

EMPLOYERS RESOURCE MANAGEMENT

EMPLOYEE WELFARE BENEFIT PLAN

THROUGH EMPLOYERS RESOURCE BENEFIT TRUST

Restated as of

JANUARY 1, 2010

SENSIBLE BASIC MEDICAL PLAN

**This self-funded medical plan sponsored by Employers Resource Benefit Trust is not insurance
and does not participate in any state guarantee association.**

TABLE OF CONTENTS

BACKGROUND	5
INTRODUCTION	6
ACCIDENT REIMBURSEMENT PLAN	7
SENSIBLE BASIC SCHEDULE OF MEDICAL BENEFITS	8
ELIGIBILITY AND PARTICIPATION	14
WHO IS ELIGIBLE	14
WHO PAYS FOR YOUR BENEFITS	14
GENERAL ENROLLMENT REQUIREMENTS AND ELECTION INFORMATION	15
CHANGES IN STATUS	15
WHEN COVERAGE BEGINS	16
HIPAA SPECIAL ENROLLMENT RIGHTS	16
CHIP SPECIAL ENROLLMENT RIGHTS	17
LATE ENROLLMENT	18
OPEN ENROLLMENT	18
PRE-EXISTING CONDITIONS	18
WHEN COVERAGE ENDS	19
SPECIAL SITUATIONS, EXTENSION OF COVERAGE	19
OTHER LEAVE OF ABSENCE AND WORKERS COMPENSATION	21
REHIRING A TERMINATED EMPLOYEE	22
DELTA TEAMCARE HEALTH CARE MANAGEMENT PROGRAM	23
DELTA TEAMCARE	23
PROFESSIONAL REVIEW STAFF	23
THE PRE-CERTIFICATION REQUIREMENT	23
CASE MANAGEMENT SERVICES	25
RISK INDEXING	25
MATERNITY MANAGEMENT – “TOMORROW’S CHILD” FOR HIGH RISK PREGNANCIES ONLY	25
NEWBORNS’ AND MOTHERS’ HEALTH PROTECTION ACT OF 1996	26
THE WOMEN’S HEALTH AND CANCER RIGHTS ACT OF 1998	26
PREFERRED PROVIDER ORGANIZATION (PPO)	27
WHAT IS A PPO	27
WHO IS YOUR PPO	27
ABOUT YOUR PPO	27
MEDICAL BENEFITS	28
DEDUCTIBLES	28
BENEFIT PERCENTAGE PAYABLE	28
CO-PAYMENTS	28
OUT-OF-POCKET MAXIMUMS	28
CLAIMS EDIT SYSTEM AND INDUSTRY STANDARD MODIFIERS	29
BENEFIT MAXIMUMS	29
COVERED MEDICAL EXPENSES	30

