30 \$80 \$120	N/A
Lifetime Benefit Maximum Per individual.	Unlimited	
Annual Benefit Maximum Per individual.	\$2,000,000	

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.
3. All other covered benefits not listed above will be subject to deductible, then payable at 80% in-network and 60% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are combined.
6. Copayments and precertification penalties are not applied to the deductible or out-of-pocket maximum.
7. The annual benefit maximum applies only to essential benefits, as defined herein.



SystemsPlus Health + Employee Health Plan Schedule of Medical Benefits Plan 4-A

Benefit	In-Network	Out-of-Network
Deductible: The amount an individual or family must pay each plan year before payments begin for services.	\$3,000 per individual \$6,000 per family	\$6,000 per individual \$12,000 per family
Plan Coinsurance:	70%	50%
Out-of-Pocket Expense Limit: The maximum amount of money that any individual or family will have to pay towards covered health expenses during any one plan year (excludes deductible).	\$12,000 per individual \$24,000 per family	\$24,000 per individual \$48,000 per family
Preventive Services:	100%	50%
Physician's Office Visits: One copayment per physician per day.	Primary Care Physician: \$20 copayment Specialist: \$40 copayment	Deductible; 50%
Colonoscopies/Flexible Sigmoidoscopies (Routine):	100%	50% to a maximum of \$3,000 per plan year; then deductible and 50%
Colonoscopies/Flexible Sigmoidoscopies (Diagnostic):	100% to a maximum of \$3,000 per plan year; then deductible and 70%	50% to a maximum of \$3,000 per plan year; then deductible and 50%
Chiropractic Care: Maximum of \$1,000 per plan year.	\$40 copayment	Deductible; 50%
Outpatient Diagnostic Laboratory Services:	70%	50%
Outpatient Diagnostic Testing/X-Ray Services:	Deductible; 70%	Deductible; 50%
Outpatient Physical, Occupational, and Speech Therapy: Combined maximum of 30 visits per plan year.	Deductible; 70%	Deductible; 50%
Home Health Care: Maximum of 25 visits per plan year.	Deductible; 70%	Deductible; 50%
Outpatient Private Duty Nursing:	Deductible; 70%	Deductible; 50%
Urgent Care Services:	\$40 copayment	Deductible; 50%



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 4-A**

Benefit	In-Network	Out-of-Network
Emergency Room Services: Copayment waived if admitted.	\$100 copayment, deductible; then 70%	\$100 copayment, in-network deductible; then 70%
Ambulance Services:	Deductible; 70%	In-Network deductible, then 70%
Anesthesiology Services:	Deductible; 70%	Deductible; 50%
Skilled Nursing Facility: Maximum of 100 days per plan year.	Deductible; 70%	Deductible; 50%
Hospice Facility/Home Hospice:	Deductible; 70%	Deductible; 50%
Durable Medical Equipment:	Deductible; 70%	Deductible; 50%
Wigs/Artificial Hairpieces: (After radiation therapy or chemotherapy); Maximum of 2 per covered person per lifetime.	Deductible; 70%	Deductible; 50%
Dialysis Maximum of 40 visits per plan year.	Deductible; 70%	Deductible; 50%
Inpatient Mental Health/Substance Abuse:	Deductible; 70%	Deductible; 50%
Outpatient Mental Health/Substance Abuse:	\$20 copayment	Deductible; 50%
Pre-Admission Certification Penalty: Inpatient stays, organs transplants, tissue transplants, & certain outpatient services (see page 30 for a list of these services)	\$500 non-compliance penalty	\$500 non-compliance penalty
Prescription Drug Benefit (Retail – 30 Day Supply)	75%, not to exceed \$125 per prescription	Not Covered
Prescription Drug Benefit (Mail Order – 90 Day Supply)	75%, not to exceed \$250 per prescription	N/A



**SystemsPlus Health + Employee Health Plan
Schedule of Medical Benefits
Plan 4-A**

Benefit	In-Network	Out-of-Network
Lifetime Benefit Maximum Per individual.		Unlimited
Annual Benefit Maximum Per individual.		\$2,000,000

NOTES:

1. This Plan is participating with Blue Cross Blue Shield of Vermont preferred provider network as well as the BlueCard Program. These preferred providers will bill the Contract Administrator directly and write off charges that exceed their contractual allowances.
2. All covered charges billed by non-participating providers will be subject to a maximum allowable benefit.
3. All other covered benefits not listed above will be subject to deductible, then payable at 70% in-network and 50% out-of-network.
4. All in and out-of-network benefit maximums are combined.
5. All in and out-of-network deductible and coinsurance amounts are combined.
6. Copayments and precertification penalties are not applied to the deductible or out-of-pocket maximum.
7. The annual benefit maximum applies only to essential benefits, as defined herein.

GENERAL PROVISIONS

PLAN ENROLLMENT

Eligibility: Only employees who satisfy the eligibility requirements set forth in the “General Information” section are eligible for coverage under this Plan. The dependent(s) of a covered employee will become eligible for coverage on the date of the employee’s eligibility for coverage or on the date which the employee acquires the dependent.

If an employee and spouse are both eligible for coverage as employees under the Plan, only one (1) will be eligible to enroll dependent(s). Also, an employee cannot be covered as an employee and a dependent.

Plan Enrollment: To become covered under the Plan, an employee must enroll themselves and/or their dependents for coverage within thirty-one (31) days of the eligibility date. The employee and dependents will be enrolled when a benefit enrollment form is completed, signed, and delivered to the employer within the time limit. Should the enrollment occur more than thirty-one (31) days following the eligibility date, the employee and/or dependents will only be eligible to enroll during the annual open enrollment period described below or, in certain circumstances, during a special enrollment period. Should multiple plan options exist, an employee may switch plan options during an annual open enrollment period or special enrollment period.

Annual Open Enrollment Period: There will be an annual open enrollment period preceding the Plan’s anniversary date. The effective date of coverage will be the Plan’s anniversary date. Any eligible employee or dependents enrolling on the Plan’s anniversary date, who did not have coverage under the Plan prior to the open enrollment period, will be subject to the Plan’s preexisting condition limitation provision.

Special Enrollment Periods: Individuals are eligible for special enrollment for the following reasons:

1. If an employee acquires a dependent through marriage, birth, adoption, or placement for adoption, the dependent (and if not otherwise enrolled, the employee and eligible dependents) may be enrolled under this Plan. The request to enroll must be within thirty-one (31) days of the event. If enrollment is not requested within thirty-one (31) days following the event, the dependents will only be eligible to enroll during the annual open enrollment period. The effective date of coverage for dependents and/or employees enrolling during a special enrollment period will be the date of the event.
2. If an employee declines enrollment in the Plan for themselves or their dependents because the employee or dependents have other health coverage, the employee may in the future be able to enroll themselves and/or their dependents in the Plan, provided they are otherwise eligible for coverage under the terms of the Plan, they meet certain conditions including any one of those set forth below and they request enrollment within thirty-one (31) days of that condition being satisfied:
 - when enrollment was declined under this Plan for employee and/or dependent coverage, the employee and/or dependent had COBRA continuation coverage under another health plan, and COBRA continuation coverage under that other plan has since been exhausted; or
 - if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, employer contributions toward the other coverage have ceased, regardless of whether coverage under the other employer’s plan has terminated; or

- if the other coverage that applied to the employee and/or dependent when coverage was declined was not COBRA continuation coverage, the other coverage has been terminated as a result of:
 - a. loss of eligibility as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employment, and any loss of eligibility after a period that is measured by reference to any of the foregoing; or
 - b. the employee and/or dependent having reached their lifetime benefit maximum under the other coverage; or
 - c. the employee and/or dependent moving out of an HMO service area if HMO coverage terminates for that reason and, no other plan options are available to the employee/dependent; or
 - d. the other plan ceasing to offer coverage to the group of similarly situated individuals that include the employee and/or dependent; or
 - e. the dependent losing dependent status per plan terms; or
 - f. the other plan terminating a benefit package option and no substitution is offered.

The effective date of coverage will be the date following the date of the loss of the other coverage. The Plan's waiting period will not be applied. However, the preexisting condition limitations provision will apply.

3. If an employee's or dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, or if the employee or dependent becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP, the employee may request to be enrolled in this Plan. The employee's request to enroll must be made within sixty (60) days of the date on which the employee or dependent either (a) loses eligibility under Medicaid or CHIP or (b) becomes eligible for a state-granted premium subsidy towards employer health coverage under either Medicaid or CHIP. The effective date of coverage will be the first day of the month following the employee's request to enroll in this Plan.

Qualified Medical Child Support Orders: If an employee is required to provide benefits for his dependent child under the direction of a court order and the employee is not enrolled in the Plan, the employee may enroll himself and his dependent child provided enrollment is requested within thirty (30) days of issuance of the court order. The Plan's open enrollment provision will not apply. The effective date of coverage will be the date of the court order. However, if the employee has not yet satisfied the Plan's waiting period, coverage will become effective after satisfaction of such waiting period.

If an employee is required to provide benefits for their ex-spouse under the direction of a court order, the employee may continue to cover their ex-spouse under the Plan, or enroll their ex-spouse in the Plan provided enrollment occurs within thirty-one (31) days of the receipt of the court order. The effective date of coverage will be the date of the court order.

PREEXISTING CONDITION LIMITATION

Employees and their dependent(s) who enroll for coverage under this Plan will be subject to the following preexisting condition limitation provision:

Should a covered person incur expenses for treatment, advice, or medication for an illness or injury during the **six (6) month period** immediately preceding the individual's enrollment date, no benefits will be payable with respect to such illness or injury, until after the individual has been enrolled under the Plan for a period of **twelve (12) consecutive months**. The enrollment date is the first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period. This date is frequently, but not always, the date of hire.

The following conditions exempt covered employees and their dependent(s) from the preexisting condition limitation provision:

- A. an individual has been continuously covered for at least twelve (12) months by creditable coverage, as defined herein, with a break in coverage of sixty-three (63) days or less; or
- B. newborns or children who are adopted or placed for adoption and enrolled in any creditable coverage within thirty (30) days; or
- C. pregnancy; or
- D. genetic predisposition without a diagnosis; or
- E. all individuals under nineteen (19) years of age.

Credit Toward Preexisting Period: Any individual seeking to reduce or eliminate a preexisting condition limitation period based on creditable coverage may do so by providing a written certificate of creditable coverage to the Contract Administrator. All covered individuals who were continuously covered by creditable coverage with a break in coverage of sixty-three (63) days or less, as defined herein, prior to their enrollment under this Plan will be given credit for each month of coverage toward this Plan's preexisting condition limitation period.

If a covered individual had prior coverage for which they think they should have received a certificate but did not, or were given a certificate but lost it, they may ask the former plan or issuer to provide them with a certificate or replacement certificate. The Human Resource Department will assist in obtaining a certificate from any prior plan or issuer if necessary.

COORDINATION OF BENEFITS (COB)

This Plan contains a Non-Duplication of Benefits provision as part of coordination of benefits. This means that when this Plan is the secondary plan, the benefits paid from all the plans combined may not total more than the amount this Plan would have paid on its own.

When this plan is the secondary payer, the plan will coordinate payment with the primary plan in such a way that when this plan's payment is combined with the primary plan's payment, the total does not exceed the amount this plan would have paid if it were primary.

If a plan does not have its own COB rules, it will be primary to this Plan (that is, it will pay benefits before this Plan does).

