

CITY OF TURLOCK

BENEFIT DOCUMENT & SUMMARY PLAN DESCRIPTION OF THE MEDICAL & PRESCRIPTION DRUG BENEFITS

NOTE: THESE BENEFITS ARE PART OF THE
"CITY OF TURLOCK HEALTH BENEFITS PLAN" — PLAN # 501

RESTATED: JULY 1, 2015

Contract Administrator

CBA Administrators

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FEDERAL HEALTHCARE REFORM NOTICES

Grandfather Status — Statement of Belief

The City of Turlock Health Benefits Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grand-fathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at (209) 668-5540. You may also contact the U.S. Department of Health and Human Services at <https://www.healthcare.gov/what-if-i-have-a-grandfathered-health-plan/>.

IMPORTANT NOTICES

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A participant can obtain additional Information about coverage of a specific drug, treatment, procedure, preventive service, etc from the office that handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the General Plan Information section for the name, address and phone number of the Contract Administrator.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

NOTE: An "attending provider" does not include a plan, hospital, managed care organization or other issuer.

THE WOMEN'S HEALTH AND CANCER RIGHTS ACT

Under Federal law, group health plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the Women's Health and Cancer Rights Act (WHCRA).

MENTAL HEALTH PARITY & ADDICTION EQUITY ACT

Under Federal law, group health plans that already provide coverage for mental health conditions and/or substance addictions (referred to in the law as "substance use disorders") must provide coverage for such covered conditions in the same manner as coverage is provided for Sickness. This law applies to group health plans on their Plan Year anniversary beginning on or after October 3, 2009.

NOTE: The Plan is not required to provide coverage for mental health conditions or substance use disorders. Also, the Plan (and not the Act) determines what will be a covered mental health condition and/or a covered substance use disorder. This legislation does not apply to employers with fewer than 51 employees.

GENETIC INFORMATION AND NON-DISCRIMINATION ACT

GINA (Genetic Information and Non-discrimination Act) was enacted on May 21, 2008 and applies to a group health plan on its Plan Year beginning after May 21, 2009. The Act makes it illegal for group health plans to deny coverage or charge a higher rate or premium to an otherwise healthy individual found to have a potential genetic condition or genetic predisposition towards a disease or disorder. The Plan's eligibility and coverage provisions exclude denial of benefits or increased rates due to a potential or predisposition of a genetic condition of covered employees and their families.

The Act defines genetic information as that obtained from an individual's genetic test results, as well as genetic test results of family members and the occurrence of a disease or disorder in family members.

DEFINITIONS

Some of the terms used in this document begin with a capital letter. These terms have special meanings and are included in the Definitions section. When reading this document, it will be helpful to refer to this section. Becoming familiar with the terms defined therein will provide a better understanding of the benefits and provisions.

UTILIZATION MANAGEMENT PROGRAM

The Plan includes a Utilization Management Program as described below. The purpose of the program is to encourage Covered Persons to obtain quality medical care while utilizing *the most* cost efficient sources.

The vendor managing the Utilization Management Program is "Ault International Medical Management (AIMM)."

PRE-SERVICE REVIEW REQUIREMENTS

The Plan Sponsor has contracted with an Independent organization to provide pre-service review. The name and phone number of the organization is shown on the Employee's coverage Identification card Compliance Procedures - The procedures outlined below should be followed to avoid a possible penalty:

Bariatric Surgery – The Covered Person must contact the Utilization Management Organization prior to the performance of Medically Necessary bariatric surgery. Elective bariatric surgery is not covered under this Plan.

Hospital Admission - Except as noted, prior to any Hospital admission that is not a Medical Emergency, the Covered Person or someone acting on his behalf must contact the Utilization Management Organization for pre-service review and authorization For an emergency admission, the Utilization Management Organization must be contacted within 48 hours alter admission or no later than the second business day following a weekend or holiday admission An emergency admission is an admission which occurs suddenly or unexpectedly and the covered individual must be treated within 48 hours to avoid an immediate threat to his or *her* life, limb or organ function.

The Covered Person or his attending Physician must also initiate a continued stay review whenever it is Medically Necessary to extend the authorized length of a Hospital stay. This must be done before the end of the previously authorized length of stay.

NOTE: Pre-service review will not be required for an inpatient admission for Pregnancy delivery that does not exceed 48 hours following a normal vaginal delivery or 96 hours following a cesarean section delivery. However, if when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, pre-service review for such extended confinement is required.

Second Surgical Opinion - A Covered Person must call the Utilization Management Organization prior to the performance of an elective (non-emergency) surgery in order to determine if a second surgical opinion is required The Plan will pay the full cost of such opinion (including any related testing).

Penalty for Non-Compliance - if the above pre-service review requirements are not completed, the Plan's benefit percentage will reduce to 50% For a Hospital admission or a period of extended stay, the benefit reduction applies to Hospital charges If a second surgical opinion. Is required but not obtained, the benefit reduction applies to the surgeon, assistant surgeon and anesthesiologist.

Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered eligible medical expenses and thus will not apply to any deductibles, coinsurance or out-of-pocket maximums of the Plan.

See "Pre-Service Claims" in the Claims Procedures section for more information, including information on appealing an adverse decision (i.e., a benefit reduction) under this program.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining pre-service review impossible or where application of the pre-service review

process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

It is the Employee's or Covered Person's responsibility to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the review organization to make certain that the facility or attending Physician has initiated the necessary processes

Pre-service review and authorization is **not a guarantee** of coverage. The **Utilization Management Program is designed ONLY to determine whether or not a** proposed setting and course of treatment is Medically Necessary and appropriate Plan benefits will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service that is not Medically Necessary or that is otherwise not covered hereunder

MEDICAL BENEFIT SUMMARY - EPO

This schedule applies to active Employees (and their eligible and enrolled Dependents).

This schedule also applies to retirees (and their eligible and enrolled Dependents) who have selected these benefits in lieu of the Alternative Retiree Option See the *Extension of Coverage for Retirees" provision In the Extensions of Coverage section for more information

CHOICE OF NETWORK OR NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using the Network or using other Covered Providers (Non-Network providers) See the Employee's medical identification card for information on how to contact the Network.

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider, his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates The Plan may also Include other benefit Incentives to encourage Covered Persons to use the Network whenever possible - see the Schedule of Medical Benefits, below.

Upon enrollment in the Plan, each Employee must choose a Primary Care Physician from the list of such Network providers If Dependents are to be covered by the Plan, they must also select a Primary Care Physician Only services which are received from the selected Primary Care Physician will be covered at the Network benefit levels except as specified below - see NOTES. A Covered Person may change Primary Care Physicians in accordance with the Network's guidelines. The Plan Administrator must also be notified of the change, in writing.

Complete lists of Network providers are automatically given to Plan participants without charge. The lists may be provided in one or more separate documents.

NOTES: Except in the instances listed below, the Network organization itself must be contacted for referral In order for any non-PCP services to be covered at the Network benefit levels The exceptions to this requirement are limited to the following:

Allowable Self-Referrals - Self-referral to a Network provider is allowed as follows:

- chiropractic services can be obtained on a self-referral basis;
- one (1) self-referral Is allowed per Plan Year for an annual prostate exam and PSA test for prostate cancer;
- one (1) self-referral Is allowed per Plan Year for an annual GYN exam and Pap smear

No Choice of Provider - if, while receiving inpatient or Outpatient treatment at a Network Hospital, a Covered Person receives ancillary services from Non-Network providers (such as an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Unavailable Specialist Services - If a Covered Person uses a Non-Network provider because the necessary specialty is not represented in the Network or is not reasonably accessible to the patient due to geographic constraints, such Non-Network care will he covered at the Network benefit levels. For Plan purposes, not reasonably accessible will mean the needed type of Network specialist Is not available within fifty (50) miles of the Covered Person's residence.

Urgent Care Facility - If an urgent situation arises on a weekend, holiday or after-hours, a Covered Person can go directly to a Network Urgent Care Facility without contacting the Network. However, the Network must be notified within 48 hours thereafter or the next business day, whichever is sooner.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges. For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable" in the Definitions section for more Information

A "Co-Pay" is an amount the Covered Person must pay Co-Pays are usually paid to the provider at the time of service.

LIFETIME / ANNUAL MAXIMUMS		
Lifetime Maximum Benefit	Unlimited	
Annual Maximum Benefit	Unlimited	
PLAN YEAR DEDUCTIBLES (7/1 – 6/30)	Network	Non-Network
Individual Deductible	-0-	\$400
Family Maximum Deductible	-0-	\$800
<p><u>Individual Deductible</u> - The Individual Deductibles are amounts which a Covered Person must contribute toward payment of eligible medical expenses when Non-Network providers are used. The Deductibles usually applies before the Plan begins to provide benefits. The Deductibles applies each Plan Year (7/1 – 6/30).</p>		
<p><u>Family Maximum Deductible</u> - If \$800 in eligible medical expenses is incurred collectively by family members during a Plan Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.</p>		
OUT-OF-POCKET MAXIMUMS	Network	Non-Network
Individual Out-of-Pocket Maximum	(see "Hospital Services")	\$2,000
Family Out-of-Pocket Maximum	N/A	\$4,000

Individual Out-of-Pocket Maximum - Except as noted, a Covered Person will not be required to pay more than \$2,000 in any Plan Year toward his percentage share of Eligible Expenses which are not paid by the Plan for Non-Network services. Once he has paid his out-of-pocket maximum, his Non-Network Eligible Expenses will be paid at 100% for the balance of the Plan Year.

Family Out-of-Pocket Maximum - Except as noted, a covered family (Employee and his Dependents) will not be required to pay more than \$4,000 in any Plan Year toward their percentage share obligations. Once the family has paid their out-of-pocket maximum, their Non-Network Eligible Expenses will be paid at 100% for the balance of the Plan Year.

NOTE: The out-of-pocket maximums do not apply to or include:

Amounts applied or paid to satisfy any Deductible or Co-Pay requirements (see "Hospital Services" below, for the special out-of-pocket limit for Network Hospital Co-Pays);

expenses which become the Covered Person's responsibility for failure to comply with the requirements of the **Utilization Management Program**.

ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Acupuncture	50%	50%
Limited to \$500 in benefits per Plan Year.		
Allergy Injections , per visit	\$5 Co-Pay	60%
Ambulance First \$50, per trip Thereafter	100% 70%	100%† 70%
Ambulatory Surgical Center , per use	\$200 Co-Pay	60%
Bariatric Surgery	\$500 Co-Pay	60%
Chiropractic Care , per visit Limited to 26 visits per Plan Year.	\$20 Co-Pay	60%
Diagnostic Lab & X-Ray, Outpatient , per visit	\$20 Co-Pay	60%
Home Health Care Limited to 100 visits per Plan Year. Each visit of 4 hours or less will count as 1 visit.	100%	60%
Hospice Care Patient Care Bereavement Counseling, per session	100% 100% to \$50	60% 60% to \$50
Hospital Services Inpatient Care, per admission (see NOTES) Emergency Room Care, per use (see NOTES) Outpatient Surgery Dept, per use Other Outpatient Services Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see Definitions) or the Usual, Customary and Reasonable charge for necessary confinement to an Intensive Care Unit. Excess charges for a private room accommodation will be covered only when a private room is Medically Necessary.	\$500 Co-Pay \$150 Co-Pay \$250 Co-Pay 100%	60% \$150 Co-Pay 60% 60%
NOTE: The \$150 emergency room Co-Pay will be waived if the patient is admitted to the Hospital. If the patient is admitted to the Hospital directly from the emergency room, only the \$500 Co-Pay for an inpatient admission will apply.		
Hospital Co-Pays will be waived after a Covered Person has paid \$1,200 out-of-pocket for such Co-		

Pays in a Plan Year.		
Mental Health & Substance Use Disorder Care		
Inpatient Care, per admission (see NOTES)	\$500 Co-Pay	60%
Emergency Room Care, per use (see NOTES)	\$150 Co-Pay	60%
Other Outpatient Services	100%	60%
Physician Inpatient Care	100%	60%
Physician Office Visits, per visit	\$20 Co-Pay	60%
<p>Mental Health Care and Substance Use Disorder Care are covered the same as Sickness. "Covered same as Sickness" means that the Plan's <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered mental health conditions or covered substance use disorders (see "Mental Health Care / Substance Use Disorder Care" in the Eligible Medical Expenses section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements).</p>		
<p>NOTE: The \$150 emergency room Co-Pay will be waived if the patient is admitted to the Hospital. Hospital Co-Pays will be waived after a Covered Person has paid \$1,200 out-of-pocket for such Co-Pays in a Plan Year.</p>		
Physician Services		
Inpatient Visits	100%	60%
Office Visit	\$20 Co-Pay	60%
In-Office Surgery	\$20 Co-Pay	60%
Other Physician Services	100%	60%
<p>NOTE: A "primary care Physician" includes a Physician in general/family practice, pediatrics, internal medicine or OB/GYN. Any other Physician is considered a specialist.</p>		
Prescription Drugs, Outpatient	(see PRESCRIPTION BENEFIT SUMMARY below)	
Preventive Care, per visit		
GYN Exam & Pap Smear	\$20 Co-Pay	60%
Prostate Exam PSA Test	\$20 Co-Pay	60%
Mammograms	\$20 Co-Pay	60%
Well Child Care	\$20 Co-Pay	Not Covered
<p>Preventive Care includes:</p> <ul style="list-style-type: none"> an annual GYN exam and Pap smear; an annual prostate exam and prostate specific antigen (PSA) test for a male age 50 or older; mammograms for breast cancer screening at the following ages/frequencies: <ul style="list-style-type: none"> - a baseline mammogram for a woman age 35-39 - a mammogram every 2 years for a woman age 40-49, or more frequently if recommended by a Physician - an annual mammogram for a woman age 50 or older; periodic well child checkups and immunizations for a covered Dependent child during the child's first 2 years of life. 		
Second Surgical Opinion – when mandated by the Utilization Management Organization	100%	100%†
<p>The Plan will pay the full cost of a second surgical opinion consultation, including any related testing, when such opinion is required by the Utilization Management Organization. See the Utilization Management Program for more information.</p>		
Skilled Nursing Facility or Rehabilitation Center	100%	60%
<p>Eligible Expenses for room and board in a Skilled Nursing Facility or Rehabilitation Center are limited to the facility's Semi-Private Room Charge. Coverage is limited to 120 days of confinement per Plan Year.</p>		

Substance Use Disorder Care	(see "Mental Health & Substance Use Disorder Care")	
Urgent Care Facility, per visit (urgent use ONLY)	\$25 Co-Pay	60%
All Other Eligible Medical Expenses	100%	60%

THIS IS A SUMMARY **ONLY**. **SEE THE ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

†Plan Year Deductible does not apply.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION ALSO.

MEDICAL BENEFIT SUMMARY - ALTERNATIVE RETIREE OPTION

This schedule applies to retirees who have selected this alternative extended coverage option (i.e. individuals who meet the eligibility requirements as included in the "**Extension of Coverage for Retirees**" provision in the **Extensions of Coverage** section) and their eligible enrolled Dependents.

CHOICE OF NETWORK OR NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using the Network or using other Covered Providers (Non-Network providers) See the retiree's medical Identification card for Information on how to contact the Network.