MEDICAL EXPENSES NOT COVERED	38
COORDINATION OF BENEFITS	42
GENERAL PROVISION	42
GOVERNMENT PROGRAMS AND OTHER GROUP HEALTH PLANS	42
AUTOMOBILE INSURANCE	42
ORDER OF PAYMENT WHEN COORDINATING WITH OTHER GROUP HEALTH PLANS	42
RIGHT TO MAKE PAYMENTS TO OTHER ORGANIZATIONS	44
OTHER IMPORTANT PLAN PROVISIONS	45
ASSIGNMENT OF BENEFITS	45
SPECIAL ELECTION FOR <i>EMPLOYEES</i> AND SPOUSES AGE 65 AND OVER	45
RESTITUTION TO THE PLAN	45
SUBROGATION	46
RECOVERY OF EXCESS PAYMENTS	46
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION	47
ALTERNATE PAYEE PROVISION	47
RELIANCE ON DOCUMENTS AND INFORMATION	47
NO WAIVER	48
PHYSICIAN/PATIENT RELATIONSHIP	48
PLAN IS NOT A CONTRACT OF EMPLOYMENT	48
RIGHT TO AMEND OR TERMINATE PLAN	48
CLAIMS AND APPEALS	49
FILING NON-URGENT PRE-SERVICE CLAIMS	50
FILING URGENT CARE CLAIMS	50
FILING POST-SERVICE CLAIMS	51
STATUS OF BENEFIT VERIFICATIONS	51
NOTIFICATION OF BENEFIT DETERMINATIONS	52
NOTIFICATION OF ADVERSE BENEFIT DETERMINATION	53
APPEALS	53
TIME PERIOD FOR DECIDING APPEALS	55
NOTIFICATION OF APPEAL DENIALS	55
SECOND LEVEL APPEAL OF POST-SERVICE CLAIMS	56
DISPUTE RESOLUTION	56
OPTIONAL CONTINUATION OF COVERAGE	58
CONTINUATION OF COVERAGE UNDER FEDERAL LAW (COBRA)	58
NOTIFICATION REQUIREMENT	59
ELECTING COBRA COVERAGE	59
NOTICE OF UNAVAILABILITY OF COBRA COVERAGE	59
MAXIMUM PERIOD OF COBRA COVERAGE	59
COST OF COBRA COVERAGE	60
WHEN COBRA COVERAGE ENDS	60
NOTICE OF TERMINATION BEFORE MAXIMUM PERIOD OF COBRA COVERAGE EXPIRES	61
COBRA SUBSIDY	61
HIPAA	62
PROVISION OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR	64
PERMITTED DISCLOSURES OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR	64
NO DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR WITHOUT CERTIFICATION BY PLAN SPONSOR	64
CONDITIONS OF DISCLOSURE OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR	64

DISCLOSURES OF SUMMARY HEALTH INFORMATION AND ENROLLMENT/DISENROLLMENT INFORMATION TO THE PLAN SPONSOR	65
REQUIRED SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR	66
DEFINITIONS	67
RIGHTS OF PLAN PARTICIPANTS	77
RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS	77
CONTINUE GROUP HEALTH PLAN COVERAGE	77
PRUDENT ACTIONS BY PLAN FIDUCIARIES	77
ENFORCE YOUR RIGHTS	78
ASSISTANCE WITH YOUR QUESTIONS	78
GENERAL INFORMATION	79

BACKGROUND

Employers Resource Management Company (“Employers Resource”) is a company in the business of providing employment-related services to client companies who contract with Employers Resource to provide those services and, in some cases, to provide certain other employment-related benefits such as medical, dental, death and similar benefits as may be selected by such client companies.

Employers Resource of America, Inc. (“ERA”) is an Idaho corporation and a subsidiary of Employers Resource. ERA provides the same services as Employers Resource in certain geographic areas of the United States and whenever reference is made to Employers Resource in this document that reference includes ERA with respect to those geographic areas.

Employers Resource Benefit Trust (“ERBT”) is a Virginia-based trust. The trustee of the trust is American Guaranty Title & Trust, Inc., which is incorporated pursuant to the state of Idaho’s Guaranty Title and Trust Company provisions. By agreement with Employers Resource, ERBT provides certain benefit programs for companies which have contracted with Employers Resource and which have elected to provide their employees the benefits that are available through ERBT. Those benefits are described in Part II of this document.

In addition to the benefits provided through ERBT, other benefits are made available to contracting employers (see below) directly through Employers Resource.

When a client company and Employers Resource enter into a business relationship, they execute an agreement (the “Client Service Agreement” or sometimes, “CSA” or other written agreement) which describes the services to be provided by Employers Resource and, in some cases, the benefit plans which are to be provided to employees of the client company. All of the benefit plans which are available for selection by the client company are described in this document.

Since Employers Resource acts, in some respects, as an employer of the employees of its client companies, the relationship between Employers Resource and the client is a co-employment relationship and the client is therefore referred to as the “co-employer.”

The benefit plans that are available to employees of any co-employer, either through Employers Resource or ERBT, depending upon the selection of such plans made by the co-employer when it signs a contract (client service agreement) with Employers Resource or at annual enrollment, when co-employers have the opportunity to elect other benefits. Each employee of a co-employer will be advised as to which, if any, of the benefits described in this document are available to the employee.

