PRIME HEALTHCARE

SUMMARY PLAN DESCRIPTION

OF THE

VALUE MEDICAL AND PRESCRIPTION DRUG BENEFITS PLAN

JANUARY 1, 2020

TABLE OF CONTENTS

PAGE

UTILIZATION MANAGEMENT PROGRAM

WARNING: THE VALUE MEDICAL AND PRESCRIPTION DRUG BENEFITS PLAN (THE "PLAN") PROVIDES COVERAGE ONLY WHEN CERTAIN PROVIDERS AND FACILITIES ARE USED. PLEASE READ THE FOLLOWING INFORMATION TO KNOW HOW TO OBTAIN COVERED SERVICES. ALL PLAN REQUIREMENTS AND BENEFITS ARE SUBJECT TO VARIATION BASED ON THE PRIME HEALTHCARE ENTITY THROUGH WHICH THE COVERED PERSON RECEIVES BENEFITS. ENTITIES WITH COLLECTIVE BARGAINING AGREEMENTS MAY HAVE VARIATIONS. PLEASE READ THE ADDENDUM FOR THE APPLICABLE PRIME HEALTHCARE ENTITY TO CONFIRM ANY SUCH VARIATION.

For quality of review and continuity of medical care, the Plan includes a **Utilization Management Program** as described below.

PRE-SERVICE REVIEW: Pre-service review and approval is required for all non-Emergency Services, with only limited exceptions set forth directly below. If the pre-service review requirements are not completed and approved, benefits will not be payable under the Plan. Any additional share of expenses that becomes the Covered Person's responsibility for failure to comply with these requirements will not be considered Eligible Expenses and thus will not apply to any Coinsurance or Out-of-Pocket Maximums of the Plan.

- **Pre-Service Review Not Required for Office Visits to Primary Care Network Provider -** Office visits with a Primary Care Network Provider are not subject to the pre-service review requirements. However, all other Plan provisions continue to apply. For example, the office testing covered under the Plan is limited to the services included on the Prime Utilization Management Auto-Authorization List.

- **Pre-Service Review Not Required for Annual Well Woman Exam with Primary Care Provider -** Annual Well Woman Exam visits with a Primary Care Network Provider or a Network Provider who specializes in Obstetrics or Gynecology are not subject to the pre-service review requirements. The Network Provider, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating Network Providers who specialize in obstetrics or gynecology, contact Prime Healthcare Customer Service at (877) 234-5227, email EHP@primehealthcare.com, or reference the Tier 1 Prime Provider Directory at www.primehealthcare.com/EHP or your local hospital website. See the **Mandatory Selection of a Primary Care Physician** section for more details.

- **Child Birth** - The Plan will pay for benefits for a hospital stay in connection with childbirth for the mother or newborn child up to at least 48 hours following a 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, prior authorization for such extended confinement is required.

HOW TO OBTAIN PRE-SERVICE REVIEWS

It is the Covered Person's responsibility to confirm that the pre-service review requirements have been satisfied. To obtain pre-service review, contact the Prime Healthcare Utilization Management Department at (877) 234-5227.

The following rules apply to Pre-Service Reviews:

- For all elective services that are subject to utilization review, a Covered Person or their Physician must initiate the pre-service review when notified that an elective service is needed or at least 14 calendar days prior to when a Covered Person is scheduled to receive services.
- The Covered Person must receive the authorized service within 90 Calendar days of the certification or a new pre-service review must be obtained.
- The Prime Healthcare Utilization Management Department will determine if services are Medically Necessary and appropriate under the terms of the Plan.
- Pre-authorization for a specialty physician referral covers only the initial consultation.

NOTE: A determination of Medical Necessity does not guarantee that the services are covered under the Plan.

MORE INFORMATION ABOUT PRE-SERVICE REVIEW

To minimize the risk of non-compliance, the Employee or other Covered Person should contact the Prime Healthcare Utilization Management Department 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 a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan 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 under the Plan.

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

SERVICES NOT AVAILABLE FROM A NETWORK PROVIDER: If a Network Physician or service is not available, a Covered Person may request pre-service review from the Prime Healthcare Utilization Management Department to determine if Non-Network Provider may be available and approved under the Plan. If a Network Physician is available or the services can be provided safely at a Network facility, however, the services will not be covered under the Plan if provided elsewhere.

EMERGENCY SERVICES: The Prime Healthcare Utilization Management Department must be immediately notified upon the presentment of a Covered Person in a non-Network

emergency room, and no later than 24 hours from presentment. It is the Covered Person's responsibility to make certain that the non-Network facility immediately calls the Prime Healthcare Utilization Management Department. Services from a non-Network facility to a Covered Person after the Covered Person's condition is stabilized will not be covered by the Plan, unless the Prime Healthcare Utilization Management Department approves the services through pre-service review.

The following rules apply to emergency admissions at non- Network facilities:

- **Stability for Transfer** – Once the Covered Person's condition has been stabilized to the point they can be Transferred, the Covered Person must be Transferred to a Network facility or benefits under the Plan may cease. It is both the Non-Network Provider's and the Covered Person's responsibility to request to be Transferred to the closest Network facility and the Non-Network Provider must make all reasonable efforts to repatriate the Covered Person to such Network facility.
- **Post-Stabilization Authorizations** – If the Prime Healthcare Utilization Management Department approves post-stabilization services at a Non- Network Provider, pre-service review by the Prime Healthcare Utilization Management Department is required every 24 hours for the services to continue being covered by the Plan.
- **Inpatient Admissions** - All inpatient admissions require the patient's attending Physician to contact the Prime Healthcare Utilization Management Department every 24 hours during the admission to be covered by the Plan.

REFERRAL AND AUTHORIZATION PROCESS:

Pre-service review and authorization is required if the Covered Person is referred to a Network Hospital or Facility for covered Inpatient and/or Outpatient services, laboratory tests and radiology procedures.

If the Covered Person is referred to a Specialist by a Primary Care Provider, the Covered Person must submit a pre-service review and authorization request to the Prime Healthcare Utilization Management Department. A referral from a Network Provider to a Network Specialist does not require pre-service review and authorization for initial consultation. A referral to any other specialist or any visits beyond initial consultation requires pre-service review and authorization. Any authorization only covers the services specified. Certain pre-approved services performed during the initial consultation are covered without need for prior authorization. For a list of those services, please see your local human resources department, call Prime Customer Service at (877) 234-5227, or email EHP@primehealthcare.com.

After the initial consultation, all Covered Persons must obtain pre-service review and authorization from the Prime Healthcare Utilization Management Department if additional care is requested by a Network Specialist. The Prime Healthcare Utilization Management Department will communicate its determination to the referring Provider and mail a copy of its determination to the Covered Person's home address.

For the status of a referral, please contact Prime Customer Service at 877-234-5227 or email EHP@Primehealthcare.com.

MEDICAL AND PRESCRIPTION DRUG BENEFITS

MANDATORY SELECTION OF A PRIMARY CARE PHYSICIAN

At the time of enrollment, each Covered Person must select a Network Primary Care Physician (PCP). The Tier 1 Prime Provider Directory can be found on www.PrimeHealthcare.com/EHP or by visiting your human resources department. You have the right to designate any Primary Care Provider who participates in the Network and who is available to accept you or your family members. To find participating Tier 2 Blue Shield BlueCard providers, you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor." If a Covered Person is a minor or otherwise incapable of selecting a PCP, the Employee should select a PCP on the minor's behalf. For information on how to select a Primary Care Provider, and for a list of the participating Primary Care Providers, contact the Prime Healthcare Utilization Management Department at (877) 234-5227, or reference the Tier 1 Prime Provider Directory at www.primehealthcare.com/EHP or your local hospital website.

Women may designate an OB/GYN as their Primary Care Provider and children may designate a Pediatrician as their Primary Care Provider.

If a Covered Person requires Hospital services or supplies, they will be referred to a Network Hospital. If services are not available at that Network facility, the Covered Person must contact the Prime Healthcare Utilization Management Department. See the **Utilization Management Program** section for details on seeking pre-service review.

COVERAGE FOR NETWORK PROVIDERS

The Plan Administrator has contracted with organizations or "networks" of Providers. Network Providers have agreed to provide services to Covered Persons at negotiated rates. Except in limited situations that are described herein, ALL HEALTH CARE must be authorized by the Prime Healthcare Utilization Management Department through pre-service review and be provided or ordered by Network Providers to be covered by the Plan.

Tier 1 Prime Healthcare – Facilities, Physicians and non-Physician Licensed Network Providers who have agreements with Prime Healthcare to participate in its Provider Network.

Tier 2 BCBS BlueCard/Blue Shield of CA Network Providers – Facilities, Physicians and non-Physician Licensed Network Providers who have signed agreements to be in the BCBS BlueCard/Blue Shield of CA Network to participate in its Prudent Buyer Preferred Provider Network or who have signed agreements to participate in the BCBS BlueCard/BlueShield of CA Network.

The Plan Sponsor will automatically provide a Covered Person with information about how they can access directories of Network Providers.

Not Tier 1 or Tier 2 – Any services or charges from an individual or entity not described in Tier 1 or Tier 2 above are Non-Network Provider charges. Non-Network Provider charges are not covered by the Plan and do not qualify as Allowable Charges (see "Allowable Charges" in the **Definitions** section) subject to only the following Emergency Services exception:

Emergency Services Care – If a Covered Person requires care for an Emergency Medical Condition and must use the services of a Non-Network Provider, any such covered expenses will be paid as defined in the "Non-Network Providers – Allowable Charges for Emergency Services" section for services provided before the Covered Person's condition has been stabilized. See the **Utilization Management Program** section for details on Emergency Services coverage.

SPECIAL PROVISIONS RELATED TO TIER 2 PROVIDERS

This section applies to the use of Tier 2 Providers only. The rest of the Plan provisions continue to apply. The Plan has a variety of relationships with other Blue Shield and/or Blue Shield Plan Licensees. Generally, these relationships are called Inter-Plan Arrangements and they work based on rules and procedures issued by the Blue Cross Blue Shield Association. Whenever you receive Services outside of California, the claims for these services may be processed through one of these Inter-Plan Arrangements described below.

When you access Covered Services outside of California, but within the United States, the Commonwealth of Puerto Rico, or the U.S. Virgin Islands (BlueCard® Service Area), you will receive the care from one of two kinds of providers. Participating providers contract with the local Blue Cross and/or Blue Shield. Licensees in that other geographic area referred to as the Host Blue. Non-participating providers don't contract with the Host Blue. The Plan's payment practices for both kinds of providers are described below.

Inter-Plan Arrangements

BlueCard Program

Under the BlueCard® Program, benefits will be provided for covered services received outside of California, but within the BlueCard Service Area (the United States, Puerto Rico, and U.S. Virgin Islands). When you receive covered services within the geographic area served by a Host Blue, the Plan will remain responsible for doing what we agreed to under the Plan. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers, including direct payment to the provider.

The BlueCard Program enables you to obtain covered services outside of California, as defined, from a healthcare provider participating with a Host Blue, where available. The participating healthcare provider will automatically file a claim for the covered services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member Copay, Coinsurance and deductible amounts, if any, as stated in this Plan.

The Plan calculates the individual's share of cost either as a percentage of the Allowable Charges or a dollar Copay, as defined in this booklet. Whenever you receive covered services outside of California, within the BlueCard Service Area, and the claim is processed through the BlueCard Program, the amount you pay for covered services, if not a flat dollar copayment, is calculated based on the lower of:

1) The billed charges for covered services; or

2) The negotiated price that the Host Blue makes available to the Plan.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to your healthcare provider. Sometimes, it is an estimated price that takes into

account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing of claims as noted above. However, such adjustments will not affect the price the Plan used for your claim because these adjustments will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Blue to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

To find participating BlueCard providers you can call BlueCard Access® at 1-800-810-BLUE (2583) or go online at www.bcbs.com and select "Find a Doctor."

Prior authorization may be required for non-emergency services. To receive prior authorization from the Plan, the out-of-area provider should call the customer service number noted on the back of your identification card.

Non-participating Providers Outside of California

When covered services are provided outside of California and within the BlueCard Service Area by non-participating providers, the amount you pay for such services will normally be based on either the Host Blue's non-participating provider local payment, the Allowable Charges the Plan pays a Non-Participating Provider in California if the Host Blue has no non-participating provider allowance, or the pricing arrangements required by applicable state law. In these situations, you will be responsible for any difference between the amount that the non-participating provider bills and the payment the Plan will make for covered services as set forth in this paragraph.

If you do not see a participating provider through the BlueCard Program, you will have to pay the entire bill for your medical care and submit a claim to the local Blue Cross and/or Blue Shield plan, or to the Plan for reimbursement. The Plan will review your claim and notify you of its coverage determination within 30 days after receipt of the claim; you will be reimbursed as described in the preceding paragraph. Remember, your share of cost is higher when you see a non-participating provider.

Federal or state law, as applicable, will govern payments for out-of-network Emergency Services. The Plan pays claims for covered Emergency Services based on the Allowable Charges as defined in this Plan.

Prior authorization is not required for Emergency Services. In an emergency, go directly to the nearest hospital. Please notify the Plan of your emergency admission within 24 hours or as soon as it is reasonably possible following medical stabilization.

Blue Shield Global® Core

Care for Covered Services Outside the BlueCard Service Area

If you are outside of the BlueCard® Service Area, you may be able to take advantage of Blue Shield Global Core when accessing Out-of-Area Covered Health Care Services. Blue Shield Global Core is unlike the BlueCard Program available within the BlueCard Service Area in

certain ways. For instance, although Blue Shield Global Core assists you with accessing a network of inpatient, outpatient, and professional providers, the network is not served by a Host Blue. As such, when you receive care from providers outside the BlueCard Service Area, you will typically have to pay the provider and submit the claim yourself to obtain reimbursement for these services.

If you need assistance locating a doctor or hospital outside the BlueCard Service Area you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week. Provider information is also available online at www.bcbs.com: select "Find a Doctor" and then "Blue Shield Global Core."

Submitting a Blue Shield Global Core Claim

When you pay directly for services outside the BlueCard Service Area, you must submit a claim to obtain reimbursement. You should complete a Blue Shield Global Core claim form and send the claim form along with the provider's itemized bill to the service center at the address provided on the form to initiate claims processing. Following the instructions on the claim form will help ensure timely processing of your claim. The claim form is available online at www.bcbsglobalcore.com. If you need assistance with your claim submission, you should call the service center at 1-800-810-BLUE (2583) or call collect at 1-804-673-1177, 24 hours a day, seven days a week.

Special Cases: Value-Based Programs

Claims Administrator Value-Based Programs

You may have access to covered services from providers that participate in a Value-Based Program. Claims Administrator Value-Based Programs include, but are not limited to, Accountable Care Organizations, Episode Based Payments, Patient Centered Medical Homes and Shared Savings arrangements.

BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Blue Shield through average pricing or fee schedule adjustments.

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., Copay requirements and benefit sharing percentages).

Except as otherwise noted below or in the **Medical Benefit Summary**, eligible medical expenses are the Allowable 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. All eligible medical expenses are subject to the pre-service review requirement of the Utilization Management Program, except for a referral from a Network Provider to a Network Specialist for initial consultation only. In addition, the Plan will not cover any eligible medical expense that is not Medically Necessary for the care and treatment of a covered Illness, Injury, Pregnancy or other covered health care condition. The Plan Administrator reserves the right to determine coverage under the Plan for all claims from any source in accordance with the standards and requirements as set forth in this summary plan description and any additional Plan documents, which are hereby incorporated by reference in their entirety and may be made available upon request, free of charge.

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.

3D Mammograms – 3D mammograms performed at a Prime Healthcare Network Facility whether as Preventive Care or part of a treatment plan, will be automatically approved by the Prime Healthcare Utilization Management Department. 3D mammograms performed at a Non-Prime Healthcare Facility will require Prior Authorization in order to be covered.

Alcoholism – see "Substance Use Disorder Care."

Allergy Testing and Treatment – Allergy testing and treatment, including allergy injections.

Ambulance – Ground or air transportation provided by a professional ambulance service to the nearest Hospital or emergency care facility equipped to treat a condition that can be classified as an Emergency Medical Condition.

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 and/or Certified Registered Nurse Anesthetist for the administration of anesthesia.

Attention Deficit Disorder ("ADD") and Attention Deficit Hyperactivity Disorder ("ADHD") – Care, services or treatments for ADD or ADHD.

Autism and Asperger's Syndrome – The Plan will cover the Medically Necessary treatment for behavior modification, family therapy, or other forms of psychotherapy, that are clinically

appropriate in terms of type, frequency, extent, site and duration, for management of behavioral symptoms related to Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder not otherwise specified (NOS). These treatments are considered Medically Necessary when required for the management of behaviors, especially where there is the potential for individuals to harm themselves or others.

Psycho-pharmacotherapy for management of target symptoms or co-morbidities related to Autism, Asperger's Syndrome, Rett Syndrome, Childhood Disintegrative Disorder and Pervasive Developmental Disorder not otherwise specified (NOS) is considered Medically Necessary.

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.

Processing, storage and administration charges for autologous blood (a patient's own blood) when a Covered Person is scheduled for a covered surgery that can reasonably be expected to require blood.

Cardiac Rehabilitation – A monitored exercise program directed at restoring both physiological and psychological well-being to an individual with heart disease. The program must be:

- Under the supervision of a Physician;
- In connection with a myocardial infarction, coronary occlusion or coronary bypass surgery, stable angina, PCI, valvular repair and replacement;
- Initiated within twelve (12) weeks after treatment for the medical condition ends;
- Provided in a covered medical care facility as defined by the Plan; and
- With a limit of 36 visits per incident.

NOTE: Maintenance care is <u>not</u> covered.

Chemical Dependency – see "Substance Use Disorder Care."

Chemotherapy and Radiation Therapy – Services and supplies related to the administration of chemical agents in the treatment or control of an Illness.

Radium and radioactive isotope therapy when provided for treatment or control of an Illness.

Chiropractic Care – Musculoskeletal spinal manipulation and modalities provided by a chiropractor (DC) to correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, fixation, abnormal spacing, sprain or strain. Extraspinal manipulation also known as Extraspinal Manipulative Therapy (EMT) is not a covered benefit. Covered treatment is limited to 20 visits per Plan Year.

Circumcision – Expenses incurred for circumcision of a child under age one. Expenses for circumcision over age one are covered when Medically Necessary.

Clinical Trials – Testing, treatment, and any other services provided in conjunction with an approved Clinical Trial are covered only if the Clinical Trial protocols and documents are submitted and pre-approved by the Prime Healthcare Utilization Management Department.

The following items, devices and/or services provided in conjunction with an approved Clinical Trial are not covered under the Plan: (1) items and services not required for clinical management; and (2) services not consistent with evidence-based guidelines or widely accepted and established standards of care for the particular diagnosis.

Complex Imaging Services – see "Diagnostic Lab and X-ray, Outpatient" below.

Contraception – Subject to reasonable medical management techniques, all Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity as prescribed by a Network Provider.

The administration of contraceptives by a Network Provider in a medical setting, such as sterilization services to place/remove/inject a contraceptive method will be covered under the Medical Benefit. For example, when performed by a Network Provider, the following contraceptive procedures and devices are covered as Preventive Care under the Medical Benefit and not the **Prescription Drug Program** without cost-sharing:

- Intrauterine devices (IUD) including insertion and removal;
- Diaphragms (covered under the pharmacy benefit if purchased by prescription at a participating pharmacy);
- Services to place/remove/inject covered FDA-approved contraceptive methods;
- Sterilization procedures for women, such as tubal ligations.
- Implantable contraceptive rods.

NOTE: Any contraceptive that can be obtained through the **Prescription Drug Program** (see **Prescription Drug Program** section), must be obtained through that program.

Contraceptive methods that are generally available over-the-counter are only included if the method is both FDA-approved and prescribed for a woman by her Network Provider.

Convalescent Facility/Rehabilitation Center - Inpatient care in Convalescent Facility/Rehabilitation Center, but only when the admission to the facility/center is Medically Necessary and is ordered by a Physician in lieu of Hospital confinement.

Dental Care – Facility services and supplies, including general anesthesia, when provided in connection with a dental procedure where Hospital services or use of the Outpatient services of a Hospital or Ambulatory Surgical Center is required because of an underlying medical condition or clinical status of a Covered Person who: (1) is under the age of seven years; (2) is developmentally disabled, regardless of age; or (3) has impaired health and general anesthesia is Medically Necessary. Prior authorization by the Prime Healthcare Utilization Management Department is required for services to be covered under the Plan.

Diabetes Education – Charges for services of a Physician or other professionals who are knowledgeable about the treatment of diabetes (such as a Registered Nurse, registered pharmacist or registered dietitian) for the purpose of enabling a diabetic and his family to understand and practice daily management of diabetes.

Diagnostic Lab, X-ray, and Radiology, Outpatient – Laboratory, X-ray, radiology, 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, Acute – Dialysis services and supplies, for acute onset of kidney failure necessitating such services. The Plan covers a maximum of 39 treatments per Covered Person for that individual's lifetime.

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.

Repair of purchased equipment when necessary to maintain its usability. Replacement of equipment but only if: (1) needed due to a change in the Covered Person's physical condition, or (2) it is likely to cost less to buy a replacement than to repair existing equipment or rent like equipment.

"Durable Medical Equipment" includes items such as crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment that: (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 Illness or Injury, and (4) are appropriate for use in the home.

For Insulin and Diabetic Supplies – see the "**Prescription Drug Program**" for additional information.

NOTE: Coverage is limited to the least expensive item that is adequate for the Covered Person's needs. Duplicate equipment, support equipment (such as racks and lifts) and excess charges for deluxe equipment or devices are <u>not</u> covered.

Emergency Medical Condition – see "**Definitions**"

Emergency Services – see "**Definitions**"

Gender Dysphoria – Services and treatment related to Gender Dysphoria including surgical services, hormone replacement therapy and Mental Health therapy.

