PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION
FOR

AgBenefits

EMPLOYEE BENEFIT PLAN

GUARANTY FUND NONPARTICIPATING NOTICE

In the event the insurer (plan established by the Multiple Employer Welfare Arrangement) is unable to fulfill its contractual obligation under this policy or contract or application or certificate or evidence of coverage (summary plan description or plan), the policyholder or certificate holder (participating employee or former employee) is not protected by an insurance guaranty fund or other solvency protection arrangement.

Form: AgBenefits-Plan Doc-Medical Web (06/18)

IMPORTANT NOTICE

1. To obtain information to make a complaint:

2. You may call the Claims Supervisor, Bentegrity Solutions, for information or make a complaint at:

1-806-568-2600

3. You may also write to Bentegrity Solutions, the Claims Supervisor, at:
1616 S. Kentucky Suite C250
Amarillo, TX 79102

4. You may contact the Texas Department of Insurance to obtain information on companies, coverages, rights, or complaints at:

1-800-252-3439

5. You may write the Texas Department of Insurance:
P.O. Box 149104
Austin Texas 78714-9104
Fax No. (512) 490-1007
Web: www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

6. PREMIUM OR CLAIM DISPUTES: Should you have a dispute concerning your premium or about a claim you should contact AgBenefits first. If the dispute is not resolved, you may contact the Texas Department of Insurance.

7. Attach this Notice to your Policy: This notice is for information only and does not become a part or condition of the attached document.

AVISO IMPORTANTE

Para obtener informacion o para presentar una queja:

Usted puede llamar al numero de telefono gratuito de Claims Supervisor, Bentegrity Solutions, para obtener informacion o para presentar una queja'al

1-806-568-2600

Usted tambien puede escribir a Bentegrity Solutions, de Claims Supervisor, al:
1616 S. Kentucky Suite C250
Amarillo, TX 79102

Usted puede comunicarse con el Departamento de Sequros de Texas para obtener informacion sobre de companias, coberturas, derechos o quejas al:

1-800-252-3439

Usted puede escribir al Departamento de Seguros de Texas:
P.O. Box 149104
Austin, Texas 78714-9104
Fax No. (512) 490-1007
Web: www.tdi.state.tx.us
Email: ConsumerProtection@tdi.state.tx.us

DISPUTAS POR PRIMAS DE SEGUROS O RECLAMANCIONES: Si tiene una disputa relacionada con a su prima de seguro o con una reclamacion, usted, debe comunicarse con el AgBenefits primero. Si la disputa no es resuelta usted, puede comunicarse con el Departamento de Seguros de Texas.

ADJUNTE ESTE Aviso A Su Poliza: Este aviso es SOLAMENTE para propositos de informativos y no se convierte en parte o en condicion del documento adjunto.

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INTRODUCTION

This document is a description of the AgBenefits Employee Benefit Plan (formerly known as Texas Ag Coop Trust Employee Benefit Plan) (the Plan). No oral interpretations can change this Plan. The Plan described is designed to protect Covered Persons against certain catastrophic health expenses.

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

AgBenefits fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason, subject to the requirements stated herein.

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

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

The Plan will pay benefits only for the expenses incurred while this coverage is in force. No benefits are payable for expenses incurred before coverage began or after coverage terminated, even if the expenses were incurred as a result of an accident, injury or disease that occurred, began, or existed while coverage was in force. An expense for a service or supply is incurred on the date the service or supply is furnished.

Healthcare fraud is a deception that could result in a non-contractual payment by a health care plan. It includes, but is not limited to: claiming benefits for non-members; failing to disclose availability of other coverage; billing for services not provided; knowingly billing for inaccurate charges or mis-coded services; over-billing for services provided; and claiming credit for copayments, deductibles, and coinsurance not collected (if a provider) and not paid (if a Covered Person). Any Covered Person or provider involved in such healthcare fraud is subject to termination and criminal prosecution and shall fully reimburse the Plan. The Plan shall cooperate with the Federal Bureau of Investigation (FBI), the Office of Inspector General of the Department of Health and Human Services (OIG), the Office of the Attorney General of Texas (OAG) and private health insurance companies in investigating and prosecuting civil and criminal healthcare fraud.

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

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

Assignment of Benefits. Assignment of Benefits means an arrangement whereby a participant of the Plan, at the discretion of the Plan Administrator, assigns its right to seek and receive payment of eligible Plan benefits, less deductibles, co-payments and coinsurance amounts, to a medical provider. If a provider accepts said arrangement, the provider's rights to receive Plan benefits are equal to those of the plan participant, and are limited by the terms of this Plan Document. A provider that accepts this arrangement indicates acceptance of an Assignment of Benefits and deductibles, co-payments, and coinsurance amounts, as consideration in full for treatment rendered. The Plan Administrator may revoke an assignment of benefits at its discretion and treat the Plan participant as the sole beneficiary

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

Medical Benefits. Provides an outline of the Plan reimbursement formulas and explains when the benefit applies and the types of charges covered. Covered Persons should also refer to the attached Schedule of Benefits for benefit information.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges.

> **This part should be read carefully since each Covered Person is required to take action to assure that the maximum payment levels under the Plan are paid.**

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

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

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

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

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

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases and the continuation options that may be available.

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

ELIGIBILITY, FUNDING, EFFECTIVE DATE AND TERMINATION PROVISIONS

A Plan Covered Person should contact the Plan Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements.

ELIGIBILITY

Minimum Employee Participation. To be eligible to participate in the Plan, an Employee must enroll 75% of the Employer's Active Employees in the Plan.

Eligible Classes of Employees. All Class I and Class II Active Employees of a participating Employer ("the Employer"), including Retiree's as defined.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

(1) is a Full-Time, Active Employee of the Employer. An Employee is considered to be Full-Time if he or she normally works at least 30 hours per week and is on the regular payroll of the Employer for that work.

(2) is in a class eligible for coverage.

(3) completes the employment Waiting Period of first of the month following 30 days as an Active Employee. A "Waiting Period" is the time between the first day of employment and the first day of coverage under the Plan. The Waiting Period will be waived for an Active Employee who previously satisfied the Waiting Period under the Plan through a prior Employer and who has maintained continuous coverage under the Plan.

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

(1) A covered Employee's Spouse and natural or adopted children from birth to the limiting age of 26 years. When a child reaches the limiting age, coverage will end on the child's birthday.

The term "Spouse" shall mean the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term "children" shall include natural children, adopted children or children who are subjects of suits for adoption to which a covered Employee is a party. Foster Children, who reside in the Employee's household, may be included from birth to the limiting age of 26 years. Step-children, who reside in the Employee's household, may also be included from birth to the limiting age of 26 years, as long as the natural parent remains married to the Employee and also resides in the Employee's household.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

Any child of a Covered Person who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

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

(2) An unmarried covered Dependent child who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap and primarily dependent upon the covered Employee for support and maintenance. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's Total Disability and dependency.

After such two-year period, the Plan Administrator may require subsequent proof not more than once each year. The Plan Administrator reserves the right to have such Dependent examined by a Physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

The phrase "primarily dependent upon" shall mean dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code and the covered Employee must declare the child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

If a person covered under this Plan changes status from Employee to Dependent or Dependent to Employee, and the person is covered continuously under this Plan before, during and after the change in status, credit will be given for deductibles and all amounts applied to maximums.

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

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

The level of any Employee contributions is set by the Employer, subject to the minimum Employer contribution amount established by the Plan Administrator, which is 75% of the cost of the Employee only contribution. The Plan Administrator reserves the right to change the minimum required Employer contribution.

ENROLLMENT

Initial Enrollment Period is the 31 day period during which an Eligible Employee or Eligible Dependent first qualifies to enroll for coverage.

Annual Open Enrollment Period is a period of at least thirty-one (31) days consisting of an entire calendar month beginning on the first day of the month and ending on the last day of the month. If the month is less than a thirty-one day month, the 31-day enrollment period shall continue into the next month**.**

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. The covered Employee must enroll any Dependents for whom Dependent coverage is requested.

Enrollment Requirements for Newborn Children.

Coverage for a newborn child of a covered Employee will be automatic for 31 days following the date of birth and will terminate on the 32nd day, unless the Covered Employee elects Dependent coverage for the newborn child within the 31 days of birth and pays any required additional contribution for the Dependent coverage within that 31 day period, consistent with the Employer's next billing cycle. If the child is required to be enrolled and is not enrolled within 31 days of birth, the enrollment will be considered a Late Enrollment.

Charges for covered nursery care will be applied toward the Plan of the covered parent.

Enrollment Requirements for Adopted Children. Coverage will be automatic for a newly adopted child for the first 31 days from the date that a Covered Employee is a party in a suit for adoption or 31 days from the date the adoption is final. To continue coverage beyond 31 days, the Covered Employee must notify the Claims Supervisor the Covered Employee is a party in a suit for adoption or that the adoption is final and must pay the required contribution within either of the 31 day periods or a period consistent with the Employer's next billing cycle. If notification is received after either of the 31 day periods, the newly adopted child will be considered a Late Enrollment.

Court Ordered Coverage for a Child. If a court has ordered a Covered Employee to provide coverage for a child, coverage will be automatic for the first 31 days from the date the Employer receives notification of the court order. To continue coverage beyond 31 days, the Covered Employee must notify the Claims Supervisor and the required contribution must be paid within the 31 day period. If the Covered Employee does not provide the required notification and contribution within the 31 day period, the child's coverage will be considered a Late Enrollment.

TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 31 days after the person becomes eligible for the coverage, either during the Initial Enrollment Period, under a Special Enrollment Period or during an Annual Enrollment Period.

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

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees and their Dependents who are not eligible to join the Plan during a Special Enrollment Period may join only during the Employer's open enrollment period.

Late Enrollee means any Eligible Employee or Eligible Dependent who submits his or her written application after the expiration of the Initial Enrollment Period, a Special Enrollment Period, or after the expiration of the Annual Open Enrollment Period.

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

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

SPECIAL ENROLLMENT PERIODS

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

(1) **Individuals losing other coverage.** An Employee or Dependent who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

(a) The Employee or Dependent was covered under another health plan or self-funded employer health benefit plan at the time the individual was eligible to enroll under this Plan;

(b) If required by the Plan Administrator, the individual stated in writing at the time of initial eligibility that coverage, under another health benefit plan or self-funded plan employer benefit plan, was the reason for declining enrollment;

(c) The Employee or Dependent has lost the coverage under another health benefit plan or self-funded employer health benefit plan as a result of termination of employment, reduction in the number of hours of employment, termination of other plan's coverage, termination of employer contributions towards the cost of coverage or death or divorce of a spouse; and

(d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion on which coverage under the other health benefit plan or self-funded employer health benefit plan terminates. Coverage will begin on the date of the occurrence.

(2) **Loss of Eligibility for Medicaid or SCHIP.** If an Employee declined coverage for himself and/or his Dependents under this Plan when first eligible to enroll because he and/or his Dependents had coverage through Medicaid or a State Children's Health Insurance Program (SCHIP), and they experience a loss of coverage, the Employee may enroll for coverage within 60 days of the loss of such coverage. Loss of

coverage means Medicaid or SCHIP terminated as a result of loss of eligibility for the coverage. Coverage will be effective on the date of the occurrence.

(3) **Premium Assistance Eligibility.** If an Employee and/or Dependent not currently enrolled in this Plan becomes eligible for a premium assistance subsidy from Medicaid or a State Children's Health Insurance Program (SCHIP), then the Employee may enroll for coverage within 60 days of the eligibility for such premium assistance subsidy. Coverage will be effective on the date of the occurrence/the first of the month following the date of the enrollment. The Preexisting Condition limitation will apply.

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

(1) **Employer with multiple plans.** An Employee may enroll in this Plan if the Employee is employed by an Employer that offers multiple health benefit plans, and the Employee elects a different health benefit plan during an open enrollment period.

(2) **Dependent beneficiaries.** If:

(a) The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period); and

(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or because the Employee becomes a party in a suit for the adoption of a child and request for enrollment is made within 31 days of marriage, birth, adoption or within 31 days of the date the Employee becomes a party in a suit for the adoption of a child; or

(c) A court has ordered coverage to be provided for a child under a Covered Employee's plan and request for enrollment is made not later than the 31st day after the date on which the Employer receives notification of the court order, or a court has ordered coverage to be provided for a spouse under a Covered Employee's plan and request for enrollment is made not later than the 31st day after the date on which the court order is issued; or

the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or the date the Employee becomes a party in a suit for adoption of the child.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, as of the date of marriage;

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

(c) in the case of a Dependent's adoption, the date of the adoption or the date the Employee becomes a party in a suit for adoption of the child.

EFFECTIVE DATE

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

(1) The Eligibility Requirement.

(2) The Active Employee Requirement.