It is also important to not that whenever the word “*employer*” appears in this document the term may mean either Employers Resource or Co-employer, or both, as the context may require.

In addition to the benefits provided through ERBT, other benefits are made available to contracting employers (see below) directly through Employers Resource. Also, any self-funded medical plan offered through Employers Resource Benefit Trust (and sponsored by Employers Resource) is not insurance and does not participate in any state guarantee association.

INTRODUCTION

Employers Resource has prepared this Summary Plan Description to help you understand your benefits. Please read it carefully. Your benefits are affected by certain limitations and conditions. Also, benefits are not provided for certain kinds of treatments or services, even if your *health care provider* recommends them.

Technical terms are printed in *italics* and defined in the “Definitions” section.

As used in this document, the word *year* refers to the *benefit year* which is the 12-month period beginning January 1 and ending December 31. All annual benefit maximums and deductibles accumulate during the *benefit year*. The word *lifetime* as used in this document refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Employers Resource and/or any of its predecessor or successor companies.

Any amount you or your eligible dependents have accumulated toward the benefit maximum amounts of any previous Employers Resource plan will be counted toward the benefit maximum amounts of this plan. In addition, any time accumulated toward satisfaction of a waiting period or pre-existing condition limitation under the previous plan will be counted toward satisfaction of the waiting period or pre-existing condition limitation of this plan.

Employers Resource reserves the right to amend, modify or terminate the plan in any manner, for any reason, at any time, which may result in the termination or modification of your coverage. Expenses incurred prior to the plan termination will be paid as provided under the terms of the plan prior to its termination.

Benefits described in this document are effective January 1, 2010.

ACCIDENT REIMBURSEMENT PLAN

Generally, bodily injury can be defined as a localized, abnormal condition of the body, internal or external, traumatically induced. However, certain conditions which are not localized are also classified as “bodily injuries” (e.g., sunstroke, heat exhaustion, generalized freezing and certain toxic effect). An accident is an event which happens without intention or design, which is unexpected, unusual and unforeseen. If such an event causes bodily injury, the second portion of the accident definition is satisfied. Lifting, bending, stooping, simple exertion, etc., are not, in themselves, accidental events. However, if in the act which precedes the injury, something unforeseen, unexpected or unusual occurs which produces the injury, then the injury has resulted through accidental means. No benefits will be paid until an accident form is received.

Benefit Description	Benefit Maximum	Additional Limitations And Explanations
Accident Reimbursement Plan	\$1,000 per individual per accident \$5,000 per individual per year	Treatment must begin within 72 hours of the accident and be completed within 90 days after the date of the accident. Payment made by the plan for this benefit will not be applied towards any other benefit deductible or out-of-pocket maximum. Prescriptions resulting from an accident are included in this benefit, payable by the plan at 80% of the prescription cost. Pay for the prescription and submit the receipt with the employee name, social security number and date of the accident to the claims address on your ID card.

This plan is available to employees only. Dependent accident expenses will be covered under the elected medical plan (Preferred or Deluxe medical plan).

Exceptions and Limitations: No payment will be made for claims arising from the following items. (These exclusions will not apply if the injury resulted from an act of domestic violence or a medical – including both physical and mental health – condition.)

- Suicide, attempted suicide or any intentionally self-inflicted injury, while sane or insane.
- Bodily injury (to include sickness or disease) resulting directly or indirectly from insurrection, war, service in the armed forces of any state or country, participation in a riot or during the commission or attempted commission of a crime, whether or not convicted.
- Accidental injury or damage to dentures, crowns or fillings, or to decayed or previously damaged teeth.
- No benefits will be provided for an accident caused by the use of alcohol or any other drug, including the misuse of prescription drugs.