Hearing Examinations – Benefits will be provided for hearing examinations for the purpose of diagnosing a medical condition. In addition, routine hearing examinations will be covered when billed as routine and included as a part of the annual well visit.

NOTE: Benefits are not provided for hearing aids or the examinations for the prescription or fitting of hearing aids.

Home Health Care – Services and supplies that are furnished to a Covered Person by a Home Health Care Agency and in accordance with a written Home Health Care plan. The Home Health Care plan must be established by the Covered Person's attending Physician and must be monitored by the Physician during the period of Home Health Care. Also, the attending Physician in conjunction with the Prime Healthcare Utilization Management Department must 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, but are not limited to:

- Intermittent services of a Registered Nurse or services by a Licensed Vocational Nurse if an Registered Nurse is not available;
- Intermittent services of Physical, Occupational and Speech Therapists;
- Intermittent services of home health aides;
- Medical supplies, drugs and medicines prescribed by a Physician and laboratory services.

NOTE: Covered Home Health Care expenses will not include food, food supplements, home delivered meals, transportation, housekeeping services or other services that are custodial in nature and could be rendered by non-professionals.

Hormone Therapy – (see "**Gender Dysphoria**" above).

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, but are not limited to, Hospice program charges for:

Inpatient care in a Hospice facility, a Hospital or a Skilled Nursing Facility Center for pain control and other acute and chronic symptom management;

Outpatient services and supplies, including: medical social services under the direction of a Physician including: (1) assessment of the person's social, emotional and medical needs and the home and family situation, and (2) identification of the community resources that are available and assisting the person to obtain those resources.

NOTE: Hospice care coverage does not include expenses for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services, or respite care.

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

Injectables – Injectables that are not available through the **Prescription Drug Program** and professional services for their administration.

Intensive Care Unit (ICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit – Treatment for critically and seriously ill or injured patients requiring constant observation as prescribed by the attending Physician, including room and board.

Maternity Services – Includes global charges such as routine antepartum care, delivery (including routine newborn Hospital care) and mother's postpartum care.

Medical Supplies, Disposable – Disposable medical supplies such as surgical dressings, catheters, colostomy bags and related supplies.

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. See the **Prescription Drug Program** for pharmacy drugs.

Mental Health Care – Eligible Expenses for the Medically Necessary treatment of Mental Health Conditions as follows:

- Inpatient Hospital and Residential Treatment Facility services as described herein;
- Physician visits during a covered Inpatient stay;
- Physician visits for Outpatient psychotherapy or psychological testing or Outpatient rehabilitative care at a Day Treatment Center for the treatment of Mental Health Conditions; and
- Inpatient Covered Prescription Drugs.

Treatment of mental health conditions in the following categories:

- Diagnosis and Medically Necessary treatment of "severe mental disorders"; and
- Diagnosis and Medically Necessary treatment of "other covered mental health conditions."
- Severe mental disorders - For these purposes, a "severe mental disorder" means:
- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorder
- Panic disorder
- Obsessive-compulsive disorder (OCD)
- Pervasive developmental disorder (except as excluded in Medical Limitations and Exclusions)
- Anorexia nervosa
- Bulimia nervosa
- Paranoia and other psychotic disorders
- Serious emotional disturbances of a child (i.e., a child who has one or more mental disorders as identified in the fourth edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) (other than a primary Substance Use Disorder or

developmental disorder), that: (1) result in behavior inappropriate to the child's age according to expected developmental norms, and (2) who meets the criteria of subdivision (a) of Section 5600.3 of the Welfare and Institutions Code that states that such persons shall meet one or more of the following criteria:

a. As a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either of the following has occurred: the child is at risk of removal from the home or has already been removed from the home, or the mental disorder and impairments have been present for more than six months or, without treatment, are likely to continue for more than one year;

b. The child displays one of the following: psychotic features: risk of suicide or risk of violence due to a mental disorder.

- Treatment of severe mental disorders may be provided through Outpatient services, Inpatient Hospital services and prescription drugs.
- Other Covered Mental Health Conditions - For these purposes, "other covered mental health conditions" will include conditions that affect thinking and the ability to figure things out, perception, mood and behavior - but not those conditions that are expressly included in the list of severe mental disorders (above) or that are excluded in the list of **Medical Limitations and Exclusions**.

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 Ill or Injured.

Also see "Pregnancy Care" for newborn expenses.

Nursing Services – Nursing services by a Registered Nurse or a nursing agency when Medically Necessary and prescribed and certified in writing by the attending Physician or surgeon in conjunction with the Prime Healthcare Utilization Management Department specifically as to duration and type.

Occupational Therapy – see "Therapy, Outpatient/Short-Term."

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 Injury.

Special footwear when needed due to foot disfigurements including disfigurement from cerebral palsy, arthritis, polio, spina bifida, diabetes and foot disfigurement caused by Injury or developmental disability.

Orthopedic Shoes – Orthopedic shoes, but only if they are an integral part of a leg brace.

Repair or replacement of an orthotic. However, replacement of an orthotic will only be

covered if:

- There is a change in the Covered Person's physical condition;
- Replacement is necessary due to normal growth or wear and tear;
- It is likely to cost less to buy a new device than to repair the existing one; or
- The existing device cannot be made serviceable.

NOTE: Expenses related to the repair and replacement of an orthotic due to misuse or loss are not covered.

Oxygen – see "Durable Medical Equipment."

Physical Therapy – see "Therapy, Outpatient/Short-Term."

Physician Services – Medical and surgical treatment by a Physician (MD or DO), including office, home or Hospital visits, clinic care and consultations.

Pregnancy Care – Pregnancy-related expenses of a covered Employee or a covered Dependent (including spouse, Registered Domestic Partner, or Dependent children) are covered. Eligible Pregnancy-related expenses are covered in the same manner as expenses for an Illness and include the following, 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;
- Expenses associated with a normal or cesarean delivery as well as expenses associated with any complications of Pregnancy;
- Genetic testing or counseling when deemed Medically Necessary;
- Newborn Hospital services provided during the Employee's, spouse's, or Registered Domestic Partner's confinement for delivery, but not to exceed the minimum requirements of the Newborns' and Mothers' Health Protection Act (see below). This will not apply, however, if the newborn is a Covered Person and the charges are covered as the newborn's own claim. Expenses of a Covered Person's daughter's newborn child are not eligible.

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. Early discharge is 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, or (3) expenses of a paid surrogate mother.

The Plan shall have full discretion to place a lien on any compensation paid to or in respect of a surrogate mother for such services and who is a Covered Person who has entered into an Assisted Reproduction Agreement under California Family Code Sections 7960 – 7962, or

other similar applicable state law.

Prescription Drugs – Medicines that are dispensed and administered to a Covered Person during Inpatient services, 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 Drug Program** for additional information.

Preventive Care Service – Preventive Care Services required by the ACA to be provided without cost sharing as described in **Appendix A**.

Prosthetics – External prosthetics such as artificial limbs, eyes or other appliances to replace natural body parts, including the fitting and adjustment of such appliances.

- Internally implanted prosthetics such as pacemakers and hip and knee joint replacements.
- A device and the installation of accessories to restore a method of speaking for a Covered Person following a laryngectomy.
- Post-mastectomy breast prostheses as required by the Women's Health and Cancer Rights Act.

NOTE: Prosthetics coverage does <u>not</u> include:

- Dental prosthetics, except as expressly included under "Dental Care" in the **Medical Limitations and Exclusions** section;
- Eyeglasses, vision aids or hearing aids;
- Communications aids, except as expressly included above;
- Repair or replacement of a prosthetic device except for: (1) replacement that is necessary due to a change in the Covered Person's physical condition, (2) repair or replacement that is necessary due to normal wear and tear, or (3) replacement when it is likely to cost less to buy a new prosthetic than to repair the existing one or when the existing prosthetic cannot be made serviceable.

Radiation Therapy – see "Chemotherapy and Radiation Therapy."

Rehabilitation Center – see "Skilled Nursing Facility."

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 Surgical Opinion – Charges for second surgical opinion, when Medically Necessary.

Semi-Private Room Accommodations – 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 up to 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.

Skilled Nursing Facility – Inpatient care in a Skilled Nursing Facility or Rehabilitation Center, but only when the admission to the facility/center is Medically Necessary and is ordered by a Physician in lieu of Hospital confinement. Coverage shall be limited to 90 days per incident.

Speech Therapy – see "Therapy, Outpatient/Short-Term."

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 – Medically Necessary treatment of Substance Use Disorders including (i) Inpatient Hospital services and services from a Residential Treatment Facility; (ii) partial hospitalization programs and visits to a day treatment center; and (iii) Outpatient services such as counseling and drug therapy monitoring and medical treatment for withdrawal symptoms.

Surgery – Surgical operations and procedures, unless otherwise specifically excluded under the Plan.

Therapy, Outpatient/Short-Term – The following therapy services when provided on an Outpatient basis, when such therapy is expected to result in the improvement of a body function (including the restoration of a speech function) that has been lost or impaired due to Injury, Illness or congenital defect, and when such therapy is expected to result in significant improvement of the person's condition within thirty (30) days from the date the therapy begins:

- Occupational therapy
- Physical therapy
- Speech therapy

For therapy services provided in the patient's home, see "Home Health Care."

Trauma Services – Medical services at a Trauma Center for Emergency Services. The Plan does not cover trauma activation fees when the services are for minor injuries not warranting Trauma Center care. Trauma activation and medical services provided at a Trauma Center for non-Emergency Services will not be covered under the Plan unless otherwise authorized under the **Utilization Management Program**.

Transplant-Related Expenses – Eligible Expenses incurred by a Covered Person who is the recipient of a listed organ or tissue transplant that is not experimental or investigational in nature:

- bone marrow transplant
- heart transplant
- heart/lung transplant
- kidney transplant
- kidney/pancreas transplant
- liver transplant
- lung transplant
- pancreas transplant

A transplant must be ordered by a Network Physician and services must be performed at a facility designated by the Prime Healthcare Utilization Management Department.

Eligible Expenses for the medical and surgical expenses of a live donor are covered only if the donor is not covered by another plan or program and the services for the donor are provided at a facility designated by the Prime Healthcare Utilization Management Department.

Evaluation, maintenance, and follow-up services that can be performed at a Prime Healthcare Network Facility will be directed and approved within the Prime Healthcare Network or a facility designated by the Prime Healthcare Utilization Management Department. Such services will not be covered unless they are obtained at Prime Healthcare Network Facilities or at facilities designated by the Prime Healthcare Utilization Management Department.

NOTE: Transplant-related expenses will not include any expenses incurred for travel, lodging, or meals for the patient or for any companion(s) traveling with the patient.

Travel Outside United States - Medical services outside the United States are not covered, unless the Employee is traveling for business for Prime. Travel insurance should be obtained prior to travel and will serve as primary insurance for all services.

Urgent Care – Services rendered for a sudden, serious or unexpected Illness, Injury or condition, which is not an Emergency Medical Condition but requires immediate care for the relief of pain or diagnosis and treatment of such condition.

MEDICAL LIMITATIONS AND EXCLUSIONS

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

Abortion – see "Family Planning" below.

Acupuncture – Acupuncture treatment.

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

Alcohol – Expenses caused by the Covered Person's intoxication or driving a motor vehicle with a blood alcohol concentration of .08% or higher or otherwise in violation.

Alcohol/Illegal Drugs or Medications – To a Covered Person, expenses for an injury arising from taking part in any activity made illegal due to the use of alcohol (e.g. driving with a blood alcohol concentration of .08 or more) or voluntary taking of, or being under the influence of, any controlled substance, drug, hallucinogen, narcotic or similar substance not administered on the advice of a Physician and not illegal under State and Federal law. Expenses will be covered for injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol, controlled or illegal substances, and expenses may be covered for Substance Use Disorder treatment as specified in this Plan, if applicable. This exclusion does not apply to: (a) if the injury resulted from being the victim of an act of domestic violence, or (b) resulted from a Covered Person's expenses for a medical condition (including both physical and mental health conditions).

Bariatric Surgical Procedures/ Weight Control - Except as provided in Appendix B, any surgical or non-surgical services or supplies other than Medically Necessary lab fees for the treatment of Obesity.

Biofeedback, Etc. – Biofeedback, recreational, or educational therapy.

Carbon Dioxide Therapy

Chiropractic Care – Extraspinal manipulation also known as Extraspinal Manipulative Therapy (EMT) is not a covered benefit.

Complications of Non-Covered Treatment and Services

Cosmetic and Reconstructive Surgery, Etc. – Any surgery, service, drug or supply designed to improve the appearance of an individual by alteration of a physical characteristic that is within the broad range of normal but that may be considered unpleasing or unsightly. This applies whether or not the service or supply is for psychological or emotional reasons unless the surgery is breast reduction covered in connection with surgery for Gender Dysphoria.

However, this exclusion will not apply to surgery intended to improve the function of a body part that is malformed (but is not a tooth or a structure that supports the teeth), when such surgery:

- Is to correct a congenital abnormality (severe birth defect) including cleft lip, webbed fingers or toes;

- Is performed to treat a Sickness, Injury, or complication resulting from non-covered treatment or service;
- Is required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as is determined by the attending Physician in consultation with the patient.

Counseling – Family, marriage, child, career, social adjustment, pastoral or financial counseling or other forms of self-care or self-help training or any related diagnostic testing.

Criminal Activities/Illegal Acts – see "General Exclusions."

Custodial and Maintenance Care – Care that does not restore health or care confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training.

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, Mouth and Jaw Care – Care or treatment on or to the teeth, jaws, jaw joints, gingival tissue, or for malocclusion, except for:

- Surgery to treat a fracture, dislocation or wound;
- Removal of partially or fully-impacted teeth, removal of teeth that will not erupt through the gum, or removal of other teeth that cannot be removed without cutting into bone;
- Removal of the roots of a tooth without removing the entire tooth;
- Removal of cysts, tumors or other diseased tissues;
- Cutting into the gums and tissues of the mouth when not done in connection with the removal, replacement or repair of teeth;
- Repair or prosthetic replacement of sound natural teeth that are damaged in an Injury;
- Nonsurgical treatment of infections or diseases that are not related to the teeth;
- Dental work, surgery and orthodontic treatment when needed to remove, repair, replace, restore or reposition natural teeth damaged, lost or removed, or other body tissues of the mouth that are fractured or cut due to Injury. Any such teeth must have been free from decay or in good repair and firmly attached to the jaw bone at the time of the accident. If crown, denture or bridgework or in-mouth appliances are installed due to such Injury, Eligible Expenses will only include charges for: (1) the first denture or fixed bridge to replace lost teeth, (2) the first crown needed to repair each damaged tooth, and (2) an in-mouth appliance used in the first course of orthodontia treatment after the Injury.

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, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin that are not specifically approved by the FDA as effective for treatment.

Environmental change, including Hospital or Physician expenses incurred in connection with prescribing an environmental change.

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 Injury or Illness, except as may be expressly included.

Enhanced External Counterpulsation Therapy (EECP)

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

Family Planning – Family planning-related services or supplies including:

- Infertility testing, treatment, or the use of advanced reproductive technologies (e.g., in vitro fertilization (IVF or egg donation);
- Reversal of a sterilization procedure;
- Elective abortion, except when the mother's life is in immediate danger; and
- When complications arise out of an abortion.

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, plantar fasciitis 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 except as expressly allowed (see "Orthotics" in the **Eligible Medical Expenses** section).

NOTE: This exclusion does not apply to the initial Physician visit and related diagnostic procedures to establish the diagnosis and 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) or covered Foot Care as defined under Medicare (CMS) Podiatry Services guidelines.

Genetic Counseling or Testing – Counseling or testing concerning inherited (genetic) disorders. However, this limitation does not apply when such services are determined by a Physician to be Medically Necessary and pre-authorized by Prime Healthcare UMO during the course of a covered Pregnancy or are Preventive Care Services.

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

Hair Pieces – Wigs, artificial hair pieces, human or artificial hair transplants, or any drug, prescription or otherwise, used to eliminate baldness.

Hearing Aids – Hearing aids or the examinations for the prescription or 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.

Maintenance Care – see "Custodial and Maintenance Care."

Massage Therapy

Medical Errors – Treatment that is required to treat Injuries that are sustained or an Illness that is contracted, including infections and complications, while the Covered Person was under, and due to, the care of a Provider wherein such Illness, Injury, infection or complication is not reasonably expected to occur. This provision works in coordination with the Plan's subrogation, reimbursement, and/or third-party responsibility provisions. This exclusion will apply to expenses directly or indirectly resulting from the circumstances of the course of treatment, that, in the opinion of the Plan Administrator, in its sole discretion, unreasonably gave rise to the expense.

Megavitamin Therapy

Newborn Care – For a child of a Dependent child.

Non-Prescription Drugs – Drugs for use outside of a Hospital or other Inpatient facility that are purchased over-the-counter and without a Physician's written prescription – except as may be included in the Plan's prescription coverages or is a Preventive Care Service.

Drugs for which there is a non-prescription equivalent available except as covered as a Preventive Care Service.

Not Medically Necessary/Not Physician Prescribed/Not Generally-Accepted – Any services or supplies that are: (1) not Medically Necessary, (2) not recommended on the advice of a Physician – unless expressly included herein, or (3) not in accordance with generally-accepted professional medical standards. For example, Trauma activation fees or services related to the treatment of minor injuries for which such care is not Medically Necessary will not be covered under the Plan.

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.

Nutrition Counseling – Dietary treatment of disease or condition except those included within the "Preventive Care" coverages (see **Appendix A**).

Orthopedic Shoes – Orthopedic shoes, unless they are an integral part of a leg brace and the cost is included in the orthotist's charge, and other supportive devices for the feet.

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.

Rolfing – A holistic system of bodywork that uses deep manipulation of the body's soft tissue to realign and balance the body's myofascial structure.

Self-Inflicted – Injuries that are the result of intentionally self-inflicted Injuries or Illnesses. This exclusion does not apply to: (a) an Injury resulting from being the victim of an act of domestic violence, or (b) resulting from a medical condition (including both physical and Mental Health Conditions).

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 – Non-organic sexual dysfunctions. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment unrelated to Gender Dysphoria.

Sleep Disorder Testing - Testing and treatment for diagnosis of sleep disorders. Sleep disorders include insomnia, narcolepsy, sleep apnea and parasomnias, including the treatment or supplies (i.e. CPAP machines, etc.)

Subrogation, Reimbursement, and/or Third-Party Responsibility – Any charge for care, supplies, treatment, and/or services of an Injury or Illness not payable by virtue of the Plan's subrogation, reimbursement, and/or third-party responsibility provisions.

Therapy, Outpatient/Short-term Therapy – Spinal manipulation is not a covered benefit when rendered by a licensed or certified Physical Therapist.

TMJ – Splint therapy or surgical treatment for, or in connection with, temporomandibular joint disorders, myofacial pain dysfunction or orthognathic treatment.

Transplant Related Services – Transplant related expenses will not include any expenses incurred for travel, lodging or meals for the patient or for any companion(s) traveling with the patient. In addition, Eligible Expenses for a live donor who is covered by another plan or

program, will not be covered.

Ultrasounds – The use of 3-D or 4-D fetal ultrasound is considered **investigational and not Medically Necessary** in all cases.

Vaccinations – Immunizations or vaccinations other than: (1) those included within the "Preventive Care" coverages (see the **Medical Benefit Summary** and **Appendix A**); (2) Hepatitis B screening and vaccination for healthcare workers; and (3) tetanus or rabies vaccinations administered in connection with an 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 an Illness or Injury, or (2) the initial purchase of glasses or contact lenses following cataract surgery, or (3) aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

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

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

Wigs or Wig Maintenance – see "Hair Restoration."

(SEE ALSO GENERAL EXCLUSIONS SECTION)

PRESCRIPTION DRUG PROGRAM

Prescription drug coverage is provided through Express Scripts – an independent prescription drug program Provider. The following is a summary of the program. See the attached addendum for Copay and additional details about the coverage provided through the prescription drug program.

Certain specialty drugs, such as injectables, must be obtained through Accredo, an Express Scripts Specialty Pharmacy. In some cases, when a prescription drug is used for the first time, a one month's supply may be available from a retail pharmacy. For certain drugs, there is no opportunity for a one month's supply through a retail pharmacy. Covered Persons may be required to enroll in SaveonSP's Copay assistance program through Accredo to maximize their savings on the cost of such drugs. Otherwise, the prescription drug will not be covered. Accredo and/or SaveonSP will contact the Covered Person directly. For a list of SaveonSP Copay assistance prescriptions, please visit www.saveonsp.com/Primehealth or call SaveonSP at (800) 683-1074.

HOW TO USE THE PRESCRIPTION DRUG PROGRAM

Using a Participating Pharmacy. To identify an individual as a Covered Person for prescription drug benefits, the individual must present his ID Card to participating pharmacies when he has a prescription filled. Provided he has properly identified himself as a Covered Person, a participating pharmacy will only charge him the Copay. Many participating pharmacies display an "Rx" decal with the Express Scripts logo in their window. For information on how to locate a participating pharmacy, a Covered Person should call (866) 718-7955.

Please note that presentation of a prescription to a pharmacy or pharmacist does not constitute a claim for benefit coverage. If a Covered Person presents a prescription to a participating pharmacy, and the participating pharmacy indicates that the prescription cannot be filled, or requires an additional Copay, this is not considered an Adverse Benefit Determination. If the Covered Person wants the prescription filled, he will have to pay either the full cost, or the additional Copay, for the prescription drug. If the Covered Person believes he is entitled to some Plan benefits in connection with the prescription drug, he should submit a claim for reimbursement to Express Scripts at the address shown below:

Express Scripts Inc.
P.O. Box 14711
Lexington, KY 40512-4711

Participating pharmacies usually have claims forms, but, if the participating pharmacy does not have claim forms, claim forms from customer service are available by calling (866) 718-7955. A Covered Person should mail his claim form, with the appropriate portion completed by the pharmacist, to Express Scripts within 90 days of the date of purchase. If it is not reasonably possible to submit the claim within that time frame, an extension of up to 12 months will be allowed.