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

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

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

TERMINATION OF COVERAGE

When coverage under this Plan stops, Covered Persons will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

When Employer Coverage Terminates. Coverage for covered Employees and Dependents of an Employer will terminate on the earliest of the following dates:

(1) The date the Employer cancels participation in the Plan;

(2) The date the required contributions are not paid;

(3) The date the Employer has committed fraud or intentionally misrepresented a material fact;

(4) The date the Employer has not complied with the terms of the Plan Document/Summary Plan Description; or

(5) The date the Plan is terminated or the Trust ceases to offer any coverage in the Employer's geographic area.

COBRA continuation through the Trust is not available to Employees or Dependents when the Employer's participation in the Plan terminates.

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

(1) The date the Employer's participation in the Plan terminates;

(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (see the COBRA Continuation Options);
Retirees eligibility of coverage will terminate the earlier of:
(a) Attainment of age 65
(b) The date the Retiree becomes eligible for another group health plan

(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

(4) The date of fraud or intentional misrepresentation of a material fact by the Employee.

Continuation During Periods of Employer-Certified Leave of Absence or Layoff. A person may remain eligible for a limited time if Active, full-time work ceases due to leave of absence or layoff. This continuance will end as follows:

For leave of absence or layoff only: the end of the 3rd calendar month period that next follows the month in which the person last worked as an Active Employee.

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

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

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

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

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements, with the exception of an Employee returning to work directly from COBRA coverage. This Employee does not have to satisfy the employment Waiting Period or provision.

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

(1) The maximum period of coverage of a person under such an election shall be the lesser of:

(a) The 24 month period beginning on the date on which the person's absence begins; or

(b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

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

(1) The date the Employee's coverage is terminated (see the COBRA Continuation Options);

(2) The date the Plan or Dependent coverage under the Plan is terminated;

(3) The end of the month when a covered Spouse loses coverage due to loss of dependency status. (see the COBRA Continuation Options);

(4) On the last day of the month that a Dependent child ceases to be a Dependent as defined by the Plan. (see the COBRA Continuation Options);

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due; or

(6) The date of fraud or intentional misrepresentation of a material fact by the Employee or Dependent.

OPEN ENROLLMENT PERIOD

OPEN ENROLLMENT PERIOD

Each Employer has established an Annual Open Enrollment Period, during which period that Employer's Employees and their Dependents, who are Late Enrollees, may enroll in the Plan. Covered Persons and Qualified Beneficiaries under COBRA are also able to change some of their benefit choices during this period. The open enrollment period is 31 days. Please consult the Employer for the dates of the Employer's Annual Open Enrollment Period.

Benefit choices for Late Enrollees made during the open enrollment period will become effective first of the month following Open Enrollment and remain in effect for twelve months unless there is a Special Enrollment event or a change in family status during the year (birth, death, marriage, divorce, adoption) or loss of coverage due to loss of a Spouse's employment. To the extent previously satisfied under the prior benefit option, Waiting Periods will be considered satisfied when changing to another benefit option under the Plan.

A Covered Person or Qualified Beneficiary, who fails to make an election during open enrollment, will automatically remain enrolled in the same benefit plan (or an equivalent plan if the specific benefit plan is no longer available under the Plan) most recently elected by the Covered Person or Qualified Beneficiary.

Covered Persons and Qualified Beneficiaries will receive detailed information regarding open enrollment from their Employer.

MEDICAL BENEFITS

Verification of Eligibility: 1-806-568-2600

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

All benefits described in this document and attached Schedule of Benefits are subject to the exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges do not exceed Maximum Allowable Charges; that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: Certain services must be preauthorized or reimbursement from the Plan may be reduced. Refer to the subsection entitled UTILIZATION REVIEW in the section entitled COST MANAGEMENT SERVICES for the services requiring preauthorization.

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for benefits under the Plan. Refer to the attached Schedule of Benefits for additional benefit information.

DEDUCTIBLE

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

Deductible Three Month Carryover. Covered expenses incurred in, and applied toward the deductible in October, November and December will be applied toward the deductible in the next Calendar Year.

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

COPAYMENTS

A copayment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be copayments on some services and other services will not have any copayments.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the attached Schedule of Benefits. No benefits will be paid in excess of any listed limit of the Plan.

OUT-OF-POCKET LIMIT

Out-of-Pocket Maximum is the amount each Covered Person incurs for Covered Charges in a Year.

Covered Charges are payable at the percentages shown each Calendar Year until the out-of-pocket limit shown in the attached Schedule of Benefits is reached. Then, Covered Charges incurred by a Covered Person will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

When a Family Unit reaches the out-of-pocket limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded) for the rest of the Calendar Year.

COVERED CHARGES

Covered charges are the amounts not exceeding Maximum Allowable Charges that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

(1) Hospital Care. The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.

Room charges made by a Hospital having only private rooms will be paid, after the deductible, at the coinsurance rate specified in the attached Schedule of Benefits, based on the hospital's billed room charge.

Charges for an Intensive Care Unit stay are payable as described in the attached Schedule of Benefits.

The Plan will cover inpatient treatment of breast cancer for a minimum of 48 hours following a mastectomy and 24 hours following a lymph node dissection.

(2) **Coverage of Pregnancy.** The amounts not exceeding Maximum Allowable Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

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 an uncomplicated vaginal delivery, or less than 96 hours following an uncomplicated cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

In the event the mother or newborn child is discharged before the minimum hours of inpatient care set forth above, the Plan will cover timely post delivery care of the mother and child by a physician or registered nurse at the mother's home, a physician's office or a health care facility, as determined by the mother. Post delivery care means postpartum health care services, provided in accordance with accepted maternal and neonatal physical assessments, and includes parent education, assistance and training in breast-feeding and bottle-feeding and the performance of any medically necessary and appropriate clinical tests. The timeliness of care shall be determined in accordance with recognized medical standards for the care.

There is no coverage of Pregnancy for a Dependent child.

(3) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:

(a) the patient is confined as a bed patient in the facility;

(b) the confinement starts within 14 days of a Hospital confinement of at least 5 days;

(c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and

(d) the attending Physician completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

(4) **Physician Care.** The professional services of a Physician for surgical or medical services.

(a) Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

(i) If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Maximum Allowable Charge that is allowed for the primary procedures; 50% of the Maximum Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would

not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

(ii) If multiple unrelated surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the Maximum Allowable Charge for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowable Charge allowed for that procedure; and

(iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Maximum Allowable Charge allowance.

(5) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to this extent:

(a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.

(b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial in nature. The only charges covered for Outpatient nursing care are those shown below, under Home Health Care Services and Supplies. Outpatient private duty nursing care on a 24-hour-shift basis is not covered.

(6) **Home Health Care Services and Supplies.** Charges for home health care services and supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject to the Home Health Care limit shown in the Schedule of Benefits.

A home health care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four hours of home health aide services.

(7) **Hospice Care Services and Supplies.** Charges for hospice care services and supplies are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

Covered charges for Hospice Care Services and Supplies are payable as described in the attached Schedule of Benefits.

(8) **Other Medical Services and Supplies.** These services and supplies not otherwise included in the items above are covered as follows:

(a) Local Medically Necessary professional land or air **ambulance** service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary. Air ambulance is limited as shown in schedule of benefits.

(b) Treatment of **acquired brain injury**. Covered charges for the following services, medically necessary and related to an acquired brain injury:

- cognitive rehabilitative therapy;
- cognitive communication therapy;
- neurocognitive therapy and rehabilitation;
- neurobehavioral, neurophysiological, neuropsychological and psychophysiological testing or treatment;
- neurofeedback therapy; remediation;
- post-acute transition services;
- community reintegration services, including outpatient day treatment services;
- other post-acute care treatment services; and
- reasonable expenses for periodic reevaluation of the care of a Covered Person who: has an acquired brain injury; has been unresponsive to treatment; and becomes responsive to treatment at a later date. A determination of reasonable expenses may include consideration of: cost; the time expired since the last evaluation; any difference in the expertise of the health care practitioner performing the evaluation; changes in technology; and advances in medicine.

Coverage will not be denied based solely on the fact that treatment or services are provided at a facility other than hospital. Treatment may be provided at a facility at which appropriate services may be provided, including: a hospital regulated under Chapter 241, Health and Safety Code, including an acute or post-acute rehabilitation hospital; or an assisted living facility regulated under Chapter 247, Health and Safety Code.

The following definitions apply to this benefit:

Acquired brain injury means a neurological insult to the brain, which is not hereditary, congenital or degenerative. The injury to the brain occurred after birth and results in a change in neuronal activity, which results in an impairment of physical functioning, sensory processing, cognition or psychosocial behavior.

Cognitive communication therapy means services designed to address modalities of comprehensive and expression, including understanding, reading, writing and verbal expression of information.

Cognitive rehabilitation therapy means services designed to address therapeutic cognitive activities, based on an assessment and understanding of the individual's brain-behavioral deficits.

Community reintegration services means services that facilitate the continuum of care as an affected individual transitions into the community.

Neurobehavioral testing means an evaluation of the history of neurological and psychiatric difficulty, current symptoms, current mental status and premorbid history, including the identification of problematic behavior and the relationship between behavior and the variables that control behavior. This may include interviews of the individual, family and others.

Neurobehavioral treatment means interventions that focus on behavior and the variables that control behavior.

Neurocognitive rehabilitation means services designed to assist cognitively impaired individuals to compensate for deficits in cognitive functioning by rebuilding cognitive skills and/or developing compensatory strategies and techniques.

Neurocognitive therapy means services designated to address neurological deficits in informational processing and to facilitate the development of higher level cognitive abilities.

Neurofeedback therapy means services that utilize operant conditioning learning procedure based on electroencephalography (EEG) parameters and that are designed to result in improved mental performance and behavior and stabilized mood.

Neurophysiological testing means an evaluation of the functions of the nervous system.

Neurophysiological treatment means interventions that focus on the functions of the nervous system.

Neuropsychological testing means the administering of a comprehensive battery of tests to evaluate neurocognitive, behavioral and emotional strengths and weaknesses and their relationship to normal and abnormal central nervous system functioning.

Neuropsychological treatment means interventions designed to improve or minimize deficits in behavioral and cognitive processes.

Outpatient day treatment services means structured services provided to address deficits in physiological, behavior and/or cognitive functions. Such services may be delivered in settings that include transitional residential, community integration or nonresidential treatment settings.

Post-acute care treatment services means services provided after acute care confinement and/or treatment, which are based on an assessment of the individual's cognitive deficits, that include a treatment goal of achieving functional changes by reinforcing, strengthening or re-establishing previously learned patterns of behavior and/or establishing new patterns of cognitive activity or compensatory mechanisms.

Post-acute transition services means services that facilitate the continuum of care beyond the initial neurological insult through rehabilitation and community reintegration.

Psychophysiological testing means an evaluation of the interrelationships between the nervous system and other bodily organs and behavior.

Psychophysiological treatment means interventions designed to alleviate or decrease abnormal physiological responses of the nervous system due to behavioral or emotional factors.

Remediation means the process or processes of restoring or improving a specific function.

Services means the work of testing, treatment and providing therapies to an individual with an acquired brain injury.

Therapy means the scheduled remedial treatment provided through direct interaction with the individual to improve a pathological condition resulting from an acquired brain injury.

(c) **Amino Acid-Based Elemental Formula.** Charges for amino acid-based elemental formulas, including Medically Necessary services for administration of the formula, regardless of the formula delivery method, when the treating Physician has issued a written order stating that the formula is Medically Necessary for the diagnosis and treatment of:

- immunoglobulin E and non-immunoglobulin E mediated allergies to multiple food proteins;
- severe food protein-induced enterocolitis syndrome;
- eosinophilic disorders, as evidenced by the results of a biopsy; and

- impaired absorption of nutrients caused by disorders affecting the absorptive surface, functional length and motility of the gastrointestinal tract.

(d) **Anesthetic**; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.

(e) **Autism Spectrum Disorder**. Coverage is provided for screening of a Covered Person at the ages of 18 months and 24 months. Coverage is provided for Covered Expenses incurred for treatment of a Covered Person who has been diagnosed with autism spectrum disorder from the date of diagnosis, provided that diagnosis is made before the Covered Person's 10th birthday and provided further that benefits for applied behavior analysis are limited to $36,000 per Calendar Year for a Covered Person 10 years of age or older. Treatment will include generally recognized services contained in a treatment plan recommended by the Covered Person's primary care physician:

- evaluation and assessment services;
- applied behavior analysis;
- behavior training and behavior management;
- speech therapy;
- occupational therapy;
- physical therapy; and
- medications or nutritional supplements used to address symptoms of autism spectrum disorder.

Charges are covered only if the treatment is provided by a health care practitioner:

- who is licensed, certified or registered by an appropriate agency of the state of Texas;
- whose professional credential is recognized and accepted by an appropriate agency of the United States; or
- who is certified as a provider under the TRICARE military health system.

