

**TEXAS ANNUAL CONFERENCE OF
THE UNITED METHODIST CHURCH**

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

REVISED EFFECTIVE: January 1, 2008

CONTRACT ADMINISTRATOR:

Boon-Chapman Benefit Administrators, Inc.

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SCHEDULE OF MEDICAL BENEFITS Plan A - PPO Area Plan

Annual Deductibles:

*\$400 Individual
\$1,200 Family

Benefit Maximum:

(Includes All Other Maximums)
\$2,000,000

Annual Out of Pocket Maximums:

(excludes deductibles and co-payments)
PPO: \$2,200 Individual
Non-PPO: \$26,000 Individual

Physician Office Visit Co-payment

(Applies to office visit charge only. Other services performed in the physician's office are subject to deductible and co-insurance.)

PPO: \$20- Primary Care Physician (PCP)
\$30- Specialist
Non-PPO: N/A

Hospital Admission Deductible outside The Methodist Hospital – Fannin facility

For participants who live within 50 miles of Methodist Hospital, hospital admissions to a hospital other than The Methodist Hospital (including San Jacinto, Willowbrook, Sugarland and new wholly owned subsidiaries) will have a per occurrence co-pay of \$1,000 for all inpatient facility charges for services that can be performed at The Methodist Hospital. For services not available at The Methodist Hospital or emergency admissions, the co-pay will be waived.

*** Retirees and surviving spouses, 65 and older, and receiving Medicare benefits are not required to select from the PPO provider directory—doctor needs to accept Medicare assignments.**

The Plan recognizes and approves of the practice that The Methodist Hospital and possibly other providers do not collect deductibles, co-pays and co-insurance from eligible participants.

The Plan will pay benefits to covered persons for covered expenses as described herein in accordance with the schedule of benefits. The Plan provides maximum benefits to the covered persons when they:

receive services or treatment from a provider who is a member of one of the assigned preferred provider organizations, HealthSmart Preferred Care for participants outside of the Greater Houston area or Private Healthcare Systems (“PHCS”) for participants in the Greater Houston area;

follow the procedures of the employee assistance program described herein, which is administered by MHNNet Employee Assistance Program; and

follow the procedures of the utilization review program described herein, which is administered by, Capitol HealthCare Review, Inc. (CHR) dba Prime Dx, a utilization review organization.

If you have questions about participating providers or need help finding a participating provider, call **HealthSmart at (800) 687-0500** or visit their website at www.healthsmart.net, or for participants inside the Greater Houston area call **Private Healthcare Systems (PHCS) at (888) 719-7427** or visit their website at www.phcs.com. If you are unsure of your PPO assignment please refer to your Boon Chapman medical identification card or call Boon Chapman eligibility. A current list of PPO providers for each of the PPO's is available, without charge, through the website. If you do not have access to a computer at your home, you may access this website at your place of employment or contact the Boon Chapman Eligibility Department.

If you have questions about the utilization review program, call Prime Dx at (512) 454-5112 in Austin or (800) 477-4625 outside Austin.

If you have questions about the EAP program, call MHNNet EAP at (800) 492-4357.

The Contract Administrator of the Plan is Boon-Chapman Benefit Administrators, Inc. If you have other questions about the Plan (including questions about claims, premiums, and eligibility), call (512) 454-2681 or (800) 252-9653.

The following schedule summarizes co-payment amounts paid by you and the plan, benefit maximums and additional explanation needed for your benefits. Please refer to the text for additional plan provisions, which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
Alcohol/ Substance Abuse			All care must be pre-certified. Plan or lifetime limit of three (3) separate series of treatments.
Inpatient Coverage			
PPO	Yes	80%	
Non-PPO	Yes	60%	
Outpatient Coverage			
PPO	Yes	80%	
Non-PPO	Yes	60%	
Allergy Injections			
PPO	\$20 co-pay	100%	
Non-PPO	Yes	60%	
Ambulance Services			
PPO	Yes	80%	
Non-PPO	Yes	80%	
Chiropractic Therapy			Calendar year maximum of 24 visits.
PPO	\$20 co-pay	100%	
Non-PPO	Yes	60%	
Emergency Room (Medical Emergency)			
PPO	Yes	80%	
Non-PPO	Yes	80%	
Emergency Room (Non-Emergency Use)			
PPO	Yes	80%	
Non-PPO	Yes	60%	
Home Health Care			Maximum up to 60 visits per calendar year.
PPO	Yes	80%	
Non-PPO	Yes	60%	
Hospital Services (Except Mental Health/Substance Abuse)			All Inpatient admissions must be pre-certified. All related charges will be reduced by 50% if you do not follow the procedures required by the Utilization Review Program. This penalty does not apply to the out of pocket maximum.
PPO	Yes	80%	
Non-PPO	Yes	60%	
Hospice Services			Bereavement Counseling Maximum Benefit per occurrence is 3 visits.
PPO	Yes	80%	
Non-PPO	Yes	60%	
Maternity			Limited to initial visit to determine pregnancy.
Initial visit	Pre-natal		
PPO	\$20 co-pay	100%	
Non-PPO	Yes	60%	
All Other Services			

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
PPO	Yes	80%	
Non-PPO	Yes	60%	
Mental and Nervous Care			All care must be pre-certified.
Inpatient Coverage			Calendar Year Maximum is 30 days.
PPO	Yes	80%	
Non-PPO	Yes	60%	
Outpatient Coverage			Calendar Year Maximum 30 visits.
PPO	Yes	80%	
Non-PPO	Yes	60%	
Outpatient Rehabilitation			
PPO	\$20 co-pay	100%	Includes charges for Physical Therapy, Speech Therapy, and Occupational Therapy. Maximum per condition is 60 visits per calendar year.
Non-PPO	Yes	60%	
Physician Office Visits			
PPO	PCP - \$20 co-pay Specialist - \$30 co-pay	100%	Primary Care Physician (PCP) includes General Practice, Family Practice, Pediatrician, Gynecologist, and Internal Medicine. Does not apply to Mental Health/Substance Abuse. Applies to office visit charge only.
Non-PPO	Yes	60%	
Second Surgical Opinion			
Physician's Office Visit			Primary Care Physician (PCP) includes General Practice, Family Practice, Pediatrician, Gynecologist, and Internal Medicine.
PPO	PCP - \$20 co-pay Specialist - \$30 co-pay	100%	
Non-PPO	Yes	60%	
Other Services			
PPO	Yes	80%	
Non-PPO	Yes	60%	
Serious Mental Illness			See Definitions for "Serious Mental Illness".
Inpatient or Outpatient			
PPO	Yes	80%	
Non-PPO	Yes	60%	
Office Visit			
PPO	PCP - \$20 co-pay Specialist - \$30 co-pay	100%	
Non-PPO	Yes	60%	
Skilled Nursing or Convalescent Facility			
PPO	Yes	80%	Maximum up to 60 days per calendar year.
Non-PPO	Yes	60%	
Well Child Care			
Physician's Office			Limited to children under age 3.
PPO	\$20 co-pay	100%	
Non-PPO	No	100%	
Associated Lab/X-ray			

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
PPO	No	100%	Limited to related services performed outside physician's office.
Non-PPO	No	100%	
Well Child Immunizations PPO or Non-PPO	No	100%	Limited to children up to age 6.
Wellness Benefit Physician's Office PPO	\$20 co-pay	100%	Calendar Year Maximum of \$200. Charges in excess of \$200 will be covered as any other eligible expense.
Non-PPO	No	100%	
Associated Lab/X-ray PPO	No	100%	Limited to related services performed outside physician's office
Non-PPO	No	100%	
All Other Covered Expenses PPO	Yes	80%	
Non-PPO	Yes	60%	

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equals the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Common Accident Provision

Not more than one individual Annual Deductible will be applied to covered expenses incurred in relation to an accident involving two or more family members.

Multiple Birth

Not more than one Annual Deductible will be applied to covered expenses incurred in the same calendar year that two or more dependents are born in a multiple birth if such covered expenses are due to:

- premature birth;
- abnormal congenital condition; or
- injury or illness which begins not more than 30 days after birth.

Benefit Maximums

The maximum payable for all eligible medical expenses for each covered person shall not exceed, in the aggregate, the maximum plan benefit shown above, which applies to all periods a person is covered under the plan. Any lesser maximum benefit amounts are also applicable to all periods a person is covered under the plan. Other maximums may apply to specific periods, conditions, or types or levels of care and are as specified.

Plan Co-Insurance

Plan co-insurance is the portion of covered expenses that the Plan will pay, excluding those covered expenses that a covered person must pay:

- as a deductible;
- as co-insurance;
- as co-payment; or
- because of a benefit maximum.

If a covered person does not comply with the utilization review program, all related charges will be reduced by 50% of what was otherwise payable.

Exceptions to Plan Co-Insurance

(Does not apply to transplants.)

If a Covered Person goes into a PPO hospital with a PPO doctor admitting, or if a Covered Person goes to a PPO hospital for outpatient services, the ancillary services (i.e. pathology, x-ray, anesthesiology) performed by non-network providers who may be used by the hospital will be paid at the PPO provider co-insurance level.

If services are unavailable at a PPO facility or by a PPO provider in the PPO service area, or in case of an emergency, the charges will be processed at the PPO benefit level. The Co-insurance level for Covered Persons residing or traveling outside of a 50-mile radius from a network provider will be at the PPO benefit level. The PPO service area is defined as a 50-mile radius from the Covered Person's home address.

All other deductibles and benefit limitations apply and payment is based on usual and customary as defined by the Contract Administrator.

Waiting Period

In accordance with the provisions set forth under the Section titled "Eligibility and Effective Dates", the employee will be covered the first day of the month following active full time employment. Effective April 1, 1998, lay employees will be covered the first day of the month following 90 days of active full time employment.

Out-of-Pocket Maximums

Except as provided below, a covered person shall not be required to pay, in one calendar year, more than \$2,200 to PPO providers for his covered medical expenses. Once he has done so, the Plan will pay all of his covered expenses for the remainder of the calendar year.

Except as provided below, a covered person shall not be required to pay, in one calendar year, more than \$4,200 to all non-PPO providers for his covered medical expenses. Once he has done so, the Plan will pay all of his covered expenses for the remainder of the calendar year.

These out-of-pocket maximums do not apply to any covered expenses a covered person must pay:

- as a deductible;
- as a co-payment;
- as co-insurance for treatment of Mental Health/Substance Abuse;
- as co-insurance because of failure to comply with the utilization review program; or
- because of a benefit maximum.

Employee's Assistance Program

Before receiving treatment for mental health or substance abuse a call must be made to the MHNet EAP at 1-800-492-4357, which is available 24 hours a day, 7 days a week.

What is an EAP?

The MHNet Employee Assistance Program (EAP) offers completely confidential support and direction day or night. MHNet Master's-level counselors answer the toll-free EAP phone number 24/7. You and your dependents can always reach a caring, compassionate professional, ready to help the caller start on the path to resolving any life issue and return to full productivity.

What types of situations can the EAP help with?

- Marriage & Family Concerns
- Parenting Issues
- Alcohol & Drug Counseling
- Legal & Financial Issues
- Gambling Addiction

- Anxiety, Depression & Stress Management
- Bereavement
- Work Related Conflict

What types of services are provided?

- A 24/7 toll-free telephone for crisis intervention and counseling, 800.492.4357
- Up to 6 face-to-face visits (per incident or per year) with an EAP counselor for short-term problem resolution,
- Referrals to community agencies, and interface with Boon Chapman when needed for additional assistance needed. (Warm transfer)

How do I obtain confidential benefits?

- Call the EAP and talk to the intake clinician
- Counseling can be face-to-face, telephonic or internet based
- MHNet Behavioral Health also provides members with hundreds of videos, articles and health assessments in their **Solution Centers** tailored to your specific life needs, providing the right tools to help you through some of life's toughest challenges. Categories in the Solution Centers include, Emotional Wellbeing, Health, Family Life, Small Business, Financial, Personal Growth, Legal, Stress.

PLEASE NOTE

Payment in both the PPO out of area and non-participating provider option within the PPO, is limited to the provider's usual, customary and reasonable fee. See definition on page 52.

SCHEDULE OF MEDICAL BENEFITS Plan B - Out of Area Plan

Annual Deductibles:

*\$400 Individual
\$1,200 Family

Benefit Maximum:

(Includes All Other Maximums)
\$2,000,000

Annual Out of Pocket Maximums:

(includes deductibles and co-payments)

PPO: \$2,200 Individual
Non-PPO: \$26,000 Individual

Physician Office Visit Co-payment

(Applies to office visit charge only. All other services performed in physician's office subject to deductible and co-insurance.)

PPO: \$20- Primary Care Physician (PCP)
\$30- Specialist
Non-PPO: N/A

Hospital Admission Deductible outside The Methodist Hospital – Fannin facility

For participants who live within 50 miles of Methodist Hospital, hospital admissions to a hospital other than The Methodist Hospital (including San Jacinto, Willowbrook, Sugarland and new wholly owned subsidiaries) will have a per occurrence co-pay of \$1,000 for all inpatient facility charges for services that can be performed at The Methodist Hospital. For services not available at The Methodist Hospital or emergency admissions, the co-pay will be waived.

*** Retirees and surviving spouses, 65 and older, and receiving Medicare benefits are not required to select from the PPO provider directory—doctor needs to accept Medicare assignments. The physician office visit co-pay does not apply to retirees and surviving spouses, age 65 and over. All eligible expenses for retirees and surviving spouses, age 65 and over, will be paid at the 80% co-insurance level.**

The Plan recognizes and approves of the practice that The Methodist Hospital and possibly other providers do not collect deductibles, co-pays and co-insurance from eligible participants.

The Plan will pay benefits to covered persons for covered expenses as described herein in accordance with the schedule of benefits. The Plan provides maximum benefits to the covered persons when they:

receive services or treatment from a provider who is a member of one of the assigned preferred provider organizations, HealthSmart Preferred Care for participants outside of the Greater Houston area or Private Healthcare Systems (“PHCS”) for participants in the Greater Houston area;

follow the procedures of the employee assistance program described herein, which is administered by MHNNet Employee Assistance Program; and

follow the procedures of the utilization review program described herein, which is administered by, Capitol HealthCare Review, Inc. (CHR) dba Prime Dx, a utilization review organization.