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider, his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of those rates. The Plan may also include other benefit incentives to encourage Covered Persons to use the Network whenever possible - see the Schedule of Medical Benefits, below.

Upon enrollment in the Plan, each retiree must choose a Primary Care Physician from the list of such Network providers. If Dependents are covered, they must also select a Primary Care Physician. Only services which are received from the selected Primary Care Physician will be covered at the Network benefit levels, except as specified below – see NOTE A Covered Person may change Primary Care Physicians in accordance with the Network's guidelines The Plan Administrator must also be notified of the change, in writing.

Complete lists of Network providers are automatically given to Plan participants without charge. The lists may be provided in one or more separate documents.

NOTES: Except in the instances listed below, the Network organization itself must be contacted for referral In order for any non-PCP services to be covered at the Network benefit levels The exceptions to this requirement are limited to the following:

Allowable Self-Referrals - Self-referral to a Network provider is allowed as follows:

- chiropractic services can be obtained on a self-referral basis;
- one (1) self-referral is allowed per Plan Year for an annual prostate exam and PSA test for prostate cancer;
- one (1) self-referral is allowed per Plan Year for an annual GYN exam and Pap smear.

No Choice of Provider - If, while receiving Inpatient or Outpatient treatment at a Network Hospital, a Covered Person receives ancillary services from Non-Network providers (such as an emergency room Physician an anesthesiologist or a provider for diagnostic services), such Non-Network services will be covered at the Network benefit levels.

Unavailable Specialist Services - If a Covered Person uses a Non-Network provider because the necessary specialty is not represented in the Network or Is not reasonably accessible to the patient due to geographic constraints, such Non-Network care will be covered at the Network benefit levels. For Plan purposes, not reasonably accessible will mean the needed type of Network specialist Is not available within fifty (50) miles of the Covered Person's residence.

Urgent Care Facility - if an urgent situation arises on a weekend, holiday or after-hours, a Covered Person can go directly to a Network Urgent Care Facility without contacting the Network. However, the Network must be notified within 48 hours thereafter or the next business day, whichever is sooner.

CLAIMS AUDIT

In addition to the Plan's Medical Record Review process, the Plan Administrator may use its discretionary authority to utilize an independent bill review and/or claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Medically Necessary and Reasonable, if any, and may include a patient medical billing records review and/or audit of the patient's medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.

SCHEDULE OF MEDICAL BENEFITS

The percentages shown in the schedule reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been applied. The percentages apply to "Usual, Customary and Reasonable" charges For Network providers, this means that the percentages apply to the negotiated rates. See "Usual, Customary and Reasonable in the Definitions section for more information.

"Co-Pay" is an amount the Covered Person must pay. Co-Pays are usually paid to the provider at the time of service.

LIFETIME / ANNUAL MAXIMUMS	
Lifetime Maximum Benefit	Unlimited
Annual Maximum Benefit	Unlimited
PLAN YEAR DEDUCTIBLES (7/1 – 6/30)	
Individual Deductible	\$500
Family Maximum Deductible	\$1,000
<p><u>Individual Deductible</u> - The Individual Deductibles are amounts which a Covered Person must contribute toward payment of eligible medical expenses when Non-Network providers are used. The Deductibles usually applies before the Plan begins to provide benefits. The Deductibles applies each Plan Year (7/1 – 6/30).</p>	
<p><u>Family Maximum Deductible</u> - If \$1,000 in eligible medical expenses is incurred collectively by family members during a Plan Year and is applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.</p>	

INDIVIDUAL OUT-OF-POCKET MAXIMUMS	Network	Non-Network
	\$5,000	\$7,500
<p>Except as noted, a Covered Person will not be required to pay more than \$7,500 (or \$5,000 for Network services and supplies) in any Plan Year toward his percentage share of Eligible Expenses which are not paid by the Plan for Non-Network services. Once he has paid his out-of-pocket maximum, Eligible Expenses will be paid at 100% for the balance of the Plan Year.</p> <p>NOTE: The out-of-pocket maximums do not apply to or include:</p> <p style="padding-left: 40px;">Amounts applied or paid to satisfy any Co-Pay requirements;</p> <p style="padding-left: 40px;">expenses which become the Covered Person's responsibility for failure to comply with the requirements of the Utilization Management Program.</p>		
ELIGIBLE MEDICAL EXPENSES	Network	Non-Network
Acupuncture	50%	50%
Limited to \$500 in benefits per Plan Year.		
Allergy Injections , per visit	\$5 Co-Pay	60%
Ambulance First \$50, per trip Thereafter	100% 70%	100%† 70%
Ambulatory Surgical Center , per use	\$200 Co-Pay	60%
Bariatric Surgery	80%	50%
Chiropractic Care , per visit Limited to 26 visits per Plan Year.	\$20 Co-Pay	60%
Diagnostic Lab & X-Ray, Outpatient , per visit	\$20 Co-Pay	60%
Home Health Care Limited to 100 visits per Plan Year. Each visit of 4 hours or less will count as 1 visit.	100%	60%
Hospice Care Patient Care Bereavement Counseling, per session	100% 100% to \$50	60% 60% to \$50
Hospital Services Inpatient Care, per admission (see NOTES) Emergency Room Care, per use (see NOTES) Outpatient Surgery Dept, per use Other Outpatient Services	\$500 Co-Pay \$150 Co-Pay \$250 Co-Pay 100%	60% \$150 Co-Pay 60% 60%
<p>Eligible Expenses for Inpatient room and board are limited to the Semi-Private Room Charge (see Definitions) or the Usual, Customary and Reasonable charge for necessary confinement to an Intensive Care Unit. Excess charges for a private room accommodation will be covered only when a private room is Medically Necessary.</p> <p>NOTE: The \$150 emergency room Co-Pay will be waived if the patient is admitted to the Hospital. If the patient is admitted to the Hospital directly from the emergency room, only the \$500 Co-Pay for an inpatient admission will apply.</p> <p>Hospital Co-Pays will be waived after a Covered Person has paid \$1,200 out-of-pocket for such Co-Pays in a Plan Year.</p>		

Mental Health & Substance Use Disorder Care		
Inpatient Care, per admission (see NOTES)	\$500 Co-Pay	60%
Emergency Room Care, per use (see NOTES)	\$150 Co-Pay	60%
Other Outpatient Services	100%	60%
Physician Inpatient Care	100%	60%
Physician Office Visits, per visit	\$20 Co-Pay	60%
<p>Mental Health Care and Substance Use Disorder Care are covered the same as Sickness. "Covered same as Sickness" means that the Plan's <u>treatment limitations</u> and <u>financial requirements</u> that apply to covered mental health conditions or covered substance use disorders (see "Mental Health Care / Substance Use Disorder Care" in the Eligible Medical Expenses section) may not be any more restrictive than the most common or frequent limitations that apply to substantially all medical and surgical benefits provided hereunder. "Treatment limitations" include limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. "Financial requirements" includes deductibles, co-pays, percentage sharing provisions and out-of-pocket expenses. "Covered same as Sickness" also extends to medical management matters (i.e., utilization review program requirements).</p> <p>NOTE: The \$150 emergency room Co-Pay will be waived if the patient is admitted to the Hospital.</p> <p>Hospital Co-Pays will be waived after a Covered Person has paid \$1,200 out-of-pocket for such Co-Pays in a Plan Year.</p>		
Physician Services		
Inpatient Visits	100%	60%
Office Visit	\$20 Co-Pay	60%
In-Office Surgery	\$20 Co-Pay	60%
Other Physician Services	100%	60%
NOTE: A "primary care Physician" includes a Physician in general/family practice, pediatrics, internal medicine or OB/GYN. Any other Physician is considered a specialist.		
Prescription Drugs, Outpatient	(see PRESCRIPTION BENEFIT SUMMARY below)	
Preventive Care , per visit		
GYN Exam & Pap Smear	\$20 Co-Pay	60%
Prostate Exam PSA Test	\$20 Co-Pay	60%
Mammograms	\$20 Co-Pay	60%
Well Child Care	\$20 Co-Pay	Not Covered
<p>Preventive Care includes:</p> <ul style="list-style-type: none"> an annual GYN exam and Pap smear; an annual prostate exam and prostate specific antigen (PSA) test for a male age 50 or older; mammograms for breast cancer screening at the following ages/frequencies: <ul style="list-style-type: none"> - a baseline mammogram for a woman age 35-39 - a mammogram every 2 years for a woman age 40-49, or more frequently if recommended by a Physician - an annual mammogram for a woman age 50 or older; periodic well child checkups and immunizations for a covered Dependent child during the child's first 2 years of life. 		
Second Surgical Opinion – when mandated by the Utilization Management Organization	100%	100%†
The Plan will pay the full cost of a second surgical opinion consultation, including any related testing, when such opinion is required by the Utilization Management Organization. See the Utilization Management Program for more information.		

Skilled Nursing Facility or Rehabilitation Center	100%	60%
Eligible Expenses for room and board in a Skilled Nursing Facility or Rehabilitation Center are limited to the facility's Semi-Private Room Charge. Coverage is limited to 120 days of confinement per Plan Year.		
Substance Use Disorder Care	(see "Mental Health & Substance Use Disorder Care")	
Urgent Care Facility , per visit (urgent use ONLY)	\$25 Co-Pay	60%
All Other Eligible Medical Expenses	100%	60%

THIS IS A SUMMARY **ONLY**. SEE THE **ELIGIBLE MEDICAL EXPENSES AND MEDICAL LIMITATIONS AND EXCLUSIONS** SECTIONS FOR MORE INFORMATION.

†Plan Year Deductible does not apply.

IMPORTANT: CERTAIN SERVICES AND/OR SUPPLIES MAY REQUIRE PRE-SERVICE REVIEW TO AVOID BENEFIT REDUCTION. SEE THE **UTILIZATION MANAGEMENT PROGRAM** SECTION ALSO.

PRESCRIPTION BENEFIT SUMMARY

PRESCRIPTION DRUG COVERAGE IS PROVIDED THROUGH SEPARATE AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND PRESCRIPTION DRUG VENDOR(S). IF THERE ARE ANY CONFLICTS BETWEEN THE PRESCRIPTION INFORMATION IN THIS DOCUMENT AND THE TERMS OF SUCH AGREEMENT(S), THE AGREEMENT(S) WILL PREVAIL.

SCHEDULE OF PRESCRIPTION BENEFITS

RETAIL PROGRAM	EPO	Alternative Retiree Option
Generic Drug	\$10 Co-Pay	\$20 Co-Pay
Brand-Name Formulary Drug	\$25 Co-Pay	\$30 Co-Pay
Non-Formulary Drug	\$40 Co-Pay	\$45 Co-Pay
MAIL ORDER OPTION	EPO	Alternative Retiree Option
Generic Drug	\$10 Co-Pay	\$20 Co-Pay
Brand-Name Formulary Drug	\$25 Co-Pay	\$30 Co-Pay
Non-Formulary Drug	\$40 Co-Pay	\$60 Co-Pay
The prescription coverages include both a retail program and mail-order option.		
To use the retail program, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. A prescription can be purchased in up to a 34-day supply or 100 dosage units, whichever is greater.		
The mail-order option is for maintenance (longer-term) drugs. A mail-order drug is available in up to a 120-day supply or 360 dosage units, whichever is greater.		
A list of covered and excluded drugs is provided elsewhere in this document or is available from the Plan Sponsor.		

COVERED DRUGS

Prescription drug coverage includes:

charges for drugs and medicines which can be obtained only by prescription and are not sold "over-the-counter" and, subject to the following exceptions and limitations, bear the legend "Caution — Federal Law Prohibits Dispensing Without a Prescription", except for insulin:

charges which are not in excess of the average wholesale cost of the ingredient to the dispensing pharmacist, plus a professional or dispensing fee, plus sales tax (if applicable) for each covered prescription lawfully dispensed;

insulin, syringes and needles for the injection of insulin and diabetic test strips;

vitamins, including pre-natal vitamins;

oral contraceptives, but ONLY if prescribed for a medical condition other than birth control. Prior authorization from the drug vendor is required;

Viagra (or a similar drug), but ONLY if prescribed for a covered medical condition (i.e., prostate cancer, etc) other than inorganic sexual dysfunction or inadequacy.

EXPENSES NOT COVERED

Prescription drug coverage will not include any of the following:

Administration - Any charge for the administration of a covered drug.

Contraceptives - Contraceptive implants or injectables (i.e., Levonorgestrel or "Norplant"), or contraceptive materials.

Excess Refills – Refills beyond the number specified by a Physician or refills more than one (1) year from the date of the Initial prescription order.

Experimental & Non-FDA Approved Drugs - Experimental drug and medicines even though a charge is made to the Covered Person Any drug not approved by the Food and Drug Administration.

Investigational Drugs - A drug or medicine labeled: "Caution — limited by federal law to investigational use."

No Charge - A prescribed drug which may be properly received without charge under a local, state or federal program or for which the cost is recoverable under any workers' compensation or occupational disease law.

Non-Prescription Drugs - A drug or medicine that can legally be bought without a written prescription. This does not apply to Insulin.

Smoking Cessation/Deterrent Drugs - Any type of prescription or non-prescription drug or supply for smoking cessation (e.g., nicotine gum, smoking deterrent patches, etc.).

DISCLAIMER: THIS IS ONLY A SUMMARY OF THE PRESCRIPTION DRUG COVERAGES OFFERED BY THE PLAN. THE ACTUAL CONTROLLING PROVISIONS AND LISTS OF COVERED AND EXCLUDED DRUGS, ETC., MUST BE OBTAINED DIRECTLY FROM THE PLAN SPONSOR OR THE PRESCRIPTION PROGRAM PROVIDER

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions that are covered by the Plan. This section must be read in conjunction with the **Medical Benefit Summary** to understand how Plan benefits are determined (e.g., application of Deductible and Co-Pay requirements and benefit sharing percentages). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and that are incurred by a Covered Person - subject to the **Definitions, Limitations and Exclusions** and all other provisions of the Plan. In general, services and supplies must be approved by and received from a Physician or other appropriate Covered Provider 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 will be deemed to be incurred on:

the date a purchase is contracted; or

the actual date a service is rendered.

Acupuncture - Acupuncture treatment by a Physician or licensed acupuncturist.

NOTE: Moxibustion and the like, herbs teas, or dietary items prescribed or provided by an acupuncturist are not covered.

Alcoholism - see "Mental Health & Substance Use Disorder Care."

Allergy Injections

Ambulance - Professional ground or air ambulance service when used to transport a Covered Person from the place where he is injured or stricken by a Sickness to the nearest Hospital where treatment can be given.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see Definitions) in connection with a covered Outpatient surgery.

Anesthesia - Anesthetics and services of a Physician or certified registered nurse anesthetist (CRNA) for the administration of anesthesia.

Attention Deficit Disorders (ADD & ADHD) - Testing and medical treatment (i.e., periodic Physician check-ups for evaluation and medication management) for attention deficit disorder (ADD) or attention deficit hyperactive disorder (ADHD).

Birthing Center - Services and supplies provided by a Birthing Center (see Definitions) in connection with a covered Pregnancy.

Blood - Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Chemical Dependency - see "Mental Health & Substance Use Disorder Care"

Chemotherapy & Radiation Therapy - Services and supplies related to the administration of chemical agents in the treatment or control of a Sickness.