The following definitions apply to this benefit:

Autism Spectrum Disorder means a Neurobiological Disorder that includes autism, Asperger's syndrome, or Pervasive Developmental Disorder—Not Otherwise Specified.

Neurobiological Disorder means an illness of the nervous system caused by genetic, metabolic, or other biological factors.

(f) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in a Medical Care Facility as defined by this Plan.

(g) Screening for detection of **cardiovascular disease**. For a covered male older than 45 years of age or a covered female older than 55 years of age, who is diabetic or has a risk of developing coronary heart disease, based on a score that is intermediate or higher, derived using the Framington Heart Study coronary prediction algorithm, once every five years, coverage of up to $200 for one of the following noninvasive screening tests for atherosclerosis and abnormal artery structure and function, performed by a laboratory certified by a national organization:

- computed tomography (CT) scanning measuring coronary artery calcification; or
- ultrasonography measuring carotid intima-media thickness and plaque.

(h) Radiation or **chemotherapy** and treatment with radioactive substances. The materials and services of technicians are included.

(i) Clinical Trials

Definitions
The following terms as used in this provision have the following meaning.

Life-threatening disease or condition – means a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

Research Institution – means the institution or other person or entity conducting a phase I, phase II, phase III, or phase IV clinical trial.

Routine Patient Care Costs – means the costs of any medically necessary health care service for which benefits are provided under this Plan, without regard to whether a Covered Person is participating in a clinical trail. Routine Patient Care Costs do not include:

1. the cost of an investigational new drug or device that is not approved for any indication by the United States Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
2. the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
3. the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
4. a cost associated with managing a clinical trial; or
5. the cost of a health care service that is specifically excluded from coverage under this Plan.

Benefits

Benefits are provided to a Covered Person for Routine Patient Care Costs in connection with a phase I, phase II, phase III, or phase IV clinical trial if the clinical trial is conducted in relation to the prevention, detection, or treatment of a life-threatening disease or condition and is described in any of the following subparagraphs:

A) Federally funded trials. The study or investigation is approved or funded by one or more of the following:

(1) the Centers for Disease Control and Prevention of the United States Department of Health and Human Services;

(2) the National Institutes of Health;

(3) the Agency for Health Care Research and Quality;

(4) the Centers for Medicare and Medicaid Services;

(5) cooperative group or center of any of the entities described in (1) - (4) or the Department of Defense or the Department of Veteran Affaires;

(6) a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants;

(7) an institutional review board of an institution in this state that has an agreement with the office of Human Research Protections of the United States Department of Health and Human Services;

(8) any of the following, if the study or investigation conducted by such Department has been reviewed and approved through a system of peer review that the Secretary of the Health and Human Services Department determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health, and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review:

(i) the United States Department of Defense;

(ii) the United States Department of Veterans affairs; or

(iii) the United States Department of Energy.

(B) The study or investigation is conducted under an investigational new drug application reviewed by the United States Food and Drug Administration.

(C) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Limitations

We are **not** required to:

a. reimburse the Research Institution conducting the clinical trial for the cost of routine patient care provided through the Research Institution unless the Research Institution, and each health care professional providing routine patient care through the Research Institution, agrees to accept reimbursement under this Plan, at the rates that are established under the Plan, as payment in full for the routine patient care provided in connection with the clinical trial; or

b. provide benefits for services that are a part of the subject matter of the clinical trial and that are customarily paid for by the Research Institution conducting the clinical trial.

(j) Initial **contact lenses** or glasses required following cataract surgery.

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

Diabetes equipment and supplies as follows (unless covered under the Prescription Drug rider):

- blood glucose monitors, including those designed to be used by or adapted for the legally blind;
- test strips specified for ruse with a corresponding glucose monitor;
- lancets and lancet devises;
- visual reading strips and urine testing strips and tablets that test for glucose, ketones and protein;
- insulin and insulin analog preparations;
-
- injection aids, including devices used to assist with insulin injection and needleless systems;
- insulin syringes;
- biohazard disposable containers, if purchased separately from insulin syringes (otherwise covered under the Prescription Drug rider);
- insulin pumps, both external and implantable, and associated appurtenances, which include:
    - skin preparation items;
    - adhesive supplies for insulin pumps;
    - insulin infusion sets and devices;

    - insulin pump batteries and cartridges;
    - durable and disposable devices to assist in the injection of insulin; and
    - other required disposable supplies;
- repairs and necessary maintenance of insulin pumps not otherwise provided for under a manufacturer's warranty or purchase agreement, and rental fees for pumps during the repair and necessary maintenance of insulin pumps, neither of which shall exceed the purchase price of a similar replacement pump;
- prescription medications and medications available without a prescription for controlling the blood sugar level;
- podiatric appliances, including up to two pairs of therapeutic footwear per year, for the prevention of complications associated with diabetes; and
- glucagon emergency kits
- other treatment and monitoring equipment, not requiring a prescription order, approved by the United States Food and Drug Administration, if medically necessary and deemed appropriate by the treating Physician through a written order.

Immunizations for influenza and pneumococcus.

Diabetes self-management training for which a practitioner has written an order for the covered person or for the caretaker of a covered person as follows: 1) a diabetes self-management training program recognized by the American Diabetes Association; 2) diabetes self-management training given by a multidisciplinary team, the non-doctor members of which coordinated by a Certified Diabetes Educator, who is certified by the National Certification Board for Diabetes Educators, or a person who has completed at least 24 hours of continuing education that meets guidelines established by the Texas Board of Health and includes a combination of diabetes-related educational principles and behavioral strategies; such team consisting of at least a dietician and nurse educator and possibly including a pharmacist or a social worker; provided that all team members, except a social worker, must have recent didactic and experiential preparation in diabetes clinical and educational issues, as determined by the team member's licensing agency, in consultation with the commissioner of public health, unless the member's licensing agency, in consultation with the commissioner of public health, determines that the core educational preparation for the member's license includes the skills the member needs to provide diabetes self-management training; 3) diabetes self-management training given by a Certified Diabetes Educator, certified by the National Certification Board for Diabetes Educators; or 4) diabetes self-management training in which one or more of the following components are provided: the nutrition counseling component provided by a licensed dietician, for which the licensed dietician shall be paid; the pharmaceutical component provided by a pharmacist, for which the pharmacist shall be paid; any component of training provided by a physician assistant or registered nurse, for which the physician assistant or registered nurse shall be paid, except for providing a nutrition counseling or pharmaceutical component unless a licensed dietician or pharmacist is unavailable to provide that component; or any component of the training provided by a doctor of medicine; provided however that a person may not provide a component of diabetes self-management training unless the subject matter of the component is within the scope of the person's practice and the person meets the education requirements, as determined by the person's licensing agency, in consultation with the commissioner of public health.

For purposes of the diabetes benefit only, a "practitioner" means a doctor of medicine, doctor of osteopathy, advance practice nurse, doctor of dentistry, physician assistant, doctor of podiatry or other licensed person with prescriptive authority.

For the purposes of the self-management training, a "caretaker" means a family member or significant other of the covered person who is responsible for insuring that a covered person, who is not able to manage his or her diabetes, due to age or infirmity, is properly managed, including oversight of diet, administration of medications and use of equipment and supplies.

Self-management training will include: the development of an individualized management plan created for and in collaboration with the covered person; and medical nutritional counseling and instructions on the proper use of diabetes equipment and supplies.

Self-management training will be provided to the covered person or to a caretaker for the covered person upon: the initial diagnosis of diabetes; a written order of a practitioner indicating that a significant change in the covered person's symptoms or condition requires changes in the covered person's regime; or a written order of a practitioner that periodic or episodic continuing education is warranted by the development of new techniques and treatment for diabetes.

(l) Rental of **durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.

(m) Treatment for hearing loss including exams, hearing aids, fitting and follow-up care limited as shown in schedule of benefits. Maintenance and supplies of hearing aids are not covered.

(n) Care, supplies and services for the diagnosis of **infertility**.

(o) Diagnostic or surgical treatment of conditions affecting the **Temporomandibular Joint syndrome** if the treatment is Medically Necessary as a result of:

- an accident;
- a trauma;
- a congenital defect; or
- a pathology.

(p) **Laboratory studies.**

(q) Treatment of **Mental Health Conditions**, including Serious Mental Illness and Substance Use Disorder.

Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

(r) Treatment for **Morbid** Obesity, as defined, must have a diagnosis from the primary care physician and must be medically managed. Covered services includes medically supervised weight loss and psychotherapy visits.

Weight loss centers including but not limited to Curves, Jenny Craig, Metabolic or professional trainers are not eligible expenses under the Plan.

(s) Injury to or care of **mouth, teeth and gums**. Medical Benefits will be covered for the following oral surgical procedures only:

- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Emergency repair due to Injury to sound natural teeth.
- Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
- Excision of benign bony growths of the jaw and hard palate.
- External incision and drainage of cellulitis.
- Incision of sensory sinuses, salivary glands or ducts.
- Removal of impacted teeth.
- Reduction of dislocations and excision of temporomandibular joints (TMJs)

- Hospital stays for the purpose of administering general anesthesia when the Covered Person us unable to undergo dental treatment in an office setting or under local anesthesia due to a documented physical, mental, or medical reason as determined by the Covered Person's Physician or by the dentist providing the dental care.

No coverage will be provided under Medical Benefits for dental and oral procedures involving orthodontic care of the teeth, and periodontal disease. Dentures and preparing the mouth for the fitting of or continued use of dentures are not covered except for the following conditions: if tooth loss is related to, or necessitated by medical treatment of an illness or injury that would be covered under the terms of this Plan.

(t) **Occupational therapy** by a licensed occupational therapist. Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Covered expenses do not include recreational programs, maintenance therapy or supplies used in occupational therapy.

(u) **Out-patient Contraceptive Services.** Charges for a consultation, examination, procedure or medical service, provided on an out-patient basis and related to the use of a prescription drug or device to prevent pregnancy, including charges for contraceptive devices approved by the United States Food and Drug Administration, provided on an outpatient basis.

(v) Routine Patient Care Costs for **Participation in Clinical Trial**. Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Covered Person is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening disease or condition, provided:

- the clinical trial is approved by:
  - the Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
  - the National Institute of Health;
  - the U.S. Food and Drug Administration;
  - the U.S. Department of Defense;
  - the U.S. Department of Veterans Affairs; or
  - an institutional review board of an institution in Texas that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and
- the research institution, conducting the clinical trial, and each health professional, providing routine patient care through the institution, agree to accept reimbursement at the applicable Allowable Amount, as payment in full for routine patient care provided in connection with the clinical trial.

Coverage will not be provided for:

- the cost of an investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the clinical trial;
- the cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in a clinical trial;
- the cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis;
- a cost associated with managing a clinical trial;
- the cost of a health care service that is specifically excluded by the Plan; or
- services that are part of the subject matter of the clinical trial and that are customarily paid for by the research institution conducting the clinical trial.

(w) **Physical therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions which are subject to significant improvement through short-term therapy.

(x) **Prescription Drugs.** See attached **Prescription Drug Benefit Rider**. Coverage will be provided under the Plan and the Rider for any Prescription drug prescribed to treat a Covered Person for a chronic, disabling, or life threatening illness if the drug:

- has been approved by the Food and Drug Administration for at least one indication; and
- is recognized for the treatment of the indication for which the drug is prescribed in:
    - Prescription Drug reference compendium approved by the Commissioner of Insurance or
    - Substantially accepted peer-reviewed medical literature.

(y) **Child and Adult Preventive Care Services.** Adult and Child Preventive Care Services will meet the requirements as determined by federal and state law. See the Schedule of Benefits for coverage information.

These services fall under four broad categories as shown below. These listings will be updated as required by federal or state law.

1. Services with an "A" or "B" rating from the United States Preventive Services Task Force.

- **Screening for abdominal aortic aneurysm** - a one-time screening for abdominal aortic aneurysm (AAA) by ultrasonography in men age 65 to 75, who have smoked.
- **Screening and counseling to reduce alcohol misuse -** screening and behavioral counseling interventions to reduce alcohol misuse by adults, including pregnant women, in primary care settings.
- **Aspirin to prevent CVD: men -** the use of aspirin for men age 45 to 79 years, when the potential benefit due to a reduction in myocardial infarctions outweighs the potential harm due to an increase in gastrointestinal hemorrhage.
- **Aspirin to prevent CVD: women -** the use of aspirin for women age 55 to 79 years, when the potential benefit of a reduction in ischemic strokes outweighs the potential harm of an increase in gastrointestinal hemorrhage.
- **Screening for bacteriuria -** screening for asymptomatic bacteriuria with urine culture for pregnant women at the later of 12 to 16 weeks' gestation or at the first prenatal visit.
- **Screening for high blood pressure -** screening for high blood pressure in adults age 18 and older.
- **Counseling and testing related to BRCA screening -** screening for women whose family history is associated with an increased risk for deleterious mutations in BRCA1 or BRCA2 genes. Women with positive screening results should receive genetic counseling and, if indicated, BRCA testing.
- **Screening for breast cancer (mammography) -** annual low-dose mammography for women, with or without clinical breast examination (CBE), for women age 35 and older. Low-dose mammography means the x-ray examination of the breast using equipment dedicated specifically for mammography, including an x-ray tube, filter, compression devise, screens, films and cassettes, with an average radiation exposure delivery of less than one rad mid-breast, with two views for each breast.
- **Chemoprevention of breast cancer -** clinician's discussion of chemoprevention with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention. For women who are at increased risk for breast cancer and at low

risk for adverse medication effects, clinician should offer to prescribe risk-reducing medications, such as tamoxifen or raloxifene.