If you have questions about participating providers or need help finding a participating provider, call **HealthSmart at (800) 687-0500** or visit their website at www.healthsmart.net, or for participants inside the Greater Houston area call **Private Healthcare Systems (PHCS) at (888) 719-7427** or visit their website at www.phcs.com. If you are unsure of your PPO assignment please refer to your Boon Chapman medical identification card or call Boon Chapman eligibility. A current list of PPO providers for each of the PPO's is available, without charge, through the website. If you do not have access to a computer at your home, you may access this website at your place of employment or contact the Boon Chapman Eligibility Department.

If you have questions about the utilization review program, call Prime Dx at (512) 454-5112 in Austin or (800) 477-4625 outside Austin.

If you have questions about the EAP program, call MHNNet EAP at (800) 492-4357.

The Contract Administrator of the Plan is Boon-Chapman Benefit Administrators, Inc. If you have other questions about the Plan (including questions about claims, premiums, and eligibility), call (512) 454-2681 or (800) 252-9653.

The following schedule summarizes co-payment amounts paid by you and the plan, benefit maximums and additional explanation needed for your benefits. Please refer to the text for additional plan provisions which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
Alcohol/ Substance Abuse			All care must be pre-certified. Plan or lifetime limit of three (3) separate series of treatments.
Inpatient Coverage	Yes	80%	
Outpatient Coverage	Yes	80%	
Allergy Injections			
PPO	\$20 co-pay	100%	
Non-PPO	Yes	80%	
Ambulance Services	Yes	80%	
Chiropractic Therapy			Calendar year maximum of 24 visits.
PPO	\$20 co-pay	100%	
Non-PPO	Yes	80%	
Emergency Room	Yes	80%	
Home Health Care	Yes	80%	Maximum up to 60 visits per calendar year.
Hospital Services (Except Mental Health/Substance Abuse)	Yes	80%	All Inpatient admissions must be precertified. All related charges will be reduced by 50% if you do not follow the procedures required by the Utilization Review Program. This penalty does not apply to the out of pocket maximum.
Hospice Services	Yes	80%	Bereavement Counseling Maximum Benefit per occurrence is 3 visits.
Maternity			
Initial Pre-natal visit			Limited to initial visit to determine pregnancy.
PPO	\$20 co-pay	100%	
Non-PPO	Yes	80%	
All Other Services	Yes	80%	
Mental and Nervous Care			All care must be pre-certified. Calendar Year Maximum is 30 days. Calendar Year Maximum 30 visits.
Inpatient Coverage	Yes	80%	
Outpatient Coverage	Yes	80%	
Outpatient Rehabilitation			Includes charges for Physical Therapy, Speech Therapy, and Occupational Therapy. Maximum per condition is 60 visits per calendar year.
PPO	\$20 co-pay	100%	
Non-PPO	Yes	80%	
Physician Office Visits			Primary Care Physician (PCP) includes

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
PPO	PCP - \$20 co-pay Specialist - \$30 co-pay	100%	General Practice, Family Practice, Pediatrician, Gynecologist, and Internal Medicine. Does not apply to Mental Health/Substance Abuse. Applies to office visit charge only. Co-pay does not apply to Retirees and Surviving Spouses whose eligible charges will be paid at 80%.
Non-PPO	Yes	80%	
Second Surgical Opinion Physician's Office Visit Charge			
PPO	PCP - \$20 co-pay Specialist - \$30 co-pay	100%	
Non-PPO	Yes	80%	
Other Services	Yes	80%	
Serious Mental Illness Inpatient or Outpatient			See Definitions for "Serious Mental Illness".
PPO	Yes	80%	
Non-PPO	Yes	80%	
Office Visit			
PPO	PCP - \$20 co-pay Specialist - \$30 co-pay	100%	
Non-PPO	Yes	80%	
Skilled Nursing or Convalescent Facility	Yes	80%	Maximum up to 60 days per calendar year.
Well Child Care Physician's Office			
PPO	\$20 co-pay	100%	Limited to children under age 3.
Non-PPO	No	100%	
Associated Lab/X-ray			
PPO or Non-PPO	No	100%	Limited to related services performed outside physician's office.
Well Child Immunizations			
PPO or Non-PPO	No	100%	Limited to children up to age 6.
Wellness Benefit Physician's Office			
PPO	\$20 co-pay	100%	Calendar Year Maximum of \$200. Charges in excess of \$200 will be covered as any other eligible expense.
Non-PPO	No	100%	
Associated Lab/X-ray			
PPO or Non-PPO	No	100%	Limited to related services performed outside physician's office
All Other Covered Expenses	Yes	80%	

Calendar Year Deductible

This is the amount of Covered Medical Expenses you pay each calendar year before benefits are paid. There is a Calendar Year Deductible that applies to each person.

Family Deductible Limit

If Covered Medical Expenses incurred in a calendar year by you and your dependents and applied against the separate Calendar Year Deductibles equals the Family Deductible Limit, you and your dependents will be considered to have met the separate Calendar Year Deductibles for the rest of that calendar year.

Common Accident Provision

Not more than one individual Annual Deductible will be applied to covered expenses incurred in relation to an accident involving two or more family members.

Multiple Birth

Not more than one Annual Deductible will be applied to covered expenses incurred in the same calendar year that two or more dependents are born in a multiple birth if such covered expenses are due to:

- premature birth;
- abnormal congenital condition; or
- injury or illness which begins not more than 30 days after birth.

Benefit Maximums

The maximum payable for all eligible medical expenses for each covered person shall not exceed, in the aggregate, the maximum plan benefit shown above, which applies to all periods a person is covered under the plan. Any lesser maximum benefit amounts are also applicable to all periods a person is covered under the plan. Other maximums may apply to specific periods, conditions, or types or levels of care and are as specified.

Plan Co-Insurance

Plan co-insurance is the portion of covered expenses that the Plan will pay, excluding those covered expenses that a covered person must pay:

- as a deductible;
- as co-insurance;
- as co-payment; or
- because of a benefit maximum.

If a covered person does not comply with the utilization review program, all related charges will be reduced by 50% of what was otherwise payable. Penalties will not be applied based on the timing of the call to PrimeDx if procedure approved or found to be medically necessary.

Exceptions to Plan Co-Insurance

(Does not apply to transplants.)

If a Covered Person goes into a PPO hospital with a PPO doctor admitting, or if a Covered Person goes to a PPO hospital for outpatient services, the ancillary services (i.e. pathology, x-ray, anesthesiology) performed by non-network providers who may be used by the hospital will be paid at the PPO provider co-insurance level.

If services are unavailable at a PPO facility or by a PPO provider in the PPO service area, or in case of an emergency, the charges will be processed at the PPO benefit level. The Co-insurance level for Covered Persons residing or traveling outside of a 50-mile radius from a network provider will be at the PPO benefit level. The PPO service area is defined as a 50-mile radius from the Covered Person's home address.

All other deductibles and benefit limitations apply and payment is based on usual and customary as defined by the Contract Administrator.

Waiting Period

In accordance with the provisions set forth under the Section titled "Eligibility and Effective Dates", the employee will be covered the first day of the month following active full time employment. Effective April 1, 1998, lay employees will be covered the first day of the month following ninety (90) days of active full time employment.

Out-of-Pocket Maximums

Except as provided below, a covered person shall not be required to pay, in one calendar year, more than \$2,200 to all providers for his covered medical expenses. Once he has done so, the Plan will pay all of his covered expenses for the remainder of the calendar year.

These out-of-pocket maximums do not apply to any covered expenses a covered person must pay:

- as a deductible;
- as co-insurance for treatment of Mental Health/Substance Abuse;
- as co-insurance because of failure to comply with the utilization review program;
- as a co-payment; or
- because of a benefit maximum.

Employee's Assistance Program

Before receiving treatment for mental health or substance abuse a call must be made to the MHNet EAP at 1-800-492-4357, which is available 24 hours a day, 7 days a week.

What is an EAP?

The MHNet Employee Assistance Program (EAP) offers completely confidential support and direction day or night. MHNet Master's-level counselors answer the toll-free EAP phone number 24/7. You and your dependents can always reach a caring, compassionate professional, ready to help the caller start on the path to resolving any life issue and return to full productivity.

What types of situations can the EAP help with?

- Marriage & Family Concerns
- Parenting Issues
- Alcohol & Drug Counseling
- Legal & Financial Issues
- Gambling Addiction
- Anxiety, Depression & Stress Management
- Bereavement
- Work Related Conflict

What types of services are provided?

- A 24/7 toll-free telephone for crisis intervention and counseling, 800.492.4357
- Up to 6 face-to-face visits (per incident or per year) with an EAP counselor for short-term problem resolution,
- Referrals to community agencies, and interface with Boon Chapman when needed for additional assistance needed. (Warm transfer)

How do I obtain confidential benefits?

- Call the EAP and talk to the intake clinician
- Counseling can be face-to-face, telephonic or internet based
- MHNet Behavioral Health also provides members with hundreds of videos, articles and health assessments in their **Solution Centers** tailored to your specific life needs, providing the right tools to help you through some of life's toughest challenges. Categories in the Solution Centers include, Emotional Wellbeing, Health, Family Life, Small Business, Financial, Personal Growth, Legal, Stress.

PLEASE NOTE

Payment in both the PPO out of area and non-participating provider option within the PPO is limited to the provider's usual, customary and reasonable fee. See definition on page 52.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements – Employees

See Schedule of Benefits for additional requirements. To be eligible to participate in the health care coverages of the plan an employee must be in one of the following categories:

Clergy

Full time

An individual who serves under appointment by the Bishop of the Texas Annual Conference of The United Methodist Church, who works thirty (30) or more hours per week. For student pastors, scheduled hours of academic classes count toward the thirty (30) hours requirement. Students not serving a local church are not eligible under this paragraph.

Retired

An individual under appointment of the Bishop of the Texas Annual Conference of The United Methodist Church, who was a participant in the plan for at least two (2) years immediately preceding retirement and receives a pension from the General Board of Pensions and Health Benefits. **Please note that the participant must enroll in Part A and B of Medicare when eligible.**

Incapacitated Clergy

Clergy appointed to incapacity leave regardless of age by the Texas Annual Conference can continue on the plan, but must submit evidence of applying for Medicare Disability benefits within six months of the effective date of their appointment to incapacity leave. Once Medicare becomes their primary coverage, the participant then pays the appropriate (65 and over) retiree rate.

Part time

Part time Clergy working twenty (20) hours or less per week are not eligible for benefits under the plan.

Appointment Changes

Clergy who receive a change in appointment during the year and are appointed to the HMO service area have 21 days from the effective date of their appointment to apply for HMO coverage if they want to change from the PPO. Without application during this 21-day period, the insurance office will assume they want to remain covered under the PPO Plan and any changes from the PPO plan can only be made during the annual open enrolment.

Surviving Spouse

The surviving spouse of a clergy who was enrolled in the plan at the time of death and who qualifies for and receives an annuity on account of the deceased participant's service. In the event a surviving spouse remarries, the surviving spouses' eligibility to participate in this plan will terminate on the Surviving Spouse's wedding date.

Lay Employee

Full time

Lay employee of a local church, agency or institution of the Texas Annual Conference if certified by such church, agency or institution and employed to work an average of at least thirty (30) hours of work per week, who does not live within 25 miles of an Insurance Committee approved HMO. Lay employees who live within 25 miles of an approved HMO are not eligible for the plan described in this booklet but are eligible for the HMO plan.

Retired

Retired lay employee, age 65 or older, with at least ten (10) consecutive years of service with a church or agency of the Texas Annual Conference and is eligible and receives a pension from the General Board of Pensions and Health Benefits and who was a participant in the plan for at least two years immediately

preceding retirement. Please note that the participant must enroll in both Parts A and B of Medicare when eligible.

Part time

Part time laity working twenty (20) hours or less per week are not eligible for benefits under the plan.

Retirees leaving the Plan

Any retiree who chooses to become a permanent resident of another country, which is defined as living in that country for six (6) months or longer, will lose eligibility for benefits under the Texas Annual Conference plan. Eligibility will be reinstated upon permanent return to the United States. This provision does not apply to any form of pastoral work outside of the United States.

Once a retiree leaves the Conference sponsored medical plan, either the PPO or Medicare HMO, they will not be allowed to return to the plan in the future. Retirees transferring to a US Military plan can return only when the Military's plan ceases to exist.

Effective Date — Employees

Eligible employees who are in active employment and enrolled on the effective date of the plan document and who were validly covered under the employer's plan of health care coverage that this plan replaces will be covered on the plan document's effective date. All other employees will be effective as shown in the Schedule of Benefits.

This plan may provide contributory coverage (each employee pays a part of the cost of his own coverage). An eligible employee's coverage is effective, subject to the effective date provision in the Schedule of Benefits, upon completion of the forms provided by the contract administrator for such purpose.

If lay employee fails to enroll within 31 days of completion of the waiting period, the employee's coverage will be effective only if enrolled during an open enrollment.

Eligibility Requirements — Dependents

If an employee is covered by the plan, the employee's eligible dependents can also be covered.

An eligible dependent of an employee is:

- a spouse. Such spouse must have met all requirements of a valid marriage contract in the state of marriage;

- any unmarried natural child under the age of 19 (including any legally adopted child or a child placed for adoption with employee; a stepchild under the age of nineteen living with the employee in a parent and child relationship and dependent on the employee for support; a foster child or grandchild under age nineteen if obtained by legal custody and dependent on employee for support.) Support is evidenced by the employee being able to claim such dependent as an exemption for federal income tax purposes. The custody and financial requirements are waived if the employee or the employee's eligible legal spouse are required to provide the child with coverage due to court order, divorce decree, or Qualified Medical Child Support Order;

- an unmarried student over age 19 but under age 25, if such child meets all of the requirements of the preceding paragraph, except age, and is in full-time school attendance for five calendar months or more each calendar year at a qualified educational institution.

As used herein, the term "qualified educational institution" shall mean high schools, junior colleges or other two-year colleges granting two-year degrees, universities or colleges granting four-year degrees or post-graduate degrees, proprietary schools such as business colleges, professional schools, and trade and technical schools that are established as other than evening schools exclusively.