Radium and radioactive isotope therapy when provided for treatment or control of a Sickness.

Chiropractic Care - Musculoskeletal manipulation and modalities (e.g., hot & cold packs) provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, displacement, fixation, abnormal spacing, sprain or strain.

Diagnostic Lab & X-ray, Outpatient - Laboratory, X-ray and other non-surgical services performed to diagnose medical disorders, including scanning and imaging work (e.g., CT scans, MRIs), electrocardiograms, basal metabolism tests, and similar diagnostic tests generally used by Physicians throughout the United States.

Dialysis - Dialysis services and supplies, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the fair market purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental injury. Excess charges for deluxe equipment or devices will not be covered.

"Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen, blood pressure kits, and dialysis equipment (see NOTE), etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: For dialysis equipment, the total purchase price will be eligible on a monthly pro-rata basis during the first twenty-four (24) months of ownership, but only so long as dialysis treatment continues to be medically required. Eligible charges will also include those for supplies, materials and repairs necessary for the proper operation of the equipment for the sole benefit of the patient.

Emergency Services

Benefits for emergency services must be provided at Network benefit levels, regardless of whether the provider is or is not a Network provider.

Home Health Care - Services and supplies which are furnished in accordance with a written home health care plan to a Covered Person who is totally disabled (see NOTES) and under the direct care of a Physician. The home health care plan must be established in writing by the attending Physician and must be certified by the Physician at least once a month during the period of home health care. Also, the attending Physician must examine the patient at least once every sixty (60) days and certify that the condition would require inpatient confinement in a Hospital or Skilled Nursing Facility in the absence of home health care.

Covered home health care services and supplies include the following. Such services and/or supplies must be provided by a Home Health Care Agency;

part-time or intermittent nursing care by a licensed vocational nurse (LVN);

part-time or intermittent services of home health aides;

social work performed by a licensed social worker;

nutrition services by a licensed nutritionist;

special meals.

NOTES: Covered home health care will not include housekeeping services or services which are custodial in nature and could be rendered by non-professionals.

"Totally disabled" means a physical or mental state resulting from a Sickness or Accidental Injury which wholly prevents: (1) an Employee from engaging in his/her own business or occupation for profit, or (2) a Dependent from performing the normal activities of a person of like age and sex.

Hospice Care - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care Eligible Expenses include Hospice program charges for:

Inpatient Hospice facility services and supplies;

professional and other services and supplies including: (1) part-time nursing care by or under the supervision of a registered nurse (RN), (2) home health aide services, (3) nutrition services, (4) special meals, and (5) counseling services by a licensed social worker or a licensed pastoral counselor.

The Plan will also cover bereavement counseling sessions for members of the immediate family following the death of the Covered Person.

Hospital Services - Hospital services and supplies provided on an Outpatient basis and Inpatient *care*, including daily room and board and ancillary services and supplies.

Infusion Therapy - Professional services of an appropriate Covered Provider for the intravenous or aerosol administration of prescription drugs or other prepared or compounded substances. Infusion therapy may be administered In a Covered Person's home Physician's office or at a Covered Provider facility.

Infusion therapy supplies including injectable prescription drugs or other substances that are approved by the Food and Drug Administration, and durable medical equipment necessary for infusion therapy.

Marriage & Family Counseling - see "Mental Health Care"

Medical Supplies, Disposable - Disposable medical supplies such as surgical dressings catheters, colostomy bags and related supplies, and insulin needles and syringes.

Medicines - Medicines that are dispensed and administered to a Covered Person during an Inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Mental Health & Substance Use Disorder Care - Inpatient, emergency, and Outpatient treatment of covered mental health conditions and covered substance use disorders.

Mental Health Conditions: For Plan purposes, a covered "mental health condition" means an emotional or mental condition characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual and emotional disturbances are the dominating factor.

Substance Use Disorders: For Plan purposes, a covered "substance use disorder" is physical and/or psychological dependence on drugs: narcotics, alcohol, toxic inhalants, or other addictive substances to a debilitating degree It does not include tobacco dependence or dependence on ordinary drinks containing caffeine.

Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy Care" below.

Newborn Care - Medically Necessary services and supplies, as listed herein, for a covered newborn who is sick or injured.

Hospital and Physician services provided during the birth confinement to a covered well newborn child Newborn circumcision.

NOTE: In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Hospital stay for a newborn (birth confinement) to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean delivery.

Nursing Services, Private Duty - Services of a registered nurse (RN) or licensed vocational nurse (LVN) for private duty nursing services. When provided on an Inpatient basis, only the services of an LVN will be eligible.

Occupational Therapy - Therapy provided by a certified occupational therapist, utilizing arts, crafts or specific training in daily living skills, to improve a patient's ability to function.

Orthotics - Orthopedic (non-dental) braces, casts, splints, trusses and other orthotics that are prescribed by a Physician and that are required for support of a body part due to a congenital condition, or an Accidental Injury or Sickness

NOTE: Foot orthotics are mg covered.

Oxygen - see "Durable Medical Equipment"

Pediatric Oral & Vision Care - Oral and vision care services for persons who are under 21 years of age.

Physical Therapy - Professional services of a licensed physical therapist, but only to the extent that the therapy is for Improvement of bodily function.

Physician Services - Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations

Pregnancy Care - Pregnancy-related expenses of a covered Employee or covered Dependent spouse. Eligible Pregnancy-related expenses include the following, are covered at least to the same extent as any other Sickness, and may include other care that is deemed to be Medically Necessary by the patient's attending Physician:

pre-natal visits and routine pre-natal and post-partum care; and

expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of pregnancy.

In accordance with the Newborns' and Mothers' Health Protection Act, the Plan will not restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a cesarean section. Also, the Utilization Management Program requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, (3) expenses of a surrogate mother who is not a Covered Person, or (4) pregnancy-related expenses of a Dependent daughter, including expenses for treatment of complications of any such pregnancy.

Prescription Drugs - Medicines that are dispensed and administered to a Covered Person during an inpatient confinement, during a Physician's office visit, or as part of a home health care or hospice care program.

Other Outpatient drugs (i.e., pharmacy purchases) are covered through a separate program. See the Prescription Benefit Summary for more information.

Preventive Care - Certain preventive services that are provided in the absence of sickness or injury. See the Medical Benefit Summary and the Prescription Benefit Summary for more information.

Prosthetics - An artificial limb or eye required to replace a natural limb or eye. To comply with the Women's Health and Cancer Rights Act, coverage also includes post-mastectomy breast prostheses.

Radiation Therapy - see "Chemotherapy & Radiation Therapy" Rehabilitation Center - see "Skilled Nursing Facility or Rehabilitation Center."

Respiratory / Inhalation Therapy - Professional services of a licensed respiratory or inhalation 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 respiratory function.

Second (& 3rd) Surgical Opinion - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility or Rehabilitation Center - Inpatient care in Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility or center is Medically Necessary and begins within fourteen (14) days of a Hospital stay of at least three (3) consecutive days.

Speech Therapy - Services of a qualified speech therapist, but only when used to restore or rehabilitate a speech loss or impairment caused by Accidental injury or Sickness but not a mental, emotional or nervous disorder. In the case of a congenital defect that can be corrected or improved with surgery speech therapy is covered only if provided after surgery for the defect.

NOTE: Speech therapy provided to a child solely due to developmental delay is not covered.

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

NOTE: Reconstruction (reversal) of a prior elective sterilization procedure is not covered.

Substance Use Disorder Care - (see 'Mental Health & Substance Use Disorder Care above).

Transplant-Related Expenses - The following transplant/implant procedures for a Covered Person who is the transplant/implant recipient:

- Artery or vein transplants
- Bone marrow transplants
- Cornea transplants
- Heart transplant
- Heart/Lung transplant
- Implantable prosthetic lenses in connection with cataracts
- Joint replacements
- Kidney transplants
- Liver transplants

Pancreas transplant
Prosthetic by-pass or replacement vessels
Skin Transplant

In addition to other Eligible Expenses as listed in this section, the recipient's Eligible Expenses will also include the cost of securing an organ from a living donor or an organ transplant bank. Benefits payable on the donor's behalf will be reduced by any amounts payable under any other public, group or private plan.

Urgent Care Facility - Use of an Urgent Care Facility for an acute medical condition that requires prompt medical attention and where delay of treatment would cause physical harm.

NOTE: Non-urgent care provided in an Urgent Care Facility is not covered (e.g., use of such facility for convenience, follow-up visits/tests for an ongoing condition, routine health care or minor problems where prompt attention is not necessary).

MEDICAL TRAVEL BENEFIT

The plan will pay 100% for covered transportation, lodging and medical care for employees and dependents who choose to have certain high-cost elective surgeries performed by a participating High Quality, Low Cost provider that is part of the Medical Travel Network. Providers are both outside of the United States as well as inside the United States. The care must be approved and arranged by our medical travel facilitator, WorldMed Assist. Elective surgeries are surgeries that are non-emergency in nature and that can be safely scheduled at your convenience. You must be healthy enough to travel for medical care. Not all elective surgical procedures will qualify. Examples of procedures that may qualify for this special benefit include:

- Cardiovascular: Angioplasty, Coronary Artery Bypass, Heart Valve Replacement, Pacemaker
- Orthopedic: Spinal Fusion, Hip Replacement/Resurfacing, Total Knee Replacement
- Transplants: Liver, Kidney, Bone Marrow

Other procedures may also qualify. Decisions are made on a case-by-case basis.

In addition to providing a 100% benefit for the medical expenses, **City of Turlock** will:

- Pay transportation, lodging and a per diem allowance for meals for a spouse or companion who wishes to accompany you, provided that all travel arrangements are made through WorldMed Assist
- Grant additional Paid Time Off (PTO) equal to the time you spend traveling to and from the country in which you are being treated, and the time spent abroad for medical reasons (hospitalization plus any initial rehabilitation), to a maximum of 10 days
- Share a portion of the savings through a schedule of cash payments ranging from \$500 to \$5,000 depending on the procedure
- Pay for Business Class air transportation (if available) for most trips, if warranted by the flight time or your medical condition

If you need to have an elective inpatient surgical procedure and are interested in finding out more about the Medical Travel Benefit, contact WorldMed Assist at **866-999-3848, ext. 740**.

Medical Travel (also known as medical tourism) is becoming increasingly popular given the rising health care costs in the United States. To enhance the benefits provided by the **City of Turlock** Health Benefits Plan (The Plan) and give covered employees and their participating dependents the option of increased savings with regard to certain elective surgical procedures covered by The Plan, The Plan will provide Medical Travel benefits as described in this section.

In order to qualify for the benefits provided under this program, all arrangements must be made through **City of Turlock's** medical travel facilitator, WorldMed Assist. You can contact WorldMed Assist at **866-999-3848, ext. 740**.

If your procedure qualifies for the program, WorldMed Assist will provide detailed information on the hospitals and doctors that may be utilized for your procedure. You will choose the hospital and/or doctor that will perform your procedure. If you decide to your Medical Travel benefit, WorldMed Assist will work directly with you to transfer your medical information to the doctor and/or hospital you have selected for your procedure. Once the doctor and/or hospital accept you as a patient, WorldMed Assist will work directly with you to arrange your travel and accommodations for the procedure.

Notwithstanding any other provision in The Plan to the contrary, if you decide to have a qualifying procedure performed through this program, the Plan will provide:

- **Full 100% coverage of the medical costs;**
- **The full cost of transportation for the patient and a companion, including Business Class air**

transportation if that fare class is available on your flight and is judged to be warranted based on travel time or your medical condition;

- The full cost of hospital and hotel accommodations for the patient and a companion for the surgery and any rehabilitation period that is required before the patient can safely travel back home;
- A per diem allowance for meals and other expenses during your stay at the destination of treatment (based on location);
- Paid time off at your regular rate of pay for the travel days and the medically necessary portion of your stay, up to a maximum of 10 working days. This paid time off will be in addition to your normal accrual and will not reduce any existing accrued balance in your paid time off account; and
- A share of the Plan savings in the form a cash payment ranging from \$500 to \$5,000 depending on the procedure and destination of treatment. WorldMed Assist can advise you of the amount of the payment based on a schedule that they establish and maintain at City of Turlock's direction.

The incentives, paid time off and the per diem allowances for your travel companion are taxable benefits and will be included on your W-2.

All billing for any qualifying procedure performed pursuant to this Medical Travel benefit will be made directly to the Plan. You will not be directly responsible for paying for any portion of your medical care to the facility.

Individual circumstances can vary, and approval is handled on a case-by-case basis, but some procedures that may be candidates for Medical Travel Benefits include:

Examples of Procedures that may qualify and associated examples of incentives

Procedure	Recommended Incentive	Procedure	Recommended Incentive
Hip replacement - unilateral	\$3000	Pace maker	\$1500
Hip replacement - bilateral	\$6000	RF Ablation Treatment	\$1500
Hip resurfacing - unilateral	\$3000	Bone Marrow Transplant	\$5000
Hip resurfacing - bilateral	\$6000	Kidney transplant	\$5000
Knee replacement - unilateral	\$3000	Liver transplant	\$5000
Knee replacement - bilateral	\$6000	Cyberknife treatment	\$3000
Disk Fusion - one level	\$3000	Prostatectomy (Lap Radical)	\$2000
Disk Fusion - two level	\$6000	DaVinci Prostatectomy	\$2000
Disk Fusion - three level	\$9000	Cochlear Implant - unilateral	\$1500
Total Disk Replacement	\$3000	Cochlear Implant - bilateral	\$3000
Laminectomy	\$1000	Gastric Bypass	\$1500
Discectomy	\$1000	Lap Band	\$1000
Spinal Cord	\$2000	Craniotomy	\$3000

Stimulator			
Heart Bypass	\$3000	Heart Valve Repair/Replacement	\$3000
Angioplasty	\$1500		

If you choose to extend your stay for tourism purposes either before or after the procedure you are welcome to do so, but the Plan will not grant additional paid time off or pay lodging or per diem expenses for any portion of your stay that is for vacation, rather than medical, purposes. Any tourism portion of your stay will also be chargeable to your paid time off account and subject to your company's requirement for scheduling of paid time off.

Procedures that are not listed above may also qualify. In order to qualify for this special benefit, the procedure must meet certain criteria that are established by WorldMed Assist, including but not limited to the following:

- The procedure must be of a type covered under the Plan if provided locally. For example, cosmetic surgical procedures would not qualify, since they are not covered if provided locally. WorldMed Assist can assist you in arranging to have a non-covered service provided through its provider network, but there would not be any benefit payable under the Plan;
- The procedure must be "elective". An elective surgery is one that is non-emergency in nature and can be scheduled at the convenience of the patient;
- Your physician must certify that your health condition is such that you can safely travel to the treatment destination for the purpose of having the procedure performed; and
- The procedure must be available from providers who have been credentialed by WorldMed Assist and must be costly enough, if performed locally, for it to make economic sense to be performed through the Medical Travel benefit.

MEDICAL TRAVEL BENEFIT OFFERING

The Plan may elect, in its sole discretion, when acting on a basis that precludes individual selection, to discuss the Medical Travel Benefit. Discussing this Benefit shall be determined on a case-by-case basis, and the Plan's determination to provide the benefits in one instance shall not obligate the Plan to provide the same or similar alternative benefits for the same or any other Covered Person, nor shall it be deemed to waive the right of the Plan to strictly enforce the provisions of the Plan.