Using a Non-Participating Pharmacy. The Plan does not provide any benefit for prescription drugs purchased at a non-participating pharmacy.

Out of State. If a Covered Person needs to purchase a prescription drug out of state, he may locate a participating pharmacy by calling (866) 718-7955.

When a Prescription is Ordered Through the Mail. A Covered Person can order his prescription through the mail service prescription drug program. Not all medications are available through the mail service pharmacy. The prescription must state the drug name, dosage, directions for use, quantity, the Physician's name and phone number, the Covered Person's name and address, and be signed by a Physician. The Covered Person must submit it with the appropriate payment for the amount of the purchase, and a properly completed order form. The Covered Person need only pay the cost of his Copay. A Covered Person's first mail service prescription must also include a completed Patient Profile questionnaire. The Patient Profile questionnaire can be obtained by calling the toll-free number below. Covered Person need only enclose the prescription or refill notice, and the appropriate payment for any subsequent mail service prescriptions or call the toll-free number. Copays can be paid by check, money order or credit card. Order forms can be obtained by contacting customer service at (866) 718-7955 or by accessing the website at www.expressscripts.com.

Maintenance Medication Program. The prescription-drug benefit includes a maintenance medication program – for those medications taken regularly to treat ongoing conditions. This program can help Covered Persons save time, spend less and stay safe by getting these medications through Home Delivery. A Covered Person can receive two fills of each maintenance medication at his participating retail pharmacy. After that, he may order these prescriptions through Home Delivery from the Express Scripts Pharmacy, or per the Plan, pay a higher Copay at the participating retail pharmacy.

- Mail the prescriptions – Request a Home Delivery order form by calling customer service at (866) 718 -7955;

OR

- Use the website or ask Express Scripts to call the Covered Person's Physician – Express Scripts will call the Covered Person's Physician to get a new prescription for Home Delivery. This process typically takes 2 to 3 weeks from the time the Covered Person completes his online request. Just visit:

www.StartHomeDelivery.com
If a Covered Person doesn't have Internet access, call: (800) 899-2125
(7:30 a.m. – 5:00 p.m., Central time, Monday-Friday)

PRESCRIPTION DRUG UTILIZATION REVIEW

Express Scripts prescription drug benefits include utilization review of prescription drug usage for its Covered Person's health and safety. Certain drugs may require prior authorization. If there are patterns of over-utilization or misuse of drugs, a medical consultant will notify the Covered Person's personal Physician and his pharmacist. The Plan reserves the right to limit benefits to prevent overutilization of drugs.

PRESCRIPTION DRUG FORMULARY

Express Scripts uses a prescription drug formulary to help a Covered Person's doctor make prescribing decisions. The presence of a drug on the Plan's formulary list does not guarantee that the Covered Person will be prescribed that drug by his Physician. This list of outpatient

prescription drugs is developed by a committee of Physicians and pharmacists to determine which medications are sound, therapeutic and cost-effective choices. These medications, which include both generic and brand name drugs, are listed in the prescription drug formulary. The committee updates the formulary quarterly to ensure that the list includes drugs that are safe and effective. NOTE: The formulary drugs may change from time to time. Some drugs may require prior authorization. If a Covered Person has a question regarding whether a particular drug is on Express Scripts' formulary drug list or requires prior authorization, he should call Express Scripts at (866) 718-7955.

Specialty drugs will be provided through Accredo, an Express Scripts, Inc. Specialty Pharmacy. If the Plan denies a request for prior authorization of a drug that is not part of the formulary, a Covered Person's Physician may file a grievance by following the procedures described in the Express Scripts Claims Disclosure Notice detailing why the Physician believes an exception to the formulary should be made.

PRESCRIPTION DRUG CONDITIONS OF SERVICE

To be covered, the drug or medication must satisfy all of the following requirements:

- It must be prescribed by a licensed prescriber and be dispensed within one year of being prescribed, subject to federal and state laws.
- It must be approved for general use by the Food and Drug Administration (FDA) or similar state agency.
- It must be for the direct care and treatment of a Covered Person's Illness, Injury or condition. Dietary supplements, health aids or drugs for cosmetic purposes are not included. However, formulas prescribed by a Physician for the treatment of phenylketonuria are covered.
- It must be dispensed from a licensed retail pharmacy, or through the mail service program.
- It must not be used while a Covered Person is an Inpatient in any facility. Also, it must not be dispensed in or administered by an Outpatient facility.
- For a retail pharmacy, the prescription must not exceed a 30-day supply.
- For the mail service program, the prescription must not exceed a 90-day supply.
- The drug will be covered only if it is not covered under another benefit of the Plan.

Step Therapy – Drugs in certain ongoing drug therapy categories could be subject to Step Therapy. Step Therapy is a program in which certain drug classes are organized in a set of "steps" with generic drugs being the first step and brand name drugs being the second step. Please call Express Scripts at (866) 718-7955 for more information if you have a question regarding a specific medication.

COVERED DRUGS

Covered drugs include most prescription drugs (i.e., federal legend drugs which are prescribed by a Physician and which require a prescription either by federal or state law – and including off-label drugs covered and dispensed by the prescription program vendor) and certain non-

prescription items.

The following is a list of prescription and non-prescription drugs and supplies which are sometimes excluded by group health plans, but which are covered by this Plan:

Breast Cancer, Chemoprevention – see **Appendix A**.

Contraceptives – Subject to reasonable medical management techniques, the Plan will cover, without cost-sharing, all categories of Food and Drug Administration (FDA) approved contraceptive drugs for all women with reproductive capacity, as prescribed by a Network Provider and purchased through Express Scripts. See **Appendix A**.

Abortifacient drugs are not covered except to the extent administered in the course of an Abortion covered under the Plan, and in such cases are not covered as Preventive Care.

Dermatology Drugs – Tretinoin agents used in the treatment of acne for Covered Persons through age 25.

NOTE: Depigmentation products used for skin conditions requiring a bleaching agent are not covered.

Diabetic Supplies – Insulin and diabetic supplies including syringes, needles, insulin injectable devices, pump supplies, swabs, blood glucose calibration solutions, and urine tests.

NOTE: The Plan will cover one (1) diabetic testing monitor every 365 days at no cost to the Covered Person.

Folic Acid, Fluoride, Aspirin, and Iron Supplements – see **Appendix A**.

Hormone Replacement Therapy – Continuous hormone replacement therapy for the treatment of Gender Dysphoria.

Hyperactivity (ADD, ADHD) Drugs – (i.e., Exubera, Dexedrine, Desoxyn, and Adderall)

Smoking Cessation/Deterrent Drugs – Any type of drug or supply for smoking cessation (e.g., Zyban, Nicotrol Inhaler).

EXPENSES NOT COVERED

Prescription drug coverage will not include any of the following:

Administration – Any charge for the administration of a drug.

Blood, Blood Plasma and Biological Sera

Compound Medications

Cosmetic Products – Cosmetic-type drugs including photo-aged skin products such as Renova and Avage.

- Hair growth agents such as Propecia and Vaniqa.
- Injectable cosmetics such as Botox.

Equipment, Devices, Etc. – Devices of any type, even though such devices may require a prescription. These include but are not limited to:

- Respiratory therapy supplies such as aerochambers, spacers or nebulizers;
- Peak flow meters;
- Non-insulin syringes; and
- Artificial appliances or braces.

Erectile Dysfunction Drugs – Erectile dysfunction drugs (e.g., Viagra, Levitra, Cialis, Muse, Caverject, or Edex).

Excess Refills – Refills which exceed the number of times specified by a Physician or which are dispensed more than one (1) year from the date of the Physician's prescription order.

Experimental and Non-FDA Approved Drugs – Experimental drugs and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration. This exclusion does not apply to (i) off-label drugs covered and dispensed by the prescription program vendor, and (ii) covered drugs dispensed in connection with Clinical Trials.

Fertility Drugs – Except Oral/Vaginal drugs are covered.

Hair Loss Drugs – see "Cosmetic Products."

Homeopathic Drugs – Homeopathic drugs, legend or non-legend.

Immunization Agents – Serums, toxoids or vaccines, except those which are Preventive Care Services. See **Appendix A and Eligible Medical Expenses** Sections for more information on covered vaccinations.

Injectables – Injectable drugs, except for insulin and Avonex.

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-Home Use – Drugs intended for use in a health care facility (Hospital, Skilled Nursing Facility, etc.) or in Physician's office or setting other than home use.

Non-Prescription Drugs – A drug or medicine that is bought without a written prescription. This does not apply to insulin.

Ostomy Supplies

OTC Equivalents – Except as provided herein or in the **Appendix A**, products obtained "over-the-counter" (i.e., without a prescription) that are identical to prescription drugs in active chemical ingredient, dosage form, strength and route of administration.

Replacement Prescriptions – Replacement of a prescription that has been lost, except that replacement of one (1) lost prescription per year will be covered.

Vitamins – Legend and non-legend vitamins, except for prenatal vitamins and legend fluoride products.

Weight Management Drugs – Drugs used to suppress appetite and control fat absorption (e.g., Xenical, Meridia).

DISCLAIMER: THIS PRESCRIPTION INFORMATION IS ONLY A SUMMARY. IF THERE ARE ANY CONFLICTS BETWEEN THIS PRESCRIPTION INFORMATION AND THE TERMS OF AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND THE PRESCRIPTION PROGRAM VENDOR, THE TERMS OF THE AGREEMENT(S) WILL GOVERN.

GENERAL EXCLUSIONS

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

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 treatment would have been covered in the absence of the court order.

Criminal Activities/Illegal Acts – Any Injury resulting from or occurring during a Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation.

This exclusion will not apply to Injuries suffered by a Covered Person who is a victim of domestic violence.

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

Excess Charges – Charges in excess of the Allowable Charges for services or supplies provided.

Experimental/Investigational Treatment – Expenses for treatments, procedures, devices, or drugs which the Plan determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

- approval of the U.S. Food and Drug Administration for marketing the drug or device has been given at the time it is furnished, if such approval is required by law; and
- reliable evidence shows that the treatment, procedure, device or drug is not the subject of ongoing phase I, II, or III Clinical Trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses; and
- reliable evidence shows that the consensus of opinion among experts regarding the treatment, procedure, device, or drug is that further studies or Clinical Trials are not necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnoses.

"Reliable evidence" shall include anything determined to be such by the Plan, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *CMS Medicare Coverage Issues Manual.*

Forms Completion – Charges made for the completion of claim forms or for providing supplemental information.

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

and for which the Covered Person has no legal obligation to pay.

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.

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

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.

No Charge/No Legal Requirement to Pay – Services for which no charge is made or for which a Covered Person is not required to pay or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved, and this Plan is a "secondary" coverage, this exclusion will apply to those amounts a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

NOTE: This exclusion does not apply to any benefit or coverage that is available through the Medical Assistance Act (Medicaid).

Not Listed Services or Supplies – Any services, care or supplies that are not specifically listed in the Benefit Document as Eligible Expenses.

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.

Outside United States – Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services or supplies, unless such services or supplies are furnished in connection with an emergency while traveling for business for Prime.

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/After Termination Date – Charges incurred prior to an individual's effective date of coverage hereunder or after coverage is terminated, except as may be expressly stated.

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 imposed under state law.

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.

War or Active Duty – Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country, to the extent not prohibited by law.

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.

COORDINATION OF BENEFITS (COB)

All health care benefits provided hereunder are subject to Coordination of Benefits as described below, unless specifically stated otherwise. These coordination provisions apply separately to each Covered Person, per Plan Year. Coordination of Benefits applies to the medical benefits included in This Plan.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Allowable Expense – Any necessary, reasonable and customary item of expense which is at least partially covered by at least one Other Plan covering the person for whom a claim is made. When a Plan provides benefits in the form of services rather than cash payments, the reasonable cash value for each service rendered will be deemed to be both an Allowable Expense and a benefit paid.

Claim Determination Period – A period that commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Other Plan – Any of the following that provides health care benefits or services:

- Group, blanket, or franchise health insurance coverage;
- Group service plan contract, group practice, group individual practice and other group prepayment coverages;
- Group coverage under labor-management trusteed plans, union benefit organization plans, employer organization plans, employee benefit organization plans or self-insured employee benefit plans;
- Medicare. However, this does not include Medicare when, by law, its benefits are secondary to those of any private insurance program or other non-governmental program.

NOTES: The term "Other Plan" refers separately to each agreement, policy, contract, or other arrangement for services and benefits, and only to that portion of such agreement, policy, contract or arrangement which reserves the right to take the services or benefits of Other Plans into consideration in determining benefits.

An "Other Plan" includes benefits that are actually paid or payable or benefits that would have been paid or payable if a claim had been properly made for them.

If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

Primary Plan – The plan which will have its benefits determined first.

This Plan – The medical benefits that are described in this Benefit Document.

EFFECT ON BENEFITS UNDER THIS PLAN

Whether This Plan is the Primary Plan or a secondary plan is determined in accordance with the following rules. However, these rules do not apply when This Plan provides "excess" benefits. See the "When This Plan Provides Excess Benefits Only" provision at the end of this section for more information.

- If this Plan is the Primary Plan, then its benefits will be determined first without taking into account the benefits or services of any Other Plan.
- If This Plan is not the Primary Plan, then its benefits may be reduced so that the benefits and services of all the plans do not exceed the Allowable Expense.
- The benefits of This Plan will never be greater than the sum of the benefits that would have been paid if the Covered Person were covered under This Plan only.

When an HMO or Service Plan Contract is the Primary Plan – If an individual is covered by a Health Maintenance Organization (HMO) or service plan contract and that coverage is the individual's Primary Plan but the individual does not use the HMO or service plan for his health care needs, then the HMO must be presented with the non-HMO health care billings. Upon the HMO's or service plan's refusal to pay for health care expenses incurred by the Claimant, the respective denials and the Claimant's bills for health care services must be submitted to the Plan's Contract Administrator before any benefits will be considered under This Plan.

When an Other Plan Does Not Contain a COB Provision – If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be the Primary Plan and This Plan will pay its benefits AFTER such Other Plan. This Plan's liability will be the lesser of: (a) its normal liability, or (b) total Allowable Expenses minus benefits paid or payable by the Other Plan.

When an Other Plan Contains a COB Provision – When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan, it will pay the lesser of: (1) its normal liability, or (2) total Allowable Expenses minus benefits paid or payable by the Other Plan.

ORDER OF BENEFIT DETERMINATION

Whether This Plan is the Primary Plan or a secondary plan is determined in accordance with the following rules. However, these rules do not apply when This Plan provides "excess" benefits. See the "When This Plan Provides Excess Benefits Only" provision at the end of this section for more information.

No COB Provision – If an Other Plan does not contain a coordination of benefit provision, then the Other Plan will be primary and This Plan will be secondary. This would include Medicare in all cases, except when the law requires that This Plan pays before Medicare.

Non-Dependent vs. Dependent – The benefits of a plan that covers the Claimant as an Employee pays before a Plan that covers the Claimant as a Dependent. But, if the Claimant is retired and eligible for Medicare, Medicare pays: (a) after the plan which covers the Claimant as a Dependent of an active Employee, but (b) before the plan which covers the Claimant as a retired Employee.

Child Covered Under More Than One Plan – When the Claimant is a Dependent child, the Primary Plan is the plan of the parent whose birthday is earlier in the Plan Year. But if one plan does not have a birthday rule provision, the provisions of that plan determine the order of benefits.

EXCEPTION: For a Dependent child of parents who are divorced, separated or domestic partnership dissolved the following rules will be used in place of the above paragraph:

- If the parent with custody of the child for whom a claim has been made has not remarried or has not entered into a domestic partnership, then the plan of the parent with custody that covers that child as a Dependent pays first.
- If the parent with custody of the child for whom a claim has been made has remarried or has entered into a domestic partnership, then the order in which benefits are paid will be as follows:

  a) The plan which covers the child as a Dependent of the parent with custody.

  b) The plan which covers the child as a Dependent of the stepparent (married/domestic partner to the parent with custody).

  c) The plan which covers the child as a Dependent of the parent without custody.

  d) The plan which covers the child as a Dependent of the stepparent (married/domestic partner to the parent without custody).

When the Claimant is a Dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, then that plan is primary. This rule applies to Claim Determination Periods commencing after the plan is given notice of the court decree.

When a Dependent child who has coverage under either or both parents' plans and also has coverage as a Dependent under a spouse's or domestic partner's plan, the Longer vs. Shorter Length of Coverage rule is used.

Active vs. Inactive Employee – The plan that covers the Claimant as a laid-off or retired Employee or as a Dependent of a laid-off or retired Employee pays after a plan that covers the Claimant as the Dependent of such a person. But if either plan does not have a provision regarding laid-off or retired Employees, the "Failure to Establish Order of Payment" provision (below) will apply.

Continuation Coverage (COBRA) Enrollee – If a Claimant is a COBRA enrollee under This Plan, an Other Plan covering the person as an Employee, Covered Person, subscriber, or retiree (or as that person's Dependent) is primary and This Plan is secondary. If the Other

Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage – If none of the above rules establish which plan is primary, the benefits of the plan that has covered the Claimant for the longer period of time will be determined before those of the plan that has covered that person for the shorter period of time.

Failure to Establish Order of Payment – If the preceding rules do not determine the order of payment between plans, then the plan under which the Claimant has been enrolled for the longest period of time will be the Primary Plan unless two of the plans have the same effective date. In this case, Allowable Expenses shall be shared equally between the two plans.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information – For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

This Plan is not responsible for coordination of benefits unless timely information has been provided by the requesting party regarding the application of this provision.

Reasonable Cash Value – If an Other Plan provides benefits in the form of services rather than cash payment, the reasonable cash value of services provided will be considered Allowable Expense. The reasonable cash value of such service will be considered a benefit paid, and This Plan's liability will be reduced accordingly.

Facility of Payment – A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery – If the amount of the payments made by This Plan is more than it should have paid under this COB section, This Plan may recover the excess from one or more of the persons it has paid or for whom it has paid – or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

BENEFITS FOR MEDICARE-ELIGIBLE COVERED PERSONS

If a Claimant is entitled to Medicare, he will receive the full benefits of This Plan, except as follows:

1. A Claimant receiving treatment for end-stage renal disease following the first 30 months is entitled to end-stage renal disease benefits under Medicare; or

2. A Claimant is entitled to Medicare benefits as a disabled person, unless he has a current employment status as determined by Medicare rules through a group plan of 100 or more Employees (according to federal COBRA legislation).

In cases where exceptions 1 or 2 apply, This Plan's payment will be determined according to these COB provisions and the following: This Plan will not provide benefits that duplicate any benefits to which a Claimant would be entitled under Medicare. This exclusion applies to all parts of Medicare in which the Claimant can enroll without paying additional premium. If a Claimant is required to pay additional premium for any part of Medicare, this exclusion will apply to that part of Medicare only if the Claimant is enrolled in that part.

WHEN "THIS PLAN" WILL PROVIDE EXCESS BENEFITS ONLY

Excess Benefits – If at the time of Injury or Illness, there is available, or potentially available any Coverage (see "Coverage" as defined in the **Subrogation and Reimbursement Provisions** section and 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. This Plan's benefits shall be excess to:

- Any responsible third 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.

Vehicle Limitation – When medical payments are available under any vehicle insurance, this 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.

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 or Illness is caused in whole or in part by, or results from the acts or omissions of Covered Persons, Plan Beneficiaries, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where another 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 one hundred percent (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. The Plan shall have an equitable lien on any funds received by the Covered Person 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 agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and the Covered Person shall be a trustee over those assets.

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 the Covered Person fails to so pursue said rights and/or action.

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 Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the

settlement, execution of a release, or receipt of applicable funds. This Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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 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. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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 Illness or Injury.

Excess Insurance – If at the time of Injury or Illness 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 **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.

Covered Person is a Trustee Over Plan Assets – Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he is required to:

- Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
- Instruct his attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;
- In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other sourced of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and

- Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any and all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

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 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)' obligation at all times, both prior to and after payment of medical benefits by the Plan to:

- 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 Illness 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;
- To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;
- 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;

- To instruct his attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;
- In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and
- To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

If the Covered Person(s) and/or his attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or Illness, 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)' cooperation or adherence to these terms.

Offset – If timely repayment is not made, or the Covered Person and/or his 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. This provision applies even if the Covered Person has disbursed settlement funds.

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 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 these provisions of 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 invalid or illegal language in such section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal provisions had never been inserted in the Plan.

ELIGIBILITY AND EFFECTIVE DATES

ELIGIBILITY REQUIREMENTS – EMPLOYEES

Employees at the facilities set forth in Appendix B are eligible to participate in the Plan if they are in 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). Please refer to the Benefit Guide for specific information regarding your facility's Eligibility requirements for Employees and Dependents.

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.

An Employee who is eligible to be covered as an Employee and as a Dependent cannot be covered as both.

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

Eligibility for Medicare, Medicaid or TRICARE or the receipt of benefits under such programs will not be taken into account in determining eligibility.

EFFECTIVE DATE – EMPLOYEES

An Employee's coverage is effective, subject to timely enrollment, on the first day of the month following or coinciding with two months of continuous active employment in an eligible status.

If an Employee fails to enroll within thirty-one (31) days after completing two months of employment, his coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights and Mid-Year Election Change Allowances" provisions below.

ELIGIBILITY REQUIREMENTS – DEPENDENTS

A Dependent who is eligible to be covered as an Employee and as a Dependent cannot be covered as both.

Except as noted at the end of this provision, an eligible Dependent of an Employee is a person who resides in the United States and is considered to be an Eligible dependent. Please refer to your facility Benefit Guide for additional information on eligibility requirements for your dependents

An "eligible child" is one who has a relationship with the Employee (e.g., a son, daughter, stepson or stepdaughter of the Employee, a legally adopted child or a child who is placed with the Employee for legal adoption. An eligible child also includes one for whom coverage is required due to an administrative or court order or a Qualified Medical Child Support Order.