"Full-time school attendance" means 12 units or more per semester in all of the above except proprietary schools. In a proprietary school, "full-time school attendance" shall mean a minimum of 25 hours of classroom attendance per week on a five-day per week schedule.

Cessation of full-time school attendance shall terminate coverage with respect to the student, however, if cessation is due to school vacation, coverage shall terminate on the date the school reconvenes; if cessation is due to graduation, coverage shall terminate at the expiration of the third calendar month following such graduation; or if cessation is due to disability that prevents the

student's full-time school attendance, coverage shall terminate on the first day of the school's next regular session following the date established by a physician's written statement to the contract administrator that the student is capable of full-time school attendance.

An eligible dependent does not include:

- any person who is on active duty in a military service;
- any person who is eligible as an employee under the plan; or
- any person who is covered as a dependent of another employee under the plan.

Qualified Medical Child Support Orders

The Plan Administrator shall enroll for immediate coverage under this Plan any Alternate Recipient who is the subject of a Medical Child Support Order that is a "Qualified Medical Child Support Order" (QMCSO) if such an individual is not already covered by the Plan as an Eligible Dependent, once the Plan Administrator has determined that such order meets the standards for qualification set forth below.

Alternate Recipient shall mean any Child of a Participant who is recognized under a Medical Child Support Order as having a right to enrollment under this Plan as the Participant's Eligible Dependent. For purposes of the benefits provided under this Plan, an Alternate Recipient shall be treated as an Eligible Dependent, but for purposes of the reporting and disclosure requirements under ERISA, an Alternate Recipient shall have the same status as a Participant.

Medical Child Support Order shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Participant's Child or directs the Participant to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or
2. Enforces a law relating to medical child support described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822) with respect to a group health plan.

National Medical Support Notice (NMSN) shall mean a notice that contains the following information:

1. Name of an issuing state agency;
2. Name and mailing address (if any) of an employee who is a Participant under the Plan;
3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Participant or the name and address of a substituted official or agency that has been substituted for the mailing address of the Alternate Recipients(s)); and
4. Identity of an underlying child support order.

Qualified Medical Child Support Order is a Medical Child Support Order that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Participant or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Participant and the name and mailing address of each such Alternate Recipient covered by the order;
2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;
3. The period of coverage to which the order pertains; and
4. The name of this Plan.

In addition, a National Medical Support Notice shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of “National Medical Support Notice”;
2. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or

Informs the Plan Administrator that, if a group health plan has multiple options and the participant is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan’s default option (if any); and

3. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as “qualified” if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to the Participants and Eligible Beneficiaries without regard to this provision, except to the extent necessary to meet the requirements of a state law relating to medical child support orders, as described in Social Security Act §1908 (as added by Omnibus Budget Reconciliation Act of 1993 §13822).

Upon receiving a Medical Child Support Order, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Participant and each Alternate Recipient covered by the Order (at the address included in the Order) in writing of the receipt of such Order and the Plan’s procedures for determining whether the Order qualifies as a QMCSO; and
2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving a National Medical Support Notice, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:
 - (a) Whether the child is covered under the Plan; and
 - (b) Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and
2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

To give effect to this requirement, the Plan Administrator shall:

1. Establish reasonable, written procedures for determining the qualified status of a Medical Child Support Order or National Medical Support Notice; and
2. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the Order.

Effective Date — Dependents

An eligible dependent will be covered beginning with the later of the following dates, provided the employee makes written application for coverage for such dependent in a form furnished by the plan sponsor or contract administrator for that purpose within 30 days of dependent’s initial eligibility and the employee has agreed to pay any required contribution for such coverage:

the date the employee's coverage begins, provided the employee enrolled all eligible dependents on or before employee's effective date; or

the date of enrollment, if the employee enrolls all eligible dependent within 30 days of employee's eligibility date.

A newborn baby or adopted child will be covered for 31 days from birth or the date an adopted child is placed in the custody of the employee if the employee has employee coverage in effect at the time of birth or placement for adoption. The dependent must be properly enrolled within 31 days in order to be eligible to continue participation in the Plan.

A dependent's coverage will not become effective prior to the employee's effective date.

Medicare HMO Participants

A qualified participant may choose to terminate coverage under the Medicare HMO plan offered by this employer and enroll. Enrollment in the plan will be effective on the first day of the first calendar month beginning after the date on which the plan receives the completed enrollment form.

Medicare Supplement Plan for Retirees Over Age 65

When a retiree becomes eligible for Medicare they will have the option to choose the current plan or a fully insured Medicare Supplement Plan. If they choose the Medicare Supplement Plan any dependent under age 65 and not eligible for Medicare will be eligible to remain on the current plan.

Open Enrollment

Participants who are not enrolled within 31 days of becoming eligible for coverage are considered late enrollees and will only be able to enroll during the annual open enrollment period. A completed enrollment form must be submitted prior to December 1 of each year. Enrollment in the plan will be effective on the first day of January after the date on which the plan receives the completed enrollment form.

Special Enrollment

If an employee does not enroll for coverage for the employee and/or the employee's dependents within thirty-one (31) days of becoming eligible for coverage and subsequently wishes to elect such coverage, in appropriate circumstances the Employee may do so under the plan's special enrollment rules.

An employee may enroll for coverage for the employee and all eligible dependents at any time provided that:

the employee is eligible for coverage under the plan but is not currently enrolled;

the employee declined coverage under the plan when it was offered previously and gave the existence of alternative health coverage as the reason for not enrolling on the employee's enrollment form; and

the alternative coverage has terminated, because either (i) it was COBRA continuation coverage that has been exhausted, or (ii) eligibility for the alternative coverage was lost (for reasons other than the individual's failure to pay premiums or for cause) or employer contributions toward the cost of the coverage terminated. In this case, the employee must submit a completed enrollment form within 30 days after the date on which (1) COBRA continuation coverage was exhausted, or (2) the coverage terminated because of loss of eligibility for coverage or the termination of employer contributions toward the cost of the coverage. Enrollment in the plan will be effective the first day of the first calendar month beginning after the date on which the plan receives the completed enrollment form.

In addition, an employee may enroll for coverage for the employee and all eligible dependents at any time provided that:

the employee is eligible for coverage under the plan but is not currently enrolled;

the employee declined coverage under the plan when it was offered previously; and

another individual (a spouse or child) has become a dependent of the employee through marriage, birth, adoption, or placement for adoption. In this case, the employee must submit a completed enrollment form within 30 days of the marriage, birth, adoption or placement for adoption.

Enrollment in the plan will be effective on the first day of the first calendar month beginning after the date (1) on which the plan receives the completed enrollment form, in the case of the employee's marriage; (2) of the new dependent's birth; or (3) of the new dependent's adoption or placement for adoption with the employee.

Effective Date Provision

A dependent's coverage or change in coverage shall not become effective until the employee's coverage or change in coverage has also become effective.

Transfer of Coverage

If a husband and wife are both employees and are covered as employees under this plan, and one of them terminates, the terminating spouse and any of his eligible and enrolled dependents will be permitted to immediately enroll under the remaining employee's coverage. Such new coverage shall be deemed a continuation of prior coverage and shall not operate to reduce or increase any coverage to which such person was entitled while enrolled as an employee or as a dependent of the terminated employee.

Adjustments for Prior Coverage

To the extent that coverages hereunder are a replacement of the prior plan offered by the Employer Group, any deductibles satisfied, with respect to such covered persons under the prior coverage, will be deemed to be deductibles satisfied under the Plan. Any contiguous periods a covered person was covered under prior coverage(s) of the Employer Group will be deemed to be time covered under the Plan. Documentation of satisfied deductibles is the responsibility of the covered person.

PRE-EXISTING CONDITIONS

The term “pre-existing condition” means a physical or mental condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the 6 month period prior to the first day of coverage under this plan or, if earlier, the beginning of any applicable waiting period. However, pregnancy does not constitute a pre-existing condition. Further, a newborn child, adopted child under age 18, or a child under age 18 who has been placed for adoption who begins dependent coverage hereunder within 30 days of birth, adoption, or placement for adoption, or who has creditable coverage from birth, adoption or placement for adoption without a significant break in coverage does not have any pre-existing conditions.

Claims resulting from pre-existing conditions are excluded from coverage under the plan except that if the combination of the covered person’s period of creditable coverage occurring since any significant break in coverage and the period of time the person has been covered under the plan equals or exceeds twelve months (eighteen in the case of a late enrollee), the pre-existing condition exclusion will no longer apply.

Proof of Creditable Coverage

A covered person may prove creditable coverage by either of the following two methods:

First, for prior coverage effective on or after July 1, 1996, the covered person may present a written certificate of coverage from the source or entity that provided the coverage showing:

the date the certificate was issued;

the name of the group health plan that provided the coverage;

the name of the employer or dependent to whom the certificate applies;

the name, address, and telephone number of the plan administrator or issuer providing the certificate;

a telephone number for further information (if different);

either (a) a statement that the employer or dependent has at least 18 months (546 days) of creditable coverage, not counting days of coverage before a significant break in coverage; or (b) the date any waiting period (and affiliation period, if applicable) began and the date creditable coverage began; and

the date creditable coverage ended, unless the certificate indicates that coverage is continuing as of the date of the certificate.

Second, if the covered person for any reason is unable to obtain a certificate from another plan (including because the prior coverage was effective prior to July 1, 1996), he or she may demonstrate creditable coverage by other evidence, including but not limited to documents, records, third-party statements, or telephone calls by this plan to a third-party provider of medical services.

This plan will treat an employee as having provided a certificate if that individual:

attests to the period of creditable coverage;

presents relevant corroborating evidence of some creditable coverage during the period; and

cooperates with the plan’s efforts to verify his or her coverage.

This Plan will treat a dependent as having provided a certificate if that individual:

attests to the dependency and the period of that status; and

cooperates with the plan’s efforts to verify his or her status.

A covered person will, within 60 days of the covered person’s effective date under the plan, provide the plan with proof of creditable coverage the covered person has that occurred since any significant break in coverage.

Notice of Pre-Existing Condition Exclusion

If, within a reasonable time after receiving the information about creditable coverage described above, the plan determines that an exclusion for pre-existing conditions applies, it will notify the employee or dependent of that conclusion and will specify the source of any information on which it relied in reaching the determination. Such notification will also explain the plan's appeals procedures and give the employee or dependent a reasonable opportunity to present additional evidence.

If this plan later determines that an individual did not have the claimed creditable coverage, the plan may modify its initial determination to the contrary. In that case, the individual will be notified of the reconsideration; however, until a final determination is reached, the plan will act in accordance with its initial determination in favor of the employee or dependent for the purpose of approving medical services.

UTILIZATION MANAGEMENT PROGRAM

Call (800) 477-4625 or (512) 454-5112

The Plan's Utilization Management ("UM") Program is designed to encourage covered persons to obtain quality medical care in a cost effective manner. The Plan's UM company is Capitol HealthCare Review, Inc. ("CHR") dba Prime Dx. The UM Company does not diagnose or treat medical conditions. You can call Prime Dx at (512) 454-5112 or (800) 477-4625. You can contact Prime Dx in writing by mailing correspondence to P.O. Box 9201 or by sending a confidential fax to (512) 454-1624.

Each covered employee has received an identification card that contains instructions concerning the UM Program. It should be carried by the employee at all times and shown to all health care providers. The UM Program requires that a covered person call Prime Dx in certain instances described below. It is always the covered person's responsibility to ensure that the call is made in a timely manner; however, the covered person's family or health care provider can make the call.

Pre-Admission Review

The covered person must call Prime Dx at least five days before a scheduled non-emergency hospitalization. Prime Dx will review the medical necessity of the proposed admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized. If authorization is not requested in accordance with this paragraph, any covered expenses will be reduced as described in the Schedule of Benefits. Penalties will not be applied based on the timing of the call to PrimeDx if there are extenuating circumstances.

Continued Stay Review

If a covered person needs to stay in the hospital longer than originally authorized, the covered person must call Prime Dx. The UM Company will review the medical necessity of the request and notify the individual or the provider whether the additional stay is authorized as medically necessary. If the authorization for the additional stay is not requested in accordance with this paragraph, any covered expenses will be reduced as described in the Schedule of Benefits. Penalties will not be applied based on the timing of the call to PrimeDx.

Urgent and Emergency Admission Review

The covered person should call Prime Dx on the first business day after an urgent or emergency hospitalization. Prime Dx will review the medical necessity of the admission and length of stay and notify the individual or the provider whether the admission and the length of stay are authorized. If authorization is not requested in accordance with this paragraph, any covered expenses will be reduced as described in the Schedule of Benefits. Penalties will not be applied based on the timing of the call to PrimeDx.

Review of Outpatient Services

The covered person should call Prime Dx at least three business days before any scheduled procedure list below:

- Arthroscopy, diagnostic & surgical;
- Blepharoplasty
- Cardiac catheterization and/or Surgery;
- Carpal tunnel Surgery;
- CT scans (Computerized Tomography);
- MRI's (Magnetic Resonance Imaging);
- Septoplasty

If authorization is not requested in accordance with this paragraph, any covered expenses will be reduced as described in the Schedule of Benefits. Penalties will not be applied based on the timing of the call to PrimeDx.

Case Management

Prime Dx will assign a case manager when it believes a patient's condition requires complex, specialty or long-term care. The case manager will attempt to coordinate health care services through direct interaction with the covered person, his family, or his physician in an effort to achieve quality care in a cost effective manner. Case management may occur in an inpatient or an outpatient setting.

A covered person must call Prime Dx within 30 days of learning that she is pregnant. In addition, a covered person must call Prime Dx within five days of becoming a possible candidate for an organ transplant. Further, a covered person must call before:

- renting or purchasing of durable medical equipment if the cost exceeds \$1,000.00;
- receiving home health care;
- receiving hospice care;
- receiving substance abuse treatment or services;
- receiving physical, occupational, or speech therapy; and
- being admitted into a skilled nursing facility.

If Prime Dx is not contacted in accordance with these provisions, then covered expenses will be reduced as described in the Schedule of Benefits. Penalties will not be applied based on the timing of the call to PrimeDx.