The Plan will provide guidance and information on available Medical Travel Benefits and by suggesting the Covered Person contact WorldMed Assist or suggest WorldMed Assist calls the Covered person. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to cover expenses included in the Medical Travel Benefit.

If you are interested in having a medical procedure performed through the Medical Travel benefit, please contact WorldMed Assist at **866-999-3848, ext. 740**

MEDICAL LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion - Elective abortion, unless the mother's life would be endangered if *the* Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Biofeedback - Biofeedback, recreational, or educational therapy, or other forms of self-care or self-help training or any related diagnostic testing.

Contraceptives - Medications, injections, implants, devices or the fitting of devices or any other services or supplies provided for birth control purposes.

Cosmetic Surgery, Etc. - Any surgery, service, drug or supply designed to improve the appearance of an Individual by alteration of a physical characteristic which is within the broad range of normal but which may be considered unpleasing or unsightly, except for care or treatment:

necessitated by an Accidental Injury;

which is incidental to or follows surgery for a Sickness, Including reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance. The Plan will also cover physical complications of all stages of a mastectomy, including lymphedemas. Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;

which is necessary to correct a congenital abnormality in covered Dependent child.

NOTE: Services or supplies to treat a complication of a cosmetic treatment or surgery are not covered.

Custodial & Maintenance Cars - Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Dental Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except *for* repair or prosthetic replacement of sound natural teeth which are damaged in an Accidental Injury and then limited to services rendered within twelve (12) months of the accident.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could **be** performed in an Outpatient setting.

Ecological or Environmental Medicine - Chelation or chelation therapy, orthomoiecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing or Training - Testing and/or training for educational purposes or to assist an Individual in pursuing a trade or occupation.

Training of a Covered Person for the development of skills needed to cope with an Accidental Injury or Sickness, except as may be expressly Included.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Foot Care, Routine - Routine and non-surgical foot care services and supplies including, but not limited to:

trimming or treatment of toenails;

foot massage;

treatment of corns, calluses, metatarsalgia or bunions;

treatment of weak, strained flat unstable or unbalanced feet;

orthopedic shoes (except when permanently attached to braces) or other appliances for support of the feet.

NOTE: This exclusion does not apply to Medically Necessary treatment of the feet (e.g., the removal of nail roots other podiatry surgeries, or foot care services necessary due to a metabolic or peripheral-vascular disease).

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders. However, this limitation will not apply when such services are determined to be Medically Necessary during a covered Pregnancy.

Hair Restoration - Any surgeries, treatments, drugs, services or supplies relating to baldness or hair loss, whether or not prescribed by a Physician.

Hearing Exams & Hearing Aids - Hearing exams, hearing aids or the fitting of hearing aids.

Holistic, Homeopathic or Naturopathic Medicine - Services, supplies, drugs or accommodations provided in connection with holistic, homeopathic or naturopathic treatment.

Hypnotherapy - Treatment by hypnotism.

Impotence - Penile prostheses or treatment of impotence.

Impregnation - Artificial Insemination, In-vitro fertilization, GIFT (Gamete Intrafallopian Transfer) or any type of artificial impregnation procedure, whether or not any such procedure is successful.

Infertility Testing or Treatment - Diagnostic tests or studies, or procedures, drugs or supplies to correct infertility or to restore or enhance fertility.

Learning & Behavioral Disorders - Except as noted, testing or treatment for learning or behavioral disorders, mental retardation, or autism.

NOTE: See "Attention Deficit Disorders (ADD & ADHD)" in the list of Eligible Medical Expenses for coverage information for such conditions

Maintenance Care - see 'Custodial & Maintenance Care "Nicotine Addiction see 'Smoking Cessation.'"

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician's written prescription - except as may be included in the Plan's prescription coverages.

Drugs for which there is a non-prescription equivalent available.

Not Medically Necessary / Not Physician Prescribed - Any services or supplies that are: (1) not Medically Necessary, and (2) not incurred on the advice of a Physician - unless expressly included herein

Inpatient room and board when hospitalization is for services that could have been performed safely on an Outpatient basis including, but not limited to: preliminary diagnostic tests, physical therapy, medical observation, treatment of chronic pain or convalescent or rest cure.

Orthognathic Surgery - Surgery to correct discrepancies In the relationship of the jaws

Personal Comfort or Convenience Items - Services or supplies that are primarily and customarily used for nonmedical purposes or are used for environmental control or enhancement (whether or not prescribed by a Physician) including but not limited to: (1) air conditioners, air purifiers, or vacuum cleaners, (2) motorized transportation equipment, escalators, elevators, ramps, (3) waterbeds or non-hospital adjustable beds, (4) hypoallergenic mattresses, pillows, blankets or mattress covers, (5) cervical pillows, (6) swimming pools, spas, whirlpools, exercise equipment, or gravity lumbar reduction chairs, (7) home blood pressure kits, (8) personal computers and related equipment, televisions, telephones or other similar items or equipment, (9) food liquidizers, or (10) structural changes to homes or autos.

Preventive or Routine Care - Routine exams, physicals or anything not ordered by a Physician or not Medically Necessary for treatment of Sickness, Accidental Injury or Pregnancy, except as may be specifically Included in the Medical Benefit Summary.

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, that are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of Eligible Medical Expenses.

Sex-Related Disorders - Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or Inadequacies Excluded services and supplies Include, but are not limited to: therapy or counseling, medications, implants, penile prosthesis, hormone therapy surgery, and other medical or psychiatric treatment.

Smoking Cessation - Smoking cessation programs or any other services or supplies intended to assist an individual to quit smoking.

TMJ / Jaw Joint Treatment - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

Tuberculosis - Treatment of pulmonary tuberculosis after diagnosis, except for surgery.

Vaccinations - Immunizations or vaccinations other than: (1) those included within the "Preventive Care*" coverages (see the Medical Benefit Summary), and (2) tetanus or rabies vaccinations administered In connection with an Accidental injury.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses.

Vision supplies (e g , eyeglasses or contact lenses) or their fitting, replacement, repair or adjustment Orthoptics, vision therapy, vision perception training, or other special vision procedures, including procedures whose purpose Is the correction of refractive error, such as radial keratotomy or laser surgery.

NOTE: This exclusion will not apply to: (1) services necessitated by a Sickness or Accidental Injury, or (2) the Initial purchase of glasses or contact lenses following cataract surgery.

Vitamins or Dietary Supplements - Prescription or non-prescription organic substances used for nutritional purposes.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

Weekend Admissions - Hospital expenses incurred on a weekend that coincides with admission between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless: (1) the admission occurs one day prior to a scheduled surgery, (2) the Covered Person is admitted on an emergency basis, or (3) the admission is for Pregnancy delivery.

Weight Control - Treatment of obesity or any programs, services, supplies or surgical procedures for weight control, including elective bariatric surgery.

Wigs or Wig Maintenance - see "Hair Restoration"

- (See also **General Exclusions** section) -

GENERAL EXCLUSIONS

The following exclusions apply to all health benefits and no benefits will be payable for:

Administrative Costs – Any charges that are solely for and/or applicable to administrative costs of completing claim forms or reports or for providing records wherever allowed by applicable law and/or regulation.

After the Termination Date – Any charges arising from care, supplies, treatment and/or service that are incurred by the Covered Person on or after the date coverage terminates, even if payments have been predetermined for a course of treatment submitted before the termination date, unless otherwise deemed to be covered in accordance with the terms of the Plan or applicable law and/or regulation.

Alcohol – Any charges arising from care, supplies, treatment and/or service that arise from a Covered Person taking part in any activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for Injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and expenses may be covered for Substance Abuse treatment as specified in this Plan, if applicable. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Court-Ordered Care, Confinement or Treatment – Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order, unless the confinement would have been covered in the absence of the court order.

Drugs In Testing Phases - Medicines or drugs that are in the Food and Drug Administration Phases I, II, or III testing, drugs that are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Excess – Any charges arising from care, supplies, treatment and/or service that are for charge(s) or portion of a charge or charges that exceed(s) Plan limits, set forth herein and including (but not limited to) the Maximum Allowable Charge. This shall include charges that are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, in the Plan Administrator's discretion and as determined by the Plan Administrator, in accordance with the Plan terms as set forth by and within this document.

Experimental / Investigational Treatment – Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are Experimental or Investigational.

Government – Services that the Covered Person obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Covered Person through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Covered Person to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

Government-Operated Facilities – Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where otherwise prohibited by law.

Hazardous Pursuit, Hobby or Activity – Services that are provided for an Injury or Sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered

Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm **including but not limited to:** hang gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

Illegal Acts – Charges that are for any Injury or Sickness which is Incurred while taking part or attempting to take part in an illegal activity, including but not limited to misdemeanors and felonies. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

OR

Illegal Acts – Charges that arise from or are caused during the commission of any illegal act for which the Covered Person could be incarcerated for any period of time. It is not necessary for an arrest to occur, charges to be filed, incarceration to occur, or a conviction to be had for this exclusion to apply. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions).

Illegal Drugs or Medications – Charges arising from care, supplies, treatment and/or services that are related to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

Incurred by Other Persons – Charges that are expenses actually Incurred by other persons.

Late-Filed Claims - Claims that are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Medical Necessity – Charges that are not Medically Necessary and/or arise from services and/or supplies that are not Medically Necessary.

Medicare – Services, supplies, and treatment that are provided, or which would have been provided had the Covered Person enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation.

Military Service - Conditions that are determined by the Veteran's Administration to be connected to active service in the military of the United States, except to the extent prohibited or modified by law.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

Negligence – Charges that are for Injuries resulting from negligence, misfeasance, malfeasance, nonfeasance or malpractice on the part of any caregiver, Institution, or Provider, as determined by the Plan Administrator, in its discretion, in light of applicable laws and evidence available to the Plan Administrator.

No Coverage – Charges that are Incurred at a time when no coverage is in force for the applicable Covered Person and/or Dependent.

No Legal Obligation – Charges that are for services provided to a Covered Person for which the Provider of a service does not and/or would not customarily render a direct charge, or charges Incurred for which the

Covered Person or Plan has no legal obligation to pay, or for which no charges would be made in the absence of this coverage, including but not limited to charges for services not actually rendered, fees, care, supplies, or services for which a person, company or any other entity except the Covered Person or the Plan, may be liable for necessitating the fees, care, supplies, or services.

Non-Prescription Drugs – Expenses that are for drugs for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician’s written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription drug must be covered under Preventive Care, subject to the Patient Protection and Affordable Care Act.

Not Acceptable – Charges that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

Not Specified As Covered – Charges for care, services, and supplies that are not specified as covered under any provision of this Plan.

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit; If you are covered as a Dependent under this Plan and you are self-employed or employed by an Employer that does not provide health benefits, make sure that you have other medical benefits to provide for your medical care in the event that you are hurt on the job. In most cases workers compensation insurance will cover your costs, but if you do not have such coverage you may end up with no coverage at all;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers’ compensation or another form of occupational Injury medical coverage is available;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers’ compensation or another form of occupational Injury medical coverage may be available;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where workers’ compensation or another form of occupational Injury medical coverage is available or would have been available had the Covered Person sought to obtain it in accordance with applicable rules and/or procedures;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where the Covered Person’s Employer/volunteer organization has failed to obtain such coverage required by law;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where the Covered Person waived his/her rights to such coverage or benefits;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where the Covered Person fails to file a claim within the filing period allowed by law for such benefits;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where the Covered Person fails to comply with any other provision of the law to obtain such coverage or benefits;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where the Covered Person is permitted to elect not to be covered by Workers' Compensation but failed to properly make such election effective;

OR

Occupational – Charges that are for any condition, Illness, Injury or complication thereof arising out of or in the course of employment, including self-employment, or an activity for wage or profit where the Covered Person is permitted to elect not to be covered by Workers' Compensation and has affirmatively made that election.

Other Coverage - Services or supplies for which a Covered Person Is entitled (or could have been entitled if proper application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof) However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer mutual benefit association, labor union, trustees or similar person(s) or group.

Other than Attending Physician – Charges that are other than those certified by a Physician who is attending the Covered Person as being required for the treatment of Injury or Disease, and performed by an appropriate Provider.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges that may occur in the transmittal of information to the Contract Administrator Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the terms of the document that this Benefit Document replaces.

Prior to Effective Date - Charges incurred prior to an Individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

Professional (and Semi-Professional) Athletics (Injury/Illness) - Charges that are in connection with any Injury or Illness arising out of or in the course of any employment for wage or profit; or related to professional or semi-professional athletics, including practice.

Prohibited by Law – Expenses that are to the extent that payment under this Plan is prohibited by law.

Provider Error – Charges that are required as a result of unreasonable Provider error.

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Sales Tax, Etc. - Sales or other taxes or charges Imposed by any government or entity However, this exclusion will not apply to surcharges required by the New York Health Care Reform Act of 1996 (or as later amended) or similar surcharges imposed by other states.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted Injury or voluntary attempted self-destruction, except that, this exclusion will not apply where such self-inflicted injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e g , depression).

Subrogation, Reimbursement, and/or Third Party Responsibility - Charges that are for an Illness, Injury or Sickness not payable by virtue of the Plan's subrogation, reimbursement, and/or third party responsibility provisions.

Telecommunications - Advice or consultation given by or through any form of telecommunication.

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included.

Unreasonable. Charges that are not "Reasonable;" and are required to treat Illness or Injuries arising from and due to a Provider's error, wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).

War/Riot- Health conditions that Incurred as a result of war or any act of war, whether declared or undeclared, or any act of aggression by any country, including rebellion or riot, when the Covered Person is a member of the armed forces of any country, or during service by a Covered Person in the armed forces of any country, or voluntary participation in a riot. This exclusion does not apply to any Covered Person who is not a member of the armed forces, and does not apply to victims of any act of war or aggression.

Work-Related Conditions - Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose, whether or not a claim is made for such benefits. If the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

ELIGIBILITY AND EFFECTIVE DATES

Coverage Options

An eligible retiree can select either the benefit schedule that applies to active Employees and their Dependents (i.e., the **Medical Benefit Summary EPO**) or the **Medical Benefit Summary - Alternative Retiree Option**.

An eligible retiree is also permitted to transfer to another Plan coverage option if he obtains a new Dependent or if a Dependent has other coverage and then loses such coverage. Upon that event, the Employee and Dependent may together enroll in another option under the Plan.

Eligibility Requirements - Employees

To participate in the Plan coverages as an "Employee" an individual must be:

in full-time active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and regularly scheduled to work at least forty (40) hours per week; or

an Employee in active employment and working on a modified work schedule of thirty-two (32) hours per week, as detailed in a signed agreement; or

an elected official.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining eligibility.

NOTE: An eligible Employee does not include one who is eligible for Medicare by reason of age and who has elected Medicare coverage in lieu of Plan coverage.

Effective Date - Employees

An Employee's coverage is effective, subject to timely enrollment, upon completion of a waiting period to the first of the month following thirty (30) days in an eligible status.