- **Interventions to support breast feeding -** interventions during pregnancy and after birth to promote and support breastfeeding.
- **Screening for Human Papillomavirus and cervical cancer (Pap Smear) -** diagnostic examination for early detection of cervical cancer, including the provider's charge for administration of the test, for any covered female age 18 or older, not to exceed one per calendar year for: a conventional Pap smear screening or a screening using liquid-based cytology methods, as approved by the United States Food and Drug Administration (FDA), alone or in combination with a test approved by the FDA for the detection of the human papillomavirus. A screening test must be performed in accordance with the guidelines adopted by the American College of Obstetricians and Gynecologists or another similar national organization of medical professionals recognized by the Insurance Commissioner.
- **Screening for chlamydial infection: non-pregnant women -** screening for chlamydial infection for all sexually active non-pregnant women age 24 and younger and for older non-pregnant women who are at increased risk.
- **Screening for chlamydial infection: pregnant women -** screening for chlamydial infection for all pregnant women age 24 and younger and for older pregnant women who are at increased risk.
- **Screening for cholesterol abnormalities: men 35 and older -** screening for men age 35 and older for lipid disorders.
- **Screening for cholesterol abnormalities: men younger 35 -** screening for men age 20 to 35 for lipid disorders if they are at increased risk for coronary heart disease.
- **Screening for cholesterol abnormalities: women 45 and older -** screening for women age 45 and older for lipid disorders if they are at increased risk for coronary heart disease.
- **Screening for cholesterol abnormalities: women younger than 45 -** screening for women age 20 to 45 for lipid disorders if they are at increased risk for coronary heart disease.
- **Screening for colorectal cancer -** screening for detection of colorectal cancer for an Insured Person at least 50 years of age and at normal risk for developing cancer, limited to: an annual fecal occult blood test and a flexible sigmoidoscopy once every five years; or a colonoscopy once every ten years.
- **Chemoprevention of dental caries -** primary care clinicians prescription for oral fluoride supplementation at currently recommended doses to preschool children older than 6 months of age whose primary water source is deficient in fluoride.
- **Screening for depression: adults -** screening of adults for depression when staff-assisted depression care supports are in place to assure accurate diagnosis, effective treatment, and follow-up.
- **Screening for depression: adolescents -** screening of adolescents (12 to 18 years of age) for major depressive disorder (MDD) when systems are in place to ensure accurate diagnosis, psychotherapy (cognitive-behavioral or interpersonal), and follow-up.
- **Screening for diabetes -** screening for type 2 diabetes in asymptomatic adults with sustained blood pressure (either treated or untreated) greater than 135/80 mm Hg.
- **Counseling for a healthy diet -** intensive behavioral dietary counseling for adult patients with hyperlipidemia and other known risk factors for cardiovascular and diet-

related chronic disease. Intensive counseling can be delivered by primary care clinicians or by referral to other specialists, such as nutritionists or dietitians.

- **Supplementation with folic acid -** a daily supplement containing 0.4 to 0.8 mg (400 to 800 µg) of folic acid for all women planning on or capable of pregnancy.
- **Screening for gonorrhea: women –** screening for all sexually active women, including those who are pregnant, for gonorrhea infection if they are at increased risk for infection (that is, if they are young or have other individual or population risk factors).
- **Prophylactic medication for gonorrhea: newborns -** prophylactic ocular topical medication for all newborns against gonococcal ophthalmia neonatorum.
- **Screening for hearing loss -** screening test for hearing loss for a child from birth through the date the child is 30 days old; and Medically Necessary diagnostic follow-up care to the screening test for a child from birth through the date the child is 24 months old.
- **Screening for hemoglobinopathies -** screening for sickle cell disease in newborns.
- **Screening for hepatitis B -** screening for hepatitis B virus (HBV) infection in pregnant women at their first prenatal visit.
- **Screening for hepatitis C** – screening for hepatitis C virus infection and a one-time screening for HCV infection for adults born between 1945 and 1965.
- **Screening for HIV -** screening for human immunodeficiency virus (HIV) in all adolescents and adults at increased risk for HIV infection.
- **Screening for congenital hypothyrodism -** screening for congenital hypothyroidism (CH) in newborns.
- **Screening for iron deficiency anemia -** screening for iron deficiency anemia in asymptomatic pregnant women.
- **Iron supplementation in children -** routine iron supplementation for asymptomatic children age 6 to 12 months who are at increased risk for iron deficiency anemia.
- **Screening and counseling for obesity: adults –** screening for all adult patients for obesity and intensive counseling and behavioral interventions to promote sustained weight loss for obese adults.
- **Screening and counseling for obesity: children –** screening for children age 6 years and older for obesity and referral to comprehensive, intensive behavioral interventions to promote improvement in weight status.
- **Screening for osteoporosis –** screening for women age 65 and older for a qualified individual for medically accepted bone mass measurement to detect low bone mass and to determine the Insured Person's risk of osteoporosis and fractures associated with osteoporosis. A "qualified individual" is: a postmenopausal woman who is not receiving estrogen replacement therapy; an individual with vertebral abnormalities, primary hyperparathyroidison, or a history of bone fractures; or an individual who is receiving long-term glucocorticoid therapy or being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy.
- **Screening for PKU -** screening for phenylketonuria (PKU) in newborns.
- **Screening for Rh incompatibility: first pregnancy visit -** Rh (D) blood typing and antibody testing for all pregnant women during their first visit for pregnancy-related care.

- **Screening for Rh incompatibility: 24 to 28 weeks gestation -** 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.
- **Counseling for STIs -** high-intensity behavioral counseling to prevent sexually transmitted infections (STIs) for all sexually active adolescents and for adults at increased risk for STIs.
- **Screening for syphilis: non-pregnant persons –** screening for persons at increased risk for syphilis infection.
- **Screening for syphilis: pregnant women -** screening for all pregnant women for syphilis infection.
- **Counseling for tobacco use -** clinicians ask all adults about tobacco use and provide tobacco cessation interventions for those who use tobacco products.
- **Counseling for tobacco use -** clinicians ask all pregnant women about tobacco use and provide augmented, pregnancy-tailored counseling for those who smoke.
- **Tobacco use intervention** – clinicians provide interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.
- **Lung cancer screening** – annual screening for lung cancer with low-dose tomography in adults ages 55 to 80 years who have a 30 pack per year smoking history and currently smoke or have 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.
- **Screening for visual acuity in children -** screening to detect amblyopia, strabismus, and defects in visual acuity in children younger than 5 years old.

2. Immunizations for children, adolescents, and adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention.

Immunizations for Children ages 0 through 6 years:

- Hepatitis B
- Rotavirus
- Diptheria, Tetanus, Pertussis
- Haemophilus influenzae type b conjugate (Hib)
- Pneumococcal
- Inactivated poliovirus (IPV)
- Influenza (seasonal), including H1N1 influenza
- Measles, mumps, and rubella (MMR)
- Varicella
- Hepatitis A (HepA)
- Meningococcal
- Polio
- Any other immunization required by law for the child

Immunizations for Children ages 7 through 18 years:

- Tetanus, Diptheria, Pertusis (Td/Tdap)
- Human papillomavirus (HPV)
- Meningococcal
- Influenza (seasonal)
- Pneumococcal polysaccharide (PPSV)
- Hepatitis A (HepA)
- Hepatitis B
- Inactivated poliovirus (IPV)
- Measles, mumps, and rubella (MMR Varicella
- Varicella

Immunizations for adults over age 18:

- Tetanus, Diptheria, Pertusis (Td/Tdap)
- Human papillomavirus (HPV)
- Varicella
- Herpes zoster
- Measles, mumps, and rubella (MMR)
- Influenza (seasonal)
- Pneumococcal polysaccharide (PPSV)
- Hepatitis A (HepA)
- Hepatitis B
- Meningococcal

3. Preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration. Covered Services are listed in the Periodicity Schedule of the Bright Futures Recommendations for Pediatric Preventive Health Care and the Uniform Panel of the Secretary's Advisory Committee on Heritable Disorders in Newborns and Children.

    - **Preventive Physical Exams at Recommended Intervals**
        - Measurements – length, height, weight, head circumference, weight for length, body mass index, blood pressure
    - **Sensory Screening**
        - Vision
        - Hearing
    - **Developmental/Behavioral Assessment**
        - Developmental Screening
        - Autism Screening
        - Developmental Surveillance
        - Psychosocial/Behavioral Assessment

- Alcohol and Drug Use Assessment

- **Procedures**
  - Newborn Metabolic/Hemoglobin Screening
  - Immunization
  - Hematocrit or Hemoglobin
  - Lead Screening
  - Tuberculin Test
  - Dyslipidemia Screening
  - Sexually Transmitted Infection (STI) Screening
  - Cervical Dysplasia Screening

- **Oral Health**
  - Risk Assessment and possible oral fluoride supplementation

4. Preventive care and screening for women provided for in the guidelines supported by the Health Resources and Services Administration.

   - Annual 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. When appropriate, this visit can include other covered Adult Preventive Care Services.
   - Screening for gestational diabetes for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes.
   - High-risk human papillomavirus DNA testing in women with normal cytology results, beginning at 30 years of age and occurring no more frequently than once every three years.
   - Annual counseling on sexually transmitted infections for all sexually active women.
   - Annual screening and counseling for human immune-deficiency virus infection for all sexually active women.
   - Prescripted FDA-approved contraceptive methods, sterilization procedures and patient education and counseling for all women with reproductive capacity.
   - Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period and rental of breastfeeding equipment.
   - Annual screening and counseling for women for interpersonal and domestic violence.

(z) **Routine Annual Physical:** Charges for one annual routine physical examination, including office visit and lab and x-ray charges.

(aa) **Charges for prostate cancer screening**, limited to: one physical examination per calendar year for the detection of prostate cancer; and one prostate-specific antigen test, used for the detection of prostate cancer, per calendar year, for each male covered by the plan who is: at least 50 years of age and asymptomatic; or at least 40 years of age with a family history of prostate cancer or another prostate cancer risk factor.

(bb) Charges for **prosthetic devices**, **orthotic devices** and professional services related to the fitting and use of those devices, but not to exceed covered benefits as provided by Medicare (42 U.S.C. Sections 1395k, 1395l and 1395m). Covered charges are limited to the most appropriate model of prosthetic device or orthotic device that adequately meets the medical needs of the Covered Person as determined by the Covered Person's treating Physician or podiatrist and the Covered Person's prosthetist or orthotist, as applicable. Covered charges include repair and replacement of a prosthetic device or orthotic device unless the repair or replacement is required because of misuse or loss by the Covered Person.

(cc) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties will be considered Covered Charges.

This mammoplasty coverage will include reimbursement for:

(i) reconstruction of the breast on which a mastectomy has been performed,

(ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and

(iii) coverage of prostheses and physical complications during all stages of mastectomy, including lymphedemas,

Also Covered:

(iv) reconstructive surgery for craniofacial abnormalities for a Covered Dependent under 18 years of age, which is; surgery to improve the function of, or to attempt to create a normal appearance of, an abnormal structure caused by congenital defects, developmental deformities, trauma, tumors, infections, or disease in a manner determined in consultation with the attending Physician and the patient.

(dd) **Speech therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy) of a person; (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder.

(ee) **Spinal Manipulation/Chiropractic services** by a licensed M.D., D.O. or D.C.

(ff) **Sterilization** procedures.

(gg) **Surgical dressings**, splints, casts and other devices used in the reduction of fractures and dislocations.

(hh) **Telemedicine Medical Services/Telehealth Services.**

(ii) Coverage of **Well Newborn Nursery/Physician Care**.

Charges for Routine Nursery Care. Routine well newborn nursery care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to the Maximum Allowable Charge for nursery care for the first 3 days after birth while the newborn child is Hospital confined as a result of the child's birth.

Charges for covered routine nursery care will be applied toward the Plan of the covered parent.

Charges for Routine Physician Care. The benefit is limited to the Maximum Allowable Charge made by a Physician for routine pediatric care for the first 3 days after birth while the newborn child is Hospital confined.

Charges for covered routine Physician care will be applied toward the Plan of the covered parent.