Second Opinion

At any time during the UM process, Prime Dx may ask the covered person to obtain a second opinion about the medical necessity of a proposed surgery, procedure or health care treatment. The physician providing the second opinion will be chosen by Prime Dx. If the covered person does not obtain the second opinion no benefits will be paid by the Plan.

Plan Administrator Utilization Management Discretion

The Plan Administrator shall have the discretion to alter or waive the normal provisions of the Plan when it is reasonable to expect a cost effective result without sacrificing the quality of care.

Effect of Obtaining an Authorization

The authorization of admission, care or services does not guarantee the payment of benefits. Eligibility and payment of benefits are subject to all of the terms and provisions of the Plan.

MEDICAL CARE COVERAGES

Eligible Medical Expenses

Except as otherwise noted below or in the medical schedule of benefits, eligible medical expenses are the usual, customary, and reasonable charges for services listed below that are incurred by a covered person, subject to the "Definitions" and "Limitations and Exclusions" sections and all other provisions of the plan document. In general, services and supplies must be approved by a physician and must be medically necessary for the care and treatment of a covered sickness, accidental injury, pregnancy, or other covered health care condition.

For benefit purposes, medical expenses shall be deemed to be incurred on the latest of the following dates:

- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

Abortion

Covered expenses are limited to abortions that eliminate a substantial danger to the mother's life, but expenses incurred as a result of medical complications arising from an abortion are also covered.

Alcoholism

See Mental and Nervous Care/Substance Abuse definition. See Schedule of Benefits for possible limitations.

Allergy Testing

See Schedule of Benefits for possible limitations.

Ambulance

Professional local ambulance service by a state-licensed ambulance company to the nearest hospital in connection with care for a medical emergency or accidental injury.

Ambulatory Surgical Center/Licensed Surgical Facility

Anesthesia

The charges made for anesthetics and by a physician or nurse anesthetist for the administration of anesthesia. If both an anesthetist and a nurse anesthetist are utilized, covered charges are limited to usual and customary charges of an anesthetist for the covered operative procedure.

Birth Centers

Blood

The charges for blood and blood plasma (if not replaced by or for the patient), including blood processing charges.

Casts, Splints, Trusses, and Surgical Dressings

Chemical Dependency

See Mental and Nervous Care/Substance Abuse definition. See Schedule of Benefits for possible limitations.

Chemotherapy

Chiropractic Care

Manipulation to correct such vertebral disorders as incomplete dislocation, off-centering, misalignment, fixation, or abnormal spacing. See schedule of benefits for possible limitations.

Contraceptives

The charges for contraceptives both oral and surgical, such as but not limited to birth control pills, Norplant, Depo Provera, and IUD's, are covered expenses.

Diabetes

Care and treatment of diabetes for a covered person who has been diagnosed with insulin dependent or non-insulin dependent diabetes; elevated blood glucose levels induced by pregnancy; or another medical condition associated with elevated blood glucose levels for the following services and supplies:

Diabetes equipment: blood glucose monitors, including monitors for use by the blind; insulin pumps and associated appurtenances; insulin infusion devices; and podiatric appliances for the prevention of complications associated with diabetes.

Diabetes supplies: test strips for blood glucose monitors; visual reading and urine test strip; lancets and lancet devices; insulin and insulin analogs; injection aids; syringes; prescriptive and nonprescriptive oral agents for controlling blood sugar levels; and glucagon emergency kits.

Diabetes self-management training: training in the care and management of diabetes provided to a qualified insured after the initial diagnosis of diabetes, including nutritional counseling and proper use of equipment and supplies; and additional training authorized by the physician on a diagnosis of a significant change in the qualified insured's symptoms or conditions which requires a change in the program.

Diagnostic Services

Diagnostic laboratory and x-ray expenses, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by physicians throughout the United States. See "Pre-Admission Testing" for further information.

Drug or Substance Abuse

See "Chemical Dependency."

Durable Medical Equipment

Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment, where only purchase is permitted, prescribed by a physician and required for temporary (generally for a period not to exceed six months) therapeutic use in treatment of an active sickness or accidental injury.

Durable medical equipment includes such items as orthotics, braces, crutches, wheelchairs, hospital beds, iron lungs, dialysis equipment, Glucometers, Dextrometers, etc., that:

can withstand repeated use;

are primarily and customarily used to serve a medical purpose;

generally are not useful to a person in the absence of sickness or accidental injury; and

are appropriate for use in the home.

Purchase or rental of luxury medical equipment (e.g., motorized wheelchairs or other vehicles or bionic or computerized artificial limbs) is not covered when standard equipment is appropriate for the patient's condition.

Home Health Care

Covered expenses are limited to those for services listed herein that are furnished by a home health care agency to a covered person who is under the care of a physician. Home health care services must be furnished in accordance with a home health care plan that is established by the attending physician, and the orders must be renewed at least every 30 days. The attending physician must also certify that the proper treatment of the sickness or accidental injury would require confinement as a resident in-patient in a hospital or skilled nursing facility in the absence of the services and supplies provided as part of the home health care plan.

Covered expenses for home health care visits are limited to those made by:

a registered graduate nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);

home health aides under supervision of a R.N.;

physical, occupational, and speech therapists; or

a licensed midwife.

Covered home health care expenses will also include medical supplies, drugs, and medicines prescribed by a physician, laboratory services, and special meals prescribed by a physician, nutritionist or dietitian, but only to the extent that such charges would have been covered if the covered person had remained in the hospital.

Home Infusion Therapy

Hospice

Covered expenses are limited to hospice care approved every thirty (30) days by the utilization review organization. In addition, eligible expenses are limited to charges for the following services provided by a hospice care program for the care of a covered person with a physician-diagnosed life expectancy of 6 months or less:

nursing care by a registered graduate nurse, a licensed practical nurse, a licensed vocational nurse, or a public health nurse who is under the direct supervision of a registered nurse;

physical therapy and speech therapy when rendered by a licensed therapist;

medical services, supplies, and drugs; or

physician's services.

In addition, bereavement counseling is a covered expense if provided by a hospice care program to a covered person's spouse, children, or parents within twelve (12) months of the death of a covered person who was in a hospice care program at the time of death. See schedule of benefits for possible limitations.

Hospital Services

For a medically necessary confinement, the plan covers:

daily room and board charges based on the average semi-private room rate. If the hospital has only private rooms, the plan will cover the hospital's most standard rate for the private room;

private room charges will be covered if medically necessary by the patient highly susceptible to contracting another illness by being in a semi-private room or patient is contagious; and

all other medically necessary services and supplies furnished by the hospital, but not for private-duty nursing care.

See schedule of benefits for pre-certification requirements and preferred provider arrangements that may determine the level of benefits.

Hospital audits by an independent auditing firm will be considered covered charges under the plan.

Immunizations

Covered expenses include any required or recommended immunizations for a covered child from birth through the date the child is six years of age.

Mastectomy Reconstruction

Covered expenses include the following in connection with a covered mastectomy:

reconstruction of the breast on which the mastectomy has been performed;

surgery and reconstruction of the other breast to produce a symmetrical appearance; and

prostheses and physical complications of all stages of mastectomy, including lymphedemas.

Medical Case Management

If medical case management is approved by the plan sponsor, such charges by the utilization review organization will be considered covered expenses under the plan.

Mental Health Care

See Mental and Nervous Care/Substance Abuse definition. See Schedule of Benefits for possible limitations.

Midwife

Services of a registered nurse midwife.

Newborn Care

Hospital and physician services rendered during the birth confinement to a covered newborn child (including such charges of a well newborn).

Nursing Services

The charges made by a registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or licensed vocational nurse (L.V.N.) for private-duty nursing services when medically necessary and prescribed in writing by the attending physician or surgeon specifically as to duration and type and when performed in the covered person's home. See schedule of benefits for possible limitations.

Out-Patient Surgery

Eligible expenses incurred in connection with any surgical procedure that is performed on an out-patient basis in a hospital, ambulatory surgical center, or physician's office. Charges must be incurred on the same day as the surgery, except that tests required by the hospital because of the surgery will be covered if they are incurred within seven days prior to the surgery.

Oxygen

Oxygen and services and supplies for the administration of oxygen.

Physical Therapy

The charges for the professional services of a licensed physical therapist, when specifically prescribed by and under the direct supervision of a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Physician Services

The charges made by a physician for medical and surgical treatment.

Pre-Admission Testing

The charges for diagnostic tests performed on an out-patient basis prior to a scheduled hospital admission when the tests are performed within seven days before admission to the hospital and the patient is subsequently admitted to the hospital.

Preferred Provider Organization

If a preferred provider organization (PPO) or specialty care referral program is shown in the schedule of benefits, usual, customary, and reasonable charges for those programs will be considered covered expenses under the plan.

Pregnancy

Pregnancy expenses of a covered employee or covered dependent spouse or child are covered to the same extent as any sickness.

Group health plans and health insurance issuers offering group health insurance coverage 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 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a provider obtain authorization from the plan or insurance issuer from prescribing a length of stay not in excess of the above periods.

Prosthetic Appliances

Covered expenses are limited to those for:

an initial temporary and permanent prosthesis required to replace natural body parts lost or removed while a person is covered by the Plan;

an initial prosthesis required to aid the function of body organs; and

a replacement prosthesis necessitated by the growth of a child.

Radiation Therapy

Radium and radioactive isotope therapy.

Respiratory Therapy

The charges for the professional services of a licensed respiratory therapist, when specifically prescribed by a physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of bodily function.

Second Surgical Opinion

The usual, customary, and reasonable fees of a physician for a second (or third) surgical opinion consultation and related diagnostic work, when recommended by the utilization review organization.

Serious Mental Illness

The following psychiatric illnesses only are covered at the same extent as any other illness, as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic depressive and mixed), major depressive orders (single episode or recurrent), schizo-affective disorders bipolar or depressive), pervasive development disorders, obsessive compulsive disorders, and depression in childhood and adolescence.

Skilled Nursing Facility

Covered expenses are limited to skilled nursing facility room and board and services when the confinement is approved and reviewed every thirty (30) days by the utilization review organization.

Sleep Disorders Treatment

Covered expenses are limited to treatment of apnea and narcolepsy.

Speech Therapy

Services by a qualified speech therapist when specifically prescribed by and under the direct supervision of a physician, to restore or rehabilitate any speech loss or impairment caused by accidental injury or sickness except a mental, emotional, or nervous disorder. In the case of a congenital defect that can be corrected or improved with surgery, expenses will be considered only if incurred after surgery for the defect.

Sterilization Procedures

Sterilization procedures for employees and spouses ONLY.

Telemedicine or Telehealth

Covered expenses include the use of interactive audio, video, or other electronic media for diagnosis, consultation, treatment, transfer of medical data, and medical education. Services performed using a telephone or facsimile machine are not covered.

Temporomandibular Joint Dysfunction (TMJ)

See schedule of benefits for possible limitations.

Transplants

Services and supplies in connection with transplant procedures, subject to the following conditions.

Case management is required by the utilization review organization for all services.

A second opinion must be obtained prior to undergoing any transplant procedure. This mandatory second opinion must concur with the attending physician's findings regarding the medical necessity of such procedure. The physician rendering this second opinion must be qualified to render such a service either through experience, specialty training or education, or similar criteria, and must not be affiliated in any way with the physician who will be performing the actual surgery.

If the donor is covered under this plan, eligible medical expenses incurred by the donor will be considered for benefits.

If the recipient is covered under this plan, eligible medical expenses incurred by the recipient will be considered for benefits. Expenses incurred by a donor who is not ordinarily covered under this plan

according to participant eligibility requirements will be considered eligible expenses to the extent that such expenses are not payable by the donor's plan. In no event will benefits be payable in excess of the maximum plan benefit still available to the recipient.

If both the donor and the recipient are covered under this plan, eligible medical expenses incurred by each person will be treated separately for each person.

The usual, customary, and reasonable cost of securing an organ from a cadaver or tissue bank, including the surgeon's charge for removal of the organ and a hospital's charge for storage or transportation of the organ, will be considered a covered expense.

Urgent Care Facilities

A freestanding facility that is engaged primarily in providing minor emergency and episodic medical care and that has a board certified physician, a registered graduate nurse (R.N.), and a registered x-ray technician in attendance at all times, and x-ray and laboratory equipment and a life support system. An urgent care facility does not include a clinic located at, operated in conjunction with, or in any way made a part of a regular hospital.

Vision Care

Covered expenses are limited to the initial purchase of glasses or contact lenses following cataract surgery covered by the plan.

Wellness Benefit

Preventive or routine medical services not necessary for the treatment of illness or injury. This benefit includes, but is not limited to routine physicals, well baby exams, mammograms, or immunizations.

Medical Limitations and Exclusions

Except as specifically stated otherwise, no benefits shall be payable for expenses incurred for:

Abortion

Elective abortion unless the mother's life would be endangered if the pregnancy were allowed to continue to term. Complications arising out of an abortion, however, are covered as any other sickness.

Air Purification Units

Air conditioners, air-purification units, humidifiers, or electric heating units.

Biofeedback

Blood

Whole blood or plasma when donated or otherwise replaced by or on behalf of the patient.

Breast Implants

Breast implants placed for cosmetic reasons, removal, reconstruction or re-implantation due to complications are not covered. There will be coverage if there is documentation of leakage of a silicone implant and/or a positive silicone antibody study for removal of implants only.

Cosmetic Surgery

Any surgery, service, drug, or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly, except when:

- necessitated by a non-occupational accidental injury;
- necessary for correction of post-surgical deformity; or
- necessary to correct a congenital abnormality in a child.

Custodial Care

Care or confinement primarily for the purpose of meeting personal needs that could be rendered at home or by persons without professional skills or training.

Dental Care Under the Medical Plan

Care or treatment of or to the teeth, alveolar processes, or gingival tissue or for malocclusion will not be covered medical expenses except for:

- treatment of fracture of facial bones;
- excision of lesions of the mandibular joints, mouth, lips, or tongue;
- incision of accessory sinuses or mouth salivary glands or ducts;
- treatment of dislocation of the jaw;
- plastic reconstruction or repair of the mouth or lips necessary to correct or repair traumatic injury or congenital defect arising after the effective date of coverage; or
- treatment required because of accidental bodily injury to natural teeth. Such expenses must be incurred within six months of the date of the accident.