If an Employee fails to enroll within thirty-one (31) days after completion of the waiting period, his coverage can become effective only in accordance with *the* "Late Enrollment/Re-Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents

Except as noted at the end of this provision, an eligible Dependent of an Employee is:

a spouse of the opposite sex. The marriage must meet all requirements of a valid marriage contract between a man and a woman in the Employee's state of residence;

a registered domestic partner when the partner and Employee have registered their domestic partnership with the Secretary of State of the State of California. The State of California permits state registration of: (1) same-sex domestic partnerships, and (2) opposite-sex partnerships after one

partner attains age 62. A domestic partnership registration from outside of California will be recognized on the same basis as a California state-registered domestic partnership only if the out-of-California partnership is a legal union of two persons, other than a marriage, and is substantially equivalent to a registered California domestic partnership. This applies regardless of whether it bears the name 'domestic partnership'. Domestic partners who register only with their cities, counties or employers are not eligible;

children who are under age 26 (i.e. a child is eligible through age 25). A child need not (1) reside with the Employee or any other person, (2) be a student, (3) be a tax-code dependent of the Employee, (4) be unmarried, or (5) be unemployed. Financial dependency upon the Employee or any other person is not a criteria for eligibility.

An eligible "child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a child of an Employee's domestic partner, a legally adopted child, a child who is placed with the Employee for legal adoption, a foster child or a child under the court-appointed guardianship of the Employee).

An eligible child will also include: (1) an Employee's grandchild if the child meets the following criteria: (a) has continuously lived with the Employee for at least the immediate twelve consecutive months prior to enrollment, (b) no natural parent of the child resides with the Employee at any time during that 12-month period, (c) there is an absence of support of the child from any natural parent, and (d) the Employee claims the grandchild as a dependent for Federal Income Tax purposes, and (2) a child for whom Plan coverage is required due to a Medical Child Support Order (MCSO) that the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (that are incorporated herein by reference and that can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and that satisfies the QMCSO requirements of ERISA (section 609(a)). A child whose coverage is subject to a court order need not be a Tax Code dependent of an Employee.

The Plan will provide coverage for an adult Dependent child if the child is not eligible to enroll in another employer-sponsored plan, except for coverage under a parent's plan.

NOTES: An eligible Dependent does not include:

a spouse following legal separation or a final decree of dissolution of marriage or divorce (including any children of the spouse who were eligible only because of the marriage);

a spouse who is eligible for Medicare coverage by reason of age and who has elected Medicare coverage in lieu of Plan coverage;

a domestic partner following the filing of a Notice of Termination of Domestic Partnership with the Secretary of State of the State of California. The termination of a domestic partnership will be treated as equivalent to a divorce between a husband and wife;

any person who is on active duty in any military service, to the extent permitted by law.

See the **Extensions of Coverage** section for instances when these eligibility requirements may be waived or modified.

Eligibility for Medicaid or the receipt of Medicaid benefits will not be taken into account in determining a Dependent's eligibility.

Effective Date - Dependents

A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date (see the "Special Enrollment Rights ." provision for details as well as instances when the loss of

other coverage and other circumstances can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the "Late Enrollment/Re-Enrollment" provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Special Enrollment Rights & Mid-Year Election Change Allowances

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when first eligible, will be allowed to apply for coverage under the Plan at a later date if:

the was covered under another group health plan or other health insurance coverage (including Medicaid or a State Children's Health Insurance Plan (CHIP)) at the time coverage was initially offered or previously available to him. "Health Insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;

the Employee stated in writing at the time Initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement;

the individual lost the other coverage as a result of a certain event and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage (and, on or after April 1, 2009, within sixty (60) days with regard to Medicaid or CHIP - see last sub-entry below) A loss of coverage event Includes but Is not limited to:

- loss of eligibility as a result of legal separation, divorce, cessation of dependent status, death of an employee, termination of employment, reduction in the number of hours of employment, and any loss of eligibility for coverage after a period that Is measured by reference to any of the foregoing;
- loss of eligibility when coverage is offered through an HMO or other arrangement in the Individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area (whether or not within the choice of the individual);
- loss of eligibility when coverage is offered through an HMO or other arrangement in the group market that does not provide benefits to individuals who no longer reside, live or work in a service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;
- loss of eligibility when an individual Incurs a claim that would meet or exceed a lifetime limit on all benefits An Individual has a special enrollment right when a claim that would exceed a lifetime limit on all benefits Is incurred, and the right continues at least until thirty (30) days after the earliest date that a claim Is denied due to the operation of the lifetime limit;
- loss of eligibility when a plan no longer offers any benefits to a class of similarly situated Individuals For example, if a plan terminates health coverage for all part-time workers, the part-time workers incur a loss of eligibility, even if the plan continues to provide coverage to other employees;
- loss of eligibility when employer contributions toward an employee's or dependent's coverage terminates. This is the case even If an individual continues the other coverage by paying the amount previously paid by the employer;
- loss of eligibility when COBRA continuation coverage is exhausted; and

- on or after April 1, 2009, loss of eligibility under Medicaid or the Children's Health Insurance Program (CHIP) or the date the Individual becomes eligible for State premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

Additional clarifications - Even if an individual initially declines Plan coverage and has no other coverage, loss of other coverage can create a special enrollment right under the Plan. The law requires that an individual must have other health coverage when Plan coverage was previously declined, as opposed to initially declined. An individual who initially chose not to enroll, in spite of having no other health coverage, might later have a special enrollment right if, after he subsequently enrolls in other coverage. He has an opportunity for late enrollment or special enrollment under the Plan and again chooses not to enroll. A later loss of the other coverage would trigger a special enrollment right.

Individuals who enroll during a special enrollment period must generally be treated the same as Individuals who enroll when first eligible. Special enrollees must be offered all the same benefit packages, cannot be required to pay more for coverage.

NOTES: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Loss of Medicaid coverage does not create a special enrollment right.

Late Enrollment / Re-Enrollment

If an individual does not enroll when he is first eligible or if he allows coverage to lapse but later applies for coverage, then Plan coverage will be effective twelve (12) months from the date application for coverage is received.

NOTE: See "Special Enrollment Rights" for exceptions to this provision.

Reinstatement / Rehire

If an Employee is rehired or returns to an eligible status after termination of Plan coverage due to reduction in hours or voluntary resignation, and completes the necessary enrollment form, such Employee (and any of his Dependents who were covered at point of termination) will have coverage become effective on the first day of the month following thirty (30) days of full-time employment. There will be no additional waiting period or time required for pre-existing conditions and coverage will resume based on the Individual's prior status under the Plan.

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave Employee discontinued paying his share of the cost of coverage, such Employee may have coverage reinstated as if there had been no lapse (for himself and any Dependents who were covered at the point contributions ceased). To avoid interruption of coverage during the leave, the Plan Sponsor will have the right to keep coverage in force at its own expense and can require that unpaid coverage contribution costs be repaid by the Employee at the end of the FMLA leave.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage hereunder immediately upon returning from military service. See "Extension of Coverage During U.S Military Service" in the Extensions of Coverage section for more information.

If an Employee or Dependent returns to an eligible status after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of

the COBRA Continuation Coverage, such person will be reinstated to active status and will have uninterrupted coverage hereunder.

NOTES: Except in the above Instances, any terminated Employee who is rehired will be treated as a new hire and will be required to satisfy all eligibility and enrollment requirements.

Benefits for any Employee or Dependent who is covered hereunder, whose employment or coverage is terminated, and who is subsequently rehired or reinstated at any time, shall be limited to the maximum benefits that would have been payable had there been no interruption of employment or coverage.

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 transferred coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.

If a Covered Person changes status from Employee to Dependent or vice versa, and the person remains eligible and covered without interruption, then Plan benefits will not be affected by the person's change in status.

TERMINATION OF COVERAGE

Employee Coverage Termination

An Employee's coverage under the Plan will terminate upon the earliest of the following:

termination of the Plan or termination of the Plan benefits as described herein; Employee's

termination of eligibility or termination of employment;

Employee's election to terminate participation, unless prohibited by law (i.e., when election changes cannot be made due to IRC section 125 "change in statute guidelines");

the date the Employee begins active duty service in the armed services of any country or organization, except for reserve duty of less than thirty (30) days. See the "Extension of Coverage During U.S. Military Service." In the **Extensions of Coverage** section for more information;

at midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer, ceases to be eligible, or ceases to be engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates section** - except when coverage is extended under the terms of any **Extension of Coverage** provision;

for medical benefits, the date the Employee becomes covered under another group medical plan offered by the Employee,

the date the Employee dies.

See also "**Termination for Fraud**" at the end of the **General Plan Information** section.

NOTES: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

An Employee otherwise eligible and validly enrolled under the Plan shall not be terminated from the Plan solely due to his health status or need for health services.

Dependent Coverage Termination

Except as noted, a Dependent's coverage will terminate upon the earliest of the following:

termination of the Plan or these Plan benefits or discontinuance of Dependent coverage hereunder;

termination of the coverage of the Employee;

the date the Dependent enters the military, naval or air force of any country or international organization;

at midnight of the last day the Dependent meets the eligibility requirements of these Plan benefits, except when coverage is extended under the **Extensions of Coverage** section. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee;

on the date the Employee requests that Dependent coverage be terminated or at the end 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 (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must

provide proof that the child support order is no longer In effect or that the Dependent has comparable replacement coverage that is in effect or will take effect immediately upon termination.

See also "Termination for Fraud" at the end of the **General Plan Information** section.

NOTE: A Dependent otherwise eligible and validly enrolled hereunder shall not be terminated solely due to his health status or need for health services.

- (See **COBRA Continuation Coverage**) -

EXTENSIONS OF COVERAGE

Coverage may be continued beyond the Termination of Coverage date in the circumstances identified below. Unless expressly stated otherwise, however, coverage will not extend: (1) beyond the date the Plan is terminated, and (2) for a Dependent, beyond the date the Employees coverage ceases.

Extension of Coverage for Handicapped, Retarded or Disabled Dependent Children

If art already covered Dependent child is incapable of self-sustaining employment by reason of mental retardation, disability or physical handicap, and:

such condition commenced on or before the child attained an age that would otherwise terminate his eligibility;

the child's condition has been diagnosed by a Physician as a permanent or long-term dysfunction or condition; and

such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will continue, Irrespective of his attaining a limiting age, so long as he remains in such condition, and otherwise conforms to the definition of "Dependent. "

The Employee must submit proof of the child's incapacity to the Plan Administrator within thirty-one (31) days of the child's attainment of a limiting age, or as may reasonably be required, but not more frequently than once a year.

Extensions of Coverage During Absence From Work

If an Employee falls to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, or is eligible for an extension required by law, etc), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis.

Except where the Family and Medical Leave Act (FMLA) may apply, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

on the date coverage terminates as specified In the Employer's written personnel policies and employee communications Such documents are Incorporated herein by reference;

the end of the period for which the last contribution was paid, if such contribution is required; the

date of termination of the Plan or these benefits of the Plan.

To the extent that the Employer is subject to the Family and Medical Leave Act of 1993 (FMLA), it intends to comply with the Act. The Employer is subject to FMLA If it Is engaged in commerce or in any Industry or activity affecting commerce and employs fifty (50) or more employees for each working day during each of twenty (20) or more calendar workweeks in the current or preceding Calendar Year.

In accordance with the FMLA, an Employee Is entitled to continued coverage if he: (1) has worked for the Employer for at least twelve months, (2) has worked at least 1,250 hours in the year preceding the start of the leave, and (3) Is employed at a worksite where the Employer employs at least fifty employees within a 75-mile radius.

Except as noted, continued coverage under the FMLA Is allowed for up to 12 workweeks of unpaid leave in any 12-month period. Such leave must be for one or more of the following reasons:

the birth of an Employee's child and in order to care for the child;

the placement of a child with the Employee for adoption or foster care;

to care for a spouse, child or parent of the Employee where such relative has a serious health condition;

Employee's own serious health condition that makes him/her unable to perform the functions of his or her job;

the Employee has a "qualifying exigency" (as defined by DOL regulations) arising because the Employee's spouse, son, daughter or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation (a specified military operation).

Plan benefits may be maintained during an FMLA leave at the levels and under the conditions that would have been present if employment was continuous. The above is a summary of FMLA requirements. An Employee can obtain a more complete description of his FMLA rights from the Plan Sponsor's Human Resources or Personnel department. Any Plan provisions which are found to conflict with FMLA are modified to comply with at least the minimum requirements of the Act.

NOTE: An eligible Employee will be entitled to take up to a combined total of 26 workweeks of FMLA leave during a single 12-month period where the Employee is a spouse, son, daughter, parent or next of kin (i.e., nearest blood relative) of a covered servicemember. A covered servicemember is a member of the Armed Forces (including the National Guard or Reserves) who is undergoing medical treatment, recuperation, or therapy, is an outpatient, or is on the temporary disability retired list, for a "serious injury or illness" (an injury or illness incurred in line of duty on active duty in the Armed Forces that may render the servicemember medically unfit to perform his or her duties).

Extension of Coverage During U.S. Military Service

Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee entering military service.

An Employee who is ordered to active military service is (and the Employee's eligible Dependent(s) are) considered to have experienced a COBRA qualifying event. The affected persons have the right to elect continuation of coverage under either USERRA or COBRA. Under either option, the Employee retains the right to re-enroll in the Plan in accordance with the stipulations set forth herein.

Notice Requirements - To be protected by USERRA and to continue health coverage, an Employee must generally provide the Employer with advance notice of his military service. Notice may be written or oral, or may be given by an appropriate officer of the military branch in which the Employee will be serving. Notice will not be required to the extent that military necessity prevents the giving of notice or if the giving of notice is otherwise impossible or unreasonable under the relevant circumstances. If the Employee's ability to give advance notice was impossible, unreasonable or precluded by military necessity, then the Employee may elect to continue coverage at the first available moment and the Employee will be retroactively reinstated in the Plan to the last day of active employment before leaving for active military service. The Employee will be responsible for payment of all back premiums from date of termination of Plan coverage. No administrative or reinstatement charges will be imposed.

If the Employee provides the Employer with advance notice of his military service but fails to elect continuation of coverage under USERRA, the Plan Administrator will continue coverage for the first thirty (30) days after Employee's departure from employment due to active military service. The Plan Administrator will terminate coverage if Employee's notice to elect coverage is not received by the end of the 30-day period. If the Employee subsequently elects to continue coverage while on active military service and within the time set forth in the subsection entitled 'Maximum Period of Coverage' below, then the Employee will be retroactively reinstated in the Plan as of the last day of active employment before

leaving for active military service. The Employee will be responsible for payment of all back premium charges from the date Plan coverage terminated.

Cost of USERRA Continuation Coverage - The Employee must pay the cost of coverage (herein "premium"). The premium may not exceed 102% of the actual cost of coverage, and may not exceed the active Employee cost share if the military leave is less than 31 days. If the Employee falls to make timely payment within the same time period applicable to those enrollees of the plan continuing coverage under COBRA, the Plan Administrator will terminate the Employee's coverage at the end of the month for which the last premium payment was made. If the Employee applies for reinstatement to the Plan while still on active military service and otherwise meets the requirements of the Plan and of USERRA, the Plan Administrator will reinstate the Employee to Plan coverage retroactive to the last day premium was paid. The Employee will be responsible for payment of all back premium charges owed.