Even if a plan does have its own COB rules, the first of this Plan's following COB rules to apply will determine which of the plans is primary:

1. Non-Dependent/Dependent - Any plan under which the covered person is covered as an employee, member or subscriber (that is, other than as a dependent) will pay first. Any plan under which the covered person is covered as a dependent of the employee will pay second.
2. Dependent Child/Parents Not Separated or Divorced - If a dependent child is covered under the plans of both the child's parents, and the parents are not separated or divorced (regardless of whether they were ever married), the plan of the parent whose birth date occurs earlier in the calendar year will pay first, and the plan of the parent whose birth date occurs later in the calendar year will pay second. If the birth dates of the parents are the same, the plan which has covered a parent for the longest period of time will pay benefits before the plan of the other parent.
3. Dependent Child/Separated or Divorced Parents - Where a dependent child is covered under the plans of both parents, the parents are separated or divorced from one another, and there is otherwise no court decree setting forth the responsibility for the child's health care costs:
 - a) the plan under which the child is covered as a dependent of the custodial parent will pay first;
 - b) the plan under which the child is covered as a dependent of the custodial parent's spouse will pay second; and
 - c) the plan under which the child is covered as a dependent of the non-custodial parent will pay third.
4. Active/Inactive Employee - Any plan under which the covered person is covered as an active employee (or as that employee's dependent) will pay first. Any plan under which the covered person is covered as a laid off or retired employee (or as that employee's dependent) will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

5. Continuation Coverage - Any plan under which the covered person is covered as an employee (or as that employee's dependent) will pay first. Any plan under which the covered person is covered under a right of continuation as provided under federal or state law (for example, under the Consolidated Omnibus Budget Reconciliation Act of 1985), will pay second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

If none of the above rules determine the order of benefits, the plan which has covered the eligible person for the longest period of time will pay first; the plan which has covered the eligible person for the shortest period of time will pay last.

Right to Receive and Release Needed Information: The Plan may release or receive any information needed to enforce this provision. Any person claiming benefits under this Plan must furnish the Plan with any information requested by the Plan to enforce the COB provisions in accordance with the HIPAA Privacy Requirements.

Right to Make Payments: Should another plan provide benefits which should have been paid by this Plan, the Plan has the right to make payment to the other plan directly. That payment will satisfy the obligation of this Plan.

Right to Recovery: The Plan has the right to recover from the covered person any overpayment made if the Plan was not made aware of the other available benefits.

Coordination with Other Liability: This Plan will pay benefits secondary to the covered person's personal automobile insurance (including, but not limited to, no-fault insurance and uninsured motorist coverage) or other liability insurance policies through which medical payments may be made for expenses resulting from or in connection with an accidental injury.

Coordination with Prescription Claims: There is no coordination of benefits with prescription drugs.

TERMINATION OF BENEFITS

An employee's and/or a dependent's coverage under the Plan will terminate:

1. on the date the Plan terminates; or
2. on the date an employee withdraws from the Plan; or
3. on the date an employee is no longer eligible; or
4. on the date which an employee is terminated, unless continuation coverage, as provided herein, is elected; or
5. on the date a dependent withdraws from the Plan or a dependent ceases to meet the definition of a dependent as defined herein or dependent coverage is discontinued under the Plan for any reason, unless continuation of coverage, as provided herein, is elected; or
6. on the date when an employee or dependent enters the military, naval, or air force of any country or international organization on a full-time, active-duty basis other than scheduled drills or other training not exceeding one (1) month in any calendar year (see Military Leave section below); or
7. on the last date of the period for which contribution has been made if the employee fails to make any required contribution.

MILITARY LEAVE

The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") provides special continuation coverage to covered employees who otherwise lose health insurance coverage under the Plan because they leave employment to serve in the uniformed services. Under USERRA, affected covered employees and their dependents must be offered the right to continue coverage for up to twenty-four (24) months. The employer may charge 102% of the applicable premium, provided the length of the military leave is longer than thirty (30) days. However, on the date that the employee completes his active duty and returns to full-time employment, the employee and his eligible dependents will be re-enrolled in the Plan and coverage will be provided immediately. However, any limitations on the employee's or dependent's coverage which were in affect before the active military duty leave will continue to apply.

REINSTATEMENT OF COVERAGE

If the employee terminates for any reason and is rehired within thirty (30) days, coverage may be reinstated on the first day of the month following rehire, if the enrollment requirements are completed within thirty-one (31) days. All accumulated plan year maximums will apply.

If the employee is rehired after thirty (30) days, or if the employee fails to enroll as required by the plan, they will be considered a new employee.

EXTENSION OF BENEFITS (COBRA)

Qualified beneficiaries may elect to continue coverage under the Plan when their coverage terminates due to a “qualifying event.” Depending on the type of qualifying event, “qualified beneficiaries” can include the employee covered under the Plan and the employee’s covered dependents. These rights are protected under the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1986.

A child who is born to or placed for adoption with the covered employee during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with the terms of the Plan and the requirements of federal law, these qualified beneficiaries can be added to COBRA coverage upon proper notification to the Plan Administrator of the birth or adoption.

Continuation coverage is the same coverage that the Plan gives to other participants or beneficiaries under the Plan who are not receiving continuation coverage. Each qualified beneficiary who elects continuation coverage will have the same rights under the Plan as other participants or beneficiaries covered under the Plan.

The employee has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee’s termination of employment for reasons other than gross misconduct.
2. The employee’s retirement or reduction in hours of employment.

The employee’s spouse has the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee’s termination of employment for reasons other than gross misconduct.
2. The employee’s retirement or reduction in hours of employment.
3. The employee’s death.
4. The employee’s divorce or legal separation.
5. The employee becomes enrolled in Medicare benefits (Part A, Part B or both).

The employee’s dependent children have the right to choose COBRA continuation of coverage under the Plan if coverage terminates for any of the following qualifying events:

1. The employee’s termination of employment for reasons other than gross misconduct.
2. The employee’s retirement or reduction in hours of employment.
3. The employee’s death.
4. The employee’s divorce or legal separation.
5. The employee becomes enrolled in Medicare benefits (Part A, Part B or both).
6. The employee’s dependent child ceases to be an eligible dependent as such term is defined in the Plan.

Similar rights may apply to certain employees, spouses and dependent children if the employer commences a bankruptcy proceeding and these individuals lose coverage.

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Contract Administrator of the qualifying event within thirty (30) days of any of these events on the form provided by the Contract Administrator to the employer.

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), the qualified beneficiary must notify the Plan Administrator. The Plan Administrator must be notified in writing within sixty (60) days after the qualifying event occurs.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. The Plan Administrator must notify the qualified beneficiary in writing of their right to COBRA continuation of coverage within fourteen (14) days from the date the Plan Administrator is notified of a qualifying event.

The qualified beneficiary has sixty (60) days from the date of the written notice or qualifying event, whichever is later, to notify the Plan Administrator of their decision to elect COBRA continuation of coverage. To receive COBRA continuation of coverage, no evidence of insurability will be required, but a monthly premium will be charged. If continuation of coverage is not elected on a timely basis, group health insurance coverage will end.

If Medicare entitlement occurs prior to a qualifying event, then COBRA begins on the date of Medicare entitlement.

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the day following the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's divorce or legal separation, or a dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to thirty-six (36) months.

If a qualifying event that is a termination of employment or reduction of hours occurs within eighteen (18) months after the covered employee becomes enrolled in Medicare, then the maximum coverage period for the spouse and dependent children who are qualified beneficiaries receiving COBRA coverage will end thirty-six (36) months from the date the employee became enrolled in Medicare (but the covered employees' maximum coverage period will be eighteen (18) months). This extension is available only if the covered employee becomes enrolled in Medicare within eighteen (18) months before the termination of employment or reduction of hours occurs.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage lasts for up to eighteen (18) months. There are two ways in which this eighteen (18) month period of COBRA continuation coverage can be extended.

Disability extension of 18-month period of continuation coverage

If a qualified beneficiary is determined by the Social Security Administration to be disabled at any time during the first sixty (60) days of COBRA continuation coverage and the Plan Administrator is notified in a timely fashion, the employee and his covered dependents can receive up to an additional eleven (11) months of COBRA continuation coverage, for a total maximum of twenty-nine (29) months. The qualified beneficiary must make sure that the Plan Administrator is notified in writing of the Social Security Administration's determination within sixty (60) days of the date of the determination and before the end of the eighteen (18) month period of COBRA continuation coverage. If a qualified beneficiary is determined by the Social Security Administration to no longer be disabled, then the beneficiary must notify the Plan within thirty (30) days of determination by the Social Security Administration.

Second qualifying event extension of 18-month period of continuation coverage

If the employee's family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children can get additional months of COBRA continuation coverage, up to a maximum of thirty-six (36) months. This extension is available to the spouse and dependent children if the former employee dies, gets divorced or legally separated. This extension may be available to a spouse or dependents if the former employee enrolls in Medicare. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. **In all of these cases, the qualified beneficiary must make sure that the Plan Administrator is notified in writing of the second qualifying event within sixty (60) days of the second qualifying event.**

In no event will COBRA coverage continue beyond thirty-six (36) months from the date of the original qualifying event.

Monthly Premium

1. The monthly premium will be 102% or, if applicable, 150% of the applicable premium (which for self-funded plans, is based on reasonable actuarial estimates or on past costs). All premium payments are due in advance and include the cost of the next month of COBRA continuation of coverage.
2. The initial premium payment is due within forty-five (45) days of electing COBRA continuation of coverage. The payment must cover all premiums due from the date of the qualifying event.
3. The maximum grace period for payment of monthly COBRA coverage premiums will not exceed thirty (30) days from the due date established by the Plan Administrator or their authorized agent.

Termination of COBRA continuation coverage

COBRA continuation of coverage may be terminated prior to the expiration of the applicable time period as follows:

1. The Plan Administrator no longer provides group health and/or dental coverage to any of its employees.

2. The applicable monthly premium for COBRA coverage is not paid within thirty (30) days of the established due date.
3. The person who has elected COBRA coverage becomes enrolled in Medicare benefits (Part A, Part B or both). COBRA coverage will terminate on the first day of the person's birthday month. Should the person's birthday be on the first day of the month, then COBRA coverage will terminate on the first day of the month prior to the person's birthday.
4. The qualified beneficiary who has elected COBRA coverage becomes covered under another group health and/or dental plan which does not contain any exclusion or limitation with respect to any preexisting condition of such covered person.

(NOTE: Should COBRA continuation provide coverage for such "preexisting" conditions, COBRA continuation of coverage will be primary for the applicable preexisting conditions only and will provide secondary coverage to all other covered expenses.)

5. The unique disability continuation period will end as of the first day of month that begins more than thirty (30) days after the date of final determination under the Social Security Act that the qualified beneficiary is no longer disabled.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) restricts the extent to which group health plans may impose pre-existing condition limitations. HIPAA coordinates COBRA's other coverage cut-off rule with these new limits as follows.

If the covered employee becomes covered by another group health plan and that plan contains a pre-existing condition limitation that affects the covered employee, the covered employee's COBRA coverage cannot be terminated. However, if the other plan's pre-existing condition rule does not apply to the covered employee by reason of HIPAA's restrictions on pre-existing condition clauses, the Plan may terminate the covered employee's COBRA coverage.

The covered employee does not have to show that he or she is insurable to choose continuation coverage. However, continuation coverage under COBRA is provided subject to the covered employee's eligibility for coverage; the Plan Administrator reserves the right to terminate the covered employee's coverage retroactively if he or she is determined to be ineligible.

Trade Act of 2002

Pursuant to the Trade Act of 2002, special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under another federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of sixty (60) days (or less) and only during the (6) six months immediately after their group health plan coverage ended. In addition, the Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance (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. If you have questions about these new tax provisions, you may call the Health Care Tax Credit Customer 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/2002act_index.asp.

If you qualify or may qualify for assistance under the Trade Act of 2002, contact the Plan Administrator for additional information. You must contact the Plan Administrator promptly after qualifying for assistance under the Trade Act of 2002 or you will lose your special COBRA rights.

The American Recovery and Reinvestment Act of 2009

The American Recovery and Reinvestment Act ("ARRA") provides a reduction in premiums and, in some cases, additional opportunities to elect continued group health coverage under COBRA for individuals who become eligible for COBRA coverage as a result of an involuntary termination of employment occurring between September 1, 2008 and December 31, 2009. The premium reduction and additional election opportunities may also apply to members of the employee's family who were covered under the group health plan at the time of the employee's involuntary termination. ARRA's premium reduction and additional election opportunity provisions will expire on December 31, 2009, and therefore will not be available to employees who are involuntarily terminated after December 31, 2009, unless ARRA is further extended by Congress.

If you believe you qualify or may qualify for assistance under ARRA, contact the Plan Administrator for additional information.

If you believe you are eligible for a reduction in COBRA premiums as a result of ARRA, but your employer disagrees, you have the right to appeal to the U.S. Department of Labor for an expedited review of your employer's decision. For more information, go to <http://www.dol.gov/recovery>.