NOTE: 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 Registered Domestic Partner following dissolution of the partnership (including any children of the Registered Domestic Partner who were eligible only because of the Registered Domestic Partnership);
- A spouse or Registered Domestic Partner who is eligible for coverage under another group medical plan that provides minimum value as described in section 36B(c)(2)(C)(ii) of the Code;
- Any person who is on active duty in any military service, except where eligibility is required by U.S. law;
- Any Dependent who is eligible for Dependent coverage but chooses to be enrolled as an Employee;
- Any person who is covered as a Dependent of another Employee;
- Any grandchild of an Employee, and other family members, i.e. brothers, sisters, (unless the Employee, spouse or Registered Domestic Partner has legal guardianship) and parents, in-laws, etc.;
- Any child born to a Covered Person resulting from an Assisted Reproduction Agreement under California Family Code Sections 7960 – 7962, or other similar applicable state law, and with respect to whom the Covered Person is not the "intended parent"; or
- Any person for whom an Employee is unable or refuses to show timely proof of eligibility as may be required from time to time by the Plan Administrator.

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 and Mid-Year Election Change Allowances" provision for additional 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 AND MID-YEAR ELECTION CHANGE ALLOWANCES

A Participant may enroll himself and/or family members into the Plan and change elections outside of the normal open enrollment period upon the happening of certain events as described below. However, the change must be requested timely (i.e. within the specified time frames).

Entitlement to Enroll Due to Loss of Other Coverage – An individual who did not enroll in the Plan when previously eligible will be allowed to apply for coverage hereunder at a later date if:

- He 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 major medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or Health Maintenance Organization (HMO) contract offered by a health insurance issuer;
- The Employee stated in writing at the time a prior enrollment was offered or available that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Administrator required such a written statement and provided the person with notice of the requirement and the consequences of failure to comply with the requirement; and
- The individual lost the other coverage as a result of an event, described below, and the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage and 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:

  a) Loss of eligibility as a result of a legal separation, divorce, cessation of dependent status, death of an Employee, termination of employment or reduction in the number of Hours of Service;

  b) 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);

  c) 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;

  d) 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;

e) Loss of eligibility when employer contributions toward the 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;

f) Loss of eligibility when COBRA continuation coverage is exhausted; and

g) Loss of eligibility under Medicaid or a state Children's Health Insurance Program (CHIP) or gain of eligibility for state premium assistance under Medicaid or CHIP.

If the above conditions are met, Plan coverage will become effective on the date the Plan is notified of the loss of other coverage.

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

Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes.

Entitlement to Enroll Due to Acquisition of New Spouse/Domestic Partner or any Dependent by Marriage/Domestic Partnership, Birth, Adoption or Placement for Adoption – If an Employee acquires one (1) or more new eligible Dependents through marriage, Registered Domestic Partnership, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage must be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (i.e. date of marriage/domestic partnership, birth, adoption or placement for adoption). Plan coverage will be effective as follows – see NOTE:

- Employee's marriage or Registered Domestic Partnership – the spouse's or partner's coverage (and the coverage of any newly eligible children) will be effective on the later of the date of marriage/registration or the date notice is provided to the Plan, subject to enrollment within thirty-one (31) days of the event;
- Acquisition of a child – the child's coverage will be effective on the date of birth, date of placement or date of adoption, subject to enrollment within 30 days of the event. The event date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty-one (31) days of birth.

NOTE: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must be eligible to enroll (i.e., must have satisfied any waiting period requirement) and must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when they were first eligible are not considered to be newly acquired and can only be enrolled in accordance with other enrollment allowances.

Court or Agency Ordered Coverage – If an Employee is required to provide coverage for a child under a Medical Child Support Order (MCSO), coverage for the child shall be effective as soon as administratively possible following the Plan Administrator's determination that the

order is qualified (i.e., is a QMCSO). A request to enroll the child may be made by the Employee or by a State Agency on the child's behalf.

If the Employee is not enrolled when the Plan is presented with a MCSO that is determined to be qualified, and the Employee's enrollment is required in order to enroll the child, both must be enrolled. The Employer is entitled to withhold any applicable payroll contributions for coverage from the Employee's pay.

OPEN ENROLLMENT

If an eligible Employee does not enroll when he is first eligible to do so or if he allows coverage to lapse, he may later enroll during an open enrollment period that will be held annually. Plan coverage will be effective on the date specified by the Plan Sponsor.

The open enrollment period is also a time when Employees can transfer coverage from one benefit option to another. The newly-elected option will become effective on the date specified by the Plan Sponsor following the open enrollment period.

NOTE: See "Special Enrollment Rights and Mid-Year Election Change Allowances" for exceptions to this provision.

REINSTATEMENT/REHIRE

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines, the Family and Medical Leave Act (FMLA), the California Family Rights Act (CFRA) or other similar applicable state law, and during the leave the 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/CFRA 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 Uniformed Services, will be reinstated to coverage hereunder immediately upon returning from such service.

See the **Extensions of Coverage** section for more information on when coverage may be continued during certain leaves of absence.

NOTE: Except in the above instances, any (i) current Employee who performs no Hours of Service, or (ii) terminated Employee who is rehired and, in either case, resumes providing services (or is otherwise credited with an Hour of Service) after a period of 13 consecutive weeks during which no Hours of Service were credited, may be treated as having terminated employment and having been rehired as a new Employee upon the resumption of services and will be required to satisfy all eligibility and enrollment requirements.

TRANSFER OF COVERAGE

If a husband and wife or members of a Registered Domestic Partnership are both Employees and are covered as Employees under this Plan and one of their employment terminates or they are on approved leave of absence, the terminating/leave spouse/Registered Domestic Partner and any of their 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

Except as noted, an Employee's coverage will terminate upon the earliest of the following:

- Termination of the Plan or termination of the Plan benefits as described herein;
- Employee's election to terminate participation, unless prohibited by law (i.e., when election changes cannot be made due to Code section 125 guidelines);
- Employee's failure to abide by the terms and conditions of the Plan;
- At midnight on the last day of the month in which the covered Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or engaged in active employment for the required number of Hours of Service as specified in **Eligibility and Effective Dates** section – except when coverage is extended under the **Extensions of Coverage** section;
- The date the Employee dies.

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

NOTE: 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 hereunder shall not be terminated 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;
- At midnight of the last day of the month in which the Dependent ceases to meet 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;
- 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;
- The date the Dependent dies;

- Immediately upon an Employee's failure to provide proof of eligibility for such Dependent as may be requested from time to time by the Plan Administrator or retroactively if coverage is Rescinded.

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 Employee's coverage ceases.

EXTENSION OF COVERAGE FOR HANDICAPPED DEPENDENT CHILDREN

If a Dependent child is incapable of self-support due to a mental or physical disability that began before the child attained the maximum age of 26 (regardless of current age), and such child is unable to be independent and is entirely dependent upon the Employee for support and maintenance, coverage may continue past the maximum age.

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 the maximum age, or if a newly eligible Employee, at the time of enrollment, and as may reasonably be required thereafter, but not more frequently than once a year.

A child's coverage will cease on the earlier of the following: (1) cessation of the disability; (2) the child is no longer primarily dependent upon the Employee for support and maintenance; (3) Employee's failure to provide proof that the disability continues when such proof is requested; or (4) when the child ceases to be eligible for any reason other than reaching the maximum age.

EXTENSIONS OF COVERAGE DURING ABSENCE FROM WORK

If an Employee fails 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 although 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), the California Pregnancy Disability Leave (PDL), the California Family Rights Act (CFRA), or other similar applicable state law, 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 the benefits of the Plan.

To the extent that the Employer is subject to FMLA and/or PDL, and CFRA, it intends to comply to the fullest extent required. Continued coverage under PDL shall run concurrently with coverage under FMLA.

Plan benefits may be maintained during an FMLA/CFRA/PDL leave at the levels and under the conditions that would have been present if employment was continuous. An Employee can obtain a more complete description of FMLA/CFRA/PDL rights from the Plan Sponsor's Human Resources or Personnel department.

Any Plan provisions which are found to conflict with the FMLA/CFRA/PDL 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 service member. A "covered service member" 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 service member medically unfit to perform his duties).

Extension of Coverage During Labor Dispute
If an Employee fails to continue in active employment due to a labor dispute, the Employee can arrange to continue coverage for up to six (6) months. This extension will cease, however, on the earlier of the following:

- at the beginning of the period for which the Employee fails to make the required payment toward the cost of coverage to his collective bargaining unit representative;
- at the beginning of the period for which the representative fails to make the required cost of coverage payments to the Plan Sponsor or Contract Administrator;
- on the date the Employee commences active employment with another employer;
- on any contribution due date when less than 75% of the affected Employees have elected to continue coverage under the terms of this provision;
- at the end of six (6) months following the cessation of active employment.

Extension of Coverage During Uniformed 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 uniformed service is (and the Employee's eligible Dependent(s) are) has the right to elect continuation of coverage under either USERRA or COBRA but not both. 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 uniformed service. Notice may be written or oral or may be given by an appropriate officer of the uniformed 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 uniformed 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 uniformed 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 uniformed 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 uniformed 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 uniformed leave is less than 31 days. If the Employee fails 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 uniformed 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 uniformed leave must notify the Employer of their intent to return to work. Notification (application for re-employment) must be made:

- Within 14 days after active uniformed service ceases for military leave of 31–180 days;

OR

- Within 90 days of completion of uniformed service for service of more than 180 days.

No re-employment application is required if the uniformed 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 re-employment.

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 USERRA 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.

(SEE **COBRA CONTINUATION COVERAGE**)

CLAIMS AND APPEALS PROCEDURES

It is the intent of the Plan Administrator that the following claims and appeals procedures comply with the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with ERISA or any other applicable law, such law shall control.

Nothing herein, shall be construed to supersede any provision of state law that regulates insurance, except to the extent that such law prevents application of a requirement under ERISA.

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 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 were received, and Provider name, address, phone number and tax identification number. Claims must be filed within one year from the date of service or the claim will be denied.

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

1. **A Pre-Service Claim** is one in which 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 a benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the Contract Administrator within one hundred eighty (180) days from the date of service. Providers may submit a Post-Service Claim on behalf of a Covered Person using HIPAA Electronic Transaction Standards.

   A Post-Service Claim should be submitted to:

   Keenan HealthCare
   P. O. Box 2744
   Torrance, CA 90509
   Fax: (310) 533-5755

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

To the extent permitted by law, and except as specified under the terms of the Plan, no benefits will be subject to alienation, sale, transfer, assignment, garnishment, execution or encumbrance of any kind, and any attempt to do so will be void. This means, for example, you may not assign to anyone your right to file a lawsuit against the Plan. Benefits under the Plan may be subject to a Qualified Medical Child Support Order (QMCSO), however.

The Plan may pay benefits directly to Providers. This payment, however, is made as a convenience to you and does not constitute an assignment of benefits under the Plan.

In the event the Plan does not pay benefits to a Provider in respect of a claim incurred by a Covered Person, the Covered Person will be responsible for paying the Provider any amounts due for the services received.

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 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 hereunder.

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 (e.g., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond). 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
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	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. The Claimant has a reasonable amount of time to provide the additional information but not less than 48 hours.

Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information.
Claimant Makes Initial Complete Claim Request	Whether adverse or not, within not more than 72 hours (and as soon as possible considering the medical exigencies), Plan responds with written or electronic benefit determination.
Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible considering the medical exigencies), after receipt of Claimant's appeal.
An "urgent claim" is an oral or written request for a 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. 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.	
Concurrent Care Claim - defined below	
Plan Wants to Reduce or Terminate Already Approved Care	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and sufficiently in advance 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.
Claimant Requests Extension for Urgent Care	Whether adverse or not, 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 treatment at least 24 hours prior to the expiration of the previously-approved period of time or treatment.
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.	

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 15 days of receipt of the incomplete claim request, Plan notifies Claimant of information needed to complete the claim request. Claimant has 45 days from receipt of the notice from the Plan within which to provide the information.
Plan Receives Completing Information	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.
Claimant Makes Initial Complete Claim Request	Whether adverse or not, 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.
Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal.
"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.	
"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of information needed to complete the claim request and the Claimant is afforded at least 45 days from receipt of the notice to provide the specified information.
Plan Receives Completing Information	Plan approves 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.
Claimant Makes Initial Complete Claim Request	Within a reasonable period of time but not later than 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to First Appeal	Within a reasonable period of time but not later than 30 days after receipt of the first appeal.
Plan Responds to Second Appeal	Within a reasonable period of time but not later than 30 days after receipt of the second appeal.
"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 or 60-day period.	

AUTHORIZED REPRESENTATIVE MAY ACT FOR CLAIMANT

Any of the above actions that can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf and who is authorized pursuant to the Plan Administrator's procedures and forms. For an urgent claim, a health care professional with knowledge of a Claimant's medical condition will be permitted to act as the authorized representative of the Claimant.

Independent Medical Examination
The Plan at its own expense will have the right and opportunity to require the examination of the person whose Injury or Illness is the basis of a claim when and as often as may be reasonably required during the pendency of a claim.

Claims Administration
For purposes of determining the amount of, and entitlement to, benefits under the Plan, the Plan Administrator or its delegate has the power to make factual determinations, request additional information and to interpret and apply the terms of the Plan in its complete and absolute discretion.

The Contract Administrator assists the Plan Administrator but does not have discretion in its administration of claims. However, the Contract Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary for the proper administration of a claim. (NOTE: The Contract Administrator is not the Plan Administrator for the purposes of ERISA.)

Avoiding Conflicts of Interest
The Plan shall ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) must not be made based upon the likelihood that the individual will support the denial of benefits.

CONTENT OF NOTICE OF INITIAL ADVERSE BENEFIT DETERMINATION

Except as provided in the subsection immediately below, the Contract Administrator shall provide a Claimant with written or electronic notification of any Adverse Benefit Determination. Any electronic notification shall comply with the standards imposed by Department of Labor Regulations at 29 CFR 2520.104b-1(c)(l)(i), (iii), and (iv) and 29 CFR 2590.715-2719. The notification shall set forth, in a culturally and linguistically appropriate manner, calculated to be understood by the Claimant:

- Information sufficient to identify the claim involved (including the date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
- The specific reason or reasons for the Adverse Benefit Determination;
- A description of the Plan's standard, if any, that was used in denying the claim;
- Reference to the specific Plan provisions on which the determination is based;
- A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
- A description of the Plan's review procedures and the time limits applicable to such procedures;
- Whichever of the following applies:

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

b) If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request.

- In the case of an Adverse Benefit Determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims; and
- A statement of the Claimant's right to bring a civil action under section 502(a) of ERISA following an External Review.

In the case of an Adverse Benefit Determination concerning a claim involving urgent care, the information described above may be provided to the Claimant orally within the time frame prescribed above, provided that a written or electronic notification is furnished to the Claimant not later than 3 days after the oral notification.

CLAIMANT RIGHTS TO A FULL AND FAIR REVIEW

A Claimant shall have a reasonable opportunity to appeal an Adverse Benefit Determination to an appropriate named Fiduciary of the Plan and shall be afforded a full and fair review of the claim and Adverse Benefit Determination.

A Claimant must appeal an initial Adverse Benefit Determination within 180 calendar days following receipt of notification of the Adverse Benefit Determination of a Post-Service Claim. Following notice of an Adverse Benefit Determination on review (i.e. first appeal), a Claimant may request a final review (i.e. second appeal) within 60 calendar days of the Notice of Adverse Benefit Determination on review.

A Claimant must submit a request for review of an initial Adverse Benefit Determination before a request for an External Review can be made unless this review process is deemed exhausted or a request for an Expedited Review is made, as described below:

- The Claimant will have an opportunity to submit written comments, evidence, testimony, documents, records, and other information relating to the claim;
- Upon request and free of charge, the Claimant will be provided reasonable access to and copies of all documents, records, and other information relevant to the claim. (A document, record, or other information shall be considered "relevant" to a claim if it was relied upon in making the benefit determination; was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination; or demonstrates compliance with administrative procedures and safeguards designed to ensure that claim determinations are made in accordance

with governing Benefit Documents and that, where appropriate, Plan provisions have been applied consistently with respect to similarly situated Claimants.);

- The Plan will take into account all comments, documents, records, and other information submitted that are related to the claim, without regard to whether such information was submitted or considered in the initial Adverse Benefit Determination;
- The Plan's review of an Adverse Benefit Determination on review must not afford deference to the initial Adverse Benefit Determination. It must ensure that a review is conducted by an appropriate named Fiduciary who is neither the individual who made the original Adverse Benefit Determination, nor that person's subordinate;
- In deciding an Appeal based, in whole or in part, on medical judgment, including a determination with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the appropriate named Fiduciary reviewing the appeal must consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment to evaluate the claim;
- Such review shall provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a Claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination;
- The Plan must ensure that a health care professional consulting on an appeal is not an individual who was consulted in connection with the original Adverse Benefit Determination, nor a subordinate of any such individual;
- Any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim will be provided, free of charge, automatically, as soon as possible and sufficiently in advance of the date of a Final Internal Adverse Benefit Determination to afford the Claimant a reasonable opportunity to respond before that date;
- Before the Plan can issue a Final Internal Adverse Benefit Determination based on a new or additional rationale, the Claimant must be provided, free of charge, with the rationale. The rationale must be provided as soon as possible, automatically, and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is required to be provided to give the Claimant a reasonable opportunity to respond prior to that date. (If the new or additional evidence is received so late that it would be impossible to provide it to Claimant in time, for the Claimant to have a rasonable opportunity to respond, the period for providing the Final Internal Adverse Benefit Determination is tolled until such time as the Claimant has a reasonable opportunity to rsepond. After the Claimant responds, or has a reasonable opportunity to respond but fails to do so, the Plan Administrator shall notify the Claimant of the Plan's benefit determination as soon as the Plan, acting in a reasonable and prompt fashion, can provide the notice, taking into account the medical exigencies.

For the purpose of these provisions, a health care professional is a Physician or other health care provider.

A request for diagnosis and treatment information, in itself, shall not be considered to be a

request for review under this Article.

Appeals should be submitted in writing to:

Keenan HealthCare
P. O. Box 2744
Torrance, CA 90509
Fax: (310) 533-5755
ATTENTION: APPEALS

A Claimant may have representation throughout the Appeals and review procedure.

CONTENT OF NOTICE OF DECISION ON INTERNAL APPEAL

The Plan Administrator shall provide a Claimant with written or electronic notice of the Plan's Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination in accordance with the applicable time frames set forth above. In the case of any Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination, the notice must state, in a culturally and linguistically appropriate manner and calculated to be understood by the Claimant:

- Information sufficient to identify the claim (including date of service, the Provider, the claim amount (if applicable), and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).
- The specific reason or reasons for the Adverse Benefit Determination.
- The reason or reasons for the Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination must include the denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim; in the case of a Final Adverse Benefit Determination, a discussion of the decision.
- Reference to the specific Plan provisions on which the benefit determination is based.
- A statement that the Claimant is entitled to receive, upon request and without charge, reasonable access to and copies of all documents, records, and other information "relevant" to the Claimant's claim for benefits.
- If the Adverse Benefit Determination on review or Final Internal Adverse Benefit Determination is based on Medical Necessity or Experimental and Investigational treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the Plan to the Claimant's medical condition, or a statement that this will be provided without charge upon request.
- A statement describing the Plan's optional appeals procedures, if any, and the Claimant's right to receive information about the procedures as well as the Claimant's right to bring a civil action under section 502(a) of ERISA.
- The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

- A description of available internal appeals and external review processes, including information regarding how to initiate an Appeal.
- If applicable, disclosure of the availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Public Health Service Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

EXTERNAL REVIEW REQUIREMENTS

A Claimant may request an External Review of an Adverse Benefit Determination (subject to the conditions stated herein) or Final Internal Adverse Benefit Determination that is based on the Plan's requirements for (i) medical judgment (including, but not limited to, the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care or effectiveness of a Covered Medical Expense); (ii) its determination that a treatment is Experimental and/or Investigational; (iii) its determination whether a Participant or other Covered Person is entitled to a reasonable alternative standard for a reward under a wellness program; (iv) its determination whether the Plan is complying with the nonquantitative treatment limitations provisions of MHPAEA (which generally require, among other things, parity in the application of medical management techniques); and (v) a Rescission (whether or not the Rescission has any effect on any particular benefit at that time).

A denial, reduction, termination, or a failure to provide payment for a benefit based upon a determination that a Covered Person fails to meet the requirements for eligibility under the terms of the Plan is not eligible for the External Review Process.

In connection with a request for an External Review, the request must be filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four (4) months after the date of receipt (e.g. February 28), the request must be filed by the first day of the fifth month following receipt of the notice. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The request is filed as described in the notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination.

External Review Process

Preliminary Review. Within five (5) business days after the date of the receipt of the External Review Request, a preliminary review must be completed by the Plan to determine whether:

- The claimant is or was covered by the Plan at the time the health care service or item was requested, or in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
- The Adverse Benefit Determination or Final Internal Adverse Benefit Determination does not relate to the individual's failure to meet the requirements for eligibility under the terms of the Plan;
- The Claimant has exhausted the Plan's internal appeal process, unless not required to exhaust the Internal Appeals Process as described in the **Expedited External Review** section; and

- The Claimant has provided all the information and forms required to process an External Review.

Completion of Preliminary Review. Within one (1) business day after completing the preliminary review, a written notification will be issued to the Claimant about the requested eligibility or ineligibility for External Review.

- If the request is complete but not eligible for External Review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefit Security Administration (EBSA) (Phone 866-444-EBSA(3272)).
- If the request is not complete, the notification must describe the information or materials needed to make the request complete, and the Claimant must be allowed to perfect the request for External Review within the four (4) month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Independent Review Organization Process

The External Review process is independent without bias and without cost or fees to the Claimant. If the request is eligible for External Review, the claim is assigned to and the review is conducted by an Independent Review Organization.