Maximum Period of Coverage - The maximum period of USERRA continuation coverage following Employee's cessation of active employment is the lesser of:

24 months; or

the duration of Employee's active military service.

Reinstatement of Coverage Following Active Duty - Regardless of whether an employee elects continuation coverage under USERRA, coverage will be reinstated on the first day the employee returns to active employment if the employee was released under honorable conditions.

An employee returning from military leave must notify their employer of their intent to return to work. Notification (application for reemployment) must be made:

within 14 days after active military service ceases for military leave of 31-180 days; or

within 90 days of completion of military service for military leave of more than 180 days

No reemployment application is required if the military leave is less than 31 days. In that case, generally the employee need only report for work on the next regularly scheduled workday after a reasonable period for travel and rest. Uniformed Service members who are unable to report back to work because they are in the hospital or recovering from an injury or illness suffered during active duty have up to two (2) years to apply for reemployment.

When coverage hereunder is reinstated, all provisions and limitations of the Plan will apply to the extent that they would have applied if the employee had not taken military leave and coverage had been continuous. No waiting period can be imposed on a returning employee or Dependents if these exclusions would have been satisfied had the coverage not been terminated due to the order to active military service.

Extension of Coverage for Retirees

If an Employee retires from active service with the Employer and has completed at least ten (10) years of service for the Employer, he (and eligible Dependents who were covered immediately prior to Employee's date of retirement) may continue to participate in the Plan until the retiree reaches age 65 or becomes Medicare eligible or eligible for another group plan. A Dependent's coverage will continue only while the Dependent continues to meet the Dependent eligibility requirements and will not extend beyond the date the retiree reaches age 65, becomes Medicare eligible or eligible for another group plan.

Retirees will be required to contribute to the Plan at rates determined by the Plan Sponsor. Contributions must be kept current in order for coverage to remain in effect. The requirements for timely payment are the same as those applied to COBRA participants.

An eligible retiree can select either the medical benefits that apply to active Employees (see the **Medical Benefit Summary — EPO**) or the **Alternative Retiree Option**. A retiree can, however, change his election during an "open enrollment" that will be held annually by the Plan Sponsor.

NOTE: Only those individuals who were covered hereunder on the day immediately prior to the Employee's retirement will be eligible for continued coverage under the terms of this provision, except that HIPAA's special enrollment rights will extend to retirees who acquire new Dependents. Also, this Plan will be secondary to Medicare for any such individuals who are eligible for Medicare - see **Coordination of Benefits** section for more information.

Extension of Coverage for Survivors

If an Employee dies while covered under the Plan, any Dependent of that Employee who is covered at the time of the Employee's death may continue coverage under the Plan until the earliest of the following dates. The Dependent will not be required to pay the cost of coverage during this extension:

the last day of the 12th month following Employee's death; the date of remarriage of the surviving spouse if any;

the date the Dependent ceases to qualify as a Dependent for a reason other than lack of primary support by the Employee; or

the date the Plan terminates.

This extension of coverage will not be considered part of the COBRA period COBRA benefits will be offered after this extended benefit period has expired.

- (See **COBRA Continuation Coverage**) -

COORDINATION OF BENEFITS (COB)

Benefits Subject to This Provision

This following shall apply to the entirety of the Plan and all benefits described therein.

Excess Insurance

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage.

The Plan's benefits will be excess to, whenever possible:

Any primary payer besides the Plan;

Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

Any policy of insurance from any insurance company or guarantor of a third party;

Workers' compensation or other liability insurance company; or

Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Vehicle Limitation

When medical payments are available under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy Deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification.

Allowable Expenses

"Allowable Expenses" shall mean the Usual and Customary charge for any Medically Necessary, Reasonable, and eligible item of expense, at least a portion of which is covered under a plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

"Claim Determination Period"

"Claim Determination Period" shall mean each Calendar Year.

EFFECT ON BENEFITS

Application to Benefit Determinations

The plan that pays first according to the rules in the section entitled "Order of Benefit Determination" will pay as if there were no Other Plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total Allowable Expenses. When there is a conflict in the rules, this Plan will never pay more than 50% of Allowable Expenses when paying secondary. Benefits will be coordinated on the basis of a Claim Determination Period.

When medical payments are available under automobile insurance, this Plan will pay excess benefits only, without reimbursement for automobile plan Deductibles. This Plan will always be considered the secondary carrier regardless of the individual's election under personal injury protection (PIP) coverage with the automobile insurance carrier.

In certain instances, the benefits of the Other Plan will be ignored for the purposes of determining the benefits under this Plan. This is the case when:

The Other Plan would, according to its rules, determine its benefits after the benefits of this Plan have been determined; and

The rules in the section entitled "Order of Benefit Determination" would require this Plan to determine its benefits before the Other Plan.

Order of Benefit Determination

For the purposes of the section entitled "Application to Benefit Determinations," the rules establishing the order of benefit determination are:

A plan without a coordinating provision will always be the primary plan;

The benefits of a plan which covers the person on whose expenses claim is based, other than as a Dependent, shall be determined before the benefits of a plan which covers such person as a Dependent;

If the person for whom claim is made is a Dependent Child covered under both parents' plans, the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year will be primary, except:

When the parents are separated or divorced, and the parent with the custody of the Child has not remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody will be determined before the benefits of a plan which covers the Child as a Dependent of the parent without custody; or

When the parents are divorced and the parent with custody of the Child has remarried, the benefits of a plan which covers the Child as a Dependent of the parent with custody shall be determined before the benefits of a plan which covers that Child as a Dependent of the stepparent, and the benefits of a plan which covers that Child as a Dependent of the stepparent will be determined before the benefits of a plan which covers that Child as a Dependent of the parent without custody.

Notwithstanding the above, if there is a court decree which would otherwise establish financial responsibility for the Child's health care expenses, the benefits of the plan which covers the Child as a Dependent of the parent with such financial responsibility shall be determined before the benefits of any Other Plan which covers the Child as a Dependent Child; and

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.

Right to Receive and Release Necessary Information

The Plan Administrator may, without notice to or consent of any person, release to or obtain any information from any insurance company or other organization or individual any information regarding coverage, expenses, and benefits which the Plan Administrator, at its sole discretion, considers necessary to determine, implement and apply the terms of this provisions or any provision of similar purpose of any Other Plan. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as requested and as may be necessary to implement this provision.

Facility of Payment

A payment made under any Other Plan may include an amount that should have been paid under this Plan. The Plan Administrator may, in its sole discretion, pay an amount pay any organizations making

such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Any such amount paid under this provision shall be deemed to be benefits paid under this Plan. The Plan Administrator will not have to pay such amount again and this Plan shall be fully discharged from liability.

Right of Recovery

In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the Maximum Amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Covered Person or his or her Dependents. Please see the Recovery of Payments provision above for more details.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the plan may seek reimbursement.

SUBROGATION

As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person(s) fails to file a claim or pursue damages against:

The responsible party, its insurer, or any other source on behalf of that party;

Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

Any policy of insurance from any insurance company or guarantor of a third party;

Workers' compensation or other liability insurance company; or

Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

RIGHT OF REIMBURSEMENT

The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

EXCESS INSURANCE

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to:

The responsible party, its insurer, or any other source on behalf of that party;

Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

Any policy of insurance from any insurance company or guarantor of a third party;

Workers' compensation or other liability insurance company; or

Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

SEPARATION OF FUNDS

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

OBLIGATIONS

It is the Covered Person's/Covered Persons' obligation at all times, both prior to and after payment of medical benefits by the Plan:

To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.

If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).

The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

OFFSET

If timely repayment is not made, or the Covered Person and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan.

MINOR STATUS

In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

LANGUAGE INTERPRETATION

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

SEVERABILITY

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

CLAIMS PROCEDURES

SUBMITTING A CLAIM

A claim is a request for a benefit determination that is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organization unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of health claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

- 1) A Pre-Service Claim is where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care. See the **Utilization Management Program** section for that information.

Important: A Pre-Service Claim is only for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A determination on a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

- 2) A Post-Service Claim is a written request for benefit determination after a service has been rendered and expense has been incurred, A Post-Service Claim must be submitted to the claims office within fifteen (15) months from the date expense is incurred unless the Claimant is legally incapable of doing so

A Post-Service Claim should be submitted to:

**CBA Administrators
4704 West Jennifer Avenue, Suite 104
Fresno, CA 93722**

If Eligible Expenses are incurred outside of the United States, conversion of claims to U.S. currency is the responsibility of the Claimant when filing the claim. Charges Incurred outside of the United States are not covered if the Covered Person traveled to such a location for the primary purpose of obtaining such services, drugs or supplies.

NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary

ASSIGNMENTS TO PROVIDERS

All Eligible Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action that he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances that apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
<p>Urgent Claim - defined below</p> <p>Claimant Makes An Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p>	<p>Within not more than 24 hours (and as soon as possible considering the urgency of the medical situation), Plan notifies Claimant of information needed to complete the claim request. Notification may be oral unless Claimant requests a written notice.</p> <p>Plan notifies the Claimant, in writing or electronically, or its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the information, or (2) the period of time Claimant was allowed to provide the completing information.</p> <p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), Plan response with written or electronic benefit determination.</p> <p>See "Appeals Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.</p>

<p>Plan Responds To Appeal</p> <p>An “urgent claim” is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant’s life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant’s condition, severe pain that could not be adequately managed without the care or treatment being claimed.</p> <p>Where the “Time Limit or Allowance” stated above reflects “or sooner if possible,” this phrase means that an earlier response may be required, considering the urgency of the medical situation.</p>	<p>Within not more than 72 hours (and as soon as possible considering the urgency of the medical situation), after receipt of Claimant’s appeal.</p>
<p>Concurrent Care Claim- defined below</p> <p>Plan Wants to Reduce or Terminate Already Approved Care</p> <p>Claimant Requests Extension for Urgent Care</p> <p>A “concurrent care claim” is a Claimant’s request to extend a previously approved and ongoing course of treatment beyond the approved period of time or number of treatments. A decision to reduce or terminate benefits already approved does not include a benefit reduction or denial due to Plan amendment or termination.</p>	<p>Plan notifies Claimant of intent to reduce or deny benefits <u>before</u> any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a response to the appeal before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care that is Medically Necessary, is subject to the urgent claim rules.</p> <p>Plan notifies Claimant of its benefit determination within 24 hours after receipt of the request (and as soon as possible considering the urgency of the medical situation), provided the Claimant requests to extend the course of the treatment at least 24 hours prior to the expiration of the previously approved period of time or treatment.</p>
<p>Non-Urgent Claim</p> <p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p>	<p>Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of information needed to complete the claim request Claimant may request written notification.</p> <p>Plan responds with written or electronic benefit determination within 15 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant – see definition of “full notice” below.</p>

<p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p>	<p>Within 15 days, Plan responds with written or electronic benefit determination 15 additional days may be allowed with full notice to Claimant – see definition of “full notice” below.</p> <p>See “Appeal Procedures” subsection</p> <p>Within 30 days after receipt of appeal (or where Plan requires 2 mandatory levels of appeal, within 15 days for each appeal).</p>
<p>“Full notice” means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15 day period.</p>	
<p>"POST-SERVICE" CLAIM ACTIVITY</p>	<p>TIME LIMIT OR ALLOWANCE</p>
<p>Claimant Makes Initial <u>Incomplete</u> Claim Request</p> <p>Plan Receives <u>Completing</u> Information</p> <p>Claimant Makes Initial <u>Complete</u> Claim Request</p> <p>Claimant Appeals</p> <p>Plan Responds to Appeal</p>	<p>Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request.</p> <p>Plan approved or denies claim within 30 days, minus the number of days under review before additional information was requested. 15 additional days may be allowed with full notice to Claimant – see definition of “full notice” below.</p> <p>Within 30 days of receiving the claim, Plan approved or denies claim. 15 additional days may be allowed with full notice to Claimant – see definition of “full notice” below.</p> <p>See “Appeal Procedures” subsection</p> <p>Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).</p>
<p>“Full notice” means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30 day of 60 day period.</p>	

CLAIMS DENIALS

If a claim is wholly or partially denied, the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances " The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

the specific reason(s) for the decision to reduce or deny benefits:

specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols that were relied upon in making the decision;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;

a description of any additional information needed to change the decision and an explanation of why it is needed;

a description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA.

APPEAL PROCEDURES

Filing an Appeal

Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker and he may submit new information (e.g. comments, documents and records) in support of his appeal. A Claimant may not take legal action on a denied claim until he has exhausted the Plan's mandatory (i.e., non-voluntary) appeal procedures - see NOTE.

In response to his appeal, the Claimant is entitled to a full and fair review of the claim and a new decision. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits.

NOTE: The Plan will not require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both will be completed within the time frame applicable to one (1) level.

Decision on Appeal

A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances"

The decision on appeal will be in writing or by electronic notification. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

the specific reason(s) for the decision;

reference to the pertinent Plan provisions on which the decision is based;

a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim;

identification of and access to any guidelines, rules, protocols that were relied upon in making the decision;

a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental injury - Any accidental bodily injury that is caused by external forces under unexpected circumstances and that is not excluded due to being employment-related (see General Exclusions section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Allowable Expenses – Any Usual and Customary charge for any Medically Necessary, Reasonable, and eligible items of expense, at least a portion of which is covered under a Plan. When some Other Plan pays first in accordance with the Application to Benefit Determinations Section, this Plan's Allowable Expenses shall in no event exceed the Other Plan's Allowable Expenses. When some Other Plan provides benefits in the form of services instead of cash payments, the reasonable cash value of each service rendered, in the amount that would be payable in accordance with the terms of the Plan, shall be deemed to be the benefit. Benefits payable under any Other Plan include the benefits that would have been payable had claim been duly made therefore.

Ambulatory Surgical Center - Any public or private establishment that:

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

has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;

provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and

does not provide services or other accommodations for patients to stay overnight.

Benefit Document - A document that describes one or more benefits of the Plan.

Birthing Center - A special room in a Hospital that exists to provide delivery and pre-natal and post-natal care with minimum medical intervention or a free-standing Outpatient 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;

provides birth services by or under the direction of a Physician specializing in obstetrics and gynecology;

has 24-hour-a-day registered nursing services;

maintains daily clinical records.

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 succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any Covered Person on whose behalf a claim is submitted for Plan benefits.

Clean Claim - A Clean Claim is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A defect or impropriety shall include a lack of required sustaining documentation as set forth and in accordance with this document, or a particular circumstance requiring special treatment which prevents timely payment as set forth in this document, and only as permitted by this document, from being made. A Clean Claim does not include claims under investigation for fraud and abuse or claims under review for Medical Necessity and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being Covered Expenses in accordance with the terms of this document.

Filing a Clean Claim. A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The Plan Administrator may require attachments or other information in addition to these standard forms (as noted elsewhere in this document and at other times prior to claim submittal) to ensure charges constitute Covered Expenses as defined by and in accordance with the terms of this document. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Covered Person has failed to submit required forms or additional information to the Plan as well.

Contract Administrator - A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (i.e., processing of claims for payment) in accordance with the terms and conditions of the Benefit Document and an administration agreement between the Contract Administrator and the Plan Sponsor.