(jj) **Wigs or hairpieces.** Wigs or hairpieces due to hair loss following chemotherapy.

(kk) Diagnostic **x-rays**.

(**ll**) Coverage for **Early Childhood Intervention Services.** Medically Necessary rehabilitative and habilitative therapy services provided to a Covered Person under the age of 18 in accordance with an individualized family service plan issued by the Texas Interagency Council on Early Childhood, under Chapter 73, Texas Human Resources Code. Rehabilitative and habilitative therapy under this benefit include: occupational therapy evaluations and services; physical therapy evaluations and services; speech therapy evaluations; and dietary or nutritional evaluations.

COST MANAGEMENT SERVICES

Care Management Organization Phone Number

Please refer to the Employee ID card for the name of and toll free number of the Care Management Organization.

The patient or family member must call this number to receive authorization of certain services. This call must be made at least in advance of services being rendered or within 2 business days after an emergency.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. Supplies and services subject to utilization review are classified as "pre-service claims." All other supplies and services are classified as "post-service claims."
To preauthorize and for additional information regarding services requiring preauthorization, refer to the Plan Identification Card for the telephone number to call for preauthorization.

The Care Management Organization does not certify, verify, authorize or guarantee payment of benefits. The Care Management Organization's authorization means only Medical Necessity of treatment. It is not a guarantee of benefits.

Preauthorization for Medical Care Facilities

If a Covered Person requires inpatient confinement and/or procedures for an Injury or Sickness, admission preauthorization and length of stay approval must be obtained from the Care Management Organization prior to a nonemergency admission. In the event of an emergency admission, preauthorization must be obtained within two (2) business days or as soon as reasonably possible given the facts and circumstances of the emergency admission.

Full benefits for Medical Care Facility charges will be paid only for approved admissions and confinement days. If confinement extends beyond the approved length of stay, additional days must be authorized by the Care Management Organization. The same requirements and reduction penalties will apply to the additional days.

Procedure Review

When certain procedures are recommended for a Covered Person, a prior review by the Care Management Organization is required. Call the preauthorization number on the Plan Identification Care for the following procedures:

- All Hospitalizations (including skilled nursing facility, inpatient rehabilitation and residential treatment facilities)
- Outpatient surgery unless performed in a physician office
- Cancer Treatment (Radiation and Chemo therapies)
- CT Scans, Pet Scans and MRIs
- Durable Medical Equipment > $1200
- Home Health care/Home Infusion services
- Hyperbaric Oxygen Therapy
- Organ and Tissue Transplant evaluations and transplant admissions
- Renal Dialysis

Authorization must be obtained for services prior to the start of treatment. Further authorization will be required at the interval specified if the duration of treatment is expected to extend beyond the preauthorization period. In addition, the penalty indicated above will apply to each date of service for which authorization has not been obtained.

Preauthorization from the Plan is not required for a maternity stay of 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. Preauthorization is required for longer prescribed maternity stay.

The purpose of the program is to determine what is payable by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The attending Physician does not have to obtain preauthorization from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery. **Preauthorization is required for any longer prescribed maternity stay.**

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Notice of Pre-Service Claims

Preauthorization. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other listed medical services, the utilization review administrator will, in conjunction with the attending Physician, authorize the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that can be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the attending Physician
- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If notice is provided, but does not include all of the required information, the Claims Supervisor or utilization review administrator will notify the claimant or the claimant's authorized representative within 24 hours, in the case of notification regarding urgent care, and within 5 days, for all other care, of the time of receipt of the insufficient notice, but only if the notice is received by the utilization review administrator and names a specific claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

If there is an **emergency** (urgent care) admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the utilization review administrator **within 2 business days** of the first business day after the admission or as soon thereafter as reasonably possible prior to the date of discharge.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been preauthorized, the attending Physician must request the additional services or days.

Notice of Utilization Review Determination for Pre-Service Claim

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other listed medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by $500.

Urgent Care

Urgent care is medical care or treatment with respect to which the application of time periods for making non-urgent care determinations: could seriously jeopardize the life or health of the claimant or the ability of the claimant to repair maximum functions; or, in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. For urgent care, this notice must be transmitted as soon as possible, but no later than 24 hours after receipt of a request for review, for which all required information has been provided. If the required information is not provided, as indicated above, the utilization review administrator will provide notice of the deficiency within 24 hours of receipt of the request. The claimant shall be allowed 48 hours in which to provide the specified information. In the event that additional information is requested, the utilization review administrator shall issue the required notice no later than 48 hours after the earlier of receipt of the specified information or the end of the period allowed to the claimant to provide the specified information.

Concurrent Care
A determination on a request by a claimant to extend the course of treatment beyond the period of time or number of treatments approved by the utilization review administrator must be made and notice of that determination given by the utilization review administrator within 24 hours of receipt of such request, provided the request is received at least 24 hours prior to the expiration of the approved period of time or number of treatments.

All Other Pre-Service Care
For all other pre-service care, notice of the determination must be provided by the utilization review administrator no later than 15 days after receipt of the request for review. The period for notice may be extended once by 15 days, provided the extension is necessary for circumstances beyond the utilization review administrator's control and provided the utilization review administrator notifies the claimant, prior to the expiration of the initial 15 day period, of the circumstances requiring the extension and the date by which the utilization review administrator expects to make a determination. If the extension is due to the claimant's failure to provide all of the required information, the notice of extension shall also specify the required information needed and the claimant shall be allowed 45 days from receipt of that notice in which to provide the specified information.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

DISEASE MANAGEMENT

Disease Management is a voluntary program whereby a disease manager works with the patient and the patient's physician to educate the patient about behavior modification, therapy choices and alternate sources for supplies and services. The Plan offers Disease Management to Covered Persons with a diagnosis of diabetes, asthma, depression, congestive heart failure and/or chronic obstructive pulmonary disease.

To participate in any of the disease management programs, the Covered Person should refer to the Employee ID card for the name of and toll free number of the Care Management Organization.
Contact should be made as soon as possible after enrolling in the Plan or after being diagnosed after enrollment with one of these chronic illnesses.

DEFINED TERMS

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

Active Employee is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time basis.

Ambulatory Surgical Center is a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Baseline shall mean the initial test results to which the results in future years will be compared in order to detect abnormalities.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

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

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

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

Creditable Coverage mean coverage under a self-funded or self-insured Employee welfare benefit plan that provides health benefits and that is established in accordance with the Employees Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); a group health benefit plan provided by a health insurance carrier or health maintenance organization; an individual health insurance policy or evidence of coverage; Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. Section 1395c et seq.); Title XIX of the Social Security Act (42 U.S.C. Section 1396 et seq.), other than coverage consisting solely of benefits under Section 1928 of that Act (42 U.S.C. Section 1396s); Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.); a medical care program of the Indian Health Service or of a tribal organization; a state or political subdivision health benefits risk pool; coverage under state programs for low-income uninsured children; a health plan offered under Chapter 89, Title 5, United States Code (5 U.S.C. Section 8901 et seq.); a public health plan as defined by federal regulations; health plans established or maintained by foreign countries or their political subdivisions; a health benefit plan under Section 5(e), Peace Corps Act (22 U.S.C. Section 2504(e)); or short term limited duration contracts (coverage provided under a contract with an issuer that has an expiration date specified in the contract, taking into account any extensions that may be elected by the contract holder without the issuer's consent, that is within 12 months of the contract effective date).

Creditable coverage does not mean accident-only or disability income insurance, or a combination of accident-only and disability income insurance; coverage issued as a supplement to liability insurance; liability insurance, including general liability insurance and automobile liability insurance; workers' compensation or similar insurance; automobile medical payment insurance; credit-only insurance; coverage for on-site medical clinics; other coverage which is: similar to the coverage described by this subsection under which benefits for medical care are secondary or incidental to other insurance benefits; and specified in federal regulations; coverage that provides limited-scope dental or vision benefits; long-term care coverage or benefits, nursing home care coverage or benefits, home health care coverage or benefits, community-based care coverage or benefits, or any combination of those coverages or benefits; coverage that provides other limited benefits specified by federal regulations; coverage for a specified

disease or illness; hospital indemnity or other fixed indemnity insurance; or Medicare supplemental health insurance as defined under Section 1882(g)(1), Social Security Act (42 U.S.C. Section 1395ss), coverage supplemental to the coverage provided under Chapter 55, Title 10, United States Code (10 U.S.C. Section 1071 et seq.), and similar supplemental coverage provided under a group plan.

Custodial Care is care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing, feeding; or supervision over medication which could normally be self-administered.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship. Class I-Executive Management employees. Class II-All other employees.

Employer is an employer who has applied and been accepted for participation in AgBenefits.

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

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

Experimental and/or Investigational means services, supplies or treatment that are experimental or investigational. A service is considered Experimental or Investigational if the Plan determines that one or more of the following is true.

(1) The service or supply is under study or in a clinical trial to evaluate it toxicity, safety or efficacy for a particular diagnosis or set of indications. Clinical trials include but are not limited to phase I, II and III clinical trials.

(2) The prevailing opinion within the appropriate specialty of the United States medical profession is that the service or supply needs further evaluation for the particular diagnosis or set of indications before it is used outside clinical trials or other research settings.

(3) The Plan will determine if the second paragraph is true based on:

Published reports in authoritative medical literature; and

Regulations, reports, publications and evaluations issued by government agencies such as the Agency for Health Care Policy and Research, the National Institutes of Health, and the FDA.

(4) In the case of a drug, a device or other supply that is subject to FDA approval:

It does not have FDA approval; or

It has FDA approval only under its Treatment Investigational New Drug regulation or a similar regulation; or

It has FDA approval, but it is being used for an indication or at a dosage that is not an accepted off-label use.

Unlabeled uses of FDA-approved drugs are not considered Experimental or Investigational if they are determined to be:

included in substantially accepted peer-reviewed medical literature, such as: The American Medical Association Drug Evaluations, The American Hospital Formulary Service Drug Information, The United States Pharmacopocia Information and other authoritative compendia as identified from time to time by the Secretary of Health and Human Services;

included in a prescription drug reference compendium approved by the Texas Commissioner of Insurance; or

in addition, the medical appropriateness of unlabeled uses not included in the compendia can be established based on supportive clinical evidence in peer-reviewed medical publications.

(5) The provider's institutional review board acknowledges that the use of the service or supply is Experimental or Investigational and subject to the board's approval.

(6) Research protocols indicate that the service or supply is Experimental or Investigational. This item applies for protocols used by the Covered Person's provider as well as for protocols used by other providers studying substantially the same service or supply.

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

Foster Child means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee's; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is <u>not</u> a child temporarily living in the covered Employee's home; one placed in the covered Employee's home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

Home Health Care Agency is an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency is an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan is a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit is a facility or separate Hospital Unit, that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital is an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

(1) A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.

(2) A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour a day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness, a Mental Health Condition or a Substance Use Disorder. Illness includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Infertility means incapable of producing offspring.

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

Intensive Care Unit is defined as a separate, clearly designated service area which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

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

Maximum Allowable Charge means the benefit payable for a specific coverage item or benefit under the Plan. The Maximum Allowable Charge will always be a negotiated rate, if one exists; if no negotiated rate exists, the Maximum Allowable Charge will be determined and established by the Plan, at the Plan Administrator's discretion, using normative data and submitted information such as, but not limited to, any one or more of the following, in the Plan Administrator's discretion:

- Medicare reimbursement rates (presently utilized by the Centers for Medicare and Medicaid Services ["CMS"]), in conjunction with the Scheduled Benefit Amount, as defined below;

- Prices established by CMS utilizing standard Medicare Payment methods and/or based upon supplemental Medicare pricing data for items Medicare doesn't cover based on data from CMS, in conjunction with the Scheduled Benefit Amount, as defined below;
- Prices established by CMS utilizing standard Medicare payment methods and/or based upon prevailing Medicare rates in the community for non-Medicare facilities for similar services and/or supplies provided by similarly skilled and trained providers of care, in conjunction with the Scheduled Benefit Amount, as defined below;
- Prices established by CMS utilizing standard Medicare payment methods for items in alternate settings based on Medicare rates provided for similar services and/or supplies paid to similarly skilled and trained providers of care in traditional settings, in conjunction with the Scheduled Benefit Amount, as defined below;
- Medicare cost data as reflected in the applicable individual provider's cost report(s);
- the fee(s) which the Provider most frequently charges the majority of patients for the service or supply;
- amounts the Provider specifically agrees to accept as payment in full either through direct negotiation or through a preferred provider organization (PPO) network;
- average wholesale price (AWP) and/or manufacturer's retail pricing (MRP);
- Medicare cost-to-charge ratios or other information regarding the actual cost to provide the service or supply;
- the prevailing range of fees charged in the same "area" (defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made) by Providers of similar training and experience for the service or supply.