Keep Plan Informed of Address Changes

In order to protect the participant's family's rights, the participant should keep the Plan Administrator informed of any changes in the addresses of family members. The participant should also keep a copy, for his or her records, of any notices sent to the Plan Administrator.

PLAN DETAILS

Preferred Provider Network Program

The Plan includes access to Blue Cross Blue Shield of Vermont's preferred provider network and the BlueCard Program in order to obtain discounts from participating providers for covered medical care. The plan identification card identifies the selected preferred provider network and a current list of the participating providers will be furnished to covered persons automatically by the Plan Sponsor. Use of the network is voluntary and the benefits of utilizing participating providers include provider fee discounts, direct billing to the Plan for covered services, and network provider write-offs of any charges in excess of the discounted fee schedule.

If a covered person is referred by an in-network provider to a specialist and no provider exists for that area of specialty within the preferred provider network, then the covered person may seek services of an out-of-network specialist and benefits for covered services will be paid as though they were furnished by an in-network provider.

Benefits related to covered services that begin at an in-network facility or provider, and subsequently result in charges from an out-of-network facility or provider, will be paid at the in-network benefit level subject to the maximum allowable benefit. (Example: Laboratory work for a sample that is drawn during a **visit** to an **in-network** physician or hospital, and the sample is subsequently sent to an out-of-network lab or pathologist, then the laboratory fees and pathologist fees will be paid at the in-network benefit level subject to the maximum allowable benefit.) Should the covered person choose services from an out-of-network provider or facility, then the services will be paid at the out-of-network benefit level.

The BlueCard Program

When you receive health care services through BlueCard outside the geographic area covered by Blue Cross Blue Shield of Vermont's preferred provider network, claims processing is coordinated with the out-of-area Blue Cross Blue Shield plans through the BlueCard Program. The amount you pay for covered services is calculated on the lower of:

- the actual billed charges for your covered services; or
- the negotiated price that the local Blue Cross Blue Shield Plan ("Host Blue") passes on to us.

Often, this "negotiated price" will consist of a simple discount which reflects the actual price paid by the Host Blue. However, sometimes it is an estimated price that factors into the actual price expected settlements, withholds, any other contingent payment arrangements and non-claims transactions with your health care provider or with a specified group of providers. The negotiated price may also be billed charges reduced to reflect an average expected savings with your health care provider or with a specified group of providers. The price that reflects average savings may result in greater variation (more or less) from the actual price paid than will the estimated price. The negotiated price may also be prospectively adjusted to correct for over- or underestimation of past prices. However, the amount you pay is considered a final price. Statutes in a small number of states may require the Host Blue to use a basis for calculating member liability for covered services that does not reflect the entire savings realized, or expected to be realized, on a particular claim or to add a surcharge. Should any state statutes mandate member liability calculation methods that differ from the usual BlueCard method noted above in paragraph one of this section or require a surcharge, the Contract Administrator would then calculate your liability for any covered health care services in accordance with the applicable state statute in effect at the time you received your care.

Transition of Care for some Ongoing Medical Treatment: Prior to the covered persons employer's original effective date in this plan, if the covered person was receiving on-going medical care for pregnancy (second or third trimester only), cardiac rehabilitation, physical/occupational/speech therapy, radiation therapy or chemotherapy, mental health or substance abuse treatment, or post-surgical care for surgery performed prior to the covered persons employer's effective date in this Plan, expenses for these services will be considered at the in-network level of benefits for the first sixty (60) days from your employer's effective date in this plan for medical care or through delivery and post-partum care for pregnancy (initial hospital confinement for newborn), even if the covered persons physician or practitioner is not currently a part of the PPO network. To qualify for these transition benefits, the covered person must call the Contract Administrator before continuing services. **If the covered person does not call, covered services will be considered at the out-of-network level of benefits.**

If the covered person qualifies because they are in the second or third trimester of pregnancy, benefits will be considered at the in-network level through delivery and post-partum care. (For the newborn, this benefit applies only to the nursery charges during the initial hospital confinement. The covered person must select a pediatrician in the network in order to receive the in-network level of benefits for the initial exam and subsequent baby care. If the covered person's newborn must be transferred to another hospital after delivery, an in-network hospital should be selected or services will be considered at the out-of-network level of benefits).

Employees and their eligible dependents who do not call or who elect to remain with their out-of-network provider after the approved transition benefit period will have their covered expenses paid at the out-of-network benefit level.

When the covered person calls the Contract Administrator they need to have the following information ready:

- Date their condition or treatment began;
- Anticipated due date (if the covered person is pregnant);
- Type of care or treatment plan;
- Name and telephone number of their physician or practitioner.

The covered persons physician or practitioner may already be a member of the PPO network. If so, the covered person will not need to use this transition benefit as their services already qualify for the higher level of benefits. To determine if the covered person's provider belongs to the network, to locate a physician or practitioner in your area, or to find out how to nominate your current physician or practitioner for membership in the PPO network, call the Contract Administrator.

Preventive Services (in-network only): Charges for preventive care services are covered expenses. Charges can include routine physical examinations (including breast and pelvic), gynecological exams, immunizations, vaccinations, inoculations, consultations, routine x-ray and laboratory services (e.g. cholesterol screenings, TSH, resting EKG's, fecal occult blood tests and double contrast barium enemas), pap smears (including laboratory fees), x-rays, routine vision exams including refraction, mammograms, and prostate cancer screenings (including PSA tests and digital rectal exams). Benefits are payable at 100%.

Physician's Office Visits (in-network only) (does not apply to Plan 1-A): Charges for physician's office visits when the employee or their dependent(s) incur expenses as a result of an illness or accidental injury are covered expenses. Benefits for physician's office visits by a primary care physician will be subject to a \$20 copayment per visit, then payable at 100%. Benefits for physician's office visits by a specialist will be subject to a \$40 copayment per visit, then payable at 100%. Incidental services provided at the time of a physician's office visit and included under the copayment may include allergy injections and testing, immunizations, laboratory tests such as strep tests, urinalysis, and cholesterol screenings. Examples of services that may be provided in a physician's office that are not included under the copayment are surgeries and related anesthesia expenses, 24 hour EKG tests, MRIs, CT Scans, PET Scans, physical/occupational/speech therapy services, chemotherapy and radiation therapy, and bone density tests. These services are subject to the plan year deductible and coinsurance provisions.

Colonoscopies/Flexible Sigmoidoscopies (Routine) (in-network only): Charge for routine colonoscopies and sigmoidoscopies, including anesthesiology services are covered expenses. Benefits are payable at 100%.

Colonoscopies/Flexible Sigmoidoscopies (Diagnostic) (in-network only): Charge for diagnostic colonoscopies and sigmoidoscopies, including anesthesiology services are covered expenses. Benefits are payable at 100% to a maximum of \$3,000 per covered person per plan year. Benefits in excess of the \$3,000 are subject to the applicable plan year deductible and coinsurance provisions.

Chiropractic Care (in-network only) (does not apply to Plan 1-A): Charges for home, office, and nursing home visits, as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered expenses. Benefits are subject to the \$40 copayment per visit, then payable at 100% to a maximum of \$1,000 per covered person per plan year.

Outpatient Diagnostic Laboratory Services (in-network only): Charges for outpatient diagnostic laboratory services rendered in an independent facility or outpatient hospital are covered expenses. Benefits are subject to the applicable in-network coinsurance provisions. The plan year deductible does not apply.

Outpatient Diagnostic Testing/X-Ray Services: Charges for outpatient diagnostic testing/x-ray services rendered in an independent facility or outpatient hospital and all outpatient CT scans, PET scans, and MRI's are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions.

Outpatient Physical, Occupational, and Speech Therapy: Charges for outpatient physical, occupational, and speech therapy are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions to a combined maximum of thirty (30) visits per covered person per plan year. Additional visits may be authorized if medically necessary. The covered person should contact the Contract Administrator for authorization.

Home Health Care: Charges for home health care services are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions to a maximum of twenty-five (25) visits per covered person per plan year. Additional visits may be authorized if medically necessary. The covered person should contact the Contract Administrator for authorization.

Outpatient Private Duty Nursing: Charges for outpatient private duty nursing care are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions.

Urgent Care Services (in-network only): Charges for urgent care services are covered expenses. Benefits are subject to a \$40 copayment per visit, then payable at 100%.

Emergency Room Services: Charges for emergency room services are covered expenses. Charges may include facility fees, physician fees, x-rays, laboratory tests, and other necessary services and supplies, unless otherwise specified herein. Benefits are subject to a \$100 copayment per visit, then subject to the applicable in-network plan year deductible and coinsurance provisions. The copayment will be waived if the covered person is admitted to the hospital as an inpatient. The amount the plan pays for out-of-network benefits (e.g. maximum allowable benefit), will be reduced by the in-network copayment or coinsurance that the individual would be responsible for if the emergency services were provided in-network.

Ambulance Services: Charges for ambulance services for inpatients or outpatients receiving accident or illness care to and from the hospital or medical facility where treatment is given are covered expenses. Benefits are subject to the applicable in-network plan year deductible, then payable at the applicable in-network coinsurance provisions.

Anesthesiology Services: Charges for inpatient and outpatient anesthesiology services are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions noted on the "Schedule of Benefits".

Skilled Nursing Facility: Charges for confinement in a skilled nursing facility are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions to a maximum of one hundred (100) days per covered person per plan year.

Hospice Facility/Home Hospice: Charges for hospice facility/home hospice are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions.

Durable Medical Equipment: Charges for durable medical equipment are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions.

Wigs/Artificial Hairpieces (after radiation therapy or chemotherapy): Charges for wigs or artificial hairpieces after radiation therapy or chemotherapy are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions noted on the "Schedule of Benefits" to a maximum of two (2) wigs or artificial hairpieces per covered person per lifetime.

Dialysis: Charges for dialysis are covered expenses. Benefits are subject to the applicable plan year deductible and coinsurance provisions to a maximum of forty (40) visits per covered person per plan year.

Pre-Admission Certification Penalty: The Plan requires that all non-emergency hospital admissions, organ and tissue transplants, and the below listed outpatient services be pre-certified and authorized by the Contract Administrator. This does not include hospital stays in connection with childbirth for the mother or newborn child which are forty-eight (48) hours or less for vaginal deliveries, or ninety-six (96) hours or less for cesarean section deliveries. When a doctor recommends that the employee or dependent be admitted to a hospital or receive one of the below listed outpatient services, **it is the employee’s responsibility** to notify the Plan and to obtain pre-certification and authorization of the hospital admission and outpatient service. **It is the employee’s responsibility** to be sure that in the event of an **emergency admission**, the Contract Administrator is notified within **forty-eight (48)** hours. Failing to obtain pre-certification will not result in a rejection of the claim, but a penalty of **\$500** will be applied. The penalty does not apply toward the out-of-pocket maximum. In the event that an employee or dependent incur expenses for services which have not been pre-certified and authorized, a thorough review will be conducted of the services to determine medical necessity at the point of claim. If the review process identifies care which is not medically necessary, services will not be covered under the Plan.

In order for the Plan to approve the inpatient stay, the attending physician must certify to the Contract Administrator that, in the physician’s professional opinion, the stay is necessary for the condition. The Plan reserves the right to request an independent medical opinion by a physician of the Plan’s choice.

The following procedures must be pre-certified:

- CT Scans
- MRI’s
- MRA’s
- PET Scans
- Dexascan
- Carpal tunnel surgery
- Sleep studies
- Diagnostic colonoscopy
- Gastric endoscopy
- Cardiac thallium stress test
- Cardiac echocardiography
- More than 2 obstetrical ultrasounds per pregnancy
- Home health care visits in excess of the plan year visit limits
- Outpatient Physical, Occupational, and Speech Therapy visits in excess of the plan year visit limits

Retail Prescription Drug Plan (does not apply to Plan 4-A): The Plan includes a prescription drug program. Prescriptions filled at participating pharmacies are limited to a maximum thirty (30) day supply. Individual prescriptions are subject to the copayments listed below. The balance of the covered prescription expense will be paid at 100%.