Replacement of teeth that were broken due to a chewing injury is not covered.

Diagnostic Hospital Admissions

Hospital confinement for diagnostic purposes only, when such diagnostic services could be performed in an out-patient setting.

Educational, Recreational, or Vocational Testing, Training, or Therapy

Exercise Equipment

Exercising equipment, vibratory equipment, or swimming or therapy pools.

Experimental Procedures

Expenses in connection with experimental or investigational surgery or treatment not considered reasonable and necessary as so classified by the Health Care Financing Administration of the United States Department of Health and Human Services are not reimbursable expenses.

Foot Care (routine)

Expenses incurred for the non-surgical treatment of the feet, treatment of corns, calluses, or toenails, or other routine foot care unless the charges are for the removal of nail roots or for the treatment of a metabolic or peripheral-vascular disease.

Expenses incurred for orthopedic shoes (except when permanently attached to braces) and other supportive appliances for the feet.

Hair Transplants**Hearing Aids or Related Examinations****Impregnation**

Artificial insemination, in-vitro fertilization, or any other type of artificial impregnation procedure.

Infertility

Charges related to or in connection with fertility studies, sterility studies, or procedures to restore or enhance fertility.

Nicotine Addiction**Not Medically Necessary**

Any services or supplies that are not medically necessary, except as expressly included herein.

Obesity

See "Weight Control."

Occupational Therapy

Occupational therapy (except during hospital confinement or as included in home health care services) or vocational, educational, recreational, art, dance, or music therapy.

Personal Comfort or Convenience Items

Services or supplies provided for personal comfort and not necessary for treatment of covered sickness, accidental injury, or pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets, mattress covers, wigs, non-prescription drugs and medicines, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits), or supplies or attachments for such equipment.

Pre-Existing Conditions

See schedule of benefits for details.

Pregnancy

Charges related to a surrogate mother are not covered.

Prescription Drugs - Outpatient

Outpatient prescription drug coverage is provided only under the terms of the section titled "Prescription Drug Benefits."

Psychiatric Testing, Counseling, or Therapy

Except as may be specifically provided herein, the plan does not cover psychiatric or psychological testing or evaluation (unless specifically related to the treatment of a psychiatric condition), hypnotherapy, or marriage or family counseling; treatment of learning disorders, behavioral problems, mental retardation, or

autism of childhood; vocational testing, evaluation, or counseling; or therapy or counseling for sexual dysfunctions or inadequacies.

Self-Procured Services

Charges for services rendered to a covered person who is not under the regular care of a physician or charges for services, supplies, or treatment, including any period of hospital confinement, not recommended, approved, and certified as medically necessary and reasonable by a physician.

Sex-Change Procedures

Sex-change counseling or treatment, services incident to sex-change surgery, or any resulting complications.

Sterilization Reversal Surgery

Expenses incurred for the reconstruction (reversal) of a previous sterilization procedure.

Vision Care

Eye examinations for the purpose of prescribing corrective lenses, eye glasses, or contact lenses or the fitting thereof.

The plan does not cover vision procedures whose purpose is the correction of refractive error, such as radial keratotomy.

Weight Control

Services or supplies for obesity, weight reduction, or dietary control.

Wigs and Wig Maintenance

See also "General Health Care Coverage Exclusions."

GENERAL HEALTH CARE COVERAGE EXCLUSIONS

The following exclusions apply to all health benefits, and no benefits shall be payable under these health care coverages for:

Court-Ordered Confinement

Any confinement of a covered person in a public or private institution as the result of a court order.

Criminal Activities

Any injury or any complication thereof resulting from or occurring during the covered person's commission of a felony offense or in the immediate flight therefrom.

Drugs in Testing Phases

Medicines or drugs that are in the Food and Drug Administration phases I or II testing. Medicines or drugs in phase III testing may be covered if specifically approved by the process of large case management by Capitol HealthCare Review.

Excess Charges

Charges in excess of the usual, customary, and reasonable fees for services or supplies provided.

Experimental Procedures

Expenses in connection with experimental or investigational surgery or treatment not considered reasonable and necessary as so classified by the Health Care Financing Administration of the United States Department of Health and Human Services are not reimbursable expenses.

Forms Completion

Charges for the completion of claim forms or for providing supplemental information.

Government-Operated Facilities

The plan does not cover loss caused by or resulting from confinement or treatment for which the covered person is not legally obligated to pay, such as in any government hospital. However, the U.S. government has a right to recover or collect benefits for any care or services incurred by a covered person as a result of a non-service-connected injury or illness. The U.S. government may recover or collect to the extent that the covered person would be eligible to receive benefits under this plan if such care or services had not been furnished by a department or agency of the United States.

Late-Filed Claims

Claims that are not filed with the contract administrator for handling within 12 months after the date the expenses are incurred.

Military Service

Charges for treatment of any injury sustained or illness contracted while in the military service of any country.

Missed Appointments

Expenses incurred for failure to keep a scheduled appointment.

No Charge/No Legal Requirement to Pay

Services for which no charge is made or for which a covered person is not required to pay, is not billed, or would not have been billed in the absence of coverage under this plan.

Other Coverage

Health care services or supplies for which a covered person is entitled (or could have been entitled if proper application had been made) to be reimbursed by or services or supplies furnished by any plan, authority, or law of any government or governmental agency (federal, state, dominion, or province or any political subdivision thereof).

Outside United States

Charges incurred outside of the United States if the covered person traveled to such location for the sole purpose of obtaining such health care services, drugs, or supplies.

Prior Coverage

Services or supplies for which the covered person is eligible for benefits under the plan that this plan replaces.

Relative or Resident Care

Any service rendered to a covered person by a relative or anyone who customarily lives in the covered person's household.

Self-Inflicted Injury

Any expenses resulting from voluntary or involuntary self-inflicted Injury or voluntary or involuntary attempted self-destruction that occurred while the Covered Person was sane or insane, regardless of whether the Covered Person was aware of or in control of his actions. However, with respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits otherwise provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

Travel

Unless approved by the utilization review organization.

Veteran's Hospital

See "Government-Operated Facilities."

War

Health conditions resulting from insurrection, war (declared or undeclared), or any act of war and any complications therefrom, or service in the armed forces of any country.

Work-Related Injury or Sickness

Any injury or sickness that is caused by, or connected in any way to, employment of the covered person. (This includes self employment or employment by others. It applies whether or not workers' compensation or similar law covers the expenses incurred.)

COORDINATION OF BENEFITS

All benefits provided under the health care coverages of this plan are subject to the following provisions and limitations, unless specifically stated otherwise.

Definitions

As used in this provision, the following terms shall have the meanings indicated:

Other Plan

Other plans include benefits, services, or treatment provided by:

group, blanket, or franchise insurance coverage;

group hospital or medical service pre-payment plans (HMOs, PPOs, EPOs);

group Blue Cross and Blue Shield coverage;

group automobile insurance;

individual auto insurance based upon the principles of no-fault coverage;

any coverage under labor-management trustee plans, union welfare plans, employer or professional organization plans, or employee benefit organization plans;

any coverage under government programs including Medicare (Titles XVIII and XIX of the Social Security Act as enacted or thereafter amended), CHAMPUS, or any coverage required or provided by a statute. For purposes of implementing this provision, eligibility alone will constitute coverage; or

any group coverage sponsored by or provided through a school or other educational institution.

This Plan

The health care coverages of this plan.

Allowable Expense

Any usual, customary, and reasonable item of expense incurred while the person for whom claim is made is covered under this plan, at least a part of which is covered under any other plan. When a plan provides benefits in the form of service rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

Claim Determination Period

A period that commences each January 1 and ends at 12 o'clock midnight on the next December 31, or that portion of such period during which the claimant has been covered under this plan.

Effect on Benefits Under This Plan

When Other Plan Does Not Contain a Coordination of Benefits Provision

As to any claim determination period to which this provision is applicable, the benefits that would be payable under this plan in the absence of this provision shall be reduced to the extent necessary so that the sum of all the benefits payable for such allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses. Benefits payable under the other plans include benefits that would have been payable had claim been duly made for them.

When Other Plan Contains a Coordination of Benefits Provision

If the other plan insuring the person covered by this plan contains a similar non-duplication of benefits provision that coordinates its benefits with those of this plan and would, according to its rules and the order of benefit rules below, determine its benefits after the benefits of this plan have been determined, then the benefits of such other plan will not be considered for the purpose of determining the benefits due under this plan.

If, according to the other plan's rules and the order of benefit rules below, this plan is to determine its benefits after the other plan's benefits are determined, then the sum of all the benefits payable for allowable expenses under this plan and all other plans shall not exceed the total of such allowable expenses incurred during the claim determination period.

If the primary plan (i.e., plan that is to pay its benefits first) has a limitation for non-compliance with a utilization review-type of program, this plan will base its coordination only on the amounts that would have been paid if the participant had met the provisions of the primary plan.

If the primary plan has a PPO arrangement or a health maintenance organization (HMO) and the participant is penalized for failure to use these providers, this plan will base its coordination on the amounts that would have been paid if PPO or HMO providers had been used.

Order of Benefit Determination

The rules establishing the order of benefit determination are:

the benefits of a plan that covers the patient as an active employee shall be determined before the benefits of a plan that covers such patient as a retired employee or as a dependent;

the benefits of a plan for individuals with COBRA continuation coverage will be secondary to the plan covering the individual as an employee or a dependent of such employee;

the benefits of a plan that covers a person as an employee who is neither laid-off nor retired, or as that employee's dependent, are determined before those of a plan that covers a person as a laid-off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefit determination, the rule of the other plan will prevail;

when claimant is a dependent child and such child's parents are not separated or divorced, the benefits of the plan of the parent whose birthday falls earlier in a year are determined before those of the plan of the parent whose birthday falls later in the year, but:

(i) if both parents have the same birthday, the benefits of the plan that covered the parent longer are determined before those of the plan that covered the other parent for a shorter period of time; or

(ii) if the other plan does not have the rule described above under (i), and if, as a result, the plans do not agree on the order of benefits, the rule of the other plan will determine the order of benefits;

when claimant is a dependent child whose father and mother are legally separated or divorced:

the benefits of a plan that covers the patient as a dependent child of the parent with custody shall be determined first;

the plan of the spouse of the parent with custody will be determined second; and

the plan of the parent not having custody of the child will be determined third; or

if a court decree assigns financial responsibility for the health care expenses of a dependent child to one of the parents, the benefits of the assigned parent's plan will be determined first.

Not with standing the foregoing, this plan is always secondary to no-fault auto insurance coverages.

If none of the above rules establishes an order of benefit determination, the benefits of the plan that has covered the claimant for the longer period of time are determined before those of the plan that has covered that person for the shorter period of time.

When this provision operates to reduce the total amount of benefits otherwise payable to a person covered under this plan during any claim determination period, each benefit that would be payable in the absence of this provision shall be reduced, and such reduced amount shall be charged against any applicable benefit limit of the plan.

Right to Receive and Release Necessary Information

For the purpose of enforcing or determining the applicability of the terms of this provision of this plan or any similar provision of any other plan, the contract administrator may, without the consent of any person, release to or obtain from any insurance company, organization, or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under this plan shall furnish to the contract administrator such information as may be necessary to enforce this provision.

Special Provisions with Respect to Medicare

In accordance with the Tax Equity Fiscal Responsibility Act of 1983 (TEFRA), an active employee or spouse over age 65 who is eligible for Medicare may elect or reject coverage under this plan. If such person elects coverage under this plan, the benefits of this plan shall generally be determined before any benefits provided by Medicare. However, whenever this plan may lawfully assume a secondary position it will do so and benefits will be determined in accordance with the coordination of benefits provision above.

When this plan may lawfully assume a secondary position and an employee or dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts A and B for all purposes under this plan. An employee or dependent is considered to be covered by Medicare on the earliest date any coverage of him under Medicare could have been effective had he applied for Medicare in a timely manner.

All health expenses covered under this Plan will be reduced by any Medicare benefits available for those expenses. This will be done before the health benefits of this Plan are calculated. Any rules for coordinating other plan benefits with those under this Plan will be applied after this Plan's benefits have been determined under the above rules. Allowable Expenses will be reduced by any Medicare benefits available for those expenses.

SUBROGATION AND REIMBURSEMENTS

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Sickness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges incurred in connection with the Injuries or Sickness. If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

Execute and deliver a Subrogation and Reimbursement Agreement;

Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;

Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise);

Notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Sicknesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the Injuries or Sickness. If the Plan pays any medical or other benefits for the Injuries or Sickness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary. The Plan Administrator also has maximum discretion to reduce, settle or otherwise compromise the amount of the Plan's Subrogation interest or the amount to which it is entitled to Reimbursement, and to agree to payment of attorneys' fees and costs, where, in its sole discretion, it determines that circumstances warrant such reduction.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries or Sickness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a

right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

Another Party

Another Party shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Sickness.

Another Party shall include the party or parties who caused the Injuries or Sickness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Sickness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Sickness.

Recovery

Recovery shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Sickness. Any Recovery shall be deemed to apply, first, for Reimbursement.

Subrogation

Subrogation shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

Reimbursement

Reimbursement shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Sickness and for the expenses incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Sicknesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his attorney who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan, because the Covered Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Sicknesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Sicknesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

TERMINATION OF COVERAGE

Employee Coverage Termination

An employee's coverage under the health coverage of the plan shall terminate upon the earliest of the following:

termination of the plan;

termination of participation in the plan by the employee;

the date of employee's entry into the armed forces of any country;

the date of expiration of the period for which employee last made the required contribution, if the coverage is provided on a contributory basis (the employee shares in the cost);

the last day of the month in which the covered employee leaves or is dismissed from the employment of the employer; or

the date the employee ceases to be eligible.

Dependent Coverage Termination

A dependent's coverage under the health care coverages of the plan shall terminate upon the earliest of the following:

termination of the plan;

termination of the coverage of the employee;

the day the covered person no longer satisfies the plan's definition of dependent; or

the date of expiration of the period for which the employee last made the required contribution for such coverage, if dependent's coverage is provided on a contributory basis (the employee shares in the cost).