The Plan Administrator may in its discretion, taking into consideration specific circumstances, deem a greater amount to payable than the lesser of the aforementioned amounts. The Plan Administrator may take any or all of such factors into account but has no obligation to consider any particular factor. The Plan Administrator may also account for unusual circumstances or complications requiring additional or a lesser amount of time, skill and experience in connection with a particular service or supply, industry standards and practices as they relate to similar scenarios, and the cause of injury or illness necessitating the service(s) and/or charge(s).

In all instances, the Maximum Allowable Charge will be limited to an amount which, in the administrator's discretion, is charged for services or supplies that are not unreasonably caused by the treating Provider, including errors in medical care that are clearly identifiable, preventable, and serious in their consequence for patients. A finding of Provider negligence and/or malpractice is not required for services or fees to be considered ineligible pursuant to this provision.

The determination that fees for services are includable in the Maximum Allowable Charge will be made by the Plan Administrator, taking into consideration, but not limited to, the findings and assessments of the following entities: (a) The National Medical Associations, Societies, and organizations; and (b) The Food and Drug Administration. To be includable in the Maximum Allowable Charge, services and fees must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The Plan Administrator has the discretionary authority to decide if a charge is covered under this Plan. The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

When applicable, the Maximum Allowable Charge will be determined based on multiplying the most applicable of the following by 150%:

- for inpatient hospital expenses, the Medicare Diagnosis Related Group ("DRG") scheduled dollar conversion amounts based upon the CMS weighted values
- for outpatient hospital expenses, the CMS Ambulatory Payment Classification (APC) based upon the CMS weighted values, or the current Medicare allowable fee for the appropriate area;
- for physicians and other eligible providers, the current Medicare allowable fee for the appropriate area; or
- for Ambulatory Surgical Centers (ASC), the current Medicare allowable fee for the appropriate area.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means medical conditions of a recent onset and severity, including but not limited to severe pain, that would lead a prudent layperson, possessing an average knowledge of medicine and health to believe that the person's condition, sickness or injury is of such a nature that failure to get immediate medical care could result in placing the patient's health in serious jeopardy; serious impairment to bodily functions; serious dysfunction of any bodily organ or part; serious disfigurement; or in the case of a pregnant woman, serious jeopardy to the health of the fetus.

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

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

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

Medicare is the Health Insurance For The Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Health Condition means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association, including Serious Mental Illness.

Morbid Obesity is a diagnosed condition in which the Body Mass Index (BMI) is greater than 40 or BMI is greater than 35 with at least one of the following co-morbid conditions: (1) Diabetes; (2) Cardiovascular Disease; (3) Sleep Apnea; (4) Asthma; or (5) Joint Disease.

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

Outpatient Care and/or Services is treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means AgBenefits Employee Benefit Plan, which is a benefits plan for certain employees of Employers participating in AgBenefits and which is described in this document.

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

Pregnancy is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Resource Based Relative Value Scale (RBRVS) refers to a specific standardized scale of healthcare charges that bases relative values on a computation of total work, practice cost, and malpractice cost involved in performing a procedure. These three elements of the value are modified by a geographic index. After the geographic modification, the three values are summed to reach a single value. The single value is then multiplied by a conversion factor, determined by Congress, to arrive at a charge.

Retiree means a former Employee classified, by the Employer, as a Class I Employee who has accumulated at least 10 consecutive years of service with such Employer and has attained age 55. Coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the Retiree. COBRA participants are not eligible for Retiree benefits.

Serious Mental Illness means any of the following psychiatric illness:

(1) Schizophrenia, paranoid or other psychotic disorders;

(2) Bipolar disorders (hypomanic, manic, depressive, and mixed);

(3) Major depressive disorders (single episode or recurrent);

(4) Schizo-affective disorders (bipolar of depressive);

(5) Obsessive-compulsive disorders; and

(6) Depression in childhood and adolescence.

Sickness is:

(1) For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

(2) For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.

(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial or educational care or care of Mental Health Conditions.

(7) It is approved and licensed by Medicare.

This term also applies to charges incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Substance Use Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a drug or alcohol abuse or dependence in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Telehealth Service means a health care service, other than a telemedicine medical service, delivered by a licensed or certified health professional, acting within the health professional's license or certification, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: compressed digital interactive video, audio or data transmission; clinical data transmission using computer imaging by way of still-image capture and store and forward; and other technology that facilitates access to health care services or medical specialty expertise.

Telemedicine Medical Service means a health care service, initiated by a physician or provided by a health professional acting under physician delegation and supervision, for purposes of patient assessment by a health professional, diagnosis or consultation by a physician, treatment, or the transfer of medical data, that requires the use of advanced telecommunications technology, other than by telephone or facsimile, including: compressed digital interactive video, audio or data transmission; clinical data transmission using computer imaging by way of still-image capture; and other technology that facilitates access to health care services or medical specialty expertise.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Total Disability (Totally Disabled) means: In the case of a Dependent child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Trust is AgBenefits.

PLAN EXCLUSIONS

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered, provided any exclusion, otherwise applicable, will not apply to services covered under the Preventive Care benefit:

(1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest. Abortion charges are not covered for dependent child, regardless of the reason for the abortion.

(2) **Acupuncture.** Services, supplies, care or treatment in connection with acupuncture.

(3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness which occurred as a result of that Covered Person's illegal use of alcohol. The arresting officer's determination of inebriation will be sufficient for this exclusion. Expenses will be covered for Injured Covered Persons other than the person illegally using alcohol and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(4) **Complications of non-covered treatments.** Care, services or treatment required as a result of complications from a treatment not covered under the Plan are not covered. Complications from a non-covered abortion are covered.

(5) **Chelation Therapy.** Services or supplies rendered to any Covered Person as, or in conjunction with, chelation therapy, except for the treatment of acute metal poisoning.

(6) **Custodial care.** Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

(7) **Educational or vocational testing.** Services for educational or vocational testing or training.

(8) **Environmental Sensitivity.** Services or supplies rendered to any Covered Person primarily for:

- Environmental Sensitivity testing or treatment
- Clinical Ecology testing or treatment; or
- Inpatient allergy testing or treatment.

(9) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Maximum Allowable Charge.

(10) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

(11) **Experimental and/or not Medically Necessary.** Care and treatment that is either Experimental and/or Investigational or not Medically Necessary.

(12) **Eye care.** Radial keratotomy or other eye surgery to correct refractive disorders. Also, routine eye examinations (unless covered under Preventive Care services), including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages.

(13) **Filing Deadline.** Charges that are submitted more than 120 -days after the incurred date. Claims filed later than 120-days may be declined unless it is not reasonably possible to submit the claim in that time and the claim is submitted within one year from the date incurred.

(14) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations or for treatment of diabetes), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease or diabetes).

(15) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.

(16) **Government coverage.** Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.

(17) **Growth hormones.** Charges associated with growth hormones and their administration.

(18) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs or hair pieces following chemotherapy.

(19) **Hazardous Hobby or Activity.** Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby or Activity. A hobby or activity is hazardous if it is an unusual activity which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities are skydiving, auto racing, hang gliding, or bungee jumping.

(20) **Hearing aid(s) maintenance.** Charges for maintenance of hearing aids.

(21) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

(22) **Illegal acts.** Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(23) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Use Disorder treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(24) **Impotence.** Care, treatment, services, or supplies in connection with treatment for impotence unless to be determined to be organic or because the condition is the result of an injury or use of a prescribed medication. Prescription Drugs are covered for Erectile Dysfunction (ED) and Benign prostatic hyperplasia (BPH) diagnosis with medical necessity and limitations. ED is limited to 6 pills per 30 day supply and BPH is limited to 30 pills per 30 day supply.

(25) **Infertility.** Care, supplies, services and treatment for infertility, except for diagnostic services rendered for infertility evaluation.

(26) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.

(27) **Non-emergency Hospital admissions.** Care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or a Saturday. This does not apply if surgery is performed within 24 hours of admission.

(28) **No obligation to pay.** Charges incurred for which the Plan has no legal obligation to pay.

(29) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment which is appropriate care for the Injury or Sickness.

(30) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan.

(31) **Obesity.** Care and treatment of obesity, weight loss or dietary control whether or not it is part of the treatment plan for another Sickness, except as provided for Preventive Care and Morbid Obesity.

(32) **Occupational.** Care and treatment of an Injury or Sickness that is occupational -- that is, arises from work for wage or profit including self-employment.

(33) **Organ or Tissue Transplants.** Charges for the care and treatment due to an organ or tissue transplant.

(34) **Orthoptics and/or vision therapy.** Care, treatment, services or supplies in connection with orthoptics and/or visual therapy.

(35) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, nonprescription drugs and medicines, and first-aid supplies and nonhospital adjustable beds.

(36) **Plan design excludes.** Charges excluded by the Plan design as mentioned in this document.

(37) **Pregnancy of child.** Care and treatment of Pregnancy for a dependent child only.

(38) **Relative giving services.** Professional services performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.

(39) **Removal of implants.** Care, treatment, services or supplies in connection with the removal of implants.

(40) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Medical Benefits section.

(41) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

(42) **Services before or after coverage.** Care, treatment or supplies for which a charge was incurred before a person was covered under this Plan or after coverage ceased under this Plan.

(43) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, and medical or psychiatric treatment.

(44) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.

(45) **Social Services.** Charges for any medical social services, except at provided for under Hospice Care services.

(46) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung Illness such as emphysema or asthma or except as provided for Preventive Care.

(47) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.

(48) **Organ and Tissue Transplants.** Changes for the care and treatment due to an organ or tissue transplant.

(49) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

(50) **War.** Any loss that is due to a declared or undeclared act of war.

HOW TO SUBMIT A CLAIM

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

When a Covered Person has a Claim to submit for payment that person must:

(1) Obtain and complete a group claim transmittal form from the Personnel Office or the Plan Administrator.

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

(3) Have the Physician complete the provider's portion of the form.

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

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

(5) Send the above to the Claims Supervisor at this address:

Paper claim submission:
Bentegrity
PO Box 211575
Eagan, MN 55121

Electronic claim submission payer ID: TXABA

CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan's reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Assignments

The Plan Administrator may revoke an assignment of benefits at its discretion and treat the participant of the Plan as the sole beneficiary. Benefits for medical expenses covered under this plan may be assigned by a Plan participant to the provider as consideration in full for services rendered; however, if those benefits are paid directly to the participant, the Plan will be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned may be made directly to the assignee unless a written request not to honor the assignment, signed by the participant,

has been received before the proof of loss is submitted, or the Plan Administrator – at its discretion – revokes the assignment.

No participant shall at any time, either during the time in which he or she is a participant in the Plan, or following his or her termination as a participant, in any manner, have any right to assign his or her right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he or she may have against the Plan or its fiduciaries.

A medical provider which accepts an assignment of benefits, in accordance with this Plan, does as consideration in full for services rendered and is bound by the rules and provisions set forth within the terms of this document.

There are different kinds of Claims and each one has a specific timetable for either approval, payment, request for further information, or denial of the Claim. If you have any questions regarding this procedure, please contact the Plan Administrator.

The definitions of the types of Claims are:

Urgent Care Claim

A Claim involving Urgent Care is any Claim for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting Physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination. Please see the Cost Management section of this booklet for further information about the authorization of certain services.

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

Notification to claimant of benefit determination	24 hours
Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:	
Notification to claimant, orally or in writing	24 hours
Response by claimant, orally or in writing	48 hours
Benefit determination, orally or in writing	24 hours
Ongoing courses of treatment, notification of:	
Reduction or termination before the end of treatment	72 hours
Determination as to extending course of treatment	24 hours

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

Pre-Service Claim

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

In the case of a Pre-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	15 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Notification, orally or in writing, of failure to follow the Plan's procedures for filing a Claim	5 days
Ongoing courses of treatment:	
Reduction or termination before the end of the treatment	15 days
Request to extend course of treatment	15 days
Review of adverse benefit determination	15 days per benefit appeal

Post-Service Claim

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

Claims should be filed with the Claims Supervisor within 180 days of the date charges for the service were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(1) it's not reasonably possible to submit the claim in that time; and

(2) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

In the case of a Post-Service Claim, the following timetable applies:

Notification to claimant of benefit determination	30 days
Extension due to matters beyond the control of the Plan	15 days
Insufficient information on the Claim:	
Notification of	15 days
Response by claimant	45 days
Review of adverse benefit determination	30 days per benefit appeal

Notice to claimant of adverse benefit determinations

An adverse benefit determination is a denial, reduction or termination of, or a failure to provide or make payment, in whole or in part, for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination that a covered person is not eligible to participate in the plan, application of medical review or determination that an item or service for which claim is made is experimental or investigational, not medically necessary or otherwise not covered by the plan. An adverse determination also includes a rescission of coverage.

Except with Urgent Care Claims, when the notification may be orally followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

(1) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

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

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

(4) 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.