Plan 1-A:

<u>Generic Copayment</u>	<u>Preferred Brand Copayment</u>	<u>Non-Preferred Brand Copayment</u>
\$10	\$25	\$50

Plan 2-A:

<u>Generic Copayment</u> \$10	<u>Preferred Brand Copayment</u> \$35	<u>Non-Preferred Brand Copayment</u> \$60
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Plan 3-A:

<u>Generic Copayment</u> \$15	<u>Preferred Brand Copayment</u> \$40	<u>Non-Preferred Brand Copayment</u> \$60
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Plan 4-A:

Individual prescriptions are payable at 75% coinsurance, not to exceed \$125 per prescription.

A list of participating pharmacies can be obtained from your Human Resource Office.

Prescriptions purchased at non-participating pharmacies are not covered expenses.

Compound drugs that are not available from a participating pharmacy will be considered a covered expense subject to the applicable participating pharmacy copayment.

Mail Order Maintenance Prescription Drug Program: Maintenance drugs to treat illnesses should be purchased through the mail order program. These illnesses usually include: diabetes, epilepsy, anemia, chronic constipation, arthritis, high blood pressure, tuberculosis, various gastric disease, emphysema, menopause, mental and nervous disorders, thyroid disease, adrenal disease, ulcers, and any other condition that requires continuous medication. Mail order prescriptions are limited to a maximum ninety (90) day supply. Mail order prescriptions are subject to the copayments listed below. The balance of the covered prescription expense will be paid at 100%.

Plan 1-A:

<u>Generic Copayment</u> \$20	<u>Preferred Brand Copayment</u> \$50	<u>Non-Preferred Brand Copayment</u> \$100
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Plan 2-A:

<u>Generic Copayment</u> \$20	<u>Preferred Brand Copayment</u> \$70	<u>Non-Preferred Brand Copayment</u> \$120
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Plan 3-A:

<u>Generic Copayment</u> \$30	<u>Preferred Brand Copayment</u> \$80	<u>Non-Preferred Brand Copayment</u> \$120
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Plan 4-A:

Individual prescriptions are payable at 75% coinsurance, not to exceed \$250 per prescription.

When filling a prescription for which a generic drug is available and the covered person chooses the brand name drug, the covered person will be responsible for paying the brand name drug copayment plus the difference in cost between the generic and the brand name drug.

Specialty Pharmacy medications are recommended to manage specific high cost medications. Services include access to, and support for, most pharmaceutical and biologic products that have high acquisition costs, are difficult to manage, and present reimbursement challenges. These medications are payable at 80% to a maximum of \$150 copayment per prescription.

There is no copayment for Prilosec OTC™ and OTC Loratadine, however, a physician's prescription is required.

There is no copayment for OTC Zaditor® and Alaway®, however, a physician's prescription is required.

Non-narcotic analgesics for the treatment of migraines (e.g. Amerge, Frova, Imitrex, Maxalt, Relpax, and Zomig) are limited to a combined quantity of eighteen (18) per month for all forms of medications.

Female libido enhancement drugs and male impotence medications, including Viagra are limited to a maximum of eight (8) tablets per month.

Stadol Nasal Spray is limited to two (2) bottles per month.

Prozac Weekly is limited to four (4) capsules per month.

Step Therapy Program: The Plan has implemented a Step Therapy program in order to control overall plan costs and to assure members access to clinically appropriate medications to treat all conditions.

The Step Therapy program establishes an order of drug therapy options within select categories for covered persons to follow that may affect their access to, and out-of-pocket costs for, medications covered under the Step Therapy program.

The Step Therapy program ensures that the covered person receives clinically appropriate, cost-effective medication based on their prescription history. Step Therapy guidelines maintain open access for covered persons and encourages the utilization of lower cost medications.

The order of medication usage will include generic and selected over-the-counter drugs first at the lowest copayments for the covered person to preferred brand name drugs at the middle copayment, and finally non-preferred brand name drugs at the highest copayment. The goal of the Plan is to achieve successful treatment outcomes at the most efficient cost to the plan.

The covered person will receive communication from RESTAT or their pharmacist if a prescription is written for them in one of the covered categories listed above.

Please visit RESTAT's website at www.restat.com for the most current version of the Step Therapy guidelines and formulary list.

MEDICAL COVERED EXPENSES

Expenses incurred for the following medical, health care services, and supplies will be considered a covered expense, provided the expenses are (i) medically necessary to treat an illness or injury or furnished in connection with participation of a covered person in a "Clinical Trial," as such term is defined here, (ii) prescribed or approved by an attending physician, and (iii) incurred during a period that coverage was in effect in accordance with the applicable provisions of the Plan. Payment of such expenses will be subject to all applicable deductibles, coinsurance limits, the maximum individual limit, and all other limitations described herein.

1. Inpatient hospital charges for room and board, operating room, x-rays, physical therapy, radiation therapy, chemotherapy, prescription drugs, anesthesia, laboratory expenses, intensive care unit, and other necessary services and supplies during any one (1) period of hospital confinement, as shown below. Should the facility have no semi-private rooms or less expensive accommodations available, or the patient's condition requires the employee or the employee's covered dependent to be isolated for their own health or the health of others, the private room rate will be allowed.

Room and Board:

semi-private room allowance.....	semi-private room rate
private room allowance.....	semi-private room rate
intensive care allowance.....	actual charge (not to exceed the maximum allowable benefit)

2. Outpatient hospital charges for necessary services and supplies incurred as a result of an illness, accident, or as a result of outpatient surgery performed (if performed on the same day), including charges for x-ray and laboratory expenses, physical therapy, radiation therapy, and chemotherapy.
3. Charges for inpatient physician visits while the employee or their dependents are hospital confined as a result of an illness or an accidental injury. No benefits will be paid for more than one (1) visit per day by any one (1) physician or for the treatment received in connection with, on, or after the date of an operation for which a surgical expense benefit is payable under the Plan if such treatment is given by the physician who performed the operation.
4. All charges of a professional anesthesiologist, radiologist, or pathologist.
5. Charges for pre-admission testing, exams, x-ray and laboratory examinations on an outpatient basis made prior to a scheduled hospital admission and related to a condition previously diagnosed.
6. Charges for medically necessary ground ambulance service for inpatients or for outpatients receiving accident or illness care to and from the hospital or medical facility where treatment is given. Air ambulance is considered a covered expense if it is medically necessary and the ground ambulance is not advisable.
7. Emergency room charges for treatment of an illness or an accidental injury.
8. Diagnostic x-rays and laboratory charges for expenses incurred as a result of an illness or injury. No benefits are payable for dental care except as provided for in this Plan.

9. Charges for physical therapy by a qualified practitioner.
10. Charges for speech therapy from a qualified practitioner to restore speech loss due to an illness, injury, or surgical procedure.
11. Charges for occupational therapy, excluding supplies.
12. Charges for oral surgery, limited to: excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of mouth; treatment of an accidental injury to the jaws, cheeks, lips, tongue, roof and floor of mouth; excision of exostoses of jaws and hard palate; treatment of cleft lip and palate; external incision and drainage of cellulitis; incision of accessory sinuses, salivary glands or ducts; frenectomies; and removal of fully or partially impacted teeth. If the covered person has elected both medical and dental coverage, expenses for frenectomies will be considered under the medical portion of this Plan.
13. Charges for the surgical and non-surgical treatment of temporomandibular joint syndrome (TMJ) will be covered.
14. Charges for orthognathic surgery.
15. Charges for physician's surgical services for treatment of an injury or illness, if performed in an inpatient or outpatient unit of a hospital, a free standing facility, a physician's office, or a dentist or an oral surgeon's services for the treatment of an accidental injury to sound natural teeth will be considered a covered expense. Injuries caused by biting or chewing are not considered accidental injuries.
16. Charges for medically necessary private duty nursing care rendered on an outpatient basis by a registered graduate nurse (RN) or, services of a licensed practical nurse (LPN) when certified by the attending physician and a registered graduate nurse (RN) is not available, but only for nursing duties and excluding custodial care.
17. Charges for x-ray, laboratory, and radium expenses excluding dental x-rays, unless rendered for the treatment of a fractured jaw, cysts, tumors or injury to sound natural teeth as a result of an accident will be considered covered expenses.
18. Charges for the professional services of a legally qualified physician for the care of a covered illness or accidental injury.
19. Charges for physician's home and office visits when the employee or his dependent incur expenses as a result of an illness or accidental injury.
20. Charges for services of a surgeon and an assistant surgeon if two (2) or more procedures are performed during the course of a single operation through the same incision or in the same operative field. The fees will be limited to the sum of the maximum allowable benefit for the largest amount billed for one procedure plus fifty (50%) of the sum of the maximum allowable benefit billed for all other procedures performed. Benefits are payable for the professional services of a legally qualified physician in rendering technical assistance to the operating surgeon when required in connection with a surgical procedure performed on an inpatient basis (benefits will not exceed twenty (20%) of the maximum allowable benefit for the procedure performed when the assistant is a physician and ten (10%) when the assistant is a PA). However, no benefits are payable for surgical assistance rendered in a hospital where it is routinely available as a service provided by a hospital intern, resident, or house officer.

21. Charges for medically necessary dressings and medicines, including prenatal vitamins for which a physician's prescription is required and dispensed by a licensed pharmacy.
22. Charges for birth control methods.
23. Charges for diabetic supplies such as insulin, accustrips, lancets, syringes, and insulin infusion pumps, necessary for the administration of prescription drugs and professional instructions, not including printed material for their use. Nutritional counseling for the treatment of diabetes will be considered a covered expense.
24. Charges for oxygen and the rental of equipment for its administration.
25. Charges for rehabilitative care, as defined herein.
26. Charges for artificial limbs or eyes, casts, splints, trusses, crutches, braces (except dental), cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in their function when impaired, rental or purchase (if appropriate) of a wheelchair or hospital type bed and the rental of durable medical equipment which has no personal use in the absence of the condition for which it was prescribed (rental charges will not exceed the retail purchase price of such equipment). The replacement of prosthetic devices are covered only if it is required because of the covered person's physical change.
27. Charges for abortions are covered expenses when the physical or mental health of the mother would be in danger if the fetus were carried to term. The attending physician will determine when the health of the mother is in danger.
28. Charges for selective or non-selective reduction of multiple pregnancy provided every effort is taken to ensure the health of the remaining fetus(es) when one (or more) fetus is abnormal, when the mother's health is in danger, or there are three (3) or more fetuses and they are all likely to be spontaneously aborted or delivered prematurely with a high risk of either dying or being harmed. This is not a covered benefit if the fetus(es) are a result of infertility services that are not covered.
29. Charges for blood and/or plasma and the equipment for its administration.
30. Charges for maternity care including prenatal, delivery, and postpartum care as well as charges arising from complications that may occur during maternity and delivery. Routine ultrasounds are limited to two (2) per pregnancy. Additional ultrasounds may be authorized if medically necessary. The covered person should contact the Contract Administrator for authorization.
31. Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility charges for not more than one hundred (100) days for any one (1) disability, but not in excess of a daily charge for room and board, services, and supplies equal to one-half (1/2) of the discharging hospital's semi-private room rate; provided however, the confinement in such a hospital or facility begins not more than fourteen (14) days after a period of confinement in a general hospital of at least five (5) consecutive days. The covered person must be under the care of an attending physician who determines the continuing need for the hospital or facility stay.