See "Continuation of Coverage Option (COBRA)."

Certificates of Coverage

The plan generally will automatically provide a certificate of coverage to any employee or dependent after the individual loses coverage in the plan. In addition, a certificate will be provided upon request, if the request is made within 24 months after the individual loses coverage under the plan. In that case, the certificate will be provided at the earliest time that the plan, acting in a reasonable and prompt fashion, can furnish it.

The plan will make reasonable efforts to collect information applicable to any dependents of the employee and to include that information on the certificate, the plan will not issue an automatic certificate for dependents until the plan has reason to know that a dependent has lost coverage under the plan.

EXTENSION OF COVERAGE

Extension of Coverage for Handicapped Dependent Children

If an already covered dependent child attains the age that would otherwise terminate his status as a dependent, and:

if on the day immediately prior to the attainment of such age the child was a covered dependent under the plan;

at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation, physical handicap, or disability that commenced prior to the attainment of such age; and

such child is primarily dependent upon the employee for support and maintenance,

then such child's status as a dependent shall not terminate solely by reason of his having attained the specified age, and he shall continue to be considered a covered dependent under the plan so long as he remains in such condition and otherwise conforms to the definition of a dependent.

The employee must submit to the contract administrator proof of the child's incapacity within thirty-one days of the child's attainment of such age and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age.

Extension of Coverage During Absence From Work

(Available during the continuance of the plan ONLY)

If an employee fails to continue in active employment due to sickness, injury, maternity leave, temporary layoff, or approved leave of absence, the employee may be permitted to continue health care coverages for himself and his dependents, though employee could be required to pay the full cost of coverage during such absence.

Any such extended coverage offered by the employer and elected by the employee shall automatically and immediately cease on the earliest of the following dates:

the date the person becomes covered under any other group plan for benefits of a type similar to that provided by this plan;

the date of expiration of the period for which the last contribution was paid, if such contribution is required; or

the date of termination of this plan.

This plan is intended to conform with the applicable provisions of the Family Medical Leave Act of 1993.

Disabled clergy may continue coverage as defined in "Eligibility and Effective Dates".

CLAIMS PROCEDURES FOR HEALTH CARE COVERAGE

The procedures outlined below must be followed by Claimants to obtain payment of health benefits under this Plan.

Health Claims

All claims and questions regarding health claims should be directed to the Contract Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Claimant is entitled to them. The responsibility to process claims in accordance with the Plan Document may be delegated to the Contract Administrator; provided, however, that the Contract Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Claimant claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Claimant has not Incurred a Covered Expense or that the benefit is not covered under the Plan, or if the Claimant shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

Under the Plan, there are three types of claims: Pre-service Non-urgent, Concurrent Care and Post-service.

Pre-Service Claims

A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Claimant or the Claimant's ability to regain maximum function, or, 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.

It is important to remember that, if a Claimant needs medical care for a condition, which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Claimant should obtain such care without delay.

Further, since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no "Pre-service Urgent Care Claim." The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Concurrent Claims

A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either (a) the Plan determines that the course of treatment should be reduced or terminated, or (b) the Claimant requests extension of the course of treatment beyond that which the Plan has approved.

It is important to remember that, in the event of an urgent care situation, the Covered Person need only notify Prime Dx on the first business day after the additional stay begins. Since the Plan does not require the Claimant to obtain approval of a medical service in an urgent care situation prior to getting treatment, there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Claimant simply follows the Plan's procedures with respect to any notice which may be required after receipt of treatment, and files the claim as a Post-service Claim.

Post-service Claims

A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

When Health Claims Must Be Filed

Health claims must be filed with the Contract Administrator within 90 days of the date charges for the service were Incurred. Failure to furnish such proof within the time required shall not invalidate or reduce

any claim if it can be shown that it was not reasonably possible to give proof within such time, provided such proof is furnished as soon as reasonably possible and in no event later than 12 months from the date on which Covered Expenses were Incurred. Claims filed later than that date shall be denied. Benefits are based upon the Plan's provisions at the time the charges were Incurred.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Contract Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Contract Administrator, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges;
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Contract Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. This additional information must be received by the Contract Administrator within 45 days from receipt by the Claimant of the request for additional information. Failure to do so may result in claims being declined or reduced.

Timing of Claim Decisions

The Plan Administrator shall notify the Claimant, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

Pre-service Non-urgent Care Claims

If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim, then the Claimant will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Claimant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Claimant (if additional information was requested during the extension period).

Concurrent Claims

Plan Notice of Reduction or Termination.

If the Plan Administrator is notifying the Claimant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Claimant will be notified 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.

Request by Claimant Involving Non-urgent Care

If the Plan Administrator receives a request from the Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).

Post-service Claims

If the Claimant has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

If the Claimant has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Claimant will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Claimant will be notified of the determination by a date agreed to by the Plan Administrator and the Claimant.

Extensions – Pre-service Non-urgent Care Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both 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 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Extensions – Post-service Claims

This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both 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 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Calculating Time Periods

The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

Notification of an Adverse Benefit Determination

The Plan Administrator shall provide a Claimant with a notice, either in writing or electronically containing the following information:

1. A reference to the specific portion(s) of the Plan Document upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Claimant to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Claimant's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;
5. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Claimant, free of charge, upon request); and
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or experimental), 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 to the Claimant, free of charge, upon request.

Appeal of Adverse Benefit Determinations

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Claimant believes the claim has been denied wrongly, the Claimant may appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Claimant with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Claimants at least 180 days following receipt of a notification of an initial adverse benefit determination within which to appeal the determination;

2. Claimants the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, 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;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a Claimant will 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 claim for benefits in possession of the Plan Administrator or the Contract Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances

Requirements for Appeal

The Claimant must file the appeal in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal, the Claimant's appeal must be addressed as follows and either mailed or faxed as follows: Pre-service Non-urgent Claims – Capital Healthcare Review, 12301 Research Blvd, #400, Fax Number – 1-512-454-1624 or Post-service Claims – Boon-Chapman Benefit Administrators, Inc., Attention: Appeals, P.O. Box 9201, Austin, Texas 78766, Fax Number: 512-459-1552.

It shall be the responsibility of the Claimant to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Claimant;
2. The Employee/Claimant's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Claimant will lose the right to raise factual arguments and theories which support this claim if the Claimant fails to include them in the appeal;
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Claimant has which indicates that the Claimant is entitled to benefits under the Plan.

If the Claimant provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Claimant of the Plan's benefit determination on review within the following timeframes:

Pre-service Non-urgent Care Claims

Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

Concurrent Claims

The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.

Post-service Claims

Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Calculating Time Periods

The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review.

The Plan Administrator shall provide a Claimant with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document on which the denial is based;
3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. 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;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Claimant upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, will be provided free of charge upon request;
7. A statement of the Claimant's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
8. 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."

Furnishing Documents in the Event of an Adverse Determination.

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

If, for any reason, the Claimant does not receive a written response to the appeal within the appropriate time period set forth above, the Claimant may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. All claim review procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within one year after the Plan's claim review procedures have been exhausted.

Appointment of Authorized Representative

A Claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Claimant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Claimant must complete a form which can be obtained from the Plan Administrator or the Contract Administrator. In the event a Claimant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Claimant, unless the Claimant directs the Plan Administrator, in writing, to the contrary.

DEFINITIONS

When used within, the following items shall have the meanings shown below.

Accidental Dental Injury

An injury to the mouth or structures within the oral cavity that is caused by an external traumatic force. It does not include damage to the teeth that is the result of biting into food or other substances.

Accidental Injury

Any accidental bodily injury that occurs while an individual is covered under the Plan and that is caused by external forces under unexpected circumstances and that does not arise out of or in the course of the employment of the covered person. Sprains and strains resulting from over-exertion, excessive use, or over-stretching are not considered accidental injuries.

Affiliation Period

A period of time that must expire before health insurance coverage provided by an HMO becomes effective, and during which the HMO is not required to provide coverage.

Alternate Procedure

The most cost effective treatment of a dental condition which will provide a professionally acceptable result as determined by national standards of dental practice. Consideration is given to the current clinical oral condition based upon the diagnostic material submitted by the dentist.

Ambulatory Surgical Center

An institution or facility, either free standing or as a part of a hospital with permanent facilities, equipped and operated for the primary purpose of performing surgical procedures and to which a patient is admitted to and discharged from within a twenty-four (24) hour period. An office maintained by a physician for the practice of medicine or dentistry, or for the primary purpose of performing terminations of pregnancy, shall not be considered to be an ambulatory surgical center.

Birthing Center

A special room in a hospital that exists to provide delivery, prenatal, and postnatal care with a minimum of medical intervention, or a free-standing out-patient facility that:

is in compliance with licensing and other legal requirements in the jurisdiction where it is located;

is engaged mainly in providing a comprehensive birth service program to persons who are considered normal low-risk patients;

has organized facilities for birth services on its premises; and

provides birth services by physicians, registered nurses, or midwife nurse practitioners when a patient is in the center.

Calendar Year

The period of time commencing at 12:01 a. m. on January 1 of each year and ending at 12:01 a.m. on the next January 1. Each succeeding like period will be considered a new calendar year.

Calendar Year Maximum Benefit

The most benefits the Plan will pay for covered expenses of a covered person incurred during a calendar year.

Certificate of Coverage

A written certification provided by any source that offers medical care coverage, including this plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Claimant

Any covered person on whose behalf a claim is submitted for benefits under the Plan.

Class of Coverage

The benefits for which a group of employees is eligible, according to criteria specified by the employer in the participation agreement or subsequent amendments thereto.

Close Relative

The spouse, parent, brother, sister, child or spouse's parent of a Covered Person.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-Insurance

The part of covered expenses that the Plan or covered person pays, excluding amounts that are payable by a covered person as a deductible or co-payment or because of a benefit maximum.

Contract Administrator

The company that provides claims adjudication and other services to the Plan in accordance with an administrative services agreement between the Contract Administrator and the Plan.

Covered Expense

An expense incurred by a covered person that is payable by the Plan as co-insurance or is payable by the covered person as a deductible, as co-insurance, as a co-payment, or because of a benefit.

Covered Person

A covered employee, a covered dependent, or a qualified COBRA beneficiary.

Creditable Coverage

Prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law.

Custodial Care

The term "Custodial Care" means that type of care or service, wherever furnished and by whatever name called, which is designed primarily to assist a Covered Person, whether or not totally disabled, in the activities of daily living. Such activities include, but are not limited to: bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible

See schedule of benefits for information.

Dependent

See "Eligibility and Effective Dates."

Durable Medical Equipment

Durable medical equipment includes such items as orthotics, braces, crutches, wheelchairs, hospital beds, iron lungs, dialysis equipment, Glucometers, Dextrometers, etc., that:

can withstand repeated use;

are primarily and customarily used to serve a medical purpose;

generally are not useful to a person in the absence of sickness or accidental injury; and

are appropriate for use in the home.

Eligible Expense

An expense that is covered by a specific benefit provision of the plan document and incurred while the person is covered by the plan document.

Employee

See "Eligibility and Effective Dates."

Employer

The employer or employers participating in the plan as stated in "General Plan Information."

Exclusive Provider Organization (EPO)

A group of providers such as physicians, hospital facilities, outpatient facilities and or other providers who have contracted with the health plan to supply services to covered individuals under special fee arrangements.

Experimental Procedures

Expenses in connection with experimental or investigational surgery or treatment not considered reasonable and necessary as so classified by the Health Care Financing Administration of the United States Department of Health and Human Services are not reimbursable expenses.

Experimental Services

Any drug, treatment, device, procedure, or other service that the Plan in its sole discretion determines:

cannot be lawfully marketed without the approval of the Food and Drug Administration or other appropriate governmental agency, such approval not having been granted at the time of use or proposed use;

is generally, commonly, and customarily regarded by experts who regularly practice in the area of treatment of the particular disease or condition in question as a drug, treatment, device, procedure, or other service whose usage should be substantially confined to research settings, as set forth in the published authoritative literature; or

is being provided pursuant to a Food and Drug Administration Phase I or Phase II clinical trial or as the experimental or research arm of a Phase III clinical trial.

The sources of information to be relied upon are:

the published authoritative medical or scientific literature regarding the drug, treatment, device, procedure, or other service at issue as it is applied to the particular injury or sickness at issue;

members' medical records;

protocol pursuant to which the treatments is to be delivered; or

any regulations and publications set forth by any governmental agency.

Home Health Care Agency

An agency or organization that:

is certified under Title 18 of the United States Social Security Act of 1965, as amended from time to time; or

is certified to participate as a home health care agency in the area in which the services are rendered.

Hospice Care Program

An entity:

providing a coordinated set of services rendered at home, in an out-patient setting, or in an institutional setting for covered persons suffering from a condition that has a terminal prognosis;

that has an interdisciplinary group of personnel including at least one physician and one registered graduate nurse;

that maintains central clinical records on all patients; and

meets the standards of the National Hospice Organization and applicable state licensing requirements.

Hospital

An institution that:

complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;

is primarily engaged in providing medical treatment to sick and injured persons as registered bed-patients;

has a staff of one or more licensed doctors of medicine or doctors of osteopathy available at all times;

continuously provides a 24-hour-a-day nursing service by registered graduate nurses;

maintains facilities for diagnosis of injury and disease;

maintains permanent facilities for major surgical operations on its premises; and

is not, other than incidentally, a place of rest, for custodial care, for the aged, for drug addicts or alcoholics, for the care of senile persons, a nursing home, a hotel, a school, or a similar institution.

A hospital will also include:

an institution that is legally constituted as a hospital and for which the laws of the state specify requirements other than those listed above and that is operated primarily for the care and treatment of sick and injured person as in-patients;

an institution or facility that provides treatment for mental illness, provided that such institution or facility:

is licensed by the state licensing body or is approved by the state department responsible for such institutions or facilities; and

renders recognized treatment for the condition for which it is licensed or approved to operate; or

an alcohol dependency treatment center that provides a program for the treatment of alcohol dependency pursuant to a written treatment plan approved and monitored by a physician and which facility is also:

affiliated with a hospital under a contractual agreement with an established system for patient referral;

accredited as such a facility by the Joint Commission on Accreditation of Hospitals; or

licensed, certified, or approved as an alcohol dependency treatment program or center by any other state agency having legal authority to so license, certify, or approve.