The Contract Administrator is not a fiduciary of the Plan and does not exercise any discretionary authority with regard to the Plan. The Contract Administrator is not an insurer of Plan benefits, is not responsible for Plan financing and does not guarantee the availability of benefits hereunder.

Convalescent Hospital - see "Skilled Nursing Facility".

Covered Expense(s) – A Covered Expense means a Usual and Customary fee for, and/or, a Reasonable, Medically Necessary service, treatment or supply, meant to improve a condition or Covered Person's health, which is eligible for coverage under this Plan. Covered Expenses will be determined based upon all other Plan provisions. When more than one treatment option is available, and one option is no more effective than another, the Covered Expense is the least costly option that is no less effective than any other option.

All treatment is subject to benefit payment maximums shown in the Summary of Benefits and as determined elsewhere in this document.

Covered Person - An individual who meets the eligibility requirements as contained herein (i.e., a covered Employee, a covered Dependent, or a Qualified Beneficiary (COBRA)) See Eligibility and Effective Dates, Extensions of Coverage and the COBRA Continuation Coverage sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - An individual who is:

licensed to perform certain health care services that are covered hereunder and who is acting within the scope of his license; or

in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;

and who is a/an:

Acupuncturist (CA);
Audiologist;
Certified or Registered Nurse Midwife;
Certified Registered Nurse Anesthetist (CRNA);
Chiropractor (DC);
Dental Technician;
Dentist (DDS or DMD);
Dietician;
Licensed Clinical Psychologist (PhD or EdD);
Licensed Clinical Social Worker (LCSW);
Licensed Practical Nurse (LPN);
Licensed Psychiatric Nurse;
Licensed Vocational Nurse (LVN);
Marriage Family and Child Counselor (MFCC);
Occupational Therapist (OTR);
Physical Therapist (PT or RPT);
Physician - see definition of "Physician";
Physician Assistant (PA);
Podiatrist or Chiropodist (DPM, DSP, or DSC);
Prosthetist or Prosthetist-Orthotist;
Psychiatrist (MD);
Registered Nurse (RN);
Respiratory Therapist;
Speech Pathologist.

A "Covered Provider will also include the following when appropriately-licensed and providing services that are covered hereunder:

any practitioner of the healing arts who is licensed and regulated by a state or federal agency, is providing services or supplies that are covered hereunder, and is acting within the scope of his license;

facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, Birthing Centers, clinics;

licensed Outpatient mental health facilities;

freestanding public health facilities;

visiting nurse associations;

hemodialysis and Outpatient clinics under the direction of a Physician (MD);

enuresis control centers;

home infusion therapy providers;

durable medical equipment providers;

prosthetists and prosthetist-orthotists;

portable X-ray companies;

independent laboratories and lab technicians;

diagnostic imaging facilities; blood banks;

speech and hearing centers; ambulance companies.

NOTE: A Covered Provider does not include: (1) a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see 'Relative or Resident Care' in the list of General Exclusions, or (2) any Physician, nurse or other provider who is an employee of a Hospital or other Covered Provider facility and who is paid by the facility for his services.

Dependent - see "Eligibility and Effective Dates" section.

Emergency – An Emergency shall mean a situation or medical condition with symptoms of sufficient severity (including severe pain) that the absence of immediate medical attention and treatment would reasonably be expected to result in: (a) serious jeopardy to the health of the individual (or, with respect to a pregnant woman, the woman's unborn child); (b) serious impairment to bodily functions; or (c) serious dysfunction of any bodily organ or part. An Emergency includes, but is not limited to, severe chest pain, poisoning, unconsciousness, and hemorrhage. Other Emergencies and acute conditions may be considered on receipt of proof, satisfactory to the Plan, per the Plan Administrator's discretion, that an Emergency did exist. The Plan may, at its own discretion, request satisfactory proof that an Emergency or acute condition did exist.

Emergency Medical Condition - Emergency Medical Condition shall mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 1395dd(e)(1)(A)). In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn Child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.

Employee - see the "Eligibility and Effective Dates" section.

Employer(s) - The Employer or Employers participating in these Plan benefits as reflected in the General Plan Information section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Essential Health Benefits - Essential Health Benefits shall mean, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits to include at least the following general categories and the items and services covered within the categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription Drugs; rehabilitative and Habilitative Services and devices; laboratory services; preventive and wellness services and chronic Disease management; and pediatric services, including oral and vision care.

Experimental and/or Investigational - Experimental and/or Investigational ("Experimental") shall mean services or treatments that are not widely used or accepted by most practitioners or lack credible evidence to support positive short or long-term outcomes from those services or treatments; these services are not included under or as Medicare reimbursable procedures, and include services, supplies, care, procedures, treatments or courses of treatment which:

Do not constitute accepted medical practice under the standards of the case and by the standards of a reasonable segment of the medical community or government oversight agencies at the time rendered; or

Are rendered on a research basis as determined by the United States Food and Drug Administration and the AMA's Council on Medical Specialty Societies.

All phases of clinical trials shall be considered Experimental.

A Drug, device, or medical treatment or procedure is Experimental:

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

If reliable evidence shows that the Drug, device or medical treatment or procedure is the subject of ongoing Phase I, II, or III clinical trials or under study to determine its:

Maximum tolerated dose;
Toxicity;
Safety;
Efficacy; and
Efficacy as compared with the standard means of treatment or Diagnosis; or

If reliable evidence shows that the consensus among experts regarding the Drug, device, or medical treatment or procedure is that further studies or clinical trials are necessary to determine its:

Maximum tolerated dose;
Toxicity;
Safety;
Efficacy; and
Efficacy as compared with the standard means of treatment or Diagnosis.

Reliable evidence shall mean:

Only published reports and articles in the authoritative medical and scientific literature;

The written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same Drug, device, or medical treatment or procedure; or

The written informed consent used by the treating facility or by another facility studying substantially the same Drug, device, or medical treatment or procedure.

Fiduciary - An entity having binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Home Health Care Agency - An agency or organization that:

is primarily engaged in and duly licensed, If such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;

has policies established by a professional group associated with the agency or organization that includes at least one registered nurse (RN) to govern the services provided;

provides for full-time supervision of its services by a Physician or by a registered nurse; maintains a complete medical record on each patient;

has a full-time administrator.

In rural areas where there are no agencies that meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice or Hospice Agency - An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel that includes at least one Physician and registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital - An institution which:

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;

is operated under the supervision of one or more Physicians;

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

maintains organized facilities for both diagnosis and surgery The requirement for surgery facilities will not apply, however, for mental health conditions.

For treatment of substance use disorder, a "Hospital" will also include a facility which is appropriately licensed to provide such specialty care in the area in which it is located and which is operating within the scope of that license.

A "Hospital" does not include: (1) a rest home, nursing home, place for custodial care, or home for the aged, (2) an institution operated by a state, county or city for the care of the mentally ill, or (3) any governmental agency of the United States or Canada.

Incurred - A Covered Expense is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Expenses are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Expenses for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (e g., Hospital, or Skilled Nursing Facility) 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. After twenty-three (23) observation hours, a confinement will be considered an Inpatient confinement.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, that provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and that is separated from the rest of the Hospital's facilities.

Lifetime - All periods an individual is covered hereunder, including any prior statements of these benefits of the Plan it does not mean a Covered Person's entire lifetime.

Maximum Amount and/or Maximum Allowable Charge – Any benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) may be the lesser of:

The Usual and Customary amount;

The allowable charge specified under the terms of the Plan;

The Reasonable charge specified under the terms of the Plan;

The negotiated rate established in a contractual arrangement with a Provider; or

The actual billed charges for the covered services.

The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medically Necessary - Medical Care Necessity, Medically Necessary, Medical Necessity and similar language refers to health care services ordered by a Physician exercising prudent clinical judgment provided to a Covered Person for the purposes of evaluation, Diagnosis or treatment of that Covered Person's Sickness or Injury. Such services, to be considered Medically Necessary, must be clinically appropriate in terms of type, frequency, extent, site and duration for the Diagnosis or treatment of the Covered Person's Sickness or Injury. The Medically Necessary setting and level of service is that setting and level of service which, considering the Covered Person's medical symptoms and conditions, cannot be provided in a less intensive medical setting. Such services, to be considered Medically Necessary must be no more costly than alternative interventions, including no intervention and are at least as likely to produce equivalent therapeutic or diagnostic results as to the Diagnosis or treatment of the Covered Person's Sickness or Injury without adversely affecting the Covered Person's medical condition.

It must not be maintenance therapy or maintenance treatment;

Its purpose must be to restore health;

It must not be primarily custodial in nature;

It must not be a listed item or treatment not allowed for reimbursement by CMS (Medicare); and

The Plan reserves the right to incorporate CMS (Medicare) guidelines in effect on the date of treatment as additional criteria for determination of Medical Necessity and/or an Allowable Expense.

For Hospital stays, this means that acute care as an Inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting. The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "Medically Necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

To be Medically Necessary, all of these criteria must be met. Merely because a Physician or Dentist recommends, approves, or orders certain care does not mean that it is Medically Necessary. The determination of whether a service, supply, or treatment is or is not Medically Necessary may include findings of the American Medical Association and the Plan Administrator's own medical advisors. The Plan Administrator has the discretionary authority to decide whether care or treatment is Medically Necessary.

Medical Record Review - Medical Record Review is the process by which the Plan, based upon a Medical Record Review and audit, determines that a different treatment or different quantity of a Drug or supply was provided which is not supported in the billing, then the Plan Administrator may determine the Maximum Allowable Charge according to the Medical Record Review and audit results.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 Including parts A, B & D and Title XVIII of the Social Security Act, and as amended from time to time.

Mental Health Parity Act (MHPA) of 1996 and Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), Collectively, the Mental Health Parity Provisions in Part 7 of ERISA - The Mental Health Parity Provisions shall mean in the case of a group health plan (or health insurance coverage offered in connection with such a plan) that provides both medical and surgical benefits and mental health or substance use disorder benefits, such plan or coverage shall ensure that:

The financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements applied to substantially all medical and surgical benefits covered by the Plan (or coverage) and that there are no separate cost sharing requirements that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage is offered in connection with such a plan); and

The treatment limitations applicable to such mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits covered by the Plan (or coverage), and that there are no separate treatment limitations that are applicable only with respect to mental health or substance use disorder benefits. If these benefits are covered by the group health plan (or health insurance coverage offered in connection with such a plan).

Mental or Nervous Disorder - Any disease or condition, regardless of whether the cause is organic, that is classified as a Mental or Nervous Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services, is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association or other relevant State guideline or applicable sources.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Participating Employer - An Employer who is participating in the Plan coverages described herein, see "General Plan Information" section for the identity of the Participating Employer(s).

Physician - A Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who is licensed to practice medicine or osteopathy where the care is provided.

A Physician will also include a Christian Science practitioner who is accredited by the Mother Church - The First Church of Christ, Scientist, in Boston, Massachusetts and who is practicing within his respective field.

NOTE: The term "Physician" will not include the Covered Person himself his relatives (see General Exclusions) or Interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the "General Plan Information" section.

Plan Administrator - see "Plan Sponsor".

Plan Document - A formal written document that describes the Plan and the rights and responsibilities of the Plan Sponsor with regard to the Plan, including any amendments.

Plan - The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the "General Plan Information" section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Pregnancy - Pre-natal and post-natal care during Pregnancy, childbirth, miscarriage or any complications. See "Pregnancy Care" in the list of Eligible Medical Expenses for further information.

Prior to Effective Date or After Termination Date - Prior to Effective Date or After Termination Date are dates occurring before a Covered Person gains eligibility from the Plan, or dates occurring after a Covered Person loses eligibility from the Plan, as well as charges Incurred Prior to the Effective Date of coverage under the Plan or after coverage is terminated, unless Extension of Benefits applies.

Rehabilitation Center - A facility that is designed to provide therapeutic and restorative services to sick or injured persons and that:

carries out its stated purpose under all relevant state and local laws; or

is accredited for its stated purpose by either the JCAHO or the Commission on Accreditation for Rehabilitation Facilities; or

is approved for its stated purpose by Medicare.

Reasonable and/or Reasonableness - The Plan Administrator's discretion, services or supplies, or fees for services or supplies, which are necessary for the care and treatment of Illness or Injury not caused by the treating Provider's error or mistake. Determination that fee(s) or services are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination will consider, but will not be limited to evidence-based guidelines, and the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; (b) CMS and (c) The Food and Drug Administration. A finding of Provider negligence and/or malpractice is not required for service(s) and/or fee(s) to be considered not Reasonable.

To be Reasonable, service(s) and/or fee(s) must also be in compliance with generally accepted billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether service(s) and/or fee(s) are Reasonable based upon information presented to the Plan Administrator.

The Plan Administrator reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, to identify charge(s) and/or service(s) that are not Reasonable and therefore not eligible for payment by the Plan.

Semi-Private Room Charge - The standard charge by a facility for a semi-private room and board accommodation (2 or more beds), or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for a single bed room and board accommodation where the facility does not provide any semi-private accommodations.

Sickness - Bodily illness or disease, covered mental health conditions and covered substance use disorders, congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

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;

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

admits patients only upon the recommendation of a Physician, maintains complete medical records, and has available at all times the services of a Physician;

has established methods and procedures for the dispensing and administering of drugs;

has an effective utilization review plan;

is approved and licensed by Medicare;

has a written transfer agreement in effect with one or more Hospitals; 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.

Substance Abuse - Any use of alcohol, any Drug (whether obtained legally or illegally), any narcotic, or any hallucinogenic or other illegal substance, which produces a pattern of pathological use, causing impairment in social or occupational functioning, or which produces physiological dependency evidenced by physical tolerance or withdrawal. It is the excessive use of a substance, especially alcohol or a Drug. The Diagnostic and Statistical Manual of Mental Disorders (DSM) definition of "Substance Use Disorder" is applied as follows:

A maladaptive pattern of substance use leading to clinically significant impairment or distress, as manifested by one or more, of the following, occurring within a twelve month period:

Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home (e.g., repeated absences or poor work performance related to substance use; substance-related absences, suspensions or expulsions from school; neglect of Children or household);

Recurrent substance use in situations in which it is physically hazardous (e.g., driving an automobile or operating a machine when impaired by substance use);

Craving or a strong desire or urge to use a substance; or

Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance (e.g., arguments with spouse about consequences of intoxication, physical fights);

The symptoms have never met the criteria for Substance Dependence for this class of substance.

Urgent Care Facility - A facility that is engaged primarily in providing minor emergency and episodic medical care and that has:

a board-certified Physician, a registered nurse (RN) and a registered X-ray technician in attendance at all times;

X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or that is part of a regular Hospital.

Usual and Customary - Usual and Customary (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges (or accepts for) the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made or accepted for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge was Incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of an individual of the same sex, comparable age and who has received such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made (or accepted) nor the specific service or supply furnished to a Covered Person by a Provider of services or supplies, such as a Physician, therapist, Nurse, Hospital, or pharmacist. The Plan Administrator will determine the usual charge for any procedure, service, or supply, and whether a specific procedure, service or supply is customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.