32. Newborn care charges are a covered expense for an employee's newborn dependents. Charges for care of newborn children to include hospital charges for nursery room and board and miscellaneous expenses, charges by a pediatrician for attendance at a cesarean section, charges for physician examination for a newborn while hospital confined and charges for circumcisions.
33. **Chiropractic Care:** Charges for home, office, and nursing home visits as well as examinations, x-rays, consultations, spinal manipulations, electrical stimulation, and interpretation are covered expenses.
34. Organ transplant benefits to include charges for organ transplants and peripheral stem cell transplants for the treatment of cancer are considered a covered expense when the transplant procedure is not considered experimental/investigative and the covered person is considered an eligible recipient. Donor charges are considered a covered expense provided the donor is a blood relative and charges are not covered under any insurance policy the donor may hold. Donor charges are limited to:
 - a) evaluating the organ or tissue;
 - b) removing the organ or tissue from the donor; and
 - c) transporting the organ or tissue from within the United States and Canada to the transplant site.
35. Hospice care charges, as defined herein. Benefits are payable for up to six (6) months of services.
36. **Preventive Care:** Charges for routine physical examinations, well-baby care, and well-adult care are covered expenses. Charges can include examinations (including breast and pelvic), gynecological exams, immunizations, vaccinations, inoculations, consultations, routine x-ray and laboratory services (e.g. cholesterol screenings, TSH, resting EKG's, fecal occult blood tests and double contrast barium enemas), pap smears (including laboratory fees), routine vision exams including refractions, x-rays, mammograms, prostate cancer screenings (including PSA tests and digital rectal exams), and EKG's.
37. **Mental Health Care and Substance Abuse:** Charges resulting from inpatient mental health care and alcohol and/or drug addiction in a hospital, public or licensed mental hospital, drug/alcohol abuse treatment facility, day treatment facility, or outpatient mental health services provided by a board certified physician, a licensed psychologist, clinical or certified social worker or certified alcohol counselor (C.A.C.) will be considered covered expenses. Benefits include treatment of or related to eating disorders and attention deficit disorders (ADD or ADHD). Two (2) days of treatment in an Outpatient Day Treatment Program are equivalent to one (1) day of inpatient care.
38. **Home Health Care:** Charges for the following services or supplies furnished to the covered person at home:
 - A. Part-time intermittent nursing care by or under the supervision of a registered professional nurse (RN); and/or visits by persons who have completed a home health aide training course under the supervision of registered nurse for the purpose of giving personal care to the patient with a maximum of one (1) visit per day for up to a maximum of twenty-five (25) visits per plan year. Four (4) hours constitutes one (1) home health care visit.

- B. Physician's home and office visits, physical therapy, occupational therapy, and speech therapy.
 - C. Medical supplies, laboratory services, drugs, and equipment prescribed by a physician to the extent such items would have been covered if you or your dependent had been hospitalized.
 - D. **Exclusions and Limitations:** In no event will home health care expenses include charges for loss resulting from services solely for custodial care, transportation services, any period during which you or your dependent are not under the continuing care of a physician, injury, or sickness arising out of or in the course of employment, declared or undeclared war or act of war.
39. Any taxes and/or surcharges applied to a covered expense are considered eligible expenses when the tax or surcharge is mandated by state or federal government until such time that ERISA preemption is clearly established by law prohibiting the applicable tax and/or surcharge.
40. Any of the following services in connection with a mastectomy:
- a) all stages of reconstruction of the breast on which the mastectomy is performed;
 - b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - c) prostheses and treatment of physical complications of the mastectomy, including lymphedema.

The Women's Health and Cancer Rights Act of 1998 requires the Plan Sponsor to notify you, as a covered participant or dependent under this Plan, of your rights related to benefits provided through the Plan in connection with a mastectomy. You as a covered participant or dependent under this Plan have rights for coverage to be provided in a manner determined in consultation with your attending physician for the above referenced services.

41. Charges for mastectomy bras are a covered expense to a maximum of two (2) bras per covered person per plan year.
42. Charges for a wig or hairpiece, only after chemotherapy or radiation therapy to a maximum of two (2) wigs or hairpiece per covered person per lifetime.
43. Charges for office visits for the treatment of smoking cessation. Prescription and over-the-counter smoking cessation aids will be covered under the prescription drug plan.
44. Charges for second and third surgical opinions.
45. Charges for treatment of or related to sleep disorders.
46. Charges for allergy testing and allergy injections (including serum).
47. Charges for amniocentesis, including any genetic testing or genetic counseling performed in connection with the procedure.

48. Charges for compression garments (e.g. Jobst garments).
49. Charges for B-12 injections.
50. Charges for the initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular surgery.
51. Charges for non-narocotic analgesics for the treatment of migraines (e.g. Amerge, Frova, Imitrex, Maxalt, Relpax, and Zomig), limited to a combined quantity of eighteen (18) per month for all forms of medications.
52. Charges for female libido enhancement drugs and male impotence medications, including Viagra to a maximum of eight (8) tablets per month.
53. Charges for Stadol Nasal Spray, limited to two (2) bottles per month.
54. Charges for testosterone replacement (e.g. Androderm, Androgel, Testim, Striant).
55. Charges for Prozac Weekly, limited to four (4) capsules per month. Prior authorization may apply.
56. Charges for podiatry surgery, limited to open cutting procedures of the foot.
57. Charges for non-surgical treatment of the feet, including treatment of metabolic or peripheral-vascular disease.
58. Charges for intravenous (IV)/antibiotic infusion therapy whether in a home, physician's office, clinic, or outpatient hospital setting.
59. Charges for infertility testing, only to establish the initial diagnosis of infertility.
60. The Plan will reimburse otherwise eligible medical covered expenses for "patient care services," as such term is defined herein, furnished in connection with participation of a covered person in a "Clinical Trial," as such term is defined herein, which is intended to treat cancer in a patient who has been so diagnosed. A copy of the "Clinical Trial" protocol may be required in order to determine if benefits are available under this Plan. Nothing herein shall create a presumption that the Employer recommended, directed, endorsed or required any covered person's participation in a Clinical Trial.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

1. Expenses for confinement, treatment, services, or supplies except to the extent herein provided which are:
 - a) not furnished or ordered by a recognized provider and not medically necessary to diagnose or treat a sickness or injury;
 - b) experimental or investigational in nature.
2. Expenses for services for disease or injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.
3. Expenses for services for disease or injury sustained as a result of participation in a riot or civil disobedience, or while committing or attempting to commit a criminal act or engage in an illegal activity.
4. Expenses incurred in connection with any accidental bodily injury or illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self employed individuals who choose not to provide themselves with insurance coverages such as, but not limited to, workers' compensation and occupational disease, regardless of whether such coverage or coverages are required by law.
5. Expenses incurred while on full-time active duty in the armed forces of any country, combination of countries or international authority.
6. Expenses for treatment or services rendered outside of the United States of America or its territories, except for accidental injuries or a medical emergency.
7. Expenses for dental services, except to the extent herein provided.
8. Expenses for vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in treatment of strabismus.
9. Expenses incurred for or in connection with any corrective treatment or surgery to correct a refractive error (i.e. such as hyperopia, myopia, astigmatism, LASIK, keratomileusis surgery, or radial keratotomy, etc.) or fitting or actual cost of corrective lenses except to the extent herein provided (i.e. intra-ocular implant of lenses in the treatment of cataracts).
10. Expenses for hearing examinations or hearing aids unless medically necessary due to a birth defect, trauma, or illness causing hearing loss.
11. Expenses for treatment, services, supplies, and facilities provided by or in a hospital owned or operated by any government or agency thereof where such care is provided at government expense under a plan or program established pursuant to the laws or regulations of any government or under a plan or program under which any government participates other than as an employer. The term "any government" includes the federal, veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a covered person who receives billable medical care at any of the above facilities.

12. Expenses for treatment, services, or supplies provided by the employee, spouse, parent, son, daughter, brother, or sister of a covered person or by a member of the covered person's household.
13. Expenses for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.
14. Expenses for services for which the covered person recovers the cost by legal action or settlement.
15. Expenses for sterilizations and reverse sterilizations.
16. Expenses for transsexual surgery or related procedures.
17. Expenses for rehabilitative care, as defined herein, in excess of one (1) year's confinement.
18. Expenses for cosmetic or reconstructive surgery except for expenses:
 - a) to repair or alleviate the damage from an accident; or
 - b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or
 - c) incurred as a result of a birth defect.
19. Expenses solely for sanitarium, rest, or custodial care.
20. Expenses for routine foot care, to include treatment of corns, callouses, bunions (except capsular or bone surgery), flat feet, fallen arches, weak feet, or chronic foot strain.
21. Expenses incurred for weight control by surgical procedures, weight loss programs or a gastric bypass; whether or not it has been determined that the services are medically necessary or the services are under the direction of a physician.
22. Expenses for telephone, radio, television, and beautification services or for the preparation of reports, evaluations and forms, phone consultations, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the physician or dentist or other health care professional in the course of rendering services.
23. Expenses for procedures which do not correct the condition of infertility but are used to induce pregnancy such as artificial insemination, in-vitro fertilization, embryo transplantation, hormone therapy or gamete intra-fallopian transfer (GIFT).
24. Routine or elective expenses except as set forth herein. [i.e. shoe inserts, ankle pads, printed material, arch supports, foot orthotics, orthopedic or corrective shoes and other supportive appliances for the feet, elastic stockings, fluoride, anabolic steroids, irrigation solutions, vitamins (except prenatal), over-the-counter vitamins, nutritional or dietary counseling (except when related to diabetes), food supplements, and any "over the counter drug" which can be purchased with or without a prescription or when no injury or illness is involved].
25. Expenses for breast reduction surgery.

26. Expenses incurred prior to the covered person's effective date of coverage or following the termination date of coverage.
27. Expenses in excess of the maximum allowable benefit in the locality where it is rendered.
28. Expenses for rolfing.
29. Expenses for acupuncture.
30. Expenses for massage therapy or rolfing.
31. Expenses for biofeedback training or equipment.
32. Expenses for surrogacy.
33. Expenses for injuries that result from being in any aircraft being used for one or more of the following: test or experimental purposes; speed test; exhibition or stunt flying; and for injuries that result from riding in or on a motorized vehicle of any type designed for or primarily used for racing, speed tests, or hazardous exhibition purposes.
34. Expenses for complications arising from any non-covered surgery or treatment, except as required by law.
35. Expenses for educational, vocational, or training services and supplies, except as specified in the Medical Covered Expenses section.
36. Expenses related to insertion or maintenance of an artificial heart.
37. Expenses for treatment of behavioral or conduct disorders.
38. Expenses for maintenance care.
39. Expenses for education, counseling, job training, or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or mental/nervous treatment.
40. Expenses for adoption services.
41. Expenses for hypnosis.
42. Expenses for genetic counseling or genetic testing, except as provided herein.
43. Expenses for marital, family, or sex counseling.

44. Expenses for equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an illness or injury.
45. Expenses for medications which are taken by or administered to a covered person, in whole or in part, while they are a patient in a licensed hospital.
46. Expenses for drugs whose sole purpose is to promote or stimulate hair growth (e.g Rogaine or Propecia) or for cosmetic purposes only (e.g. Renova or Vaniqa).
47. Expenses for immunization agents.
48. Expenses for anorexiant or weight loss medications.
49. Expenses for extemporaneous or compounded dosage forms of natural estrogen or progesterone, including, but not limited to, oral capsules, suppositories, and troches.
50. Expenses related to "Never Events." These events are procedures performed on the wrong side, wrong body part, wrong procedure, or wrong person. These "Never Events" are not medically necessary as they are not required to diagnose or treat an illness, injury, disease or its symptoms and are not consistent with generally accepted standards of medical practice.

CLAIM FILING PROCEDURES

Written notice of the employee or the employee's dependent's claim (proof of claim) must be given to the Contract Administrator as soon as is reasonably possible but within twelve (12) months after the occurrence or commencement of any loss covered by the Plan. Failure to furnish written proof of claim within the time required will invalidate the claim. It is the employee's responsibility to inform his provider(s) of this claim submission time limit.

Filing an In-Network or Out-of-Network Medical Claim:

To obtain benefits under this Plan, a diagnostic bill must be submitted that provides sufficient information, including the employee's name, claimant's name, claimant's address, and Plan number to allow the Contract Administrator to properly adjudicate each claim. The Contract Administrator may require additional forms and information to assist them in this process. The covered person should instruct their medical care providers, both in-network and out-of-network, to mail claims to the following address:

CBA Blue
P.O. Box 2365
South Burlington, VT 05407-2365

[Should the employee have any questions, please feel free to call or write to the Contract Administrator.]

CLAIM REVIEW PROCEDURES**I. Failure to Follow Pre-Service Claim Procedures:**

In the case of a failure by a claimant or an authorized representative of a claimant to follow the Plan's procedures for filing a Pre-Service Claim, the claimant or representative will be notified of the failure and the proper procedures to be followed in filing a claim for benefits as soon as possible, but not later than five (5) days (twenty-four (24) hours in the case of a failure to file a Claim involving Urgent Care) following the failure. This notification will be oral unless written certification is requested by the claimant or authorized representative. This section shall only apply in the case of a failure that:

1. Is a communication by a claimant or an authorized representative of a claimant that is received by the Pre-Certification Administrator; and
2. Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service or product for which approval is requested.