(5) A description of the Plan's review procedures, incorporating any voluntary appeal procedures offered by the Plan, and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

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

(7) The denial code and its corresponding meaning, and if the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the adverse benefit determination and a copy will be provided free of charge to the claimant upon request.

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

Adverse Determination Internal Review Procedure

In cases where coverage is rescinded or a claim for benefits payment is denied in whole or in part, the claimant may appeal the rescission or denial. This appeal provision will allow the claimant to:

(1) Request from the Plan Administrator a review of the rescission of coverage.

(2) Request from the Plan Administrator a review of the eligibility status for any claim denied in whole or in part.

(3) Request from the Plan Administrator a review of any claim payment. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Group Identification Number, if any.

(4) File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator or Claims Administrator within 180 days after the date of the claimant's receipt of an adverse determination.

At such time as the claimant requests a review, the claimant may submit written comments, documents, records and other information relating to the rescission or claim and be provided, upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to the rescission or claim. A document, record or other information is relevant if such document, record or other information:

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

(2) was submitted, considered or generated in the course of making the benefit determination, without regard to whether such document, record or other information was actually relied upon in making the benefit determination;

(3) demonstrates compliance with the procedures set forth in the Plan Document/Summary Plan Description and, where appropriate, demonstrates that those provisions have been consistently applied to similarly situated claimants; or

(4) constitutes a statement of policy as a guideline with respect to the Plan concerning the desired treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The review will be conducted by an appropriate named fiduciary of the Plan who is neither the person who made the adverse determination nor a subordinate of that person. The review must:

(1) not afford deference to the initial adverse determination;

(2) if the adverse determination is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental or investigational or not medically necessary or appropriate, provide that the named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was neither consulted in connection with the adverse determination or a subordinate of such person; and

(3) identify any medical or vocational expert who was consulted in connection with the adverse determination, without regard to whether such expert's advice was relied upon in making the determination.

If the appeal involves urgent care, the appeal process must provide for an expedited review. A request for an expedited review may be submitted orally or in writing by the claimant. The necessary documents and information, including the Plan's appeal determination, must be transmitted between the Plan and the claimant by telephone, facsimile or other available expeditious methods.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the claimant with a written response within 60 days of the date the Plan Administrator receives the claimant's written request for review, unless special circumstances require an extension of time and except as provided below for urgent care and pre-service claims. If, because of special circumstances, the Plan Administrator is unable to complete the review process within 60 days, the Plan Administrator shall notify the claimant of the delay within the 60 day period, explaining the special circumstances requiring an extension, the Plan Administrator shall provide a final written response to the request for review within 120 days of the date the Plan Administrator received the claimant's original written request for review.

In the case of an urgent care claim, the plan will notify the claimant of the appeal decision as soon as possible, taking into account medical emergencies, but no later than 24 hours after receipt of the claimant's request for review of an adverse benefit determination. In the case of a pre-service claim, the notice must be provided within a reasonable period of time, appropriate to the medical circumstances, but no later than 30 days after receipt of the claimant's request for review.

For purposes of calculating the applicable time periods for review, the period shall begin on the date an appeal is filed in accordance with the plan's procedures for filing an appeal, without regard to whether all of the information

necessary to make a benefit determination on review accompanies the filing. If the period of time for making a decision is extended, as provided above, because additional information from the claimant is necessary, the period for making the review decision will be extended from the date on which notification of the extension is sent to the claimant until the date the claimant responds to the request for additional information.

The Plan will provide the claimant with a written or electronic notification of the review decision. In the event of an adverse determination of the review, the notification will state:

(1) the specific reason or reasons for the adverse determination;

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

(3) a statement of the claimant's right to bring an action under section 502(a) of ERISA;

(4) if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either a copy of the specific rule, guideline, protocol or other similar criterion or a statement that such was relied upon and an offer to provide a copy, upon request and free of charge;

(5) if the adverse determination is based on medical necessity or experimental or investigational 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;

(6) the claimant's possible right to an external review; and

(7) the following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

The decision on review will be in writing, will include the specific reason for the decision, and will reference the pertinent provisions on which the decision is based.

Adverse Determination External Review

In the event of an adverse determination resulting from an internal review, the claimant may have the right to an external review of the decision by an Independent Review Organization ("IRO"). External review is not available for an adverse determination that is a rescission of coverage.

Request for External Review

A claimant may file a request for an external review by the first day of the fifth (5^{th}) month after the date the claimant receives notice of an initial adverse benefit determination or an adverse benefit determination after an internal review procedure. Within five (5) business days following the date the Plan receives the claimant's request for external review, the Plan will complete a preliminary review of the request to determine whether:

(1) the claimant is or was covered by the Plan at the time the health care item or service was requested or rendered;
(2) the denial does not relate to the claimant's failure to meet the eligibility requirements under the terms of the Plan;
(3) the claimant has exhausted the Plan's internal review process; and
(4) the claimant has provided all of the information required to process an external review.

Within one (1) business day after completion of the preliminary review, the Plan will issue a written notification to the claimant whether the claim is eligible for external review or not or whether additional information is needed to make that determination. If the request is complete, but not eligible for external review, the notice will include the

reasons for its ineligibility and contact information for the Employee Benefits Security Administrator (toll free number 866-444-EBSA (3272)). If the request is incomplete, the notice will describe the information or materials needed; the claimant must correct the deficiency within 48 hours after receipt of the notice or within the four (4) months filing period, whichever is later.

Referral to an Independent Review Organization (IRO)

The Plan will assign an IRO, accredited by URAC or a similar nationally-recognized accrediting organization to conduct an external review. The Plan has contracted with at least three (3) IROs and makes assignments between those IROs on a rotating basis. Each IRO uses legal experts when appropriate to make coverage determinations under the Plan.

Within five (5) business days after the review is assigned to IRO, the Plan will provide to the IRO any documents and any information considered by the Plan in making the initial adverse determination or in confirming the adverse determination after the internal review. If the Plan does not timely provide the documents and information to the IRO, the IRO may terminate the external review and reverse the Plan's adverse determination. Within one (1) business day of making that decision, the IRO will notify the claimant and the Plan.

When the IRO receives a review assignment, it will provide written notice to the claimant of receipt and acceptance of the request for external review, including a statement that the claimant may, within ten (10) business days after receipt of that notice, provide in writing additional information for the IRO's review. Within one (1) business day of receipt of such information from the claimant, the IRO will forward it to the Plan. If, after review of such information the Plan reconsiders and reverses its adverse determination, the Plan will notify the claimant and the IRO within one (1) business day of making such a decision and the IRO will terminate the external review. The Plan's consideration of the information, however, will not delay the external review.

The IRO will review all documents and information timely received on a de novo basis and will not be bound by any decisions or conclusions of the Plan. The IRO must provide written notice to the claimant and the Plan of its final external review decision within forty-five (45) days after it received the request for review. The notice must include: a general description of the reason for the external review, including information sufficient to identify the claim; the date the IRO received the review request and the date of its decision; references to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision; a discussion of the principal reason or reasons for its decision; a statement that the determination is binding except to the extent that other remedies may be available under state and Federal law to the Plan or the claimant; a statement that judicial review may be available to the claimant; and contact information for any applicable office of an ombudsman for health coverage issues, established under federal law. The decision of the IRO is binding on the Plan. If the Plan's adverse determination is reversed, the Plan must immediately provide coverage or payment for the claim.

Expedited External Review

If an initial adverse determination by the Plan involves a medical condition for which the time for completion of the Plan's internal review process would seriously jeopardize the claimant's life, health or ability to regain maximum function or, if the internal appeal is completed, but the standard time for completion of an external review would have the same impact, or if the internal review adverse determination concerns an admission, availability of care, continued stay or a health care item or service for which the claimant received emergency care and the claimant has not been discharged from a facility, the claimant can request an expedited external review from the Plan. Upon receipt of such a request, the Plan must immediately determine if the request satisfies the requirements for an expedited review and must immediately notify the claimant of its determination. If the Plan determines that the claim is eligible for an expedited review, the claim will be assigned to an IRO in the standard manner and the Plan will provide the necessary documents and information to the IRO in an expeditious manner. The IRO will provide a notice of its decision as soon as possible but in no event later than 72 hours after the IRO receives the request for expedited external review. If the initial notice of its decision is not provided in writing, the IRO will send written notice within 48 hours after its initial, non-written notice.

IRO Records

After a final external review decision, the IRO will maintain records of all claims and notices associated with the review for six (6) years. Upon request, those records will be made available for examination by the claimant, the Plan or a state or Federal oversight agency, except where such disclosure would violate state or federal privacy law.

COORDINATION OF BENEFITS

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

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans will pay the balance due up to 100% of the total allowable expenses.

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

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

(2) Blue Cross and Blue Shield group plans.

(3) Group practice and other group prepayment plans.

(4) Federal government plans or programs. This includes Medicare.

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

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

Allowable charge. For a charge to be allowable it must not exceed the Maximum Allowable Charge and at least part of it must be covered under this Plan.

In the case of HMO (Health Maintenance Organization) or other in-network only plans: This Plan will not consider any charges in excess of what an HMO or network provider has agreed to accept as payment in full. Also, when an HMO or network plan is primary and the Covered Person does not use an HMO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the HMO or network plan had the Covered Person used the services of an HMO or network provider.

In the case of service type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

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

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

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

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

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

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

(d) When a child is covered as a Dependent and the parents are not separated or divorced, these rules will apply:

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

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

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

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

(ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a Dependent will be considered next. The benefit plan of the parent without custody will be considered last.

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

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

(f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the Plan will never pay more than 50% of allowable charges when paying secondary.

(3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.

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

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

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

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

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

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

THIRD PARTY RECOVERY PROVISION

RIGHT OF SUBROGATION AND REFUND

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

The Covered Person:

(1) automatically assigns to the Plan his or her rights against any Third Party or insurer when this provision applies; and

(2) must repay to the Plan the benefits paid on his or her behalf out of the Recovery made from the Third Party or insurer.

In addition to, neither the Plan nor the Company shall be responsible for any of the Covered Individual's attorney's fees or the costs of the Covered Individual's litigation.

Amount subject to Subrogation or Refund. The Covered Person agrees to recognize the Plan's right to Subrogation and reimbursement. These rights provide the Plan with a 100%, first dollar priority over <u>any</u> and all Recoveries and funds paid by a Third Party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any and all rights the Covered Person may have to recover payments from any Responsible Third Party. Further, accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan the Covered Person's Third Party Claims.

Notwithstanding its priority to funds, the Plan's Subrogation and Refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan. The Plan reserves the right to be reimbursed for its court costs and attorneys' fees if the Plan needs to file suit in order to recover payment for medical

or dental expenses from the Covered Person. Also, the Plan's right to Subrogation still applies if the Recovery received by the Covered Person is less than the claimed damage, and, as a result, the claimant is not made whole. In addition, the Plan shall not be responsible for any of the Covered Person's attorney's fees or the costs of the Covered Person's litigation.

When a right of Recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of Subrogation as a condition to having the Plan make payments. In addition, the Covered Person will do nothing to prejudice the right of the Plan to Subrogate.

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

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

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

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

"Subrogation" means the Plan's right to pursue and lien upon the Covered Person's claims for medical or dental charges against the other person.

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

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

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

COBRA CONTINUATION OPTIONS

A federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), requires that certain employers (generally, those with 20 or more full-time and/or part-time employees) sponsoring a group health plan ("Plan") offer Employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the Plan would otherwise end. An Employee should check with his or her Employer to determine if COBRA applies to that Employer. This notice is intended to inform Covered Persons and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other

information, will be provided by the Plan Administrator to Covered Persons who become Qualified Beneficiaries under COBRA.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Covered Persons and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

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

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

(3) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Dependent child was a beneficiary under the Plan.

The term "covered Employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director).

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a qualified beneficiary, then a Spouse or Dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

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

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

(1) The death of a covered Employee.

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

(3) The divorce or legal separation of a covered Employee from the Employee's Spouse.

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

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

(6) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

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

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the Employer's Plan. A Plan can condition availability of COBRA continuation coverage upon the timely election of such coverage. An election of COBRA continuation coverage is a timely election if it is made during the election period. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and must not end before the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(1) A Dependent child's ceasing to be a Dependent child under the generally applicable requirements of the Plan.

(2) The divorce or legal separation of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of

the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

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

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

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

(3) The date upon which the Employer ceases to participate in this Plan, provided that, if the Employer provides any other group health plan (including successor plans) to any Employee, the Qualified Beneficiary may have the right to continue coverage under one of those other plans.

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

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

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

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

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

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

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

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

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

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

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

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

(3) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

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

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

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

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

Can a Plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a Plan can require the payment of an amount that does not exceed 102% of the applicable premium except the Plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled qualified beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a qualified beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that qualified beneficiary.

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

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means payment that is made to the Plan by the date that is 30 days after the first day of that period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered Employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non COBRA beneficiaries for the period.