Each IRO has been contracted by the Plan. Assignments are rotated among IRO's on an objective and standardized basis. The IRO is not eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits. Referral timelines are as follows:

- The assigned IRO shall notify the Claimant, in a timely manner and in writing, whether the request is eligible for External Review. The notice from the IRO will include a statement that the Claimant may submit in writing to the assigned IRO, within ten (10) business days following the date of receipt of the notice, additional information. The assigned IRO must consider information submitted by the Claimant within the ten (10) business day period. The IRO may but is not required to accept and consider additional information submitted after ten (10) business days.
- Within five (5) business days after the assignment of the External Review to the IRO, the Plan will provide the IRO the documents and any information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the External Review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination.
- Upon receipt of information submitted by the Claimant, the IRO must within one business day forward the information to the Plan. Upon receipt of the information, the Plan may reconsider its determination. Reconsideration by the Plan must not delay the External Review. The External Review may be terminated as a result of the Plan's reconsideration only if the Plan decides to reverse its decision and provide coverage or payment. Within one business day after making such decision, the Plan must provide written notice of its decision to the Claimant and IRO. The IRO must terminate the External Review upon receipt of the notice from the Plan.
- The IRO will review all of the information and documents timely received to review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

- The assigned IRO must provide written notice of its Final External Review Decision within 45 days after receiving the request for the External Review from the Plan. The notice must be delivered to the Claimant and to the Plan. The written notice will contain:

  a) A general description of the reason for the request for External Review, including information sufficient to identify the claim;

  b) The date the IRO received the assignment;

  c) Reference to evidence or documentation, including the specific coverage provisions and evidence-based standards considered in reaching the decision;

  d) A discussion of the principal reason or reasons for its decision;

  e) A statement that the Final External Review Decision is binding except to the extent that other remedies may be available to the Plan or Claimant; and

  f) A statement that judicial review may be available to Claimant.

Upon receipt of the Final External Review Decision from the IRO that reverses (in whole or in part) the Adverse Benefit Determination of the Plan, the Plan must immediately provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim to the extent reversed by the Final External Review Decision.

EXPEDITED EXTERNAL REVIEW

External Review procedures may be expedited for cases where an Adverse Benefit Determination or a Final Internal Adverse Benefit Determination involves:

- a medical condition for which the timeframe for completion of an expedited internal Adverse Benefit Determination on review would seriously jeopardize the life or health of the Claimant, or would jeopardize the Claimant's ability to regain maximum function and the Claimant has filed a request for an expedited internal review of the initial Adverse Benefit Determination;
- with respect to a Final Internal Adverse Benefit Determination, the Claimant has a medical condition where the timeframe for completion of the standard External Review would seriously jeopardize the life or health of the Claimant or would jeopardize the Claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care service for which the Claimant received Emergency Services, but has not been discharged from a facility;
- Upon receipt of the request for Expedited External Review, the Plan must determine whether the request meets the preliminary review requirements;
- The Plan must provide all documents and any necessary information to the assigned IRO electronically, by telephone or facsimile or any other available expeditious method; and
- For an expedited External Review, the IRO must provide notice of the Final External Review Decision as expeditiously as the Claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an

expedited External Review. If the notice to the Claimant is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to the Claimant and the Plan.

ARBITRATION AGREEMENT

For cases that do not qualify for expedited External Review, all such disputes between a Plan participant, a participant's heirs, relatives, personal representatives, or other associated parties on the one hand, and the Plan, the Plan sponsor or any of its affiliates, its contracted health care providers, their agents, employees, or other associated parties on the other hand, arising out of or relating to the Plan, including any claim for benefits under the Plan (after exhausting the claims and appeals provisions provided herein), any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or the delivery of, services or items, irrespective of the legal theories upon which the claim is asserted, shall be decided by binding and confidential arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. Such arbitration shall address claims on an individual basis, and not on a class, collective or representative basis. By accepting coverage and/or benefits under the Plan, all participants and beneficiaries expressly waive their right to a court or jury trial and accept the use of binding arbitration pursuant to the rules of the American Arbitration Association and waive their right to be part of any class action related to the Plan. The venue for such arbiration shall be Los Angeles County unless otherwise agreed to by all parties to the dispute. Any demand for arbitration must be filed within two years after the Claimant's initial claim or within six months from the date of the claim decision on appeal, whichever comes first.

DEFINITIONS

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

An Injury will also include Injuries suffered by a Covered Person who is the victim of domestic violence.

Adverse Benefit Determination – Any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Participant's or other Covered Person's eligibility to participate in the Plan, and including, any denial, reduction or termination (in whole or in part) for a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

Adverse Benefit Determinations apply to pre-service claims, post-service claims and Rescissions (whether or not there is an adverse effect on any particular Benefit at that time), including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

- A determination of an individual's eligibility to participate in the Plan;
- A determination that an item or service is not a Covered Medical Expense or that a Prescription Drug is not a Covered Prescription Drug;
- The imposition of a source-of-injury exclusion, network exclusion, or other limitation on otherwise Covered Medical Expenses or Covered Prescription Drugs;
- A determination that an item or service is experimental, investigational, or not Medically Necessary or appropriate;
- A determination of entitlement to a reasonable alternative standard for a reward under a wellness program; or
- A determination of whether the Plan is complying with the nonquantitative treatment limitation provisions of the Mental Health Parity and Addiction Equity Act.

Affordable Care Act (ACA) – The Patient Protection and Affordable Care Act enacted on March 23, 2010.

Allowable Charge(s) – Except as expressly allowed in the **Medical and Prescription Drug Benefits** section of this Plan, Allowable Charges will apply to covered services that are approved under the rules of the Utilization Management Program as follows:

Network Providers – Allowable Charges shall be the lesser of:

- The amount billed;
- The amount contracted (the Network Provider's Prime negotiated rate, if any); or
- The amount determined by the Plan Administrator to be the Usual, Customary, and Reasonable (UCR) rate.

Non-Network Providers – Allowable Charges for pre-approved non-Emergency Services shall be the lesser of:

- The amount billed; or
- The amount determined by the Plan Administrator to be the Usual, Customary, and Reasonable (UCR) rate.

Non-Network Providers – Allowable Charges for Emergency Services shall be the greatest of:

- The median amount negotiated with In-Network Providers for the Emergency Service;
- The amount for the Emergency Service calculated using the same method the Plan generally uses to determine payments for Out-Of-Network services (such as the Usual, Customary, and Reasonable (UCR) amount); or
- The amount that would be paid under Medicare for the Emergency Service.

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.

Authorized Representative – An individual who has been authorized to act on behalf of a Claimant with respect to a Benefit claim or an Appeal of an Adverse Benefit Determination in accordance with the procedures set forth in the **Claims and Appeals Procedures** section. An assignment for purposes of payment (e.g. to a Health Care Provider) does not constitute appointment of an Authorized Representative under the **Claims and Appeals Procedures** section. Health Care Providers are not, and shall not be construed as, either "Covered Persons" or "beneficiaries" under the Plan and have no rights to receive benefits from the Plan or pursue legal causes of action on behalf of (or in place of) the Participant or other Covered Persons under any circumstances

Bariatric Surgical Procedures – Surgical procedure performed on the stomach to induce weight loss.

Benefit Document – A document that describes one (1) 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.

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

Clinical Trial – A Clinical Trial that is an "approved Clinical Trial" within the meaning of Section 2709(d) of the Affordable Care Act, that is, a phase I, phase II, phase III, or phase IV Clinical Trial in which a Qualified Individual participates and which is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition, which is Federally Funded, conducted under an investigational new drug application reviewed by the Food and Drug Administration or if the study or investigation is a drug trial that is exempt from having such an investigational new drug application.

For purposes of this definition, "life-threatening disease or condition" means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

For purposes of this section, a "Qualified Individual" is generally a Covered Person who is eligible to participate in an approved Clinical Trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition; and either: (1) the referring Network Provider is a participating Provider and has concluded that the individual's participation in such trial would be appropriate; or (2) the Covered Person provides medical and scientific information establishing that the individual's participation in such trial would be appropriate.

Code – The Internal Revenue Code of 1986, as amended.

Coinsurance – The Covered Person's share of the costs of a covered health care service, calculated as a percent of the Allowable Charges for the service.

Contract Administrator – A company that performs all functions reasonably related to the administration of one or more benefits of the Plan (e.g., 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.

Copay – A fixed amount which is required to be paid by or on behalf of a Covered Person for Plan benefits.

Covered Person – An individual who meets the eligibility requirements as contained herein (e.g., a covered Employee, a covered Dependent, or a Qualified Beneficiary). 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.

Day Treatment Center – A licensed or certified facility which is licensed to provide Outpatient Mental Health and Outpatient Substance Use Disorder Care under the supervision of Physicians.

Deductible - The amount a Covered Person owes for health care services covered by the Plan before it begins to pay.

Dependent – see **Eligibility and Effective Dates** section.

Eligible Expense(s) – Health care expenses as defined in this Benefit Document/Summary Plan Description, for which benefits may be payable.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such 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 (i) 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, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part; or with respect to a pregnant woman who is having contractions, that there is inadequate time to effect a safe transfer to another Hospital before delivery, or that transfer may pose a threat to the health or safety of the woman or the unborn child.

Emergency Services – With respect to an Emergency Medical Condition, (i) a medical screening examination that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, and (ii) within the capabilities of the staff and facilities available at the Hospital, such further medical examination and treatment as may be necessary To Stabilize the individual.

Employee – A person regularly employed by the Employer as a common law Employee on its payroll (W-2), being compensated for specific duties performed and who performs services for an Employer and whom the Employer controls the individual's performance, time and the manner and means by which the work is performed, regardless of that individual's official title within the Employer's organization.

The term "Employee" shall not include any individual for the period of time such individual was classified by the Employer as an independent contractor, leased Employee (whether or not a "Leased Employee" under the Code) or any other classification other than Employee. In the event an individual who is excluded from Employee status under the preceding sentence is reclassified as an Employee of the Employer pursuant to a final determination by the Internal Revenue Service, another governmental entity with authority to make such a reclassification, or a court of competent jurisdiction, such individual shall not retroactively be an Employee under the Plan. Such reclassified Employee may become a Covered Person in the Plan at such later time as the individual satisfies the conditions of participation set forth in

the Plan.

Employer(s) – The Employer or Employers participating in the Plan as reflected in the Plan document.

Essential Health Benefits – Items and services covered within the following categories: ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; Mental Health Conditions and Substance Use Disorder services, including behavioral health treatments; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services, chronic disease management; and pediatric services, including oral and vision care. Not all items and services covered under the Plan are Essential Health Benefits and not all Essential Health Benefits are covered under the Plan.

Fiduciary – An individual who has discretionary control or authority over Plan management and has binding power to make decisions regarding Plan policies, interpretations, practices or procedures.

Final External Review Decision – A determination by an Independent Review Organization at the conclusion of an External Review.

Final Internal Adverse Benefit Determination – An Adverse Benefit Determination that has been upheld by the Plan at the completion of two Internal Appeals (or an Adverse Benefit Determination with respect to which the Internal Appeals process has been exhausted under the deemed exhausted rules of 29 C.F.R. §2590.715-2715(b)(2)(ii)(F).

Health Insurance Marketplace ("Exchange") – The Health Insurance Marketplace ("Exchange"), created by the Affordable Care Act, for purchasing coverage under common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them.

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 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 Covered Person under its care;
- 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 one 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 licensed by the State in which it is situated and operated in accordance with that State's laws. The Hospital must provide Inpatient care and treatment through medical, diagnostic, and major surgical facilities on its premises. Inpatient care and treatment must be provided under the supervision of a staff of Physicians with 24-hour-a-day nursing services.

Hours of Service – Each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer; and each hour for which an Employee is paid, or entitled to payment by the Employer for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military leave or leave of absence.

Bona Fide Volunteers and Students. Hours of Service do not include any hour for services performed as a bona fide volunteer or any hour for services to the extent those services are performed as part of a Federal Work-Study Program as defined under 34 CFR 675 or a substantially similar program of a State or political subdivision thereof. Hours of Service do not include the services of a student intern or extern to the extent the student does not receive, and is not entitled to, payment in connection with those hours.

Non-Hourly Employees. Hours of Service may be calculated using a "days-worked" equivalency or "weeks-worked" equivalency that substantially reflect the Hours of Service performed and does not understate such Hours of Service in a manner that would cause the Employee to lose coverage under the Plan.

Hourly Employees. Hours of Service are calculated from payroll records reflecting actual Hours of Service worked and Hours of Service for which payment is made or due.

On-Call Employees. Hours of Service include on-call hours for which payment is made or due by the Employer, for which the Employee is required to remain on-call on the Employer's premise, or for which the Employee's activities while remaining on-call are subject to substantial restrictions that prevent the Employee from using the time effectively for the Employee's own purposes.

ID Card – Prime Healthcare will provide ID cards to Covered Persons for purposes of identifying him to Network Providers.

Illness – Sickness or disease (including covered Mental Health Conditions and covered Substance Use Disorders), congenital abnormalities, birth defects and premature birth. A condition must be diagnosed by a Physician or other appropriate Provider in order to be considered an Illness hereunder. Illness does not include any Work-related Injury including self-employment or occupation for compensation or profit (see **General Exclusions** section).

Independent Review Organization (IRO) – An entity that conducts independent external reviews of Adverse Benefit Determinations and Final Internal Adverse Benefit

Determinations and renders a Final External Review Decision pursuant to the section entitled **Claims and Appeals Procedures.**

Injury – Any Injury including accidental bodily Injury that is caused by external forces under unexpected circumstances and which is not a consequence of any Work-related Injury including self-employment or occupation for compensation or profit (see **General Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Injuries for purposes of benefit determination.

Inpatient – Occupation of a room and being charged for room and board in a facility (e.g., Hospital, Skilled Nursing Facility or Residential Treatment Center) 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.

Medical Child Support Order (MCSO) – A judgment, decree, or order, including a National Child Support Order, that is made pursuant to State domestic relations law or certain other State laws relating to medical child support and provides for child support or health benefits coverage for a child of a Covered Person under a group health plan and relates to benefits under the plan.

Medically Necessary (Medical Necessity) – Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

- It is ordered by a Physician exercising prudent clinical judgment for the purposes of evaluation, diagnosis or treatment of an Illness or Injury or a covered Mental Health Condition or a covered Substance Use Disorder (a "Condition");
- Such services must be clinically appropriate in terms of type, frequency, extent, site and duration for the diagnosis or treatment of that Condition;
- The 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 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 Condition without adversely affecting that Condition;
- The prevailing opinion within the appropriate specialty of the United States Medical Profession is that it is safe and effective for its intended use and that omission would adversely affect the person's condition;
- It is furnished by a Provider with appropriate training and experience, acting within the scope of his license; and

a) It must not be maintenance therapy or maintenance treatment;

b) Its purpose must be to restore health;

c) It must not be primarily custodial in nature;

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

e) The Plan Administrator reserves the right to incorporate Medicare guidelines in effect on the date of treatment as additional criteria for determination of Medically Necessary.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment that can be provided ONLY on an Inpatient basis. 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 the Plan because they are not "Medically Necessary" does not mean that any other services are deemed to be "Medically Necessary."

Medically Necessary treatment, services or supplies for routine patient Eligible Expenses provided to Qualified Individuals participating in Clinical Trials

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listings in the following compendia: The American Hospital Formulary Service Drug Information and The United States Pharmacopoeia Dispensing Information, and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare – Health Insurance for the Aged and Disabled as established by Title I of Public Law 8998 including Parts A, B and D and Title XVIII of the Social Security Act, and as amended from time to time.

Mental Health Condition – A syndrome characterized by clinically significant disturbance in an individual's, cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning as described in DSM V.

Network Provider – Providers of health care designated by Prime Healthcare as "Prime Healthcare Network Providers," "BCBS BlueCard Network Providers" and "Blue Shield of CA Network Providers".

Non-Network Provider – A facility, Physician, or other licensed Provider who does not have a Network Provider agreement with Prime Healthcare, or is not a member of the BCBS BlueCard/Blue Shield of CA Network.

Out-of-Pocket Maximum – Out-of-Pocket-Maximum means:

- Prime Healthcare Network Medical Eligible Expenses – The most a Covered Person pays for medical Eligible Expenses during a Plan Year before the Plan begins to pay 100% of the medical Allowable Charges.
- Prime Healthcare Network Prescription (Rx) Eligible Expenses – The most a Covered Person pays for Prescription (Rx) Eligible Expenses during a Plan Year before the Plan begins to pay 100% of the Prescription Allowable Charges.
- Non-Prime Healthcare Network (BCBS BlueCard/Blue Shield of CA PPO) & Rx – The most a Covered Person pays for all Eligible Expenses (Medical and Rx combined) during a Plan Year before the Plan begins to pay 100% of the Allowable Charges.

NOTE: These amounts include Coinsurance, and Copays for services provided by Prime Healthcare and BCBS BlueCard/Blue Shield of CA Network Providers and Prescriptions, but do not include Employee contributions (premiums), payments for services not covered by the Plan, balance billing amounts (when a Provider bills for the difference between the Provider's charge and the allowed amount), payments made to Non-Network Providers) or penalties for non-compliance of Pre-Service Review requirements.

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

Participant – An Employee who is a Covered Person.

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.

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 Prime Healthcare Welfare Benefits Plan.

Plan Administrator – see "Plan Sponsor."

Plan Sponsor – Prime Healthcare Services, Inc.

Plan Year – The calendar year.

Pregnancy – The state of a female after conception and until termination of the gestation. See "Pregnancy Care" in the list of **Eligible Medical Expenses** for further information.

Preventive Care Services – Services that are required to be provided without cost sharing under the Affordable Care Act as described in **Appendix A.**

Primary Care Provider – A Physician in family practice, internal medicine, obstetrics/gynecology, or pediatrics who is a Covered Person's first contact for health care in a medical office setting and who coordinates referrals to specialists as needed. Covered Persons do not need prior authorization for the Annual Well Woman exam from Prime Healthcare Utilization Management Department or from any other person (including a Primary Care Provider) in order to obtain access to obstetrical or gynecological care from a Prime Healthcare Network Provider or a BCBS BlueCard/Blue Shield of CA Network Provider who specializes in obstetrics or gynecology.

Provider – An individual who is:

- Licensed in the state 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:

- Audiologist
- Certified or Registered Nurse Midwife
- Certified Registered Nurse Anesthetist
- (CRNA)
- Chiropractor (DC)
- Dentist (DDS or DMD)
- Dietician
- Enterostomal Therapist
- Licensed Clinical Psychologist (PhD or EdD)
- Licensed Clinical Social Worker (LCSW)
- Licensed Professional Counselor (LPC)
- Licensed Vocational Nurse (LVN)
- Marriage Family and Child Counselor (MFCC)
- Mental Health Professional
- Nurse Practitioner
- Occupational Therapist (OTR)
- Optometrist (OD)
- Physical Therapist (PT or RPT)
- Physician – see definition of "Physician"
- Physician Assistant (PA)
- Podiatrist or Chiropodist (DPM,
- DSP, or DSC)
- Psychiatrist (MD)
- Registered Nurse (RN)
- Respiratory Therapist
- Speech Pathologist

A 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, Residential Treatment Facilities, Ambulatory Surgical Facilities, Birthing Centers, clinics;
- Licensed Outpatient Mental Health Condition facilities;
- Freestanding public health facilities;
- 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 Network 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 Network Provider facility and who is paid by the facility for his services.

Qualified Medical Child Support Order (QMCSO) – A Medical Child Support Order that creates or recognizes the right of an alternate recipient to receive benefits for which a Covered Person is eligible under a group health plan and is recognized by the Plan as "qualified."

Rehabilitation Center – See "Skilled Nursing Facility."

Rescission or Rescind – The retroactive cancellation of coverage under the Plan following 30 days' notice.

Registered Domestic Partner – A relationship established under California Family Code Sections 297-297.5 or other similar applicable state law.

Residential Treatment Facility – A state-licensed facility and community-based facility that is not a Hospital, but that provides residential care for persons with serious and persistent Mental Health Conditions or Substance Use Disorders. The facility must be operated 24 hours per day to provide psychiatric and/or substance use disorder and dependency treatment to its resident patients.

Semi-Private Room – Inpatient Hospital or Facility room shared by two or more patients.

Skilled Nursing Facility – An institution that is licensed to provide, and does provide, the following on an Inpatient basis for persons who are convalescing from Illness or Injury:

- Professional nursing care by a Registered Nurse or by a Licensed Vocational Nurse directed by a full-time Registered Nurse; and
- Provides physical restoration services to help a patient meet a goal of self-care in daily living activities;
- Provides 24-hour-a-day nursing care by licensed nurses directed by a full-time Registered Nurse;
- Is supervised full-time by a Physician or Registered Nurse;
- Keeps a complete medical record on each patient;
- Has a utilization review plan;

- Is not mainly a place for rest, for the aged, for Substance Use Disorders or for Mental Health Conditions, custodial or educational care; and
- Makes charges for the services and supplies it provides.

Stabilize or To Stabilize – With respect to an Emergency Medical Condition, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition for a pregnant woman, that the woman has delivered (including the placenta).

Substance Use Disorder – Recurrent use of alcohol and/or drugs that causes clinically and functionally significant impairment, such as health problems, disability, and failure to meet major responsibilities at work, school or house based on DSM V criteria.

Transfer – With respect to an Emergency Medical Condition and Stabilize, the movement (including the discharge) of an individual outside a Hospital's facilities at the direction of any person employed by (or affiliated or associated, directly or indirectly, with) the Hospital, but does not include such a movement of an individual who (i) has been declared dead, or (ii) leaves the facility without the permission of any such person.

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 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, Customary, and Reasonable (UCR) – For purposes of this Plan, the Usual, Customary, and Reasonable rate shall be 100% of Medicare rates.

Utilization Management Organization (UMO) – For services provided at a Prime Healthcare Network facility or at a BCBS BlueCard/BlueShield of CA facility, the UMO is the Prime Healthcare Utilization Management Department.