II. Timing of Notice of Benefit Claim Determinations:**(a) Provisions Applicable to All Benefits Under the Plan.**

- (i) The various time periods set forth in this Section II within which benefit determinations must be made shall begin at the time a claim is filed in accordance with the Plan's procedures without regard to whether all the information necessary to make a benefit determination accompanies the filing.
- (ii) If any period of time set forth in this Section II is extended because of a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

(b) Additional Provisions Applicable to Health Benefits.

- (i) **Urgent Care Claims:** In the case of a Claim involving Urgent Care, the Contract Administrator will notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical urgencies, but not later than seventy-two (72) hours after receipt of the claim by the Contract Administrator, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Contract Administrator will notify the claimant as soon as possible, but not later than twenty-four (24) hours after receipt of the claim by the Contract Administrator, of the specific information necessary to complete the claim. The claimant will be afforded a reasonable amount of time, taking into account the circumstances, but not less than forty-eight (48) hours, to provide the specified information. Notification of any Adverse Benefit Determination will be made in accordance with the Written Denial provisions set forth

below. The Contract Administrator will notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than forty-eight (48) hours after the earlier of:

1. The Contract Administrator's receipt of the specified information, or
2. The end of the period afforded the claimant to provide the specified additional information.

- (ii) Concurrent Care Decisions: If an ongoing course of treatment to be provided over a period of time or number of treatments has been approved by the Plan, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an Adverse Benefit Determination. The Contract Administrator will notify the claimant, in a manner in accordance with the Written Denial provisions set forth below, of the Adverse Benefit Determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a Claim involving Urgent Care shall be decided as soon as possible, taking into account the medical urgencies, and the Contract Administrator shall notify the claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours after receipt of the claim by the Contract Administrator, provided that any such claim is made to the Contract Administrator at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse determination concerning a request to extend the course of treatment, whether involving Urgent Care or not, shall be made in accordance with the Written Denial provisions set forth below, as appropriate.

- (iii) Pre-Service Claim: In the case of a Pre-Service Claim, the Contract Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than fifteen (15) days after receipt of the claim by the Contract Administrator. The period may be extended one time by the Plan for up to fifteen (15) days, provided that the Contract Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial fifteen (15) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information. Notification of any Adverse Benefit Determination pursuant to this paragraph shall be made in accordance with the Written Denial provisions set forth below.

- (iv) Post-Service Claim: In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Written Denial provisions set forth below, of the Plan's Adverse Benefit Determination within a reasonable period of time, but not more than thirty (30) days after receipt of the claim. This period may be extended one time by the Contract Administrator for up to fifteen (15) days, provided that the Contract Administrator determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the information, and the claimant shall be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.
- (c) Additional Provisions Applicable to Benefits other than Health Benefits. If a claim for benefits other than health benefits is wholly or partially denied, the Contract Administrator shall notify the claimant of the Adverse Benefit Determination within a reasonable period of time not to exceed ninety (90) days after receipt of the claim by the Contract Administrator, unless the Contract Administrator determines that special circumstances require an extension of time for processing the claim. If the Contract Administrator determines that such an extension is required, written notice (in accordance with the Written Denial provisions set forth below) of the extension shall be provided to the claimant prior to the termination of the ninety (90) day period. In no event shall such extension exceed a period of ninety (90) days from the end of the initial ninety (90) day period. The notice of the extension provided to the claimant shall indicate the circumstances requiring an extension and the date by which the Contract Administrator expects to render the benefit determination.

III. Written Denial Provisions

- (a) Provisions Applicable to All Benefits under the Plan. The Contract Administrator shall provide a claimant with written or electronic notification of any determination of a claim. In the case of an Adverse Benefit Determination, the notification shall set forth in a manner calculated to be understood by the claimant:
 - (i) The specific reason(s) for the denial;
 - (ii) Specific references to pertinent Plan provisions upon which the denial is based;
 - (iii) 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;
 - (iv) An explanation of the Plan's claim review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse determination on review.

(b) Additional Provisions Applicable to Health Benefits.

In the case of an Adverse Benefit Determination concerning health benefits, the notification shall also set forth in a manner calculated to be understood by the claimant:

- (i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination (a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request);
- (ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgement for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- (iii) In the case of an adverse determination concerning a Claim involving Urgent Care, a description of the expedited review process applicable to such claims.

In the case of an Adverse Benefit Determination concerning an Urgent Care Claim, the information described above in this Section III may be provided to the claimant orally, provided that a written or electronic notification is furnished to the claimant not later than three (3) days after the oral notification.

IV. Appeal of Adverse Benefit Determinations(a) Provisions Applicable to All Benefits under the Plan.

- (i) Each claimant shall be afforded a full and fair review of any Adverse Benefit Determination.
- (ii) Each claimant may appeal an Adverse Benefit Determination within one hundred eighty (180) days (sixty (60) days in the case of an Adverse Benefit Determination relating to benefits other than health benefits) following receipt of notification of the Adverse Benefit Determination.
- (iii) In connection with such review, the claimant shall have the opportunity to submit any written comments, documents, records or other information the claimant believes is relevant.
- (iv) In connection with such review, the claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claimant's appeal.
- (v) The review of the Adverse Benefit Determination shall take into account all comments, documents, records and other information submitted by the claimant that relate to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

- (b) Additional Provisions Applicable to Health Benefits.
- (i) The review shall not afford deference to the initial Adverse Benefit Determination.
 - (ii) The review shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the review, nor a subordinate of such individual.
 - (iii) In deciding an appeal of an Adverse Benefit Determination that is based in whole or in part 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 person conducting the review will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. The health care professional engaged for purposes of consultation in accordance with the previous sentence shall be an individual who is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual.
 - (iv) The identity of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination, will be provided to the claimant.
 - (v) In the case of a Claim involving Urgent Care, an expedited review process will be provided, pursuant to which a request for an expedited appeal to an Adverse Benefit Determination may be submitted orally or in writing by the claimant and all necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

V. Timing of Notice of Benefit Determination Following Review

- (a) Provisions Applicable to All Benefits under the Plan.
- (i) The various time periods set forth in this Section V within which the review of an Adverse Benefit Determination must be completed shall begin at the time an appeal is filed in accordance with the procedures of the Plan, without regard to whether all the information necessary to make a determination on review accompanies the filing.
 - (ii) If any period set forth in this Section V is extended as permitted herein due to a claimant's failure to submit information necessary to decide a claim, the period for making the determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

- (b) Additional Provisions Applicable to Health Benefits.
- (i) Urgent Care Claims: In the case of a Claim involving Urgent Care, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review as soon as possible, taking into account the medical urgencies, but not later than seventy-two (72) hours after receipt of the claimant's request for review of an Adverse Benefit Determination by the Plan.
 - (ii) Pre-Service Claims: In the case of a Pre-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination provisions below, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than thirty (30) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.
 - (iii) Post-Service Claims: In the case of a Post-Service Claim, the Contract Administrator shall notify the claimant, in accordance with the Notification of Benefit Determination, of the plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than sixty (60) days after receipt by the Plan of the claimant's request for review of an Adverse Benefit Determination.

VI. Notification of Benefit Determination

- (a) Provisions Applicable to All Benefits under the Plan. The Contract Administrator shall provide a claimant with a written or electronic notification of a Plan's benefit determination on review. In the case of an Adverse Benefit Determination, the notification shall set forth, in a manner calculated to be understood by the claimant:
- (i) The specific reason(s) for the adverse determination;
 - (ii) Reference to the specific Plan provisions on which the benefit determination is based;
 - (iii) 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 claimant's claim for benefits;
 - (iv) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures, and a statement of the claimant's right to bring an action under Section 502(a) of ERISA.

- (b) Provisions Applicable to Health Benefits. In the case of an Adverse Benefit Determination on review concerning health benefits, the notification shall also set forth, in a manner calculated to be understood by the claimant:
- (i) The specific internal rule, guideline, protocol, or other similar criterion if such rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination (a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge to the claimant upon request);
 - (ii) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
 - (iii) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Effective May 1, 2011, claimants will have such additional claim and appeal rights as are specified in Section 2719 of the Public Health Service Act and implementing regulations, which are incorporated by reference.

MISCELLANEOUS PROVISIONS

Discharge: All plan benefits made in accordance with the terms and provisions contained herein will discharge the Plan Sponsor from all future liability to the extent of the payments so made.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator's decisions will be binding on all employees, dependents, and beneficiaries.

Except for functions reserved by the Plan to the Employer or Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. In accordance with Sec. 503 of Title I of ERISA, the Plan Administrator will designate one or more named fiduciaries under the Plan, each with complete authority to review all denied claims for benefits under the Plan with respect to which it has been designated named fiduciary (including, but not limited to, the denial of certification of medical necessity of hospital or medical treatment). In exercising its fiduciary responsibilities, the named fiduciary will have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms. The named fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Federal Guidelines for a Plan Subject to the Employee Retirement Income Security Act of 1974 (ERISA): This Plan will comply with all federal law and guidelines relative to welfare benefit plans under ERISA. These federal laws and guidelines will supersede any provisions and terminology contained herein which may be to the contrary.

Family and Medical Leave Policy: All eligible employees have the right to take family and medical leave according to the provisions of the federal and state laws as amended from time to time.

Increases/Decreases in Coverage: Any amendments to the Plan providing an increase in the amount of a covered employee's and/or dependent's coverage will become effective as of the date of such amendment, provided coverage is in effect on the date of such amendment. Any amendment to the Plan providing a decrease in the amount of a covered employee's and/or dependent's coverage will begin on the effective date of such amendment.

Invalidity of Certain Provisions: If any provisions of the Plan will be held invalid or unenforceable, such invalidity or enforceability will not affect any other provision herein and this Plan will be construed and enforced as if such provisions had not been included.

Medicare Provision: All eligible employees and their dependents, age sixty-five (65) and over, who are eligible for coverage under the Plan, will be provided with coverage under this Plan on the same basis as available to covered employees under the age of sixty-five (65). Each employee over the age of sixty-five (65) has the right to reject the employer provided group health plan and elect to have Medicare for the employee and their spouse as their only coverage. Should the employee elect this option, Medicare will become the employee's health insurance coverage. The absence of any written documentation to the contrary will construe this Plan as primary.

For an eligible employee or dependent under age sixty-five (65), if Medicare eligibility is due solely to end-stage renal disease (ESRD), the Plan will be primary only during the first thirty (30) months of Medicare coverage. Thereafter, the Plan will be secondary with respect to Medicare Coverage. If an eligible employee or dependent is under age sixty-five (65) when Medicare eligibility is due solely to ESRD, and the employee or dependent subsequently attains age sixty-five (65), the Plan will be primary for a full thirty (30) months from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary. If an eligible employee or dependent is age sixty-five (65) or over, working and develops or is undergoing treatment for ESRD, the Plan will be primary for a full thirty (30) months from the date of ESRD eligibility. Thereafter, Medicare will be primary and the Plan will be secondary.

This provision will comply with the Social Security Act as amended from time to time.

Qualified Medical Child Support Orders: Participants and beneficiaries may obtain upon request from the Contract Administrator, without charge, a copy of the Plan's procedures relating to qualified medical child support orders.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly deliver plan benefits. These payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan Administrator from further liability to the extent that payments are made.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purpose of another plan, the Plan Administrator may release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Contract Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Contract Administrator such information as may be required to implement this provision in accordance with the HIPAA Privacy Requirements.

Right to Recovery: Whenever the Plan has allowed benefits to be paid which have been paid or should have been paid by any other plan, or which were erroneously paid, the Plan will have the right to recover any such excess payments from the appropriate party.

Right to Amend the Plan: The Plan Sponsor has the authority to amend the Plan Document, modifying any of the provisions herein, or terminating the Plan at any time without the consent of or notice to any covered person hereunder. The Plan may be amended, modified, or terminated as required by plan utilization, costs, market forces, federal legislation, or other general business concerns of the Plan Sponsor. When a Plan amendment, modification, or termination is executed, the Plan Sponsor will provide notice of such action, in writing, to all covered persons.

Should the Plan be amended and, thereby, terminated, the Plan Administrator will provide for:

First: Payment of benefits to each covered person of all covered expenses for services which were incurred while the Plan was in effect.

Second: Payment of expenses incurred in the liquidation and distribution of the Plan and any payments due to the Plan Administrator.