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

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

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the 180- day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non COBRA beneficiaries under the Plan. If such a conversion option is not otherwise generally available, it need not be made available to Qualified Beneficiaries.

American Recovery and Reinvestment Act of 2009 (ARRA) The American Recovery and Reinvestment Act of 2009 (ARRA) provides for a 65% premium reduction for certain assistance eligible individuals who elect COBRA continuation coverage. Under ARRA, an assistance eligible individual is a Qualified Beneficiary as the result of an involuntary termination that occurred during the period from September 1, 2008 through December 31, 2009, is eligible for COBRA continuation coverage at any time during that period, and elects COBRA continuation coverage. The Plan will treat assistance eligible individuals who pay 35% of the premium otherwise payable for COBRA continuation coverage as having paid the full amount of the premium.

The premium reduction applies as of the first period of coverage beginning on or after February 17, 2009. An assistance eligible individual is eligible for the premium reduction for up to 9 months from the first month the premium reduction provisions of ARRA apply to the individual. The premium reduction period ends if the individual becomes eligible for coverage under any other group health plan or for Medicare benefits. In addition, the premium reduction does not extend beyond the period of COBRA continuation coverage. An individual receiving the premium reduction who becomes eligible for coverage under any other group plan or Medicare is required to notify the Plan of eligibility for that other coverage. If the individual fails to notify the Plan, the individual is subject to a tax penalty of 110% of the premium reduction improperly received after eligibility for the other coverage.

ARRA provides an extended election period for certain individuals who did not have an election of COBRA continuation coverage in effect on February 17, 2009. The election is available for individuals who would be assistance eligible individuals if they had a COBRA continuation coverage election in effect (that is, as the result of an involuntary termination on or after September 1, 2008). This extended election period is for 60 days after the Qualified Beneficiaries are provided notice of the extended election period. The resulting COBRA continuation coverage extends no longer than the original maximum period required (as measured with respect to the qualifying event) and begins with the first period of coverage beginning on or after February 17, 2009.

Generally, a plan is not required to take into account creditable coverage prior to a significant break in coverage (i.e., 63 days without creditable coverage). For an individual who becomes covered pursuant to an election under the ARRA extended election period, the individual is treated as not having a significant break in coverage because ARRA provides that the period between the loss of coverage and the beginning of coverage is disregarded. Thus, the individual's creditable coverage accumulated prior to the involuntary termination remains available to reduce any future Preexisting Condition exclusion. The period between the loss of coverage and the beginning of coverage, however, would not be treated as creditable coverage.

If the premium reduction is provided with respect to COBRA continuation coverage for an individual or the individual's Dependents, and the individual's modified adjusted gross income exceeds $145,000 ($290,000 for married filing jointly), the amount of the premium reduction is recaptured as an increase in the individual's Federal income tax liability. The recapture is phased in for individuals with modified adjusted gross income in excess of $125,000 ($250,000 for married filing jointly). An individual may elect to permanently waive the right to the premium reduction (for example, to avoid receiving and then repaying the premium reduction). In addition, an individual who receives the premium reduction under ARRA for a month is disqualified from receiving the Health Coverage Tax Credit for that month.

If any provision of this section is contrary to the American Recovery and Reinvestment Act of 2009, the provision is changed to comply with the law.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

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

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

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

DUTIES OF THE PLAN ADMINISTRATOR.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

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

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

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

PLAN IS NOT AN EMPLOYMENT CONTRACT

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

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Covered Person, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

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

The Plan Sponsor intends to maintain this Plan indefinitely; but since future conditions affecting the Plan Sponsor cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right:

(1) To determine eligibility for benefits or to construe the terms of the Plan.

(2) To alter or postpone the method of payment of any benefit.

(3) To amend any provision of these administrative provisions.

(4) To 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.

(5) To terminate, suspend, discontinue, amend, or modify the plan in whole or in part at any time. Changes in the plan may be made to any and all provisions, including benefits, deductibles, co-benefit amounts, exclusions, eligibility, etc.

The Plan Sponsor may elect to cancel or refuse to renew all coverage issued by the Plan. In that event, the Plan Sponsor will notify:

(1) The commissioner of insurance of the election no later than the 180th day before the first date coverage would terminate as to a participating Employer under the Plan; and

(2) Each affected Employer not later than the 180th day before the date on which coverage terminates for that Employer.

The Plan Sponsor will also notify each participating Employer of the cancellation or refusal to renew no later than the 30th day before the date termination of coverage is effective. Each Employer is responsible for notifying participating Employees of the cancellation or refusal to renew.

If the Plan Sponsor elects to cancel or refuses to renew all coverage issued by the Plan, coverage may not be issued by the Plan Sponsor for a period of five years from the date the election notice is delivered to the commissioner.

The Plan Sponsor may also elect to discontinue a health benefit plan issued by the Plan provided:

(1) Notice is given to each participating Employer of the discontinuation of such health benefit plan at least 90 days before the date of discontinuance of such plan;

(2) Each Employer is given the option to purchase other coverage offered by the Plan; and

(3) The Plan Sponsor acts uniformly without regard to the claims experience of an Employer or the health status related factor of a participating Employee or Dependent or new Employee or Dependent who may become eligible for the coverage.

If the Plan is terminated, the rights of Covered Persons are limited to covered expenses incurred before termination. In the event of Plan termination, the remaining assets of the Plan shall be applied to pay covered expenses incurred before termination. Any assets remaining after such claims are paid, will be disbursed prorata by number of employees to the employers participating in the Plan at the time of Plan termination. Any claim obligations, unpaid at the time of termination due to lack of Plan funds, will be returned to the Employer for whose Employee or Employee's Dependent such claim was incurred.

CERTAIN COVERED PERSONS RIGHTS UNDER ERISA

Covered Persons in this Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifies that all Covered Persons shall be entitled to:

(1) Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents governing the Plan, including 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.

(2) Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

(3) Continue health care coverage for a Plan Covered Person, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Employees or dependents may have to pay for such coverage.

(4) Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

(5) Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan, if an Employee or dependent has Creditable Coverage from another plan. The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, a Plan Covered Person may be subject to a Pre-Existing Conditions exclusion for 12 months (18 months for Late Enrollees) after the Enrollment Date of coverage.

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

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

In addition, if a Plan Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

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

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

If the Plan Covered Person has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Covered Person has any questions about this statement or his or her rights under ERISA or the Health Insurance Portability and Accountability Act (HIPAA), that Plan Covered Person should contact either the nearest area office of the Employee Benefits Security Administration, U.S. Department of Labor listed in the telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, at 200 Constitution Avenue, N.W., Washington, DC 20210.

HIPAA PRIVACY RULE

AgBenefits Employee Benefit Plan ("Health Plan") complies with the requirements of the Health Insurance Portability and Accountability Act ("HIPAA") and it's implementing regulations ("HIPAA Privacy Rule") by establishing the extent to which the Plan Sponsor will receive, use and/or disclose Protected Health Information ("PHI").

Health Plan's Designation of Person/Entity to Act on its Behalf

The Plan has determined that it is a group health plan within the meaning of the HIPAA Privacy Rule, and the Health Plan designates the Plan Sponsor to take all actions required to be taken by the Health Plan in connection with the HIPAA Privacy Rule.

Definitions

All terms defined in the HIPAA Privacy Rule, shall have the meaning set forth therein. The following additional definitions apply to the provisions set forth in this Amendment.

Health Plan means the AgBenefits Employee Benefit Plan.

Plan Documents mean the Health Plan's governing documents and instruments (i.e., the documents under which the Health Plan was established and is maintained), including but not limited to the AgBenefits Employee Benefit Plan Document.

Plan Sponsor means "plan sponsor" as defined at section 3(16)(B) of ERISA, 29 U.S.C. § 1002(16)(B). The Plan sponsor is AgBenefits.

Certification of Compliance by Plan Sponsor

Except as provided below with respect to the Health Plan's disclosure of summary health information, the Health Plan will disclose Protected Health Information to the Plan Sponsor, or permit the disclosure of Protected Health Information to the Plan Sponsor by a health insurance issuer or HMO with respect to the Health Plan, only upon receipt of a certification by the Plan sponsor that:

(1) The Plan Documents have been amended to establish the permitted and required uses and disclosures of such information by the Plan sponsor, consistent with the HIPAA Privacy Rule, and

(2) The Plan Documents have been amended to incorporate the provisions set forth in this Amendment, and

(3) The Plan Sponsor agrees to comply with the provisions as modified by this Amendment.

Health Plan's Disclosure of Individuals' Protected Health Information to Plan Sponsor

The Health Plan (and any business associate acting on behalf of the Health Plan), or any health insurance issuer or HMO servicing the Health Plan, will disclose individuals' Protected Health Information to the Plan Sponsor only to permit the Plan Sponsor to carry out plan administration functions. Such disclosure will be consistent with the provisions of this Amendment.

All disclosures of the Protected Health Information of the Health Plan's individuals by the Health Plan's business associates, health insurance issuer, or HMO to the Plan Sponsor will comply with the restrictions and requirements set forth in this Amendment and in the HIPAA Privacy Rule.

The Health Plan (and any business associate acting on behalf of the Health Plan), may not disclose, and may not permit a health insurance issuer or HMO to disclose, individuals' Protected Health Information to the Plan Sponsor for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will not use or further disclose individuals' Protected Health Information other than as described in the Plan Documents and permitted by the HIPAA Privacy Rule.

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

The Plan Sponsor will not use or disclose individuals' Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to the Health Plan any use or disclosure of Protected Health Information that is inconsistent with the uses or disclosures provided for in the Plan Documents (as amended) and in the HIPAA Privacy Rule, of which the Plan sponsor becomes aware.

Health Plan's Disclosure of Summary Health Information and Enrollment Information to the Plan Sponsor

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

(1) Obtaining premium bids for providing health insurance coverage under the Health Plan, or

(2) Modifying, amending, or terminating the Health Plan.

The Health Plan (or a health insurance issuer or HMO with respect to the Health Plan) may disclose enrollment and disenrollment information to the Plan Sponsor.

Disclosure of Individuals' Protected Health Information by Plan Sponsor

The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with the HIPAA Privacy Rule.

The Plan Sponsor will make individuals' Protected Health Information available for amendment and incorporate any amendments to individuals' Protected Health Information in accordance with the HIPAA Privacy Rule.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individuals' Protected Health Information that it must account for in accordance with the HIPAA Privacy Rule.

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

The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information that it still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan sponsor will ensure that the required adequate separation, described in paragraph 7 below, is established and maintained.

Adequate Separation

In accordance with the HIPAA Privacy Rule, the following employees or classes of employees or workforce members under the control of the Plan Sponsor may be given access to individuals' Protected Health Information received from the Health Plan or from a health insurance issuer or HMO servicing the Health Plan:

Executive Director
Assistant Director
Director of Wellness
Director of Client Services

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

Any suspected occurrences of improper use or disclosure of PHI may be reported to the Health Plan's Privacy Officer at (806) 747-7894. The Plan sponsor will promptly report any such breach, violation, or noncompliance to the Health Plan and will cooperate with the Health Plan to correct the violation or noncompliance, to impose appropriate disciplinary action and/or sanctions, and to mitigate any deleterious effect of the violation or noncompliance.

HIPAA SECURITY REQUIREMENTS APPLICABLE TO ELECTRONIC PHI

Effective April 21, 2005, the Plan Sponsor will:

(1) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan;

(2) Ensure that the adequate separation between the Plan and the Plan Sponsor with respect to electronic PHI is supported by reasonable and appropriate security measures;

(3) Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and

(4) Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION
The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Supervisor. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME
AgBenefits

PLAN NUMBER
501

TAX ID NUMBER
85-6127618

PLAN YEAR
The Plan operates on a fiscal year basis, which begins on June 1st of each year and ends on the last day of May of the succeeding year.

PLAN ADMINISTRATOR/PLAN SPONSOR
AgBenefits
1616 S. Kentucky St.
Suite C250
Amarillo, TX 791021-806731-4740

NAMED FIDUCIARY
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1616 S. Kentucky St.
Suite C250
Amarillo, TX 791021-806-731-4740

AGENT FOR SERVICE OF LEGAL PROCESS
Commissioner/Texas Department of Insurance
Tower I
333 Guadalupe
Austin, Texas 78701
(Legal process may also be served on the Plan Sponsor/Administrator.)

CLAIMS SUPERVISOR
Bentegrity Solutions
1616 S. Kentucky Suite C250
Amarillo, Texas 79102
(806) 568-2600

PHARMACY BENEFIT MANAGER
HealthSmart
222 W Las Colinas Blvd, Ste 600 N
Irving TX 75039
www.healthsmart.com (website)

EXCESS LOSS INSURER
National Underwriting Services, Inc.
14893 State Hwy 16 North, Suite 1
Helotes, Texas 78023
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210-695-2387 Fax

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