GENERAL PLAN INFORMATION

For Those Participating Facilities Set Forth in the Prime Healthcare List in Appendix B

Name of Plan:	**Prime Healthcare Welfare Benefits Plan**
Plan Sponsor / Plan Administrator:	**Prime Healthcare Services, Inc.**
Address:	3480 East Guasti Road, 1st Floor Ontario, CA 91761
Business Phone Number:	(909) 235-4400
Plan Sponsor ID Number (EIN):	**33-0943449**
Plan Number:	**501**

For Those Participating Facilities Set Forth in the Foundation List in Appendix B

Name of Plan:	**Prime Healthcare Foundation Welfare Benefits Plan**
Plan Sponsor / Plan Administrator:	**Prime Healthcare Foundation**
Address:	3480 East Guasti Road, 1st Floor Ontario, CA 91761
Business Phone Number:	(909) 235-4400
Plan Sponsor ID Number (EIN):	**20-8065139**
Plan Number:	**507**

For Both Plans

Plan Year:	**January 1 through December 31**
Named Fiduciary:	**Prime Healthcare Services, Inc.**
Address:	3480 East Guasti Road, 1st Floor Ontario, CA 91761

(See also definition of "Fiduciary")

Agent for Service of Legal Process:	**General Counsel Prime Healthcare**
Address:	3480 East Guasti Road, 2nd Floor Ontario, CA 91761

(Legal process may be served upon the Plan Administrator or a Fiduciary)

Type of Plan:	**An Employee welfare benefit plan providing group benefits**
Applicable Collective Bargaining Agreement(s):	**(See "Collective Bargaining Agreement(s)" in the Administrative Provisions, below)**

Plan Benefits Described in this Benefit Document:	**Self-Funded Medical and Prescription Drug Benefits**
Type of Administration for Benefits Described herein:	**Contract Administration** – see "Administrative Provisions" for additional information
COBRA Administrator: Mailing Address: Phone:	**HR Simplified** 5320 West 23rd Street, Ste. 350 Minneapolis, MN 55416 (888) 318-7472
Contract Administrator: Mailing Address: Phone:	**Keenan & Associates** 2355 Crenshaw Blvd. Torrance, CA 90501 (800) 653-3626 or (800) 6 Keenan
EHB Benchmark Plan:	**Utah Basic Plus**

FUNDING – SOURCES AND USES

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 code section 125 pre-tax premium plan.

See the **COBRA Continuation Coverage** section for more information.

ADMINISTRATIVE PROVISIONS

Administration
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.

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 Administrator'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 Administrator 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 Administrator'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 Participating Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any Covered Person or beneficiary:

- Reduce, modify or terminate 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 made by written

amendment that is signed by an authorized representative of the Plan Sponsor. 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 Plan Administrator will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Collective Bargaining Agreement(s)
The Plan is subject to the terms of collective bargaining agreement(s). A complete list of the bargaining units participating in the Plan may be obtained upon written request to the Plan Sponsor and is available for examination by Covered Persons and beneficiaries at the office of the Plan Sponsor. Covered Persons and beneficiaries may receive from the Plan Sponsor, upon written request, information as to whether a particular Employee organization is participating in the Plan and, if the organization is participating, the address of such entity.

Discrepancies
In the event that there may be a discrepancy between this Benefit Document and any other document or communication, this Benefit Document will control.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Covered Persons rights; and to determine all questions of fact and law arising under the Plan.

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 Administrator 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 Plan Administrator. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefor under the Plan.

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.

Legal Actions
Until the Plan Administrator has issued its final decision on a claim, no legal action can be brought to recover under this Plan. No such action may be brought at all unless it is brought within two (2) years from the deadline for filing a claim.

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 covered Employee or other Covered Person 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 Covered Person'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 Covered Person 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; or
- A Covered Person's fraud or intentional misrepresentation of material fact related to the Plan.

Misuse of Identification Card
See "Termination for Fraud."

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

Payment of Fees
Expenses required or permitted by law and otherwise to be paid by the Plan, are payable by the Plan from Plan assets.

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.

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 source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid including the Employee, or any other persons, insurance companies or other payees. 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 deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan of the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

A Covered Person, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for other Injuries or Illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other Injuries or Illnesses) under any other group benefits plan of the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability – The Plan Administrator 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 therefor 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 Administrator 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

Except for those rights expressly granted under ERISA §502, 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 employ of the Employer.

Termination for Cause

An individual's Plan coverage or eligibility may be terminated if the Plan Administrator determines that it should be terminated for Cause. Examples of "Cause" include but are not limited to, the submission of false claims or covering ineligible Dependents (e.g. a divorced spouse or overage Dependent children).

Termination for Fraud
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form, and found to be (i) fraudulent or (ii) an intentional misrepresentation of a material fact by the Plan Administrator, 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 fraud committed or intentional misrepresentation of such status or of a material fact with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be Rescinded, retroactively to the date thereof, to reflect his true status.

A fraudulent or intentional misrepresentation of marital status, Dependent status, age or other material fact will Rescind coverage, retroactively from the date thereof, 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.

In the case of any fraud, or intentional misrepresentation of material fact, the Plan Administrator will provide at least 30 days advance written notice to each Covered Person who would be affected before coverage may be Rescinded.

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.

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.

No employment rights
The Plan does not provide confer employment rights upon any person. No person shall be entitled by virtue of the Plan to become or to remain in the employ of the Employer and nothing in the Plan shall restrict the right of the Employer to terminate the employment of any eligible employee or other person at any time.

Conflict with Plan document
In the event that there is a conflict between this SPD and the underlying Plan document, the Plan document will control.

STATEMENT OF RIGHTS

Covered Employees are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that a Covered Person shall be entitled to:

RECEIVE INFORMATION ABOUT THIS PLAN AND BENEFITS

This includes the right to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration;
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of a Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The administrator may make a reasonable charge for the copies. Where permitted by law, these documents may be provided electronically; and
- Receive a summary of a Plan's annual financial report. The Plan Administrator is required by law to furnish each covered Employee with a copy of this summary annual report.

CONTINUE GROUP HEALTH PLAN COVERAGE

This includes:

The right to continue health care coverage for himself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or his Dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for covered Employees, ERISA imposes duties upon the people who are responsible for the operation of a Plan (the Fiduciaries). Fiduciaries have a duty to operate a Plan prudently and in the interest of Covered Persons and beneficiaries. No one, including the Employer, may fire a covered Employee or discriminate against him to prevent him from obtaining a welfare benefit or exercising rights under ERISA.

ENFORCEMENT OF RIGHTS

If an individual's claim for benefit is denied, in whole or in part, he must receive a written explanation of the reason for the denial. He has the right to obtain copies of documents relating to the decision without charge and have the Plan Administrator review and reconsider his claim, all within certain timeframes.

Under ERISA there are steps a covered Employee can take to enforce the above rights. For instance, if he requests materials from a Plan and does not receive them within 30 days, he may file suit in a Federal Court. In such a case, the court may require the Plan Administrator to provide the materials and pay him up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If he has a claim for benefits which is denied or ignored, in whole or in part, he may resolve the claim through binding and confidential arbitration. In addition, if he disagrees with the Plan decision or lack thereof, concerning the qualified status of a Medical Child Support Order (QMCSO), he may file suit in Federal court.

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

ASSISTANCE WITH QUESTIONS

If a Covered Person has any questions about the Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, he should contact: (1) the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor as listed in his telephone directory, or by calling EBSA at (866) 444-3272 or (2) the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210. A Covered Person may also obtain certain publications about his rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

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.

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 coverages 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 Domestic 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 Service 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).

Non-COBRA 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 OF RESPONSIBILITIES

If the Employer is the Plan Administrator and if the Qualifying Event is Employee's termination/reduction in Hours of Service, 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 spouse. A Qualified Beneficiary is also responsible for other notifications. See the section entitled COBRA Notice Requirements for Covered Persons (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(ies) 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 latter 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. Failure to make a COBRA election within the 60-day period will result in the inability to elect COBRA continuation coverage.

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 Non-COBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of 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 Provider regarding a Qualified Beneficiary's right to coverage during the election period.

NOTE: See the "Effect of the Trade Act" provision for information regarding a second 60-day election period allowance.

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 Non-COBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated Non-COBRA 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 OF COVERAGE

The cost of COBRA continuation coverage is fixed in advance for a 12-month determination period and will not exceed 102% of the Plan's full cost of coverage during the period for similarly situated Non-COBRA 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 Non-COBRA Beneficiaries. Qualified Beneficiaries will be charged 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. If payment is not made within such time period, the COBRA election is null and void. The initial premium 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. 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 during the Plan's 12-month determination period if:

- The cost previously charged was less than the maximum permitted by law;
- The increase occurs due to a Disability Extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which 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) which 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.

NOTE: 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.

There may be other coverage options for the Qualified Beneficiaries. They will be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, they could be eligible for a tax credit that lowers monthly premiums right away, and individuals can see what the premium, deductibles, and out-of-pocket costs will be before making a decision to enroll. Being eligible for COBRA does not limit a Qualified Beneficiary's eligibility for coverage for a tax credit through the Marketplace. Additionally, Qualified Beneficiaries may qualify for a special enrollment opportunity for another group health plan for which they are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if enrollment is requested within 30 days.

See the "Effect of the Trade Act" provision for additional cost of coverage information.

OTHER COVERAGE OPTIONS BESIDES COBRA

Instead of enrolling in COBRA continuation coverage, there may be other coverage options available through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. To learn more about many of these options please visit www.healthcare.gov.

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 Service 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 Service 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 period. 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 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 OF 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 the 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 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:

  a) 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

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

  c) 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 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 Non-COBRA 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.

EFFECT OF THE TRADE ACT

In response to Public Law 107-210, referred to as the Trade Act of 2002 and the Trade Preferences Extension Act of 2015 (collectively, "TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in

the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended. These provisions will expire on December 31, 2019 unless extended by Congress.

Eligible Individuals – The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement or federal income tax filings. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

- Non-Electing TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.
- TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.
- TAA-Related Election Period – With respect to a TAA-Related Loss of Coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.
- TAA-Related Loss of Coverage – With respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Non-Electing TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period but only if such election is made not later than six (6) months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period.

Applicable Cost of Coverage Payments – Payments of any portion of the applicable COBRA cost of coverage by the federal government on behalf of a TAA-Eligible Individual pursuant to TAA shall be treated as a payment to the Plan. Where the balance of any contribution owed the Plan by such individual is determined to be significantly less than the required applicable cost of coverage, as explained in Treasury Regulation 54.4980B-8, the Plan will notify such individual of the deficient payment and allow thirty (30) days to make full payment. Otherwise, the Plan shall return such deficient payment to the individual and coverage will terminate as of the original cost of coverage due date.

COBRA NOTICE REQUIREMENTS FOR COVERED PERSONS

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 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 in the first 60 days of continuation coverage, or a Qualified Beneficiary has subsequently been determined by the Social Security Administration to no longer be disabled.

It is also important that the Plan Administrator be kept informed of the current addresses of all Covered Persons or beneficiaries who are or may become Qualified Beneficiaries.

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 changes have not occurred before relying on this information. The most current information should be included in the Employer's COBRA Initial General Notice that is provided to new hires.

Any individual who is the covered Employee, a Qualified Beneficiary with respect to the Qualifying Event, or any Authorized 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 and Delivery – Notification of the Qualifying Event must be made to the Plan Administrator in care of the following office:

HR Simplified
5320 West 23rd Street, Ste. 350
Minneapolis, MN 55416
Phone: (888) 318-7472

Notification should include: (1) the name of the plan or plans under which coverage has been or will be lost, (2) the name and address of the Employee covered under the plan(s), (3) the name(s) and address(es) of the Qualified Beneficiary(ies), and the type of Qualifying Event and the date it happened.

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 date of the Qualifying Event. If Notice is not received 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 Trade Act" in the **COBRA Continuation Coverage** section."

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 date of the determination. 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.

IMPORTANT NOTICES

This is a self-funded employee benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with Employee and/or Employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

MINIMUM ESSENTIAL COVERAGE (ACA)

This Plan offers to Employees, Children and, if not eligible for other group health coverage that provides minimum value (as defined in Code section 36B(c)(2)(C)(ii)), Spouses and Registered Domestic Partners the opportunity to enroll in "minimum essential coverage" under an "eligible employer-sponsored plan" as those terms are defined in Code sections 5000A(f)(1) and 5000A(f)(2).

NONDISCRIMINATION

The Plan shall not discriminate against any Network Provider. This provision shall not require that the Plan contract with any Network Provider willing to abide by the terms and conditions for participation established by the Plan.

STATEMENT OF NONDISCRIMINATION ACCESSIBILITY TO INFORMATION FOR DISABLED INDIVIDUALS/LIMITED ENGLISH PROFICIENCY

The Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. The Plan and the Plan Sponsor, Prime Healthcare, provide:

- Free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters; and
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Free language services to people whose primary language is not English, such as:
  - Qualified interpreters; and
  - Information written in other languages

If you need these services, please contact Prime Customer Service at (877) 234-5227, by email at EHP@primehealthcare.com, or by facsimile at (909) 235-4414. If you believe that the Plan has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with: Prime Legal Department, 3480 East Guasti Road, Ontario, CA 91761, (909) 687-3636, TTY: (844) 987-4123, Fax: (909) 235-4316. You can file a grievance in person or by mail, fax, or email. If you need help filing a grievance, the Prime Legal Department is available to provide resources. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services 200 Independence Avenue, SW

Room 509F, HHH Building Washington, D.C. 20201 (800) 368-1019, (800) 537-7697 (TDD) Complaint forms are available at: http://www.hhs.gov/ocr/office/file/index.html.

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-844-203-2025, Acct # 501025769, Pin 0679（TTY:1-844-987-4123).

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123).

Filipino
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123) 번으로 전화해 주십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY (հեռատիպ)՝ 1-844-987-4123):

Persian
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123) تماس بگیرید.

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-844-203-2025, Acct # 501025769, Pin 0679 (телетайп: 1-844-987-4123).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-844-203-2025, Acct # 501025769, Pin 0679（TTY:1-844-987-4123）**まで、お電話にてご連絡ください。**

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-844-203-2025, Acct # 501025769, Pin 0679 (رقم هاتف الصم والبكم: 1-844-987-4123).

Punjabi
ਧਿਆਨ ਦਿਓ :ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ ,ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)' ਤੇ ਕਾਲ ਕਰੋ।

Mon-Khmer Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123) ។

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123) पर कॉल करें।

Thai
เรียน :ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-844-203-2025, Acct # 501025769, Pin 0679 (TTY: 1-844-987-4123)

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Covered Person can obtain additional information about coverage of a specific drug, treatment, procedure, Preventive Care 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.

COBRA NOTICE PROCEDURES

In some circumstances, an Employee or a Qualified Beneficiary is the first to know that a COBRA Qualifying Event has occurred (e.g., in the case of a divorce or legal separation, or where a child reaches a maximum age limit and is no longer eligible). In such instances, it is the Employee's or the COBRA Qualified Beneficiary's responsibility to provide notice to the Plan that a COBRA Qualifying Event has occurred.

The procedures for providing notice of a COBRA Qualifying Event are included in the Employer's COBRA notice communication piece that is provided to newly-hired Employees.

NOTE: It is important that the Plan Administrator be kept informed of the current addresses of all Covered Persons or beneficiaries who are or may become COBRA Qualified Beneficiaries.

THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans 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 mother's or newborn's attending Network Provider (see NOTE), 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 may not, under Federal law, require that a Network Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTE: An "attending Network 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.

Covered Persons 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).

GENETIC INFORMATION AND NON-DISCRIMINATION ACT

The Genetic Information and Non-discrimination Act (GINA) prohibits group health plans from collecting genetic information and discriminating in enrollment and cost of coverage based on an individual's genetic information – which includes family medical information.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act was enacted to provide for parity in the application of Mental Health and Substance Use Disorder benefits with medical/surgical benefits. In general, a group health plan that provides medical/surgical benefits and benefits for Mental Health Conditions and Substance Use Disorders must offer benefits for Mental Health Conditions and Substance Use Disorders that are no more restrictive than the predominant financial requirements and treatment limitations applied to substantially all medical/surgical benefits covered under a plan.

A Covered Person or Network Provider, upon request, has a right to receive the criteria for Medical Necessity relating to covered Mental Health Care and Substance Use Disorder Care by contacting the Prime Healthcare Utilization Management Department at (877) 234-5227.

HIPAA PRIVACY

As a Participant in the Plan, your "protected health information" is subject to safeguard under the privacy provisions of the Health Insurance Portability and Accountability Act ("HIPAA"). As a Participant, you will receive or have received a "privacy notice" that describes the important uses and disclosures of protected health information and your rights under HIPAA. If you need a copy of this notice, you should contact the Plan Administrator.

PREMIUM ASSISTANCE UNDER MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM (CHIP)

If you or your children are eligible for Medicaid or CHIP and you are eligible for health coverage from your employer, your State may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children are not eligible for Medicaid or CHIP, you will not be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your Dependents are already enrolled in Medicaid or CHIP and you live in a qualifying State, you can contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your Dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your Dependents might be eligible for either of these programs, you can contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, you can ask the State if it has a program that might help you pay the premiums

for an employer-sponsored plan.

Once it is determined that you or your Dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your Employer plan, your Employer must permit you to enroll in your Employer plan if you are not already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your Employer plan, you can contact the Department of Labor electronically at www.askebsa.dol.gov or by calling toll-free (866) 444-EBSA (3272).

APPENDIX A

2020 PREVENTIVE CARE SERVICES

Preventive Care Services are based on recommendations of the U.S. Preventive Task Force, Centers for Disease Control and Prevention and the Health Resources and Services Administration. The extent and timing of such services are based on guidance from these organizations. To the extent not specified within these recommendations, Preventive Care Services will be available without cost sharing during the annual physical. Routine office visits for children may be Incurred more frequently if a recommendation requires services more than annually (e.g. a child's vaccination). The frequency, method, treatment or setting is based on reasonable medical management techniques. More information on Preventive Care Services for adults, women including pregnant women and children can be found at https://www.healthcare.gov/what-are-my-preventive-care-benefits/. The specific recommendations of the U.S. Preventive Services Task Force can be found at https://www.uspreventiveservicestaskforce.org/Page/Name/recommendations.

- Other than as described in the Schedule of Benefits, Preventive Care services are not covered on a Non-Network Provider basis. However, where a particular Preventive Care Service is not offered by a Network Provider, the item or service when performed by a Non-Network Provider will be covered with no cost-sharing.
- Other than as described in the Schedule of Benefits, Preventive Care Services that are billed separately from an office visit, will require an office visit Copay.
- If Preventive Care Services are not billed separately from an office visit and the primary purpose of the office visit is the delivery of Preventive Care Services, then there is no Copay with respect to the office visit.
- If Preventive Care Services are not billed separately from an office visit and the primary purpose of the office visit is not the delivery of Preventive Care Services, then the office visit is subject to a Copay.

TOPIC	DESCRIPTION
Abdominal aortic aneurysm screening: men	The USPSTF recommends one-time screening for abdominal aortic aneurysm by ultrasonography in men ages 65 to 75 years who have ever smoked.
Alcohol and drug use: adolescents	Assessments for adolescents.
Alcohol use, unhealthy: adults 18 years or older, including pregnant women	The USPSTF recommends screening for unhealthy alcohol use in primary care settings in adults 18 years or older, including pregnant women, and providing persons engaged in risky or hazardous drinking with brief behavioral counseling interventions to reduce unhealthy alcohol use.
Anemia	Iron supplements for children ages 6 to 12 months at risk for anemia.
Anemia	Routine screening for pregnant women.
Aspirin preventive medication: adults aged 50 to 59 years with a ≥10% 10-year cardiovascular risk	The USPSTF recommends initiating low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased

	risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
Autism Screening	Screenings at 18 and 24 months.
Bacteriuria screening: pregnant women	The USPSTF recommends screening for asymptomatic bacteriuria with urine culture in pregnant persona.
Blood Pressure Screening: adults	The USPSTF recommends screening for high blood pressure in adults aged 18 years or older. The USPSTF recommends obtaining measurements outside of the clinical setting for diagnostic confirmation before starting treatment.
BRCA risk assessment and genetic counseling/testing	The USPSTF recommends that primary care providers screen women who have family members with breast, ovarian, tubal, or peritoneal cancer with one of several screening tools designed to identify a family history that may be associated with an increased risk for potentially harmful mutations in breast cancer susceptibility genes (*BRCA1* or *BRCA2*). Women with positive screening results should receive genetic counseling and, if indicated after counseling, BRCA testing.
Breast cancer preventive medication	The USPSTF recommends that clinicians engage in shared, informed decision making with women who are at increased risk for breast cancer about medications to reduce their risk. For women who are at increased risk for breast cancer and at low risk for adverse medication effects, clinicians should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.
Breast cancer screening	The USPSTF recommends screening mammography for women, with or without clinical breast examination, every 1 to 2 years for women age 40 years and older.
Breastfeeding interventions	The Women's Preventive Services Initiative recommends comprehensive lactation support services (including counseling, education, and breastfeeding equipment and supplies) during the antenatal, perinatal, and after birth to ensure the successful initiation and maintenance of breastfeeding
Cervical cancer screening	The USPSTF recommends screening for cervical cancer every 3 years with cervical cytology alone in women aged 21 to 29 years. For women aged 30 to 65 years, the USPSTF recommends screening every 3 years with cervical cytology alone, every 5 years with high-risk human papillomavirus (hrHPV) testing alone, or every 5 years with hrHPV testing in combination with cytology (cotesting).
Chlamydia screening: women	The USPSTF recommends screening for chlamydia in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Cholesterol Screening for abnormalities: men 35 and older	Screening men aged 35 and older, men under age 35 who have heart disease or risk factors for heart disease and women who have heart disease or risk factors for heart disease; every 5 years.
Colorectal cancer screening	The USPSTF recommends screening for colorectal cancer starting at age 50 years and continuing until age 75 years using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults. The risks and benefits of these screening methods vary. Frequency depends on risk. Includes bowel preparation, required specialist consultation and pathology examination on any polyp biopsy
Contraceptive methods and counseling	All Food and Drug Administration approved contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity, as prescribed by a health care Provider.
Dental caries prevention: infants and children up to age 5 years	The USPSTF recommends the application of fluoride varnish to the primary teeth of all infants and children starting at the age of primary tooth eruption in primary care practices. The USPSTF recommends primary care clinicians prescribe oral fluoride supplementation starting at age 6 months for children whose water supply is fluoride deficient.