Third: Direct disposition of all assets, if applicable, held in the Plan to covered persons as determined by the Plan Administrator, subject to the limitations contained herein and any applicable requirements of law or regulation.

Subrogation, Reimbursement & Third Party Recovery Provision:

WHEN THIS PROVISION APPLIES: The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

If you, your spouse, one of your dependents, or anyone who receives benefits under this Plan becomes ill or is injured and is entitled to receive money from any source, including but not limited to any party's liability insurance or uninsured/underinsured motorist proceeds, then the Plan may elect, but is not required, to conditionally advance payment or extend credit of medical benefits in those situations where an injury, sickness, disease or disability is caused in whole or in part by, or results from, the acts or omissions of a third party, or from the acts or omissions of covered persons and their dependents where any insurance coverage, no-fault, uninsured motorist, underinsured motorist, medical payment provision or other insurance policies or funds is available. If at the time of injury, sickness, disease or disability there is available, or potentially available (based on information known or provided to the Plan, or to the Plan Beneficiary) any other Coverage (including but not limited to coverage resulting from a judgment at law or settlements) the benefits under this Plan shall apply only as an excess over such other sources of Coverage.

As a condition to participating in and receiving benefits under this Plan, the Plan Beneficiary agrees to subrogate the Plan to any and all claims, causes of action or rights that they have or that may arise against any person, corporation and/or other entity and to any Coverage for which the Plan Beneficiary claims an entitlement to benefits under this Plan, regardless of how classified or characterized and to reimburse the Plan for any such benefits paid when recovery is made. The employee or covered person agrees that acceptance of benefits is constructive notice of this provision in its entirety and agrees to reimburse the Plan one hundred percent (100%) of benefits provided without reduction for attorney's fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The person receiving benefits further agrees that the plan shall have an equitable lien on any funds received by said person and/or their attorney, if any, from any source for any purpose and shall be held in trust until such time as the obligation under this provision is fully satisfied. If the employee or covered person retains an attorney, then the employee or covered person agrees to only retain one who will not assert the Common Fund or Made-Whole Doctrines.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Beneficiary agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Plan Beneficiary. Failure to comply with any of these requirements by the Plan Beneficiary, his or her attorney or guardian may, at the Plan's discretion, result in forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Plan Beneficiary satisfies his or her obligation. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgement or settlement received, the Plan Beneficiary will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

No court costs, expert fees, attorney's fees, filing fees, or other costs or expenses of a litigation nature may be deducted from the Plan's recovery without prior, expressed written consent of the Plan. Reimbursement shall be made immediately upon collection of any sum(s) recovered regardless of its legal, financial, or other sufficiency. If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds.

The employee or covered person agrees to the following: (i) to sign any documents requested by the Plan including but not limited to reimbursement and/or subrogation agreements as the Plan or its agent(s) may request, (ii) to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage and (iii) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights. Also, the employee or covered person agrees to furnish any other information as may be requested by the Plan or its agent(s). Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan. Any excess after one hundred percent (100%) reimbursement of the Plan may be divided up between the employee or covered person and their attorney if applicable. Any accident related claims made after satisfaction of this obligation shall be paid by the employee or covered person and not the Plan.

The Plan will not pay or be responsible, without its written consent, for any fees or costs associated with a Plan Beneficiary pursuing a claim against any Coverage. The Plan Beneficiary agrees to hold the Plan harmless against any claims made against the Plan by the attorneys retained by the Plan Beneficiary.

The employee or covered person agrees to take no action which in any way prejudices the rights of the Plan. If it becomes necessary for the Plan to enforce this provision by initiating any action against the employee or covered person, then the employee or covered person agrees to pay the Plan's attorney's fees and costs associated with the action regardless of the action's outcome.

The Plan Sponsor has sole discretion to interpret the terms of this provision in its entirety and reserves the right to make changes as it deems necessary. Furthermore, the Plan may reduce or deny future benefits by the amount of any recovery received, but not reimbursed, by the Participant as it relates to an accident or injury for which the Plan paid benefits.

If the employee or covered person takes no action to recover money from any source, then the employee or covered person agrees to allow the Plan to initiate its own direct action for reimbursement.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgement of these rights is required by the Plan and signed by the employee or covered person.

In the event that the Plan Beneficiary dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights still apply.

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

The Use and Disclosure of Protected Health Information:

A. Use and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted or required by the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated pursuant thereto ("HIPAA"). Specifically, to the extent allowed by law, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations.

B. The Plan Will Use and Disclose PHI in accordance with and as Required by Law and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will disclose PHI in accordance with and as required by law. For example, (i) the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of obtaining premium bids for health insurance coverage under the Plan, or for modifying, amending or terminating the Plan; (ii) the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; and (iii) to the extent allowed by law, the Plan may use and disclose PHI for purposes related to health care treatment, payment for health care, and health care operations. Except for these uses and disclosures, the Plan shall obtain a written authorization from the individual who is the subject of the PHI prior to a disclosure. "Summary health information" means information that may be individually identifiable health information and that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Plan Sponsor has provided health benefits under the Plan; and from which identifying information has been deleted, except that geographic information may be aggregated at the level of a five digit zip code.

C. For Purposes of This Section, the Plan Sponsor is named in the General Information section herein

The Plan has received a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in D, below.

D. With Respect to PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- make available the information required to provide an accounting of disclosures;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and
- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic protected health information; and
- ensure adequate separation required by 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures.

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

- the benefits manager; and
- staff designated by the benefits manager.

The following employees, classes of employees or other persons under the Plan Sponsor's control may have access to PHI including PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business:

Benefits Department

F. Limitations of PHI Access and Disclosure

The persons described in section E may only have access to and use and disclose PHI for plan administration functions that the Plan Sponsor performs for the Plan.

G. Noncompliance Issues

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

H. Security Requirements

The security rule requires plans to comply with four (4) general requirements. The plan must:

- ensure the confidentiality, integrity, and availability of all electronic protected health information that it creates, receives, maintains, or transmits;
- protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic protected health information;
- protect against any reasonably anticipated uses or disclosures of electronic protected health information that are not permitted or required under HIPAA; and
- ensure compliance with the security standards by its workforce.

ERISA STATEMENT OF RIGHTS

As a participant in this Plan, the employee is entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants will be entitled to:

1. Examine, without charge, at the Plan Administrator's office all Plan documents including insurance contracts and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and plan descriptions.
2. Obtain copies of all Plan documents and other plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
4. File suit in a federal court if any materials requested are not received within thirty (30) days of the participant's request, unless the materials were not sent because of matters beyond the control of the Plan Administrator. The court may require the Plan Administrator to pay up to \$110 per day until the employee receives the materials.
5. File suit in a state or a federal court if the employee is improperly denied a welfare benefit in whole or in part. The employee must receive a written explanation of the reason for the denial. The employee has the right to have the Plan review and reconsider the employee's or their dependent's claim.
6. Seek assistance from the U.S. Department of Labor or file suit in a federal court if:
 - a) plan fiduciaries misuse the Plan's money. In addition to creating rights for Plan participants, ERISA imposes duties to the people who are responsible for this operation of the Plan. The people who operate the employee's Plan called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the employee and other Plan participants.
 - b) the employee is discriminated against for asserting the employee's rights. The employee's employer may not fire the employee or otherwise discriminate against the employee in any way to prevent the employee from obtaining a welfare benefit or exercising the employee's rights under ERISA.

The court will decide who should pay court costs and legal fees. Should the employee be successful, the court may require the other party to pay the employee's legal costs and fees.

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) or ninety-six (96) hours as applicable. In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of forty-eight (48) hours or ninety-six (96) hours.

Should the employee have any questions about this statement or about the employee's rights under ERISA, the employee should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington D.C. 20210.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

Accident: An unforeseen or unexplained sudden injury occurring by chance without intent or volition.

Active Service: An employee will be considered in active service with the employer on a day which is one of the employee's scheduled work days if he is performing in the customary manner all of the regular duties of their employment with the employer on that day, either at one of the employer's business establishments or at some location to which the employer's business requires him to travel. A regular vacation day, properly scheduled in accordance with normal practices and policies of SystemsPlus Health + Employee Health Plan will qualify as a scheduled work day for purposes of this definition.

Adverse Benefit Determination: Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's beneficiary's eligibility to participate in the Plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Aggregate: The combined total of all family members.

Ambulatory Surgical Center: A facility which is not physically attached to a health care facility, which provides surgical treatment to patients not requiring hospitalization, and does not include the offices of private physicians or dentists whether in an individual or group practice.

Birthing Center: A public or private facility, other than private offices or clinics of physicians, which meets the free standing birthing center requirements of the State Department of Health in the state where the covered person receives the services.

The birthing center must provide: a facility which has been established, equipped, and operated for the purpose of providing prenatal care, delivery, immediate postpartum care and care of a child born at the center; supervision of at least one (1) specialist in obstetrics and gynecology; a physician or certified nurse midwife at all births and immediate postpartum period; extended staff privileges to physicians who practice obstetrics and gynecology in a area hospital; at least two (2) beds or two (2) birthing rooms; full-time nursing services directed by an R.N. or certified nurse midwife; arrangements for diagnostic x-ray and lab services; and the capacity to administer local anesthetic or to perform minor surgery.

In addition, the facility must only accept patients with low risk pregnancies, have a written agreement with a hospital for emergency transfers and maintain medical records on each patient and child.

Claim for benefits: A request for a Plan benefit or benefits made by a claimant in accordance with the Plan's procedure for filing benefit claims. This includes any Pre-Service Claims and any Post-Service Claims.

Claim involving Urgent Care: Any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determination:

- (i) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function; or
- (ii) In the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim;

Except as set forth in the next paragraph, whether a claim is a Claim involving Urgent Care is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine.

Any claim that a physician with knowledge of the claimant's medical condition determines is a Claim involving Urgent Care shall be treated as Claim involving Urgent Care.

Clinical Trial: A clinical trial that meets the following conditions:

1. The clinical trial is intended to treat cancer in a patient who has been diagnosed; and
2. The clinical trial has been peer reviewed and is approved by at least one of the following:
 - a. One of the United States National Institutes of Health,
 - b. A cooperative group or center of the National Institutes of Health,
 - c. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
 - d. The United States Food and Drug Administration pursuant to an investigational new drug exemption,
 - e. The United States Department of Defense of Veterans Affairs,
 - f. Or, with respect to Phase II, III and IV clinical trials, a qualified institutional review board, and
3. The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial, and
5. The patient has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial, and
7. The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Coinsurance: Coinsurance percentages represent the portions of covered expenses paid by the covered person and by the Plan after satisfaction of any applicable deductible. These percentages apply only to covered expenses which do not exceed the maximum allowable benefit. The covered person is responsible for all non-covered expenses and any amount which exceeds the maximum allowable benefit for covered expenses.

Contract Administrator: Third party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit payments and providing explanation of benefits to covered employees and/or providers;
2. remitting benefit payments for covered expenses under the Plan to covered employees and/or providers;
3. reviewing all claims appeals.

Contributory Coverage: Plan benefits for which an employee enrolls and agrees to make any required contributions toward the cost of coverage.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing treatment for individuals convalescing from injury or illness, including that part or unit of a hospital which is similarly constituted and operated, and:

1. Has organized facilities for medical treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a physician or a registered nurse. Full-time supervision means a physician or a registered nurse is regularly on the premises at least forty (40) hours per week;
2. Maintains daily clinical records concerning each patient and has a written agreement or arrangement with a physician to provide services and emergency care for its patients;
3. Provides appropriate methods for dispensing and administering drugs and medicines;
4. Has transfer agreements with one (1) or more hospitals, a utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) physician. A convalescent hospital/extended care facility will not include any institution which is a rest home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism, or a nursing home.
5. Qualifies as an "extended care facility" under the health insurance provided by Title XVIII of the Social Security Act, at the time.

Covered Person: A covered employee or a covered dependent as determined under the applicable Plan provision.

Creditable Coverage: Coverage with a previous carrier that is credited toward the preexisting condition limitation provision of this Plan. Creditable coverage includes Medicare, Medicaid, state health benefits risk pool coverage, group health plans, etc. Waiting periods are not considered breaks in coverage. Days in a waiting period are not creditable coverage.