EMPLOYERS RESOURCE
SENSIBLE BASIC SCHEDULE OF MEDICAL BENEFITS

	PPO	NON-PPO
Annual Deductibles:	None	None
Lifetime Benefit Maximum: (Includes All Other Maximums)	\$1,000,000 Per Individual	

The following schedule summarizes benefit percentages payable by the plan, benefit maximums and additional explanation. You should call the Delta TeamCare Health Care Management Program prior to receiving any inpatient services. The benefit payable will be reduced by \$500 if you do not follow the procedures outlined in the Delta TeamCare Health Care Management section of the plan. Penalties for failure to pre certify will not apply to any out of pocket maximum. Any amounts that exceed the usual and customary charge (for non-PPO services) are not recognized by the plan for any purpose and are the responsibility of the patient. Payment is subject to all of the other terms, conditions and limitations of the plan, as set forth in the rest of this document.

Benefit Description	PPO Plan Pays	Non-PPO Plan Pays	Additional Limitations And Explanations
Treatment of Accidental Injury	100%	100%	\$1,000 individual per accident maximum and \$5,000 individual annual maximum. Expenses in excess of the \$1,000 per accident maximum will be considered as All Other Covered Expenses (subject to deductible and coinsurance). This benefit is limited to spouses and dependents.
Urgent Care Facility Consultation	Plan pays up to \$25 per visit.		Limited to 4 visits per year. Other services will be paid according to the General Plan Provision Expense Category with respective limits and maximums.
Emergency Room Services	Plan pays 100% up to \$300 per ER visit.		\$900 individual annual maximum. Services must be for a <i>medical emergency</i> . Use of an emergency room for treatment of a condition other than a <i>medical emergency</i> is NOT covered under this plan.
Ambulance Services	80%	80%	Limited to 1 trip per year up to a \$1,000 individual annual maximum. Ground/air transportation provided by a professional ambulance service to and from (limited to one return trip per year) a hospital or emergency care facility which is equipped to treat a condition that is classified as a <i>medical emergency</i> .

Benefit Description	PPO Plan Pays	Non-PPO Plan Pays	Additional Limitations And Explanations
Inpatient Hospital Services	ICU – Plan pays 100% up to \$3,000 per day/15 days per year.		The benefit payable will be reduced by \$500 if you do not follow the procedures outlined in the Delta TeamCare Health Care Management section of the plan.
	Semi-Private Room and Board – Plan pays 100% up to \$1,500 per day/15 days per year/300 days per lifetime.		
Surgically Implanted Devices	80%	60%	Limited to 1 surgically implanted device up to a \$1,000 individual annual maximum. The plan pays the lesser of any contracted rate or invoice +20% of the cost of such device.
Outpatient Hospital Services	Plan pays 100% up to \$750 per day.		Limited to one procedure per year (or 2 or more procedures within the same surgical session).
Outpatient Surgery at a Hospital or Surgical Center	Plan pays 100% up to \$750 per day.		Limited to one procedure per year. Precertification is required. The benefit payable will be reduced by \$500 if you do not follow the pre certification procedures.
Anesthesiology	Plan pays 100% up to \$375.		Limited to one procedure per year.
Surgical Procedures:	Plan pays 100% up to:		
Inpatient – 1 per year	\$1,500		
Outpatient – 1 per year	\$750		
Outpatient Minor – 1 per year	\$75		
Outpatient Venipuncture – 1 per year	\$25		
My Health Toolbox	100%	N/A	This educational/research benefit includes a pH test, CBC panel blood test, health risk assessment as well as newsletters and quality health information. This educational/research benefit is available once per year for employees and spouses.