Illness

A bodily disorder, disease, physical sickness, mental infirmity, Functional Nervous disorder or Pregnancy of a Covered Person. A recurrent illness will be considered one illness. Concurrent illnesses will be considered one illness unless the concurrent illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one illness.

Immediate Family

You, your spouse, and the children, brothers, sisters, and parents of you and your spouse.

Incurred

Expenses shall be deemed to be incurred on the latest of the following dates:

- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

Injury

A condition caused by accidental means which results in damage to the Covered Person's body from an external force.

In-Patient

A person physically occupying a room and being charged for room and board in a facility (hospital, skilled nursing facility, etc.) that is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Late Enrollee

An individual who is allowed to enroll in the plan, other than during the period of initial eligibility.

Local Community Network (LCN)

See Exclusive Provider Organization and other local community provider arrangements.

Maximum Plan Benefit

The total of all benefits the Plan will pay for covered expenses of a covered person incurred during all periods a person is covered under the Plan.

Medically Necessary or Medical Necessity

When a service, medicine or supply is necessary and appropriate for the diagnosis or active treatment of an Illness or Injury based on generally accepted medical practice.

To be Medically Necessary, Covered Expenses must:

- be rendered in connection with an Injury or Illness;
- be consistent with the diagnosis and treatment of your condition; and
- be in accordance with the standards of good medical practice.

To be Medically Necessary, Covered Expenses must also be provided at the most appropriate level of care or in the most appropriate type of health care facility. Only your medical condition (not the financial status or family situation, the distance from a Facility or any other non-medical factor) is considered in determining which level of care or type of health care is appropriate. Medically Necessary is the criteria by which the plan determines the necessity of medical service and treatment under this Plan.

A service, medicine or supply will not be considered Medically Necessary if:

- it is provided only as a convenience to the Covered Person or provider;
- it is not appropriate treatment for the Covered Person's diagnosis or symptoms;
- it exceeds (in scope, duration or intensity) that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment;
- it is part of a plan of treatment that is considered to be investigative, experimental or for research purposes in the diagnosis or treatment of an Illness or Injury. "Investigative, experimental or for research purposes" means services or supplies not recognized or proven to be effective treatment of an Illness or Injury in accordance with generally accepted medical practice, based on consultation with an appropriate source; or
- it involves the use of a drug or substance not formally approved by the United States Food & Drug Administration, even if approval is not required.

The fact that any particular Physician may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply Medically Necessary.

Medicare

Health insurance for the aged as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Mental and Nervous Care/Substance Abuse

Such term includes treatment for mental and nervous care, disorders, or conditions, as accepted by the general psychiatric community, including treatment for substance abuse.

Nurse

A person who is a licensed registered graduate nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.).

Nurse Anesthetist

A Certified Registered Nurse Anesthetist (CRNA) is a trained nurse who has specialized in anesthesia and possesses documented capability for giving anesthetics.

Occupational Injury or Sickness

Any injury or sickness that:

the covered person has or had a right to compensation under any workers' compensation law, occupational disease law, or other law of similar purpose; or, resulted from employment or occupation for compensation.

Oral Surgery

Necessary procedures for surgery in the oral cavity, including pre- and post-operative care.

Orthodontic Treatment

The movement of teeth through bone, by means of active appliances, to correct the position of maloccluded or malpositioned teeth.

Out-Patient

Services rendered on other than an in-patient basis.

Physician

A doctor of medicine, (M.D.), or doctor of osteopathy (D.O.), who is licensed to practice medicine or osteopathy where the care is provided.

"Physician" also includes the following providers, but only when the provider is licensed to practice where the care is rendered and is rendering a service within the scope of that license:

- Dentist (D.D.S. or D.M.D.);
- Optometrist (O.D.);
- Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.);
- Psychologist (Ph.D.); and
- Chiropractor (D.C.).

"Physician" will also include the following providers, but only when the provider is licensed to practice where the care is rendered, is rendering a service within the scope of that license, and is rendering a service to an individual who was referred to him by an M.D. or D.O.:

- Physical therapist (P.T. or R.P.T.);
- Speech pathologist;
- Audiologist;

Certified Registered Nurse Anesthetist (C.R.N.A.);

Medical Social Worker (M.S.W.);

Licensed Professional Counselor (L.P.C.);

Physician's Assistant (P.A.);

Certified Nurse Practitioner;

Certified Midwife; and

Occupational therapist (O.T.R.).

For purposes of certifying total disability, "physician" will include only doctors of medicine (M.D.) and doctors of osteopathy (D.O.).

Plan Administrator

See "Plan Sponsor."

Plan Sponsor

The entity sponsoring this Plan.

Plan Year

The period of time commencing at 12:01 a.m. on the effective date of each employer's plan and ending at 12:01 a.m. on the same day twelve consecutive months later.

PPO

Preferred provider organization.

Pre-Existing Condition

See the schedule of benefits.

Preferred Provider Organization (PPO)

An organization that has contracted with the plan sponsor or the contract administrator to provide certain dental care services to covered persons at specific rates. See the schedule of medical benefits for the special benefit level that applies to services obtained from contracted providers.

Pregnancy

Childbirth or miscarriage or complications arising therefrom.

Primary Care Network (PCN)

A group of primary care physicians who have joined together to provide health care services to covered individuals under special fee arrangements and contracted with the health plan.

Primary Care Physician

A physician in family practice, general practice, internal medicine, pediatrician or OB/GYN.

Prosthesis

An artificial device to replace a missing part of the body or to aid the function of a bodily organ.

Relative

A spouse or a parent, brother, sister, or child of the employee or the employee's spouse.

Semi-Private Room Charge

The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or the lowest charge by the facility for single bed room and board accommodations if the facility does not provide any semi-private accommodations.

Serious Mental Illness

The following psychiatric illnesses only, as defined by the American Psychiatric Association in the Diagnostic and Statistical Manual (DSM): schizophrenia, paranoid and other psychotic disorders, bipolar disorders (hypomanic, manic depressive and mixed), major depressive orders (single episode or recurrent), schizo-affective disorders bipolar or depressive), pervasive development disorders, obsessive compulsive disorders, and depression in childhood and adolescence.

Sickness

Physician-diagnosed bodily illness or disease, or congenital abnormalities of a covered newborn child. Mental health conditions are not included.

Significant Break in Coverage

A period of 63 consecutive days during all of which an individual did not have any creditable coverage, but does not include a waiting period or an affiliation period.

Skilled Nursing Facility

An institution that:

is duly licensed as a convalescent hospital, extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;

is primarily engaged in providing accommodations and skilled nursing care 24 hours a day for convalescing persons and has facilities for the full-time care of at least five (5) patients;

is under the full-time supervision of a physician or a registered graduate nurse;

admits patients only upon the recommendation of a physician;

maintains complete medical records;

has the services of a physician available at all times; and

is not, other than incidentally, a nursing home, a hotel, a school, or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Specialists

Specialists are other covered physicians who are not listed under Primary Care Physician.

Surgery

Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through any natural body opening or incision.

Temporomandibular Joint Dysfunction

Any services or supplies for the treatment of the temporomandibular joint or jaw-related neuromuscular conditions with oral appliances, oral splints, oral orthotics, devices, prosthetics, dental restorations, orthodontics, physical therapy, or alteration of the occlusal relationships of the teeth or jaws to eliminate pain or dysfunction of the temporomandibular joint and all adjacent or related muscles and nerves.

Total Disability or Totally Disabled

With reference to an employee, disability resulting solely from a sickness or accidental injury that prevents the employee from engaging in any employment or occupation for which he is or becomes qualified by reason of education, training, or experience.

For a dependent, disability that prevents the dependent from engaging in substantially all the normal activities of a person in good health of like age and gender.

A covered person must also be under the care of a physician (M.D. or D.O.) in order to be considered totally disabled for benefit purposes.

Usual, Customary, and Reasonable Charge

A charge, made by a provider, that the Plan determines does not exceed the general level of charges made by other providers in the area or community who have similar experience and training for the treatment of health conditions comparable in severity and nature to the health condition being treated. The term "area" as it would apply to any particular service, medicine, or supply means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges. With regard to charges made by a provider of service participating in the Plan's PPO program, "usual, customary, and reasonable" shall mean the rates negotiated between the preferred provider organization and the Plan Sponsor.

Waiting Period

The period that must pass before an employee or dependent is eligible to enroll under the terms of a group health plan. If an employee or dependent enrolls as a late enrollee, any period before such late enrollment is not a waiting period. If an individual seeks and obtains coverage in the individual market, any period after the date the individual files a substantially complete application for coverage and before the first day of coverage is a waiting period.

STATEMENT OF RIGHTS OF EMPLOYEES

As a participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all participants are entitled to:

1. Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a Certificate of Coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months (18 months for Late Enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other participants and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a Medical Child Support Order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administration, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your 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. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY RULE

This Plan complies with the requirements of § 164.504(f) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160 through 164 (the regulations are referred to herein as the “HIPAA Privacy Rule” and § 164.504(f) is referred to as “the “504” provisions”) which establish the extent to which the Plan sponsor will receive, use and/or disclose Protected Health Information.

The Plan’s Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Plan designates Lydia Fay Lopez, Privacy Officer, to take all actions required to be taken by the Plan in connection with the HIPAA Privacy Rule (*e.g.*, entering into business associate contracts; accepting certification from the Plan sponsor).

The Plan’s disclosure of Protected Health Information to the Plan sponsor – Required Certification of Compliance by Plan sponsor

Except as provided below with respect to the Plan’s disclosure of summary health information, the Plan will (a) disclose Protected Health Information to the Plan sponsor or (b) provide for or permit the disclosure of Protected Health Information to the Plan sponsor by a health insurance issuer or HMO with respect to the Plan, only if the Plan has received a certification (signed on behalf of the Plan sponsor) that:

1. the Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the “504” provisions;
2. the Plan Documents have been amended to incorporate the Plan provisions set forth in this section; and
3. the Plan sponsor agrees to comply with the Plan provisions as described by this section

Permitted disclosure of members’ Protected Health Information to the Plan sponsor

The Plan (and any health insurance issuer or HMO servicing the Plan) will disclose members’ Protected Health Information to the Plan sponsor only to permit the Plan sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this section.

All disclosures of the Protected Health Information of the Plan’s members by a health insurance issuer or HMO to the Plan sponsor will comply with the restrictions and requirements set forth in this section and in the “504” provisions.

The Plan may not, and may not permit a health insurance issuer or HMO, to disclose members’ Protected Health Information to the Plan sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor.

The Plan sponsor will not use or further disclose members’ Protected Health Information other than as described in the Plan Documents and permitted by the “504” provisions.

The Plan sponsor will ensure that any agent(s), including a subcontractor, to whom it provides members’ Protected Health Information received from the Plan (or from the Plan’s health insurance issuer or HMO), agrees to the same restrictions and conditions that apply to the Plan sponsor with respect to such Protected Health Information.

The Plan sponsor will not use or disclose members’ Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan sponsor. The Plan sponsor will report to the Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the “504” provisions, of which the Plan sponsor becomes aware.

Disclosure of members’ Protected Health Information – Disclosure by the Plan sponsor

The Plan sponsor will make the Protected Health Information of the member who is the subject of the Protected Health Information available to such member in accordance with 45 C.F.R. § 164.524.

The Plan sponsor will make members' Protected Health Information available for amendment and incorporate any amendments to members' Protected Health Information in accordance with 45 C.F.R. § 164.526.

The Plan sponsor will make and maintain an accounting so that it can make available those disclosures of members' Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan sponsor will make its internal practices, books and records relating to the use and disclosure of members' Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan sponsor will, if feasible, return or destroy all members' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that the required adequate separation, described below, is established and maintained.

Disclosures of Summary Health Information and Enrollment and Disenrollment Information to the Plan sponsor

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose summary health information to the Plan sponsor, if the Plan sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
2. Modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose enrollment and disenrollment information to the Plan sponsor without the need to amend the Plan Documents as provided for in the "504" provisions.

Required separation between the Plan and the Plan sponsor

In accordance with the "504" provisions, this section describes the employees or classes of employees or workforce members under the control of the Plan sponsor who may be given access to members' Protected Health Information received from the Plan or from a health insurance issuer or HMO servicing the Plan. (Classes may include, for example: Analyst/Administrators; Service Personnel; Information Technology Personnel; Clerical Personnel; Supervisors/Managers; Quality Assurance Unit)

1. Service Personnel
2. Clerical Personnel
3. Broker / Consultant
4. Group Health Benefits Committee

This list reflects the employees, classes of employees, or other workforce members of the Plan sponsor who receive members' Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan sponsor provides for the Plan. These individuals will have access to members' Protected Health Information solely to perform these identified functions, and they will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the Plan sponsor) for any use or disclosure of members' Protected Health Information in violation of, or noncompliance with, the provisions of this section.

The Plan sponsor will promptly report any such breach, violation, or noncompliance to the Plan and will cooperate with the Plan to correct the violation or noncompliance; to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

CONTINUATION OF COVERAGE OPTION (COBRA)

This option does not apply to participants whose employers have fewer than 20 employees, in accordance with federal law.

In order to comply with COBRA, the Plan includes a continuation of coverage option that is available to certain Covered Persons whose health care coverage under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law and its amendments, the law will prevail.

Definitions

Qualified Beneficiary

Qualified Beneficiary is an Employee who was covered by the Plan on the day before the Qualifying Event or an Employee's Dependent who was covered by the Plan on the day before the Qualifying Event, or a child who is born to, or placed for adoption with, a covered Employee during continuation coverage.

Qualifying Event

Qualifying Event shall mean any one of the following that would result in the loss of coverage under the Plan: the death of the covered Employee, the termination of the covered Employee (other than by the Employee's gross misconduct), reduction in a covered Employee's hours of employment to an ineligible status, the divorce or legal separation of the covered Employee from the Employee's spouse, the Employee's coverage termination due to Medicare entitlement, or the cessation of covered Dependent child coverage by operation of a plan provision.

While an individual may incur more than one Qualifying Event, the length of continued coverage will never exceed 36 months (except for certain circumstances under COBRA's special bankruptcy rules for retirees and their Dependents).