Custodial Care: Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Custodial care includes services that could be performed by a relative or friend with minimal instruction or supervision.

Custodial Parent: The parent awarded custody by court decree. If there is no court decree, the custodial parent is the one with whom the child resides for more than half the year.

Day of Confinement: Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a hospital.

Day Treatment: Mental Health care on an individual or group basis for more than two (2) hours but less than twenty-four (24) hours per day in either a licensed hospital, rural health center, community mental health center. This type of care is also referred to as partial hospitalization.

Deductible: The amount of covered expenses the covered employee must pay during each plan year before the Plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible is the maximum deductible applied to each family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of that plan year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

Dependent:

1. The lawful spouse of an eligible employee, including a same sex spouse, who has entered into a legal marriage in a state which recognizes same sex marriage; or
2. the married or unmarried child of an eligible employee who has not attained their twenty-sixth (26th) birthday.

The word "child", as used above, will include an eligible employee's natural child, a legally adopted child (including a child in the custody of the employee under an interim court order of adoption, whether or not a final adoption order is ever issued), a stepchild, a foster child, or a child for whom legal guardianship has been granted, but excludes a child who is eligible for employee coverage under this Plan.

Should an employee have a child covered under the Plan who reaches the age at which the child would otherwise cease to be a covered person and if such child is then mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider such child as a dependent beyond such age, while such child remains in such condition, subject to all of the terms of the Plan, provided the employee has, within thirty-one (31) days of the date on which the child attained such age, submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

Dependent Coverage: Plan benefits extended to the dependent(s) of a covered employee.

Durable Medical Equipment: Equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Such equipment will not be covered under the plan if it could be useful to a person in the absence of an illness or injury and could be purchased without a physician's prescription.

Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Eligibility Date: The date an employee and/or their dependent(s) become eligible to enroll in the Plan.

Employee: Any employees who qualify for employee coverage under the eligibility requirements set forth in the "General Information" section contained herein. The definition of an employee does not include independent contractors, contingent workers, or leased employees.

Employee Coverage: Group medical benefits provided under the Plan on behalf of a covered employee.

Employer: The company providing employment to the covered employees.

Enrollment Date: The first day of coverage under the Plan or, if there is a waiting period, the first day of the waiting period. This date is frequently, but not always, the date of hire.

Essential Benefits: Benefits including at least the following general categories and items and services covered within these categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Expense: A charge a covered person is legally obligated to pay. An expense is deemed to be incurred on the date the service or supply is furnished.

Experimental/Investigative: A drug, device, medical treatment or procedure that is not the subject of, or in some manner related to, the conduct of a Clinical Trial, as such term is defined herein, is experimental or investigative:

- a) 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
- b) 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
- c) if reliable evidence shows that the drug, device, medical treatment, or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, 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
- d) 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 will 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, device, 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.

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.

Health Care Operations: include, but are not limited to the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:
 - a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
 - b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Health Care Professional: A physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.

Home Health Care Agency: A licensed and state approved home health care facility possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act and licensed and approved by the appropriate state authorities which specializes in providing health care and therapeutic services to a person in such person's home.

Home Health Care Plan: A program for care and treatment of a covered person established and approved, in writing, by such covered person's attending physician, together with such physician's certification that the proper treatment of the injury or sickness would require confinement as a resident inpatient in a hospital or confinement in a skilled nursing facility as defined in Title XVIII of the Social Security Act, at the time, in the absence of services and supplies provided as part of the home health care plan.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual who has been diagnosed by a physician as having a life expectancy of six (6) months or less. Room and board may be provided. The agency must meet all of the following tests: (i) approved under any required state or governmental Certificate of Need; (ii) provides twenty-four (24) hour a day, seven (7) day a week service; (iii) it is under the full-time supervision of at least one (1) duly qualified physician; (iv) has a nurse coordinator who is a registered graduate nurse with at least four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients; (v) has a social service coordinator who is licensed in the area in which it is located; (vi) the main purpose of the agency is to provide hospice services; (vii) has a full-time administrator; (viii) maintains written records of services given to each patient; (ix) its employees are bonded; (x) it provides malpractice and malplacement insurance; (xi) is established and operated in accordance with any applicable state laws.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and treatment of sick or injured persons on an inpatient and/or outpatient basis, and which provides such care and treatment: (i) under the supervision of one (1) or more physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an extended care facility, a place (primarily) for the treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible expenses. In such instances, if a covered person is confined in a school facility that does not meet the definition of a hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the maximum allowable benefit for the disability involved.

Hospital Confinement: Being registered as a bed-patient in a hospital upon the recommendation of a physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.

Illness: Sickness or disease which results in expenses for medical care, services, and supplies covered by the Plan. Such expense must be incurred while the covered person, whose illness is the basis of the claim, is covered under the Plan. Medical expenses incurred by a covered person because of pregnancy will be covered to the same extent as any other illness.

Injury: Accidental bodily harm resulting from an accident.

Inpatient Basis: Hospital confinement including one (1) or more days of confinement for which a room and board charge is made by a hospital.

Intensive Care Unit: An accommodation in or part of a hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. Is established by the hospital for the purpose of providing formal intensive care;
2. Is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a physician and performed by a physician or by a specifically trained registered nurse; and
3. Provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Maintenance Therapy: Any treatment, service, or therapy that preserves the member's level of function and prevents regression of that function. Maintenance therapy begins when therapeutic goals of a treatment plan have been achieved or when no further functional progress is apparent or expected to occur.

Maximum Allowable Benefit: An amount a provider is allowed for a particular service. If an out-of-network provider charges more than the maximum allowable benefit, the Plan will not cover more than the maximum allowable benefit and the person is responsible for the difference.

Medical Emergency: The sudden, unexpected onset of a medical condition with severe symptoms that are considered hazardous to the patient's life, health, or physical well-being, requiring urgent and immediate medical attention.

Medical Intervention: Any medical treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or treatment will be considered medically necessary if:

- a) there is a sickness or injury which requires treatment; or
- b) the confinement, service, or supply used to treat the sickness or injury is:
 - required;
 - generally professionally accepted as usual, customary, and effective means of treating the sickness or injury in the United States; and
 - approved by regulatory authorities such as the Food & Drug Administration; and
- c) diagnostic x-rays and laboratory tests when they are performed due to definite symptoms of sickness or injury, or they reveal the need for treatment.

Mental Hospital: An institution (other than a hospital as defined) which specializes in the diagnosis and treatment of mental illness or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

1. Is licensed to give medical treatment and is operated under the supervision of a physician;
2. Offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical treatment;
3. Is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Illness: Neuroses, psychoneuroses, psychoses, and other mental and emotional disorders falling within any of the diagnostic categories in the mental disorders section of the international classification of diseases.

Never Events: These events, as defined by The National quality Forum, a private organization whose members include the American Medical Association (AMA), are "errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and that indicate a real problem in the safety and credibility of a health care facility."

Newborn Care Charges: Charges for care of newborn children as more specifically defined herein.

Non-Contributory Coverage: Plan benefits for which the employee enrolls and for which he is not required to make contribution toward the cost of coverage.

Out-of-Pocket Maximum: Under the terms of this Plan, the maximum amount any individual covered under the Plan would be required to pay toward the maximum allowable benefit on all covered expenses during a plan year. The out-of-pocket maximum under Plan 2-A, Plan 3-A, and Plan 4-A will be determined by adding the employee share of coinsurance amounts as set forth by this Plan. The out-of-pocket maximum under Plan 1-A will be determined by adding the deductible and employee share of coinsurance amounts as set forth by this Plan.

Outpatient Basis: Any hospital expenses incurred for which no room and board charge is made.

Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited hospital, or community mental health center or other mental health clinic or day care center which furnished mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or treatment of mental illness or emotional disorder.

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

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review; and
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan).

Patient Care Services: Medical covered services, as described in this Plan, that are furnished to an individual enrolled in a Clinical Trial, as such term is defined here, which are consistent with the usual and customary standard of care for someone with the patient's diagnosis and, are consistent with the study protocol for the Clinical Trial. Notwithstanding the foregoing, patient care services do not include any of the following:

1. an FDA approved drug or device which is paid for by the manufacturer, the distributor or the provider of the drug or device;
2. non-health care services that a patient may be required to receive as a result of being enrolled in the Clinical Trial;
3. costs associated with managing the research related to the Clinical Trial;

4. costs that would not be covered under the Plan for non-investigational/experimental treatments;
5. any item, service or cost that is reimbursed or otherwise furnished by the sponsor of the Clinical Trial; or
6. the cost of services which are not provided as part of the Clinical Trial's stated protocol or other similar guidelines.

Physician: A duly licensed doctor of medicine, a medical professional, or a practitioner who is duly licensed under appropriate state licensing authorities, provided: (i) a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of medicine, and (ii) under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a medical doctor.

Plan: The SystemsPlus Health + Employee Health Plan, as described herein, and adopted by Plan Sponsor, and named in the General Information section herein.

Plan Administrator: Plan Sponsor, acting through its exclusive agent, Allison Hazen, Trustee of the NFA Member Plan Master Trust.

Plan Anniversary Date: The date occurring in each plan year which is an anniversary of the effective date of the Plan.

Plan Document: The master contract which describes the terms of coverage and association between the Contract Administrator and the Plan Sponsor.

Plan Sponsor: Your company, named in the General Information section herein.

Post-Service Claim: Any claim for a benefit under the Plan that is not a Pre-Service Claim.

Pre-Service Claim: Any claim for a benefit under the Plan with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

Prior Plan: The prior group medical plan offered by the Plan Sponsor.

Protected Health Information: Health information, including demographic information, which is collected from an individual, and which;

- is created or received by the Plan;
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and
 - a) that identifies the individual; or
 - b) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and
- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Protected Health Information excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as employer.

Qualified Beneficiary: Any covered person who loses coverage as a result of a qualifying event described in the "Extension of Benefits" section. These beneficiaries are:

1. covered employees (and their spouses and dependent children) who have been terminated for reasons other than the covered employee's gross misconduct, or have had their hours reduced (resulting in a loss of coverage);
2. widowed spouses and dependent children;
3. divorced or legally separated spouses and their dependent children;
4. Medicare ineligible spouses and their dependent children;
5. a covered dependent child who no longer meets the Plan's definition of a covered dependent child;
6. a child born to, or placed for adoption with the covered employee during the period of COBRA coverage.

Rehabilitation Hospital: A facility which meets all requirements of a hospital (as defined herein) other than the "surgical facilities" requirements and, in addition, meets the following criteria:

1. It must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified hospital;
2. It must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies;
3. It must maintain a utilization review committee.

Rehabilitative Care: Necessary inpatient medical care (as prescribed by a physician) rendered in a rehabilitation hospital (as defined herein) excluding custodial care or occupational training.

Relevant: In the context of whether a document, record or other information shall be considered "relevant," means the following: a document, record, or other information

- (i) relied upon in making the benefit determination;
- (ii) submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- (iii) demonstrating compliance with the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated claimants in making the benefit determination; or

- (iv) constituting a statement of policy of guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In no event should the provisions of this Claim Review Procedures section be interpreted to require any claimant to file more than two (2) appeals of an Adverse Benefit determination prior to bringing a civil action under Section 502(a) of ERISA.

Residential Treatment Facility: A child care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Substance Abuse: Any use of alcohol or drugs which produces a state of psychological and/or physical dependence.

Substance Abuse Treatment Facility:

1. A public or private facility providing services especially for detoxification or rehabilitation of substance abusers and which is licensed to provide such services;
2. A comprehensive health service organization, community mental health clinic or day care center which furnishes mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of substance abusers and which is licensed to provide such services.

Totally Disabled: A covered employee shall be considered totally disabled if, as a result of a non-occupational illness or a non-occupational accidental injury, the employee is unable to perform the full duties of his/her occupation or is unable to engage in any gainful occupation.

Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.


Waiting Period: The period of time between the employee's enrollment date and the employee's first date of coverage under the Plan.

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This Plan Document, known as the SystemsPlus Health + Employee Health Plan, is hereby executed at:

So. Burlington, Vermont on May 10, 2011
(City) (State) (Date)

BY: 

TITLE: Trustee of the NFA Member Plan Master Trust
acting as exclusive agent of the Plan Sponsor