GENERAL PLAN INFORMATION

Name of Plan:	City of Turlock Health Benefits Plan
Plan Sponsor / Plan Administrator: Address:	City of Turlock 156 S Broadway, Suite 230 Turlock, CA 95380-5454
Business Phone Number:	(209) 668-5540
Participating Employer:	City of Turlock
Plan Sponsor ID Number (EIN):	94-6000445
Plan Number:	501
Plan Year:	July 1 through June 30
Named Fiduciary(ies) / Title(s):	City of Turlock
Address: (See also definition of "Fiduciary")	166 S Broadway, Suite 230 Turlock, CA 95380-5454
Agent for Service of Legal Process:	City of Turlock
Address:	166 S. Broadway, Suite 230 Turlock, CA 95380-5454
(Legal process may be served upon the Plan Administrator or a Fiduciary)	
Type of Plan:	This is an employee welfare benefit plan providing group benefits
Plan Benefits Described Herein:	Self-Funded Medical and Prescription Drug Benefits
Type of Administration:	Contract Administration — see "Administrative Provision" for additional information
Applicable Collective Bargaining Agreement(s):	None
Contract Administrator:	CBA Administrators
Address:	4704 West Jennifer Avenue, Suite 104 Fresno, CA 03722
Phone:	(559) 275-3984 or (800) 709-4739

FUNDING - SOURCES AND USES

Employee & Employer Obligations

Plan benefits described herein are paid from the general assets of the Plan Sponsor. Any amounts to be paid by active Employees are handled through a Section 125 pre-tax premium plan.

See the COBRA Continuation Coverage section for more information.

Taxes

Any taxes that may be imposed by any taxing authority and that are applicable to the Plan will be paid by the Plan Sponsor.

ADMINISTRATIVE PROVISIONS

Administration (type of)

The Plan benefits described herein are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care

In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan Sponsor elects to provide alternative benefits for a Covered Person In one instance it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to provide benefits thereafter in strict accordance with the provisions of the Benefit Document.

Amendment or Termination of the Plan

Since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to without the consent of any participant or beneficiary:

reduce, modify or terminate retiree health care benefits hereunder, If any;

alter or postpone the method of payment of any benefit; amend any provision of these administrative provisions;

make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and

terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, If necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those Plan benefits to which he has become entitled.

NOTE: Any modification, amendment or termination action will be done In writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment that is signed by at least one Fiduciary of the Plan Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer

Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error

Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Discrepancies

In the event that there may be a discrepancy between any separate booklet(s) provided to Employees ("Summary Plan Descriptions") and the Benefit Document the Benefit Document will prevail.

Facility of Payment

Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciary Responsibility, Authority and Discretion

Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation for such services, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may

delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1) establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure

Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number

Except when otherwise indicated by the context, any masculine terminology will include the feminine (and vice-versa) and any term in the singular will include the plural (and vice-versa).

Illegality of Particular Provision

The illegality of any particular provision of the Benefit Document will not affect the other provisions and the Benefit Document will be construed in all respects as if such invalid provision were omitted.

Indemnification

To the extent permitted by law. Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions

No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Benefit Document and Plan Document.

No legal action may be brought to recover on the Plan: (1) more than three years from the written proof of loss is required to be given, or (2) until the Plan's mandatory claim appeal(s) are exhausted. See the Claims Procedures section for more information.

Loss of Benefits

To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

an employee's cessation of active service for the employer;

a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner,

a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);

a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;

a claim for benefits is not filed within the time limits of the Plan

Material Modification

in the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days.

"Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage and generally would include any Plan modification or change that: (1) eliminates or reduces benefits payable under the Plan, including a reduction that occurs as a result of a change in formulas, methodologies or schedules that serve as the basis for making benefit determinations, (2) Increases premiums, deductibles, coinsurance, copays, or other amounts to be paid by a Plan participant or beneficiary, or (3) establishes new conditions or requirements (i.e., preauthorization requirements) to obtaining services or benefits under the Plan.

Misstatement / Misrepresentation

If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card

If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any Identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status

An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Not a Contract

This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document is not to be construed as a contract of any type between the Company and any Covered Person or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be

deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Physical Examination

The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan

The plan of employee welfare benefits provided by the Plan Sponsor. The name of the Plan is shown in the General Plan Information section. The Plan and the Employer or Employers are distinct legal entities (i.e., an Employer is completely separate from the Plan).

Plan Administrator Discretion & Authority

The Plan Administrator has the exclusive authority, in its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations there under. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator (or the delegated Contract Administrator acting within the scope of its delegated authority on behalf of the Plan) shall make determinations regarding Plan benefits.

Privacy Rules, Security Standards & Breach Notification Rules

To the extent required by law, the Plan is amended and will comply with: (1) the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA), and (2) the HIPAA Security Standards with respect to electronic Protected Health Information.

HIPAA's Privacy Rules and Security Standards apply to group medical and dental benefits as well as health flexible spending account (Health FSA) benefits offered through a Section 125 cafeteria plan.

The Plan and the Plan Sponsor will not intimidate or retaliate against employees who file complaints with regard to their privacy, and employees will not be required to give up their privacy rights in order to enroll or have benefits.

The 2009 breach notification regulations and the Health Information Technology for Economic and Clinical Health (HITECH) Act, require HIPAA covered entities and their business associates to provide notification to an affected individual following a breach of unsecured protected health information. Such Individual notification must be provided within a reasonable period of time and in no case later than 60 days following the discovery of a breach. To the extent possible, such affected individual must also be provided with a description of the breach, a description of the types of information that were involved in the breach, the steps the individual should take to protect themselves from potential harm, a brief description of what the covered entity is doing to investigate the breach, mitigate the harm, and prevent further breaches, as well as contact information for the covered entity. More information is available on the U.S. Department of Health & Human Services' website.

NOTES: The Privacy Rules requirements do not apply to "summary health information" which is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is health-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient-identifying numbers or characteristics.

Purpose of the Plan

The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents.

Reimbursements

Plan's Right to Reimburse Another Party - Whenever any benefit payments that should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will

be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Payment in Error - When, as a result of error, clerical or otherwise, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rescission of Coverage

The Plan may not rescind an individual's coverage under the Plan (e.g., cancelling coverage after a Covered Person has submitted a claim). However, the Plan may rescind coverage if a Covered Person commits fraud or makes an intentional misrepresentation of a material fact.

Rights Against the Plan Sponsor or Employer

Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employment of the Employer.

Termination for Fraud

An Individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

a civil or criminal court finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;

an individual has submitted a claim that, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Titles or Headings

Where titles or headings precede explanatory text throughout the Benefit Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Benefit Document and will not affect the validity, construction or effect of the Benefit Document provisions.

Type of Plan

This Plan is not a plan of insurance. This Plan is a self-funded nonfederal governmental group health plan that, for the most part, is exempt from the requirements of the Employee Retirement Income Security Act (ERISA). However, governmental plans are not automatically exempted from the following amendments to ERISA, The Health Insurance Portability and Accountability Act (HIPAA), the Mental Health Parity Act (MHPA), the Newborns and Mothers Health Protection Act (NMHPA), and the Women's Health and Cancer Rights Act (WHCRA). To be exempt from certain requirements of these laws, the Plan must make an affirmative written election to be excluded. Such election must be filed with the Centers for Medicare and Medicaid Services (CMS) prior to the beginning of each Plan Year, with notice provided to each Plan participant. Unless such written election is filed and participant notices are made, this Plan intends to fully comply with the above-stated federal laws.

Workers' Compensation

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, that is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law but it is only a summary of the major features of the law. In any individual situation, the law and its clarifications and intent will prevail over this summary.

If a retired Employee is covered under the Plan and one of his Dependents has a Qualifying Event (e.g., divorce or loss of Dependent child eligibility), such Dependent may be eligible for COBRA Continuation Coverage. Also, certain other COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced herein it means only those retired Employees who were covered under the Plan.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An Individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverage the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.

An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law the individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An Individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States if such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

NOTE: A same-sex Domestic Partner (or any child of such a partner) is not a Qualified Beneficiary and does not have Independent COBRA election rights.

Qualifying Event - Any of the following events that would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;

reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur if a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;

for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is In effect;

for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;

for an Employee's spouse or child, the death of the covered Employee;

for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who Is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notice Responsibilities - If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in hours, death, or Medicare entitlement, then the Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights, or the unavailability of COBRA rights, within 44 days of the event if the Employer is not the Plan Administrator, then the Employer's notification to the Plan Administrator must occur within 30 days of the Qualifying Event and the Plan Administrator must provide Qualified Beneficiaries with their COBRA rights notice within 14 days thereafter Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

If COBRA continuation coverage terminates early (e.g., the Employer ceases to provide any group health coverage, a Qualified Beneficiary fails to pay a required premium in a timely manner, or a Qualified Beneficiary becomes entitled to Medicare after the date of the COBRA election), the Plan Administrator must provide the Qualified Beneficiary(ies) with notification of such early termination. Notice must include the reason for early termination, the date of termination and any right to alternative or conversion coverage. The early termination notice(s) must be sent as soon as practicable after the decision that coverage should be terminated.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred that permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear Identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is a Dependent child's ceasing to be eligible under the requirements of the Plan, or the divorce or legal separation of the Employee from his/her spouse. A Qualified Beneficiary Is also responsible for other notifications. See the section entitled COBRA Notice Requirements for Plan Participants (and the Employer's "COBRA General Notice" or "Initial Notice") for further details and time limits Imposed on such notifications. Upon receipt of a notice, the Plan Administrator must notify the Qualified Beneficiary(les) of their continuation rights within 14 days.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary See NOTE.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law or by the spouse of the Qualified Beneficiary.

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

Open enrollment rights that allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

Effective Date of Coverage - COBRA 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 the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The full cost includes any part of the cost that is paid by the

Employer for NonCOBRA Beneficiaries Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- the cost previously charged was less than the maximum permitted by law;

- the increase is due to a rate increase at Plan renewal;

- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law that is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or

- the Qualified Beneficiary changes his coverage option(s) that results in a different coverage cost.

Timely payments that are less than the required amount but are not significantly less (an "insignificant shortfall") will be deemed to satisfy the Plan's payment requirement. The Plan may notify the Qualified Beneficiary of the deficiency but must grant a reasonable period of time (at least 30 days) to make full payment. A payment will be considered an "insignificant shortfall" if it is not greater than \$50 or 10% of the required amount, whichever is less.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTES: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the loss of coverage due to the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;

- if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;

for any other Qualifying Event, the maximum coverage period ends 36 months after the loss of coverage due to the Qualifying Event.

If a Qualifying Event occurs that provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for Individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event.

COBRA entitlement runs concurrently with continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) - USERRA does not extend the maximum period of COBRA coverage. If coverage is continued under USERRA, the equivalent number of months of COBRA entitlement will be exhausted.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to be disabled in the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date that falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension himself.

Termination of Continuation Coverage - Except for an initial Interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of loss of coverage due to the Qualifying Event and ending on the earliest of the following dates:

the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;

the date on which the Employer ceases to provide any group health plan to any Employee;

the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation that would reduce or exclude benefits for such condition in the Qualified Beneficiary;

the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the Individual has been notified that his or her Medicare coverage is in effect;

in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

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

the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

COBRA NOTICE REQUIREMENTS FOR PLAN PARTICIPANTS

An Employee or Qualified Beneficiary is responsible for notifying the Plan of a Qualifying Event that is:

a Dependent child's ceasing to be eligible (e.g., due to reaching the maximum age limit);

the divorce or legal separation of the Employee from his/her spouse;

the occurrence of a second Qualifying Event after a Qualified Beneficiary has become entitled to **COBRA Continuation Coverage** with a maximum duration of 18 (or 29) months;

where a Qualified Beneficiary entitled to receive **COBRA Continuation Coverage** with a maximum duration of 18 months has been determined by the Social Security Administration to be disabled at any time during the first 60 days of continuation coverage, or (b) a Qualified Beneficiary as described in lay has subsequently been determined by the Social Security Administration to no longer be disabled.

Notification must be made in accordance with the following procedures. Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one Individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Notification must be made in accordance with the following procedures. However, these procedures are current as of the date the document was prepared and a Qualified Beneficiary should make certain that procedure claims have not occurred before relying on this information. The most current Information should be Included in the Employers COBRA initial General Notice that is provided to new hires.

Any individual who is either the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary may provide the Notice. Notice by one individual shall satisfy any responsibility to provide Notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Form, Content & Delivery - Notification of the Qualifying Event must in writing:

Notification must Include evidence that a Qualifying Event or other event extending coverage has occurred (e.g. , copy of divorce decree, copy of child's birth certificate, copy of the Social Security Administration's disability determination letter).

Notification must be received by the claims office: CBA Administrators at 4704 West Jennifer Avenue, Suite 104, Fresno, CA 93722.

Time Requirements for Notification - In the case of a divorce, legal separation or a child losing dependent status, Notice must be delivered within 60 days from the later of: (1) the date of the Qualifying Event, (2) the date health plan coverage is lost due to the event, or (3) the date the Qualified Beneficiary is notified of the obligation to provide Notice by way of the Summary Plan Description or the Plan Sponsor's General COBRA Notice If Notice Is not made within the 60-day period, **COBRA Continuation Coverage will not** be available, except in the case of a loss of coverage due to foreign competition where a second COBRA election period may be available — see 'Effect of the Trade Act' In the **COBRA Continuation Coverage** section of the Plan's Summary Plan Description or Benefit Document.

If an Employee or Qualified Beneficiary Is determined to be disabled under the Social Security Act, Notice must be delivered within 60 days from the later of: (1) the date of the determination, (2) the date of the Qualifying event, (3) the date coverage is lost as a result of the Qualifying Event, or (4) the date the covered Employee or Qualified Beneficiary Is advised of the Notice obligation through the SPD or the

Plan Sponsor's General COBRA Notice. Notice must be provided within the 18-month COBRA coverage period. Any such Qualified Beneficiary must also provide Notice within 30 days of the date he is subsequently determined by the Social Security Administration to no longer be disabled.

The Plan will not reject an incomplete Notice as long as the Notice identifies the Plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event/disability determination and the date on which it occurred. However, the Plan is not prevented from rejecting an incomplete Notice If the Qualified Beneficiary does not comply with a request by the Plan for more complete Information within a reasonable period of time following the request.

ADOPTION OF THE DOCUMENT

Adoption

The Plan Sponsor hereby adopts this document on the date shown below. This document replaces any and all prior statements of the Plan benefits that are described herein.

Purpose of the Plan

The purpose of the Plan is to provide certain benefits for eligible Employees of the Participating Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the General Plan Information section

Conformity with Law

If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Participating Employers

Employers participating in this Plan are as stated in the section entitled General Plan Information.

The Plan Sponsor may act for and on behalf of any and all of the Participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Restatement/ Replacement of Benefits

This document replaces prior benefits offered by the Plan Sponsor but this is not a new Plan Except to the extent benefits are expressly added, removed or modified. Any benefits provided with respect to covered persons under the prior benefits will be deemed to be benefits provided hereunder for a person who is eligible as an active enrollee or a COBRA enrollee under the document on its effective date. Any contiguous periods a person was covered under the benefits replaced by this document will be deemed to be time covered hereunder.

Acceptance of the Document

IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2015.

City of Turlock

By: _____

Title: _____

WITNESS:

By: _____

Title: _____