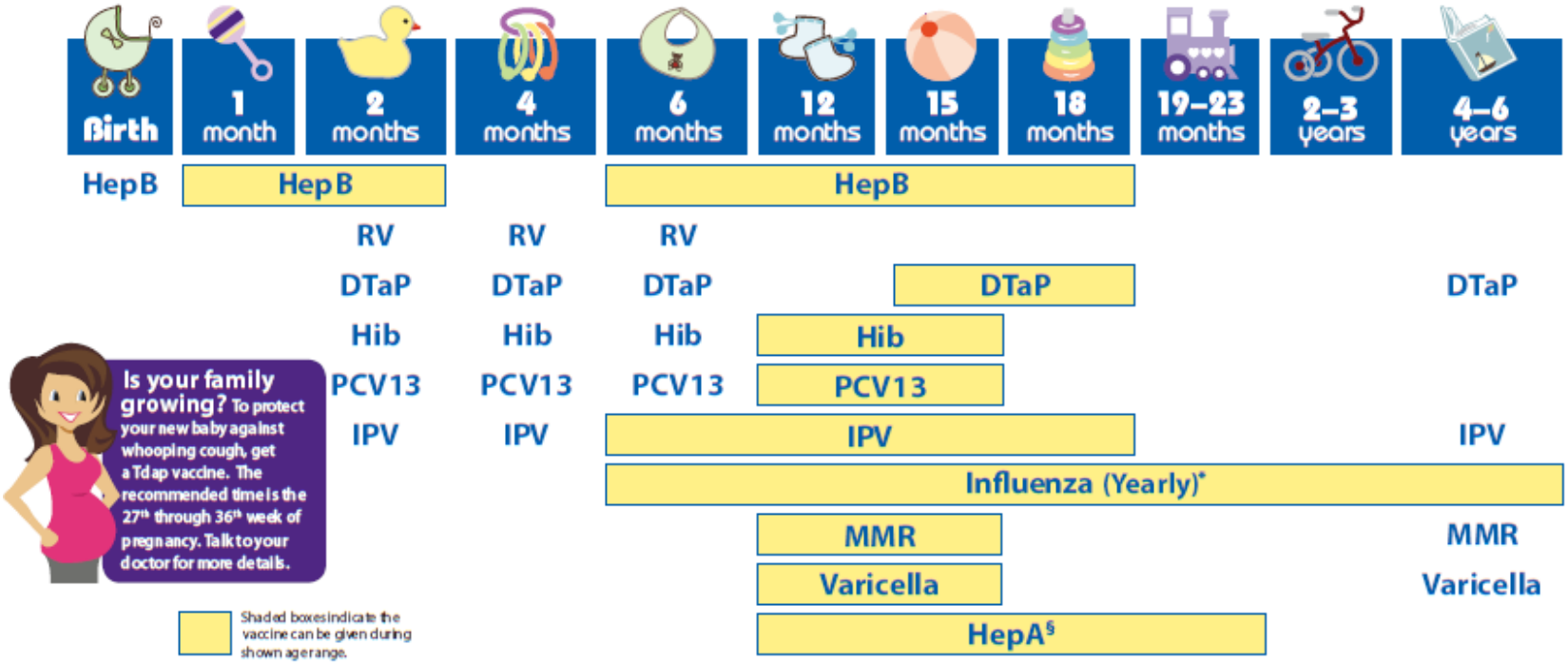
Depression screening: adolescents	The USPSTF recommends screening for major depressive disorder (MDD) in adolescents aged 12 to 18 years. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Depression screening: adults	The USPSTF recommends screening for depression in the general adult population, including pregnant and postpartum women. Screening should be implemented with adequate systems in place to ensure accurate diagnosis, effective treatment, and appropriate follow-up.
Developmental Screening for Children under 3	Developmental screenings for babies through age 3 for signs of speech or language display.
Diabetes screening	The USPSTF recommends screening for abnormal blood glucose as part of cardiovascular risk assessment in adults aged 40 to 70 years who are overweight or obese. Clinicians should offer or refer patients with abnormal blood glucose to intensive behavioral counseling interventions to promote a healthful diet and physical activity.
Falls prevention in older adults: exercise or physical therapy	The USPSTF recommends exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Falls prevention in older adults: vitamin D	The USPSTF recommends vitamin D supplementation to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
Folic acid supplementation	The USPSTF recommends that all women who are planning or capable of pregnancy take a daily supplement containing 0.4 to 0.8 mg (400 to 800 μg) of folic acid.
Gestational diabetes mellitus screening	The USPSTF recommends screening for gestational diabetes mellitus in asymptomatic pregnant women after 24 weeks of gestation and after pregnancy
Gonorrhea prophylactic medication: newborns	The USPSTF recommends prophylactic ocular topical medication for all newborns for the prevention of gonococcal ophthalmia neonatorum.
Gonorrhea screening: women	The USPSTF recommends screening for gonorrhea in sexually active women age 24 years or younger and in older women who are at increased risk for infection.
Healthy diet and physical activity counseling to prevent cardiovascular disease: adults with cardiovascular risk factors	The USPSTF recommends offering or referring adults who are overweight or obese and have additional cardiovascular disease (CVD) risk factors to intensive behavioral counseling interventions to promote a healthful diet and physical activity for CVD prevention.
Hearing screening: newborns	The CDC recommends hearing screening for all newborns.
Hemoglobinopathies screening: newborns	The USPSTF recommends screening for sickle cell disease in newborns.
Hepatitis B screening: nonpregnant adolescents and adults	The USPSTF recommends screening for hepatitis B virus infection in persons at high risk for infection.
Hepatitis B screening: pregnant women	The USPSTF strongly recommends screening for hepatitis B virus infection in pregnant women at their first prenatal visit.
Hepatitis C virus infection screening: adults	The USPSTF recommends screening for hepatitis C virus (HCV) infection in persons at high risk for infection. The USPSTF also recommends offering one-time screening for HCV infection to adults born between 1945 and 1965.
HIV screening: nonpregnant adolescents and adults	The USPSTF recommends that clinicians screen for HIV infection in adolescents and adults ages 15 to 65 years. Younger adolescents and older adults who are at increased risk should also be screened.

HIV screening: pregnant women	The USPSTF recommends that clinicians screen all pregnant women for HIV, including those who present in labor who are untested and whose HIV status is unknown.
Human papillomavirus DNA testing	High-risk human papillomavirus DNA testing in women with normal cytology results. Screening should begin at 30 years of age for women with normal cytology and should occur no more frequently than every 3 years.
Hypothyrodism screening: newborns	The USPSTF recommends screening for congenital hypothyroidism in newborns.
Immunizations for Adults	Doses, recommended ages, and recommended populations vary and include: Hepatitis A, Hepatitis B, Herpes Zoster, Human Papillomavirus, Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Tetanus, Diphtheria, Pertussis, Varicella.
Immunizations for Children	Immunization vaccines for children from birth to age 18 —doses, recommended ages, and recommended populations vary, including: Diphtheria, Tetanus, Pertussis, Haemophilus Influenza type b, Hepatitis A, Hepatitis B, Human Papillomavirus, Inactivated Poliovirus. Influenza (Flu Shot), Measles, Mumps, Rubella, Meningococcal, Pneumococcal, Rotavirus and Varicella.
Intimate partner violence screening: women of childbearing age	The USPSTF recommends that clinicians screen women of childbearing age for intimate partner violence and provide or refer women who screen positive to ongoing services.
Lung cancer screening	The USPSTF recommends annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years. Screening should be discontinued once a person has not smoked for 15 years or develops a health problem that substantially limits life expectancy or the ability or willingness to have curative lung surgery.
Obesity screening and counseling: adults	The USPSTF recommends that clinicians offer or refer adults with a body mass index of 30 or higher (calculated as weight in kilograms divided by height in meters squared) to intensive, multicomponent behavioral interventions, up to 26 sessions per year.
Obesity screening: children and adolescents	The USPSTF recommends that clinicians screen for obesity in children and adolescents 6 years and older and offer or refer them to comprehensive, intensive behavioral interventions to promote improvements in weight status.
Osteoporosis screening: postmenopausal women younger than 65 years at increased risk of osteoporosis	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in postmenopausal women younger than 65 years who are at increased risk of osteoporosis, as determined by a formal clinical risk assessment tool.
Osteoporosis screening: women	The USPSTF recommends screening for osteoporosis in women age 65 years and older.
Osteoporosis screening: women 65 years and older	The USPSTF recommends screening for osteoporosis with bone measurement testing to prevent osteoporotic fractures in women 65 years and older.
Phenylketonuria screening: newborns	The USPSTF recommends screening for phenylketonuria in newborns.
Preeclampsia prevention: aspirin	The USPSTF recommends the use of low-dose aspirin (81 mg/d) as preventive medication after 12 weeks of gestation in women who are at high risk for preeclampsia.
Preeclampsia screening	The USPSTF recommends screening for preeclampsia in pregnant women with blood pressure measurements throughout pregnancy.

Rh incompatibility screening: 24–28 weeks' gestation	The USPSTF recommends repeated Rh (D) antibody testing for all unsensitized Rh (D)-negative women at 24 to 28 weeks' gestation, unless the biological father is known to be Rh (D)-negative.
Rh incompatibility screening: first pregnancy visit	The USPSTF strongly recommends Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.
Sexually transmitted infections counseling	The USPSTF recommends intensive behavioral counseling for all sexually active adolescents and for adults who are at increased risk for sexually transmitted infections.
Skin cancer behavioral counseling	The USPSTF recommends counseling young adults, adolescents, children, and parents of young children about minimizing exposure to ultraviolet (UV) radiation for persons aged 6 months to 24 years with fair skin types to reduce their risk of skin cancer.
Statin preventive medication: adults ages 40–75 years with no history of CVD, 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater	The USPSTF recommends that adults without a history of cardiovascular disease (CVD) (i.e., symptomatic coronary artery disease or ischemic stroke) use a low- to moderate-dose statin for the prevention of CVD events and mortality when all of the following criteria are met: 1) they are ages 40 to 75 years; 2) they have 1 or more CVD risk factors (i.e., dyslipidemia, diabetes, hypertension, or smoking); and 3) they have a calculated 10-year risk of a cardiovascular event of 10% or greater. Identification of dyslipidemia and calculation of 10-year CVD event risk requires universal lipids screening in adults ages 40 to 75 years.
Syphilis screening: nonpregnant persons	The USPSTF recommends screening for syphilis infection in persons who are at increased risk for infection.
Syphilis screening: pregnant women	The USPSTF recommends early screening for syphilis infection in all pregnant women.
Tobacco use counseling and interventions: nonpregnant adults	The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)–approved pharmacotherapy for cessation to adults who use tobacco.
Tobacco use counseling: pregnant women	The USPSTF recommends that clinicians ask all pregnant women about tobacco use, advise them to stop using tobacco, and provide behavioral interventions for cessation to pregnant women who use tobacco.
Tobacco use interventions: children and adolescents	The USPSTF recommends that clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
Tuberculosis screening: adults	The USPSTF recommends screening for latent tuberculosis infection in populations at increased risk.
Urinary Screening for Women	The Women's Preventive Services Initiative recommends screening women for urinary incontinence annually. Screening should ideally assess whether women experience urinary incontinence and whether it impacts their activities and quality of life. The Women's Preventive Services Initiative recommends referring women for further evaluation and treatment if indicated.
Vision screening: children	The USPSTF recommends vision screening at least once in all children ages 3 to 5 years to detect amblyopia or its risk factors.
Well baby and well child care	Includes behavioral assessments, screenings for blood pressure, dyslipidemia, hematocrit or hemoglobin, lead, measurements including height, weight and body mass index, medical history, oral health assessments, tuburcelin testing.
Well woman care	Well-woman preventive care visit for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including

	preconception and prenatal care. This well-woman visit should, where appropriate, include other preventive services listed in this set of guidelines. Annual, although HHS recognizes that several visits may be needed to obtain all necessary recommended preventive services, depending on a woman's health status, health needs, and other risk factors.

2019 Recommended Immunizations for Children from Birth Through 6 Years Old



NOTE:
If your child misses a shot, you don't need to start over. Just go back to your child's doctor for the next shot. Talk with your child's doctor if you have questions about vaccines.

FOOTNOTES:

* Two doses given at least four weeks apart are recommended for children age 6 months through 8 years of age who are getting an influenza (flu) vaccine for the first time and for some other children in this age group.

§ Two doses of HepA vaccine are needed for lasting protection. The first dose of HepA vaccine should be given between 12 months and 23 months of age. The second dose should be given 6 months after the last dose. HepA vaccination may be given to any child 12 months and older to protect against hepatitis A. Children and adolescents who did not receive the HepA vaccine and are at high risk should be vaccinated against hepatitis A.

If your child has any medical conditions that put him at risk for infection or is traveling outside the United States, talk to your child's doctor about additional vaccines that he or she may need.

See back page for more information on vaccine-preventable diseases and the vaccines that prevent them.

For more information, call toll-free
1-800-CDC-INFO (1-800-232-4636)
or visit
www.cdc.gov/vaccines/parents

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

AAFP

American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Disease	Vaccine	Disease spread by	Disease symptoms	Disease complications
Chickenpox	Varicella vaccine protects against chickenpox.	Air, direct contact	Rash, tiredness, headache, fever	Infected blisters, bleeding disorders, encephalitis (brain swelling), pneumonia (infection in the lungs)
Diphtheria	DTaP* vaccine protects against diphtheria.	Air, direct contact	Sore throat, mild fever, weakness, swollen glands in neck	Swelling of the heart muscle, heart failure, coma, paralysis, death
Hib	Hib vaccine protects against *Haemophilus influenzae* type b.	Air, direct contact	May be no symptoms unless bacteria enter the blood	Meningitis (infection of the covering around the brain and spinal cord), intellectual disability, epiglottitis (life-threatening infection that can block the windpipe and lead to serious breathing problems), pneumonia (infection in the lungs), death
Hepatitis A	HepA vaccine protects against hepatitis A.	Direct contact, contaminated food or water	May be no symptoms, fever, stomach pain, loss of appetite, fatigue, vomiting, jaundice (yellowing of skin and eyes), dark urine	Liver failure, arthralgia (joint pain), kidney, pancreatic and blood disorders
Hepatitis B	HepB vaccine protects against hepatitis B.	Contact with blood or body fluids	May be no symptoms, fever, headache, weakness, vomiting, jaundice (yellowing of skin and eyes), joint pain	Chronic liver infection, liver failure, liver cancer
Influenza (Flu)	Flu vaccine protects against influenza.	Air, direct contact	Fever, muscle pain, sore throat, cough, extreme fatigue	Pneumonia (infection in the lungs)
Measles	MMR** vaccine protects against measles.	Air, direct contact	Rash, fever, cough, runny nose, pinkeye	Encephalitis (brain swelling), pneumonia (infection in the lungs), death
Mumps	MMR**vaccine protects against mumps.	Air, direct contact	Swollen salivary glands (under the jaw), fever, headache, tiredness, muscle pain	Meningitis (infection of the covering around the brain and spinal cord), encephalitis (brain swelling), inflammation of testicles or ovaries, deafness
Pertussis	DTaP* vaccine protects against pertussis (whooping cough).	Air, direct contact	Severe cough, runny nose, apnea (a pause in breathing in infants)	Pneumonia (infection in the lungs), death
Polio	IPV vaccine protects against polio.	Air, direct contact, through the mouth	May be no symptoms, sore throat, fever, nausea, headache	Paralysis, death
Pneumococcal	PCV13 vaccine protects against pneumococcus.	Air, direct contact	May be no symptoms, pneumonia (infection in the lungs)	Bacteremia (blood infection), meningitis (infection of the covering around the brain and spinal cord), death
Rotavirus	RV vaccine protects against rotavirus.	Through the mouth	Diarrhea, fever, vomiting	Severe diarrhea, dehydration
Rubella	MMR** vaccine protects against rubella.	Air, direct contact	Sometimes rash, fever, swollen lymph nodes	Very serious in pregnant women—can lead to miscarriage, stillbirth, premature delivery, birth defects
Tetanus	DTaP* vaccine protects against tetanus.	Exposure through cuts in skin	Stiffness in neck and abdominal muscles, difficulty swallowing, muscle spasms, fever	Broken bones, breathing difficulty, death

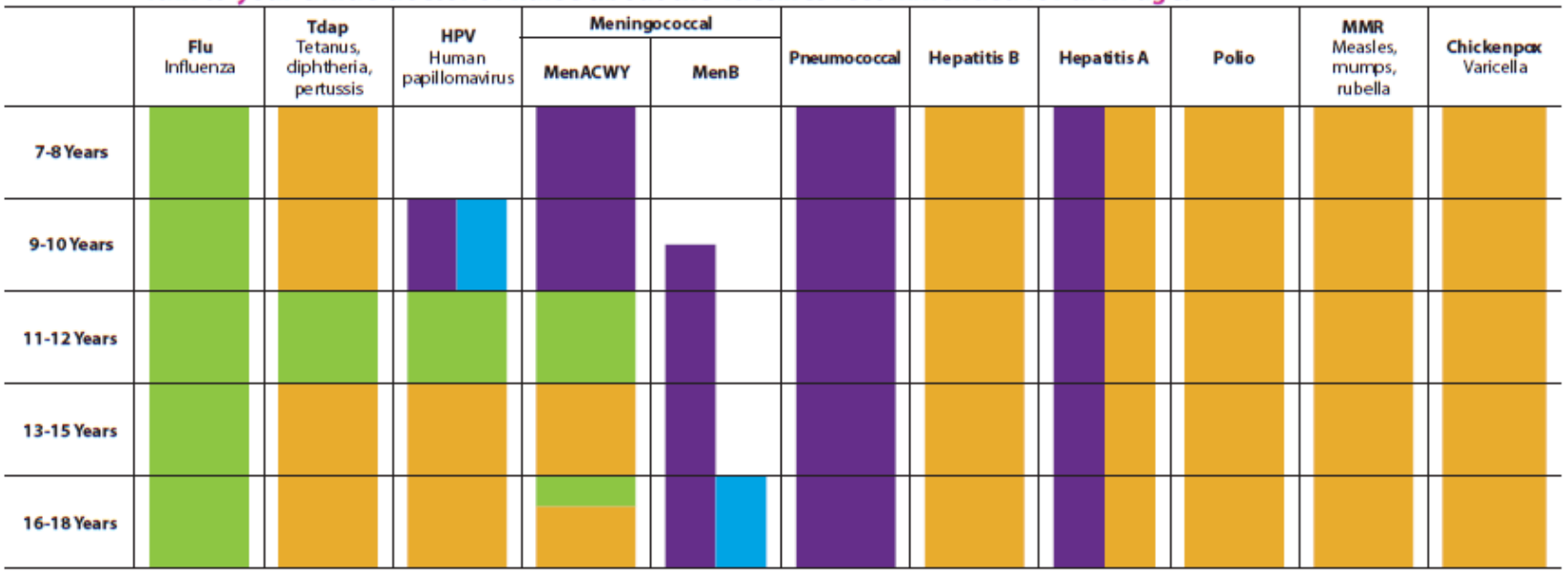
*DTaP combines protection against diphtheria, tetanus, and pertussis.
** MMR combines protection against measles, mumps, and rubella.

Last updated January 2019 • CS300526-A

INFORMATION FOR PARENTS

2019 Recommended Immunizations for Children 7–18 Years Old

Talk to your child's doctor or nurse about the vaccines recommended for their age.



More information:

- Everyone 6 months and older should get a flu vaccine every year.
- All 11- through 12-year olds should get one shot of Tdap.
- All 11- through 12-year olds should get a 2-shot series of HPV vaccine. A 3-shot series is needed for those with weakened immune systems and those who start the series at 15 years or older.
- All 11- through 12-year olds should get one shot of meningococcal conjugate (MenACWY). A booster shot is recommended at age 16.
- Teens 16–18 years old **may** be vaccinated with a serogroup B meningococcal (MenB) vaccine.

These shaded boxes indicate when the vaccine is recommended for all children unless your doctor tells you that your child cannot safely receive the vaccine.

These shaded boxes indicate the vaccine should be given if a child is catching up on missed vaccines.

These shaded boxes indicate the vaccine is recommended for children with certain health or lifestyle conditions that put them at an increased risk for serious diseases. See vaccine-specific recommendations at www.cdc.gov/vaccines/hcp/acip-recs/.

This shaded box indicates children not at increased risk may get the vaccine if they wish after speaking to a provider.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

American Academy of Pediatrics
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AAFP

Vaccine-Preventable Diseases and the Vaccines that Prevent Them

Diphtheria (Can be prevented by Tdap vaccination)

Diphtheria is a very contagious bacterial disease that affects the respiratory system, including the lungs. Diphtheria bacteria can be spread from person to person by direct contact with droplets from an infected person's cough or sneeze. When people are infected, the bacteria can produce a toxin (poison) in the body that can cause a thick coating in the back of the nose or throat that makes it hard to breathe or swallow. Effects from this toxin can also lead to swelling of the heart muscle and, in some cases, heart failure. In serious cases, the illness can cause coma, paralysis, or even death.