Benefit Description	PPO Plan Pays	Non-PPO Plan Pays	Additional Limitations And Explanations
Routine And Preventive Services For Participants Over Age 6	100%	100%	\$200 individual annual maximum. Benefits include routine physicals; PAP tests, including the exam; colo-rectal exams; prostate exams; mammograms, including the visit; thermograms (limited to \$200 per scan), blood work for hormone replacement therapy and vaccinations, inoculations and immunizations. Routine blood and urinalysis tests are covered laboratory services; chest x-ray and electrocardiograms (EKGs) are not considered routine care.
Routine Well-Child Care Through Age 6	100%	100%	\$200 individual annual maximum. Benefits include routine physicals, including the visit; vaccinations, inoculations and immunizations. Routine blood and urinalysis tests are covered laboratory services; chest x-ray and electrocardiograms (EKGs) are not considered routine care.
Integrative Preferred Professionals	100%	N/A	The plan will pay up to \$75 per visit for the consultation and lab work when performed in the Integrative Preferred Professionals provider's office. Providers may be located by visiting the following website: www.myhealthroadmapallstarlist.com.
Physician Office Visits	Plan pays 100% up to \$50 per visit.		Limited to 4 visits per year. This benefit includes the consultation only. Generally, lab, x-rays and minor surgeries are not included in this benefit.
Home Health Care	100%	100%	Limited to 100 visits per year and a maximum plan payment of \$50 per visit. Expenses in excess of \$50 will be paid at 80%, after the deductible.
Hospice Care	100%	100%	Limited to 100 visits per year and a maximum plan payment of \$50 per visit. Expenses in excess of \$50 will be paid at 80%, after the deductible.
Skilled Nursing Facility	Plan pays 100% up to \$750 per day.		Limited to 60 days per year. Must follow a hospital stay of at least 3 days to be covered.

Benefit Description	PPO Plan Pays	Non-PPO Plan Pays	Additional Limitations And Explanations
Chiropractic Services / Acupuncture / Alternative Care Services	Plan pays 100% up to \$35 per visit.		Limited to a combined 6 visits per year. Chiropractic services from any licensed chiropractic practitioner. Alternative Care including oriental medicine, acupuncture and Chinese herbology accredited practitioner. Benefit includes practitioner fee only, no supplies.
Physical Therapy	Plan pays 100% up to \$50 per visit.		Limited to 4 visits per year.
Outpatient Diagnostic X-Ray and Labs (Non-routine)	100%	100%	\$500 individual annual maximum. Includes all services performed in a physician's office or by an independent lab. Refer to Diagnostic Services Including X-Ray and Laboratory in the Covered Medical Expenses section. MRI's and CT scans must be pre-certified. The benefit payable will be reduced by \$500 if you do not follow the pre certification procedures. This penalty does not apply to any out of pocket accumulation.
Outpatient Mental Health and Substance Abuse Treatment	Not Covered	Not Covered	EAP available.
Inpatient Mental Health and Substance Abuse Treatment	Not Covered	Not Covered	EAP available.
Durable Medical Equipment	100%	100%	\$250 individual annual maximum. Precertification is required for DME \$1000 and over. The benefit payable will be reduced by \$500 if you do not follow the pre certification procedures. This penalty does not apply to the out of pocket maximum.

Benefit Description	PPO Plan Pays	Non-PPO Plan Pays	Additional Limitations And Explanations
Diabetic Education and Nutritional Counseling	100%	Not Covered	\$250 individual lifetime maximum for educational materials and treatment reviews through Dr. Julian Whitaker, Whitaker Wellness Institute (Center of Excellence). The plan will not consider benefits for any other provider.
Initial Prescription Contact Lenses or Eyeglasses Following Intraocular Surgery	80%	60%	\$100 individual lifetime maximum.
Smoking Cessation Services/Supplies	80%	60%	\$300 individual lifetime maximum.
Natural Supplements	80%	80%	\$250 individual annual maximum. Refer to the Covered Medical Expenses section for more information.
All Other Covered Medical Expenses	80%	60%	\$2,500 Individual annual maximum. Benefits are provided for expenses listed in the Covered Medical Expenses section of this plan.