Notification

Employees must notify the employer or contract administrator within 60 days of a qualifying event in event of divorce, legal separation, or dependent child becoming ineligible. Qualified beneficiaries must notify the employer or contract administrator within 60 days of a qualifying event or secondary qualifying event in event of divorce, legal separation, or dependent child becoming ineligible.

The Plan Administrator must notify Qualified Beneficiaries of continuation of coverage rights in the event of the Employee's death, termination, reduction of hours, or entitlement to Medicare. Notice mailed to Qualified Beneficiary's last known address will be considered adequate. Notice to a spouse is treated as notification to all other Qualified Beneficiaries residing with spouse at the time notice is made. Notification must be made to Qualified Beneficiaries within 44 days of the Plan Administrator's notice of the occurrence of a Qualifying Event.

Election and Election Period

Continuation of coverage may be elected during the period beginning on the date coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following:

60 days after coverage ends due to a Qualifying Event; and

60 days after the Qualified Beneficiary receives notice of the continuation of coverage option rights.

If continued coverage is elected by one Qualified Beneficiary, it will be deemed to be an election for all other beneficiaries who would otherwise lose coverage. However, each individual who would otherwise lose coverage is entitled to make an individual election that would allow one to elect continued coverage even if others in the same family have declined, or, if optional benefits were available, an Eligible Employee and his Dependents could elect different coverage.

Effective Date of Coverage

Continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and Qualified Beneficiary will be retroactively charged for coverage accordingly.

Level of Benefits

Continuation coverage hereunder will be equivalent to coverage provided to a similarly situated Covered Person to whom a Qualifying Event has not occurred. If coverage of similarly situated Covered Persons is modified, the same modification shall apply to Qualified Beneficiaries.

Cost of Continuation of Coverage

Except as provided below, the cost of coverage may be paid in monthly installments, and such cost will not exceed 102% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Retroactive premiums must be paid by the Qualified Beneficiary to the Plan within 45 days of election of continuation of coverage hereunder. Thereafter, payments are due on the 1st day of each month to continue coverage for that month. If a payment is not made within 30 days of the due date, coverage will be cancelled and will not be reinstated.

Termination of Continuation of Coverage

Coverage under this provision will terminate on the occurrence of the earlier of:

the end of 36 months, if the Qualifying Event is the death of the covered Employee, divorce or separation, Employee's entitlement to Medicare, or a Dependent child who no longer qualifies as a Dependent;

at the end of 18 months, if the Qualifying Event is termination of employment or reduction of hours to an ineligible status. However, in the case of a Qualified Beneficiary who is determined under the Social Security Act ("the Act") to have been totally disabled within 60 days of such Qualifying Event, the Qualified Beneficiary may continue coverage (including coverage for Dependents who were covered under the continuation coverage) for a total of 29 months provided the Qualified Beneficiary notifies the Plan Administrator of the disability prior to the end of the 18 months of continuation coverage, and within 60 days of the determination of total disability under the Act. The cost for continuation coverage for months 19 through 29 will not exceed 150% of the cost of coverage, during the same period, for a similarly situated Covered Person to whom a Qualifying Event has not occurred. Further, if during continuation coverage months 19-29, the Qualified Beneficiary is finally determined under the Act not to be Totally Disabled, then the Qualified Beneficiary shall within 30 days notify the Plan Administrator, and continuation coverage shall terminate the last day of the month following 30 days after the date of the determination;

the termination of all group health plans provided by the Plan Sponsor;

the failure to make timely premium payments to the Plan (coverage may be terminated if the beneficiary is more than 30 days delinquent in paying his premium);

the date the Qualified Beneficiary is covered under any other group health plan, as a result of employment, re-employment, or remarriage, that does not have a pre-existing condition that applies to the Qualifying Beneficiary; and

the date the Qualified Beneficiary becomes entitled to Medicare benefits.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, keep the employer or contract administrator informed of any changes in addresses of you or your family members.

Certificates of Coverage

The Plan will provide individuals with an automatic Certificate of Coverage in cases where they lose coverage under this Plan. Such certificates will be provided within the following time frames:

for an individual who is a Qualified Beneficiary entitled to elect continuation coverage, no later than when a notice is required to be provided for a Qualifying Event, as set forth above;

for an individual who is not a Qualified Beneficiary entitled to elect continuation coverage, within a reasonable time after coverage ceases; and

for an individual who is a Qualified Beneficiary and who has elected continuation coverage, within a reasonable time after cessation of continuation coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

In addition, a Certificate of Coverage will be provided upon request, if the request is made within 24 months after the individual loses coverage under this provision.

PREScription DRUG CARD PROGRAM

The prescription drug card program is a benefit supplement for the plan selected. The drug card can be used to purchase prescription drugs at participating pharmacies.

	Annual Deductible:
Individual	\$ 50
Family	\$100
	Co-Payments:
Retail (30-day supply)	
Generic	\$10 co-pay plus 20% of cost over \$50
Preferred Name Brand	\$55 co-pay plus 20% of cost over \$275
Non-Preferred Name Brand	\$80 co-pay plus 20% of cost over \$400
Mail Order (90-day supply)	
Generic	\$25 co-pay plus 20% of cost over \$125
Preferred Name Brand	\$137.50 co-pay plus 20% of cost over \$687.50
Non-Preferred Name Brand	\$200 co-pay plus 20% of cost over \$1,000

The Deductible and Co-pay applies to prescriptions purchased through a participating pharmacy as designated by the prescription drug card program. Deductibles or Co-payments for the prescription drug card program will not apply to Major Medical Plan deductibles or out of pocket expenses. **If prescription drugs are purchased without using the drug card, they will be reimbursed at 50% of the contracted price unless documentation is received designating the claim as an emergency.**

Maintenance prescriptions may be purchased in quantities limited to a 90-day supply or 100 units, whichever is greater. There will be one co-pay for each 30-day supply.

The prescription drug card program will be shown on the Employee Identification Card. For a list of participating pharmacies, please contact Script Care, Inc. at (800) 880-9988.

Covered prescription drug expenses are limited to those for:

prescription legend drugs (i. e., any medicinal substance whose label is required to bear the legend: "Caution: Federal Law Prohibits Dispensing Without a Prescription");

FDA approved and specific to the diagnosis;

oral, injectable and other contraceptives;

compound medications, of which at least one ingredient is a prescription legend drug;

prescribed prenatal legend vitamins;

any other drugs that under the applicable state or federal law may be dispensed only upon the written prescription of a physician; and

injectable insulin, including disposable insulin needles or syringes, or other injectable drugs which have been approved by the FDA for the particular diagnosis for which being treated;

and do not include those expenses for:

tretinoin, all dosage forms (e. g. Retin-A), for individuals 26 years of age or older;

Nicorette or any other drug containing nicotine or other smoking-deterrent medications;

anorectics (drugs used for the purpose of weight control);

vitamins (singly or in combination);

Rogaine (minoxidil);

dietary supplements;

fluoride supplements;

non-legend drugs other than insulin;

charges for the administration or injection of any drug;

therapeutic devices or appliances, including needles, syringes, support garments, and other non-medicinal substances regardless of their intended use, except those listed above;

prescriptions that a covered person is entitled to receive without charge under any workers' compensation law;

drugs labeled: "Caution — limited by federal law to investigational use" or experimental drugs, even if a charge is made to the covered person;

immunization agents, biological sera, blood, or blood plasma;

medication that is to be taken by or administered to an individual, in whole or part, while he is a patient in a licensed hospital, rest home, sanitarium, extended care facility, convalescent hospital, nursing home, or similar institution that operates on its premises, or allows to be operated on its premises, a facility for dispensing pharmaceuticals;

any quantity of drugs or medicines dispensed that exceeds a 34-day supply or 100 unit doses, whichever is greater, when taken in accordance with the direction of the prescriber; unless provided through any special program or mail order program specified in the schedule of benefits.

infertility medications; and

any prescription refilled before 75% of the supply is used or in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

Starter Dose Program

New prescriptions for certain medications will be dispensed initially as a trial dose for a maximum of 10 days. This applies only to new prescriptions, not refills for current medications. It is not necessary for your doctor to do anything different when prescribing medication. The prescription can be for a duration up to a 60-day or 100 units supply. When the pharmacy processes the prescription with Script Care, the on-line system will recognize the new prescription and message the pharmacy to dispense the trial dose and to collect up to a \$15.00 co-pay. If the prescription is tolerated and is producing the desired results then the remaining supply of medication can be dispensed, and you pay the additional co-payment minus the co-payment you paid for the trial dose. If not, the patient should contact their physician and discuss the results. If a new prescription is required for a different medication it will also be dispensed as a trial dose with a co-payment up to \$15.

ScriptCare Specialty Drug Program

The ScriptCare Specialty Pharmacy Program focuses on the delivery and management of pharmaceutical products that are generally, but not exclusively, biotechnological in nature, and on coordinating care for members required to take these medications.

The Program's drug list includes core treatment therapies for disease states such as:

- Growth Hormone
- Multiple Sclerosis
- Hepatitis
- Hemophilia

- Cancer
- Pulmonary Disorders
- Infertility
- Rheumatoid Arthritis
- Other Various Disease States
- Patient Benefits

This Program has been designed to support the needs of the patient's therapy. Along with integrated claims administration, the Program offers drug therapy benefits for the patient such as case management, delivery information, customer care support, home health agency support and nurse consultation regarding the medication.

The medications included in this Program are not items you find behind the counter at the retail pharmacy. The Program focuses solely on the distribution of these non-retail medications. The Specialty Pharmacy Customer Care Staff is readily available for plan members to answer questions regarding the patient's medication, administering the drug or delivery of the product. For the available physician-administered therapies, members have the option of delivery to their doctor's office or their home.

ADOPTION OF THE PLAN DOCUMENT

Adoption

Plan sponsor hereby adopts this plan document as the written description of its employee welfare benefit plan (the "plan"). This plan document is a restatement of the plan, with benefit changes, and is effective on January 1, 2008.

Purpose of the Plan

The purpose of the plan is to provide certain benefits for eligible employees of the employer and their eligible dependents. The benefits provided by the plan include:

HEALTH CARE COVERAGES

Medical Coverage (Hospital, Physician Services, etc.)
Prescription Drug Card

Intent to Comply with ERISA

About the Plan

While the Texas Annual Conference intends to continue this plan indefinitely, it reserves the right to change or end the plan in its entirety or with respect to any covered class or classes. In addition, the Insurance Committee reserves the right to determine who is eligible for benefits, the amount of benefits to be paid, and to determine all plan provisions.

The Plan is sponsored by the Texas Annual Conference of The United Methodist Church. Administration of the plan is the responsibility of the Group Health Benefits Office under the direction of Conference Insurance Committee. The plan is a self-funded plan and payments are derived from apportionments, church contributions, personal contributions, and interest.

It is intended that the plan will serve to describe the nature, funding, and benefits of the plan. It is also intended that the plan shall conform to the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended from time to time, as that act applies to employee welfare benefit plans. If any portion of the plan now or in the future conflicts with ERISA or federal regulations, such regulations will govern.

Acceptance of the Plan Document

IN WITNESS WHEREOF, the plan sponsor has caused this instrument (pages 1-60 inclusive) to be executed, effective as of January 1, 2008.

TEXAS ANNUAL CONFERENCE OF THE UNITED METHODIST CHURCH

By: _____

Title: _____

Date: _____

ADMINISTRATIVE INFORMATION

Name of Plan: Texas Annual Conference of
The United Methodist Church
Employee Benefit Plan

Plan Sponsor: Texas Annual Conference of
The United Methodist Church
Address: 5215 Main Street
Houston, Texas 77002-9792

Business Phone Number: (713) 521-9383, (800) 606-0350

Plan Sponsor ID Number (EIN): 74-1491628

Plan Number: 501

Plan Year: January 1

Plan Benefits: Medical
Prescription Drug Card

Fiduciaries: Lydia Fay Lopez
Texas Annual Conference of
The United Methodist Church
Address: 5215 Main Street
Houston, Texas 77002-9792

Designated Legal Agent: Lydia Fay Lopez
Texas Annual Conference of
The United Methodist Church
Address: 5215 Main Street
Houston, Texas 77002-9792

Privacy Officer: Lydia Fay Lopez
Texas Annual Conference of
The United Methodist Church
Address: 5215 Main Street
Houston, Texas 77002-9792

(Legal process may also be served upon the plan sponsor or a fiduciary)

Contract Administrator: Boon-Chapman Benefit Administrators, Inc.
Street Address: 12301 Research Blvd, Suite 400
Austin, Texas 78759

Mailing Address: P.O. Box 9201
Austin, Texas 78766

Phone: (512) 454-2681 / (800) 252-9653

FAX: (512) 459-1552

BOON-CHAPMAN

P.O. Box 9201 / Austin, TX 78766 / 512-454-2681 / 800-252-9653 / Fax 512-454-8700

1. Employer's Name: _____
2. Employee's Name: _____
3. Employee's Address: _____
 - a. Check here if a new address: Yes No
4. Employee's Social Security Number: _____ Group Number: _____
5. Patient's Name: _____ Relationship: _____ Birthdate: _____
6. Was treatment the result of an occupational injury? Yes
 No
7. Was treatment the result of an accident? Yes
 No
8. If yes, please state below how, where, and when the accident occurred: _____
9. Is patient covered by any other group medical plan? Yes
 No
10. If yes, give insured's name, SS#, and plan sponsor's name, address and phone number: _____
11. Make benefits payable to: Me Provider (If you have assigned benefits, we must pay the provider.)

Authorization to Release Information:

I hereby authorize the physician/provider to release any information acquired in the course of my or my dependent's examination or treatment. I understand that such information will be used by Boon-Chapman for the purpose of verifying that the services charged for were provided and that my authorized representative or I will receive a copy of this authorization upon request. This authorization is valid from the date signed for the duration of the claim, unless revoked in writing by me or my legal representative. The information I have provided on this form is true and correct to the best of knowledge. I agree that a photographic copy of this authorization shall be as valid as the original.

Signature of Participant

Date

A Claim form must be submitted annually with your first Claim.

Please submit to:

BOON-CHAPMAN

P.O. BOX 9201
AUSTIN, TX 78766