Hepatitis A (Can be prevented by HepA vaccination)

Hepatitis A is an infection in the liver caused by hepatitis A virus. The virus is spread primarily person to person through the fecal-oral route. In other words, the virus is taken in by mouth from contact with objects, food, or drinks contaminated by the feces (stool) of an infected person. Symptoms can include fever, tiredness, poor appetite, vomiting, stomach pain, and sometimes jaundice (when skin and eyes turn yellow). An infected person may have no symptoms, may have mild illness for a week or two, may have severe illness for several months, or may rarely develop liver failure and die from the infection. In the U.S., about 100 people a year die from hepatitis A.

Hepatitis B (Can be prevented by HepB vaccination)

Hepatitis B causes a flu-like illness with loss of appetite, nausea, vomiting, rashes, joint pain, and jaundice. Symptoms of acute hepatitis B include fever, fatigue, loss of appetite, nausea, vomiting, pain in joints and stomach, dark urine, grey-colored stools, and jaundice (when skin and eyes turn yellow).

Human Papillomavirus (Can be prevented by HPV vaccination)

Human papillomavirus is a common virus. HPV is most common in people in their teens and early 20s. About 14 million people, including teens, become infected with HPV each year. HPV infection can cause cervical, vaginal, and vulvar cancers in women and penile cancer in men. HPV can also cause anal cancer, oropharyngeal cancer (back of the throat), and genital warts in both men and women.

Influenza (Can be prevented by annual flu vaccination)

Influenza is a highly contagious viral infection of the nose, throat, and lungs. The virus spreads easily through droplets when an infected person coughs or sneezes and can cause mild to severe illness. Typical symptoms include a sudden high fever, chills, a dry cough, headache, runny nose, sore throat, and musde and joint pain. Extreme fatigue can last from several days to weeks. Influenza may lead to hospitalization or even death, even among previously healthy children.

Measles (Can be prevented by MMR vaccination)

Measles is one of the most contagious viral diseases. Measles virus is spread by direct contact with the airborne respiratory droplets of an infected person. Measles is so contagious that just being in the same room after a person who has measles has already left can result in infection. Symptoms usually include a rash, fever, cough, and red, watery eyes. Fever can persist, rash can last for up to a week, and coughing can last about 10 days. Measles can also cause pneumonia, seizures, brain damage, or death.

Meningococcal Disease (Can be prevented by meningococcal vaccination)

Meningococcal disease has two common outcomes: meningitis (infection of the lining of the brain and spinal cord) and bloodstream infections. The bacteria that cause meningococcal disease spread through the exchange of nose and throat droplets, such as when coughing, sneezing, or kissing. Symptoms include sudden onset of fever, headache, and stiff neck. With bloodstream infection, symptoms also include a dark purple rash. About one of every 10 people who gets the disease dies from it. Survivors of meningococcal disease may lose their arms or legs, become deaf, have problems with their nervous systems, become developmentally disabled, or suffer seizures or strokes.

Mumps (Can be prevented by MMR vaccination)

Mumps is an infectious disease caused by the mumps virus, which is spread in the air by a cough or sneeze from an infected person. A child can also get infected with mumps by coming in contact with a contaminated object like a toy. The mumps virus causes swollen salivary glands under the ears or jaw, fever, muscle aches, tiredness, abdominal pain, and loss of appetite. Severe complications for children who get mumps are uncommon, but can include meningitis (infection of the lining of the brain and spinal cord), encephalitis (inflammation of the brain), permanent hearing loss, or swelling of the testes, which rarely results in decreased fertility.

Pertussis (Whooping Cough) (Can be prevented by Tdap vaccination)

Pertussis spreads very easily through coughing and sneezing. It can cause a bad cough that makes someone gasp for air after coughing fits. This cough can last for many weeks, which can make preteens and teens miss school and other activities. Pertussis can be deadly for babies who are too young to receive the vaccine. Often babies get whooping cough from their older brothers or sisters, like preteens or teens, or other people in the family. Babies with pertussis can get pneumonia, have seizures, become brain damaged, or even die. About half of children under 1 year of age who get pertussis must be hospitalized.

Pneumococcal Disease (Can be prevented by pneumococcal vaccination)

Pneumonia is an infection of the lungs that can be caused by the bacteria called "pneumococcus." These bacteria can cause other types of infections, too, such as ear infections, sinus infections, meningitis (infection of the lining of the brain and spinal cord), and bloodstream infections. Sinus and ear infections are usually mild and are much more common than the more serious forms of pneumococcal disease. However, in some cases, pneumococcal disease can be fatal or result in long-term problems like brain damage and hearing loss. The bacteria that cause pneumococcal disease spread when people cough or sneeze. Many people have the bacteria in their nose or throat at one time or another without being ill—this is known as being a carrier.

Polio (Can be prevented by IPV vaccination)

Polio is caused by a virus that lives in an infected person's throat and intestines. It spreads through contact with the stool of an infected person and through droplets from a sneeze or cough. Symptoms typically include sore throat, fever, tiredness, nausea, headache, or stomach pain. In about 1% of cases, polio can cause paralysis. Among those who are paralyzed, about 2 to 10 children out of 100 die because the virus affects the muscles that help them breathe.

Rubella (German Measles) (Can be prevented by MMR vaccination)

Rubella is caused by a virus that is spread through coughing and sneezing. In children, rubella usually causes a mild illness with fever, swollen glands, and a rash that lasts about 3 days. Rubella rarely causes serious illness or complications in children, but can be very serious to a baby in the womb. If a pregnant woman is infected, the result for the baby can be devastating, including miscarriage, serious heart defects, mental retardation, and loss of hearing and eyesight.

Tetanus (Lockjaw) (Can be prevented by Tdap vaccination)

Tetanus mainly affects the neck and belly. When people are infected, the bacteria produce a toxin (poison) that causes muscles to become tight, which is very painful. This can lead to "locking" of the jaw so a person cannot open his or her mouth, swallow, or breathe. The bacteria that cause tetanus are found in soil, dust, and manure. The bacteria enter the body through a puncture, cut, or sore on the skin. Complete recovery from tetanus can take months. One to two out of 10 people who get tetanus die from the disease.

Varicella (Chickenpox) (Can be prevented by varicella vaccination)

Chickenpox is caused by the varicella zoster virus. Chickenpox is very contagious and spreads very easily from infected people. The virus can spread from either a cough or sneeze. It can also spread from the blisters on the skin, either by touching them or by breathing in these viral particles. Typical symptoms of chickenpox include an itchy rash with blisters, tiredness, headache, and fever. Chickenpox is usually mild, but it can lead to severe skin infections, pneumonia, encephalitis (brain swelling), or even death.

If you have any questions about your child's vaccines, talk to your child's doctor or nurse.

Last updated on January 24, 2019 • CS300526-B

Source: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult.html.

Table 1 Recommended Adult Immunization Schedule by Age Group
United States, 2019

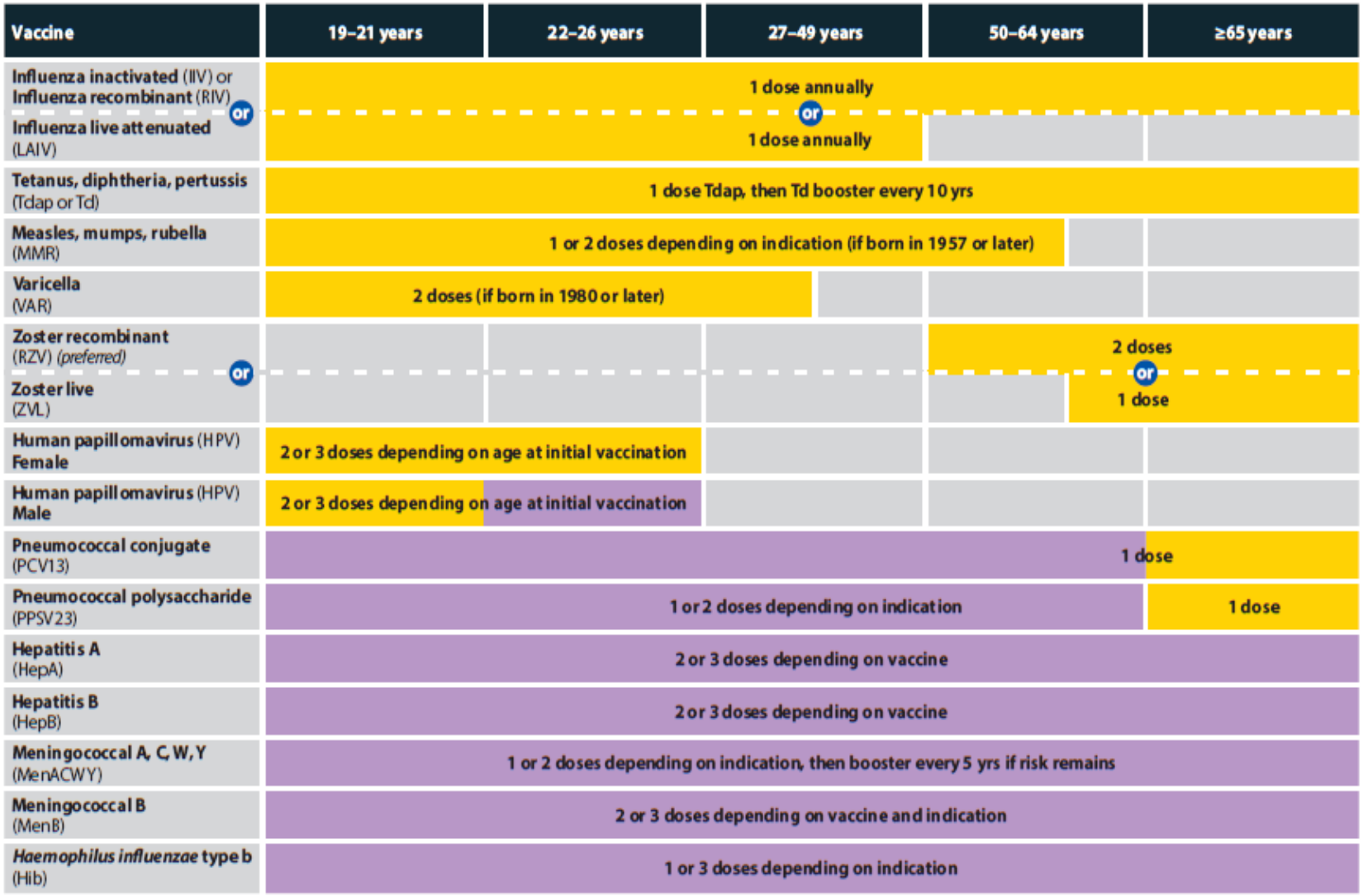

Table 2 Recommended Adult Immunization Schedule by Medical Condition and Other Indications
United States, 2019

Vaccine	Pregnancy	Immuno-compromised (excluding HIV infection)	HIV infection CD4 count <200	HIV infection CD4 count ≥200	Asplenia, complement deficiencies	End-stage renal disease, on hemodialysis	Heart or lung disease, alcoholism[1]	Chronic liver disease	Diabetes	Health care personnel[2]	Men who have sex with men
IIV or RIV or LAIV	1 dose annually										
Tdap or Td	1 dose Tdap each pregnancy	CONTRAINDICATED			PRECAUTION					1 dose annually	
	1 dose Tdap, then Td booster every 10 yrs										
MMR	CONTRAINDICATED	1 or 2 doses depending on indication									
VAR	CONTRAINDICATED	2 doses									
RZV (*preferred*) or ZVL	DELAY	CONTRAINDICATED			2 doses at age ≥50 yrs or 1 dose at age ≥60 yrs						
HPV Female	DELAY	3 doses through age 26 yrs			2 or 3 doses through age 26 yrs						2 or 3 doses through age 26 yrs
HPV Male		3 doses through age 26 yrs			2 or 3 doses through age 21 yrs						
PCV13		1 dose									
PPSV23		1, 2, or 3 doses depending on age and indication									
HepA		2 or 3 doses depending on vaccine									
HepB		2 or 3 doses depending on vaccine									
MenACWY		1 or 2 doses depending on indication, then booster every 5 yrs if risk remains									
MenB	PRECAUTION	2 or 3 doses depending on vaccine and indication									
Hib		3 doses HSCT[3] recipients only			1 dose						

Recommended vaccination for adults who meet age requirement, lack documentation of vaccination, or lack evidence of past infection

Recommended vaccination for adults with an additional risk factor or another indication

Precaution—vaccine might be indicated if benefit of protection outweighs risk of adverse reaction

Delay vaccination until after pregnancy if vaccine is indicated

Contraindicated—vaccine should not be administered because of risk for serious adverse reaction

No recommendation

1. Precaution for LAIV does not apply to alcoholism. 2. See notes for influenza; hepatitis B; measles, mumps, and rubella; and varicella vaccinations. 3. Hematopoietic stem cell transplant.

Source: https://www.cdc.gov/vaccines/schedules/hcp/imz/adult-conditions.html.

APPENDIX B

PARTICIPATING FACILITIES

Prime Healthcare Facilities

Alvarado Hospital Medical Center
Bio-Med Services, Inc.
Centinela Hospital Medical Center
Chino Valley Medical Center
Dallas Medical Center
Dallas Medical Physician Group
Dallas Regional Medical Center
Desert Valley Hospital
Desert Valley Medical Group
Garden Grove Hospital Medical Center
Garden City Hospital
Harlingen Medical Center
Lake Huron Medical Center
Lake Huron Medical Group
Lehigh Regional Medical Center
Lower Bucks Hospital
Monroe Hospital
North Vista Hospital
North Vista Medical Group
Paradise Valley Hospital
Paradise Valley Medical Group
Prime Garden City Medical Group
Prime Healthcare Management, Inc.
Providence Medical Center
Riverview Regional Medical Center
Roxborough Memorial Hospital
Saint Clare's Behavioral Health
Saint Clare's Denville Hospital
Saint Clare's Dover Hospital
Saint John Hospital
St. Joseph Medical Center
St. Mary's Medical Center
Saint Mary's General Hospital
Saint Mary's Regional Medical Center
Saint Mary's Medical Group
Saint Michael's Medical Center
San Dimas Community Hospital
Shasta Regional Medical Center
Shasta Regional Medical Group
Summit Surgery Center at Saint Mary's Galena
West Anaheim Medical Center

Foundation Facilities

Coshocton Regional Medical Center
Encino Hospital Medical Center
East Liverpool City Hospital
Glendora Oaks Behavioral Health Hospital
Huntington Beach Hospital
Knapp Medical Center
Knapp Medical Group
La Palma Intercommunity Hospital
Landmark Medical Center
Mission Regional Medical Center
Montclair Hospital Medical Center
Ohio Valley Home Health Services
River Valley Physicians
Pampa Regional Medical Center
Rehabilitation Hospital of Rhode Island
Sherman Oaks Hospital
Sherman Oaks Hospital Medical Group
Southern Regional Medical Center
Suburban Community Hospital
Suburban Medical Group

ADDENDUM 101

SCHEDULE OF MEDICAL BENEFITS

The Prime Healthcare entity included in the following schedule of medical benefits is:
Alvarado Hospital Medical Center, Bio Med Services Inc., Centinela Hospital Medical Center, Chino Valley Medical Center, Coshocton Regional Medical Center, Dallas Medical Center, Dallas Medical Physician Group, Dallas Regional Medical Center, Desert Valley Hospital, Desert Valley Medical Group, East Liverpool City Hospital, Encino Hospital Medical Center, Garden City Hospital, Prime Garden City Medical Group, Garden Grove Hospital Medical Center, Glendora Oaks Behavioral Health Hospital, Harlingen Medical Center, Huntington Beach Hospital, Knapp Medical Center, Knapp Medical Group, Lake Huron Medical Center, Lake Huron Medical Group, La Palma Intercommunity Hospital, Lehigh Regional Medical Center, Lower Bucks Hospital, Mission Regional Medical Center, Monroe Hospital, Montclair Hospital Medical Center, North Vista Hospital, North Vista Medical Group, Ohio Valley Home Health Services, Pampa Regional Medical Center, Paradise Valley Hospital, Paradise Valley Medical Group, Prime Healthcare Management, Inc., Providence Medical Center, Riverview Regional Medical Center, River Valley Physicians, Roxborough Memorial Hospital, Saint Clare's Behavioral Health, Saint Clare's Denville Hospital, Saint Clare's Dover Hospital, Saint John Hospital, St. Joseph Medical Center, St. Mary's General Hospital, St. Mary's Medical Center, Saint Mary's Medical Group, Saint Mary's Regional Medical Center, Saint Michael's Medical Center, San Dimas Community Hospital, Shasta Regional Medical Center, Shasta Regional Medical Group, Sherman Oaks Hospital, Sherman Oaks Hospital Medical Group, Southern Regional Medical Center, Suburban Community Hospital, Summit Surgery Center at Saint Mary's Galena, and West Anaheim Medical Center.

The percentages shown in the schedule reflect the amounts the Covered Person pays after any required Copay has been applied. The percentages apply to "Allowable Charges." See "Allowable Charges" in the **Definitions** section for more information. A "Copay" is a fixed amount the Covered Person must pay and is usually paid to the Provider at the time of service.

Please refer to your facility's Benefit Guide for additional information on eligibility requirements.

Tier 1 Prime Healthcare Network	
Annual Deductible	$2,500 Individual / $5,000 Family (New!)
Annual Out-of-Pocket Maximum	$3,000 Individual / $6,000 Family (New!)
Office Visit • Primary Care PCP • Specialist	 $20 copay $40 copay
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	20% coinsurance, No Deductible (New!)
Lab and X-ray	20% coinsurance, No Deductible
Inpatient Hospital Services	Deductible plus 20% coinsurance (New!)
Outpatient Hospital Services – Surgical	Deductible plus 20% coinsurance (New!) **Ambulatory Surgical Center:** $250 copay plus Deductible and 20% coinsurance (New!)

Urgent Care	$40 copay, No Deductible (New!)
Emergency Room	$300 copay (copay waived if admitted) (New!)
Ambulance	$300 copay plus Deductible and 30% coinsurance per trip
Rehab Therapy[1] Physical, Occupational, Speech (24 visit combined limit per calendar year)	20% coinsurance, No Deductible
Acute Dialysis[1]**:** 39 lifetime visits	20% coinsurance, No Deductible
Home Health Care[1] (24 visit limit per calendar year)	20% coinsurance, No Deductible
Durable Medical Equipment	20% coinsurance, No Deductible

[1]Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 Blue Shield of CA Network / Tier 2 BCBS BlueCard Network.

Tier 2 Blue Shield of CA Network / BCBS BlueCard Network	
Annual Deductible	$5,000 Individual / $10,000 Family
Annual Out-of-Pocket Maximum	$5,150 Individual / $10,300 Family (New!)
Office Visit • Primary Care PCP • Specialist	 $60 copay, No Deductible $100 copay plus 20% coinsurance
Preventive Care Service	No charge
Chiropractic[1] (20 visit limit per calendar year)	Deductible plus 60% coinsurance
Lab and X-ray	Deductible plus 60% coinsurance
Inpatient Hospital Services	$500 copay plus Deductible and 60% coinsurance
Outpatient Hospital Services – Surgical	Deductible plus 60% coinsurance **Ambulatory Surgical Center:** $750 copay plus Deductible and 60% coinsurance
Urgent Care	$100 copay plus Deductible and 60% coinsurance
Emergency Room	$300 copay plus Deductible and 60% coinsurance (copay waived if admitted)
Ambulance	$300 copay plus Deductible and 30% coinsurance per trip
Rehab Therapy[1] Physical, Occupational, Speech (24 visit combined limit per calendar year)	Deductible plus 60% coinsurance
Acute Dialysis[1]**:** 39 lifetime visits	Deductible plus 60% coinsurance
Home Health Care[1] (24 visit limit per calendar year)	Deductible plus 60% coinsurance
Durable Medical Equipment	Deductible plus 60% coinsurance

[1] Visit limits are combined with Tier 1 Prime Healthcare Network and Tier 2 Blue Shield of CA Network / Tier 2 BCBS BlueCard Network.

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

SCHEDULE OF PRESCRIPTION COPAYS

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and a prescription program vendor.

Prescription coverage includes a retail feature with participating retail pharmacies and a mail order option. A "participating pharmacy" has a contract with the prescription program vendor to dispense drugs to Covered Persons. The mail order option allows a Covered Person to receive a larger quantity of a prescription and is generally useful for long-term or maintenance-type drugs. Prescriptions filled at non-participating pharmacies will not be covered.

Express Scripts	Prime Pharmacy*	Retail
Annual Out-of-Pocket Limit	Combined with Tier 2 Medical Out-of-Pocket Maximum	
Pharmacy Generic Formulary Brand	**Up to 30-day Supply** $10 copay $50 copay	**Up to 30-day Supply** $25 copay $100 copay
Specialty Drugs (Available through Accredo) Generic Formulary Brand	Not Covered Not Covered	**Up to 30-day Supply** $200 copay $300 copay
Mail Order Generic Formulary Brand	**Up to 90-day Supply** $20 copay $100 copay	**Up to 90-day Supply** $50 copay $200 copay

*Prime Pharmacy: CPCN Physicians Service, East Liverpool City Hospital, Ohio Valley Home Health Services, River Valley Physicians, Garden City Hospital, Prime Garden City Medical Group, Lake Huron Medical Center, Lake Huron Medical Group St. Joseph's Medical Center, St. Mary's Medical Center and South Kansas City Surgical Center.

NOTE: RX COPAYS AND PERCENTAGES ARE THE COVERED PERSON'S RESPONSIBILITY. HOWEVER, THE ANCILLARY FEE (DIFFERENCE IN COST BETWEEN THE BRAND AND THE GENERIC) FOR A BRAND DRUG WILL NOT COUNT TOWARD THE OUT-OF-POCKET MAXIMUM IF A GENERIC DRUG IS AVAILABLE AND MEDICALLY APPROPRIATE (AS DETERMINED BY THE COVERED PERSON'S PERSONAL PHYSICIAN). BENEFITS UNDER THE PLAN, INCLUDING COST SHARING PROVISIONS SUCH AS COPAYS, ARE SUBJECT TO CHANGE.