TREATMENT EXCELLENCE

Second Surgical Opinion for: --Back Surgery --Knee Surgery --Cholecystectomy- (gall bladder removal) --Prostatectomy- (prostate removal) --Non-Metastatic - Mastectomy --Hip Replacement Surgery	<ol style="list-style-type: none"> 1) Call Employer's Resource Patient Advocate at 800-376-3000. They will put you in touch with a national expert on your procedure, who will provide a second opinion to validate the treatment plan and/or consider other alternatives. 2) If the second opinion validates your doctors opinion, all related services will be covered at the amounts listed under the plan. 3) If the second opinion provides an alternate treatment and/or treatment provider, all related services/treatment, if chosen, will be paid at a level of twice the amounts listed under the plan up to reasonable and customary charges. 4) If you choose to not obtain a second opinion for these procedures, or you proceed with your doctor's treatment, and such treatment differs from the Treatment Excellence opinion, all related services will not be covered under the plan. 5) Note, the actual Treatment Excellence opinion and any applicable related reasonable and customary travel and handling charges are covered at 100%.
---	--

NETWORK AND OUT-OF-NETWORK BENEFIT APPLICATION

- 1) *Ancillary services rendered by a PPO provider which are sent to a non-PPO lab or x-ray facility will be reimbursed at the PPO benefit level. This includes radiology services and pathology services.*
- 2) *Non-PPO surgeons and other providers who render services at a PPO or non-PPO facility, whether referred by a PPO or non-PPO provider will be treated as out-of network benefit coverage. The only exceptions to this provision are anesthesiologists and emergency room physicians providing care at an in-network inpatient hospital, where even as out-of network physicians, they would be reimbursed as in-network.*
- 3) *If a covered person obtains services at a non-network hospital due to a medical emergency, the eligible claims will be paid at the network benefit level.*
- 4) *All eligible claims paid for services outside the United States will be paid at the in-network level of benefits at the exchange rate for the date of service. Note, the only coverage provided outside the United States is for medical emergencies, unless the covered person is permanently stationed overseas when the full schedule of benefits applies.*
- 5) *If a covered person resides more than 50 miles from a PPO facility, claims incurred from a non-PPO facility will be paid at the PPO benefit level.*

**P5 Health Plan Solutions
Claims & Customer Service
Toll-free number: 800-922-1855, prompt 1
Website: www.p5health.com**

**Beech Street
Toll-free number: 866-922-1855
Website: www.beechstreet.com**

**Interplan
Toll-free number: 800-444-4036
Website: www.interplanhealth.com**

**First Choice of the Midwest
Toll-free number: 888-246-9949
Website: www.1choicem.com**

**MedCost
(Through America Healthcare Alliance)
Toll-free number: 800-824-7406
Website: www.medcost.com**

**Delta TeamCare
Health Care Management Program
Toll-free number: 800-922-1855, prompt 2
Website: www.p5health.com**

**Idaho Physician Network (IPN)
Toll-free number: 866-476-1076
www.ipnmd.com**

**Valley Preferred
Toll-free number: 800-955-6620
Website: www.valleypreferred.com**

**PHCS
Toll-free number: 800-546-3887
Website: www.phcs.com**

**Arizona Foundation
Toll-free number: 602-252-4042 (inside
Maricopa County) -- 800-624-4277 (outside
Maricopa County)
Website: www.azfmc.com**

ELIGIBILITY AND PARTICIPATION

Who Is Eligible

You are eligible to participate in this plan if you are a regular, full-time *employee* of the *employer* and are regularly scheduled to work a minimum of 30 hours per week. Note: part-time *employees* may only be covered under the “Accident Reimbursement Plan” (*employee* only coverage). Eligibility for *Medicaid* or the receipt of *Medicaid* benefits will not be taken into account in determining eligibility.

Your eligible dependents may also participate. Eligible dependents include: your legally married spouse of the opposite gender, excluding any common law marriage under state law; natural children; stepchildren; children who, before reaching the age of 18, are either adopted by you or placed in your home for adoption as determined under applicable state law; and children for whom you are legal guardian. A dependent child must be unmarried and rely on you for over one-half of his/her support (as described in Section 152 of the Internal Revenue Code and proof of such may be required). Dependent children remain eligible until age 25.

If a dependent child is enrolled in the plan and is *physically or mentally disabled* on the date coverage would otherwise end, the child's eligibility will be extended for as long as you are covered by this plan, the disability continues and the child continues to qualify for coverage in all aspects other than age. The plan may require you at any time to obtain a *physician's* statement certifying the *physical or mental disability*. Coverage continued under this provision is in addition to coverage described under the section entitled “Optional Continuation of Coverage (COBRA).”

You may not participate in this plan as both an *employee* and a dependent. If both you and your spouse are employed by Employers Resource your dependents may be covered under you or your spouse, but not under both.

If your *employer* determines that your separated or divorced spouse or any state child support or *Medicaid* agency has obtained a legal qualified medical child support order (QMCSO), through a court order or an administrative process established under state law, you will be required to provide coverage for any child(ren) named in the QMCSO. If a QMCSO requires that you provide health coverage for your child(ren) and you do not enroll the child(ren), your *employer* must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or *Medicaid* agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your *employer* that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). You may obtain, without charge, a copy of the procedures utilized by the *plan sponsor* to determine if a child support order satisfies the requirements of a QMCSO.

If you are not enrolled for coverage, you will be required to enroll along with the child and your share of the cost of such coverage will be withheld from your pay.

Who Pays For Your Benefits

Employers Resource shares the cost of providing benefits for you and your dependents. From time to time, Employers Resource may adjust the amount of contributions required for coverage. In addition, the

deductibles and co-payments may also change periodically. You will be notified of any changes in the cost of plan coverage before they take effect.

General Enrollment Requirements and Election Information

You must enroll for coverage within 31 days of your eligibility date. If you desire dependent coverage, you must enroll your eligible dependents at this time. If you do not have any eligible dependents at the time of initial enrollment, but acquire eligible dependents at a later date, including by birth, you must enroll the dependent(s) within 60 days of the date you acquire them. To enroll, you must complete and return any enrollment forms required or provided by your *employer* within the applicable time period. You may also enroll yourself or your eligible dependents during the annual open enrollment period. You are required to obtain and provide your *employer* with a Social Security number for each covered dependent. In addition, acceptable proof of dependent status, as determined by the plan, must be submitted upon request.

Immediate sickness coverage, from and after the moment of birth shall be provided to each newborn child or infant of any covered family, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is so placed. To continue coverage beyond sixty (60) days, you must enroll the newborn or adopted child within sixty (60) days of birth or placement. Your claim for newborn maternity expenses is not considered an acceptable form of notification to your *employer* for enrollment of your newborn child to continue coverage beyond sixty (60) days.

Right to Recovery

If a newborn child or adopted child is not enrolled after the first sixty (60) days and claims are paid for expenses incurred within the first sixty days, the Plan as the right to recover these expenses from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered. Refer to the Recovery of Excess Payments section for more information.

Changes in Status

You are allowed to change your enrollment elections during a *benefit year* if you have a qualifying change in status. If you have a qualifying change in your status, you may change your enrollment decision within 60 days of the change in status by notifying your *employer* and completing and returning any required forms. Your change in enrollment election must be "consistent" with your change in status. In other words, you may only change your election if the change in status causes you, your spouse or your dependent child to gain or lose eligibility for coverage under this or another plan, and the election change must be on account of and correspond with the change of status. For example, if you gained a spouse through marriage, adding the spouse to coverage under this plan would be consistent with that event. This "consistency" requirement is established by federal tax law under a complex set of regulations. The *employer* in its sole discretion shall determine, based on prevailing IRS guidelines, whether a requested coverage change satisfies the consistency requirement.

A qualifying change in status is any of the following events (as well as any other events included under subsequent changes to Internal Revenue Code Section 125 or accompanying regulations that the plan administrator, in its sole discretion, decides to recognize on a uniform and consistent basis):

- Change in the Employee’s Legal Marital Status – including marriage, divorce, death of spouse, legal separation, and annulment of marriage;
- Change in Number of Dependents – including birth, adoption or placement of a child for adoption, and death;
- Change in Employment Status – any of the following events that change the employment status of you, your spouse or your dependent child: termination or commencement of employment; a reduction or increase in hours of employment, including a switch between part-time and full-time, a strike, or lockout, commencement or return from an unpaid leave of absence, or a change in work site;
- Dependent Eligibility Requirements – an event that causes your dependent child to satisfy or cease to satisfy the dependent eligibility requirements of the plan due to attainment of age, gain or loss of student status, marriage or similar circumstances;
- Change in Residence – a change in residence for you, your spouse or your dependent child;
- Change in Cost/Coverage – a significant change in cost or a significant curtailment of health coverage for you, your spouse or your child;
- HIPAA Special Enrollment Events – a special enrollment event under the Health Insurance Portability and Accountability Act (“HIPAA”), as explained in more detail under “HIPAA Special Enrollment Rights” below;
- Judgments, Decrees, Orders – issuance of a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody (such as a Qualified Medical Child Support Order (QMCSO)) that requires health coverage for your dependent child; or
- Entitlement to *Medicare/Medicaid* – you, your spouse or your child becomes entitled to either *Medicaid* or *Medicare* or loses entitlement to either *Medicaid* or *Medicare*.

When Coverage Begins

When the enrollment requirements are met, coverage for you and your dependents begins on the first day of the month following eligibility.

HIPAA Special Enrollment Rights

As required by federal law, the plan provides a special enrollment right in the following two circumstances:

1. **Loss of Other Coverage.** If you decline coverage under this plan for yourself or your dependents because of other health plan coverage, and provide written notice to the plan that you are declining coverage due to the existence of other coverage, and such other health plan coverage is subsequently terminated due to:

- (a) a loss of eligibility for such coverage (loss of eligibility does not include a loss due to: failure to pay premiums when due; failure to exhaust COBRA continuation coverage, if elected; or causes such as making a fraudulent claim or misrepresentation); or
- (b) termination of any company contributions for such coverage;

then you and/or your eligible dependents who have lost such coverage may enroll in the plan.

2. **New Dependents.** If you acquire a new dependent as a result of marriage, birth, adoption or placement for adoption, you and/or your newly eligible dependents may enroll in this plan. In the case of the birth, adoption, or placement for adoption of a dependent child, your spouse may also enroll if he/she is otherwise eligible for coverage. Immediate accident and sickness coverage, from and after the moment of birth, to each newborn child or infant of any covered family covered, including a newborn child placed with the adoptive covered family within sixty (60) days of the adopted child's date of birth. Coverage under the self-funded plan for an adopted newborn child placed with the adoptive covered family more than sixty (60) days after the birth of the adopted child shall be from and after the date the child is placed. Coverage provided in accordance with this section shall include, but not be limited to, coverage for congenital anomalies. For the purpose of this section, "child" means an individual who has not reached eighteen (18) years of age as of the date of the adoption or placement for adoption. For the purpose of this section, "placed" shall mean physical placement in the care of the adoptive covered family, or in those circumstances in which such physical placement is prevented due to the medical needs of the child requiring placement in a medical facility, it shall mean when the adoptive covered family signs an agreement for adoption of such child and signs an agreement assuming financial responsibility for such child. Prior to legal finalization of adoption, the coverage required under the provisions of the subsection (1) as to a child placed for adoption with a covered family continues in the same manner as it would with respect to a naturally born child of the covered family until the first to occur of the following events:

- a) Date the child is removed permanently from the placement and the legal obligation terminates or;
- b) The date the covered family rescinds in writing, the agreement of adoption or agreement assuming financial responsibility. No such plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of covering relative to the coverage or insurability of the newborn or adopted children or infants of a covered family covered from and after the moment of birth that is inconsistent with the provisions of this section.

To enroll under either of these special enrollment rights, you must notify your *employer* and complete and return any required forms within 60 days of the underlying event, e.g., loss of other coverage, date of the marriage, birth, adoption or placement for adoption. Coverage will generally begin on the first day of the calendar month following the timely enrollment request. Coverage for newborns, adopted children and children placed for adoption will begin as of the date of birth, adoption or placement for adoption.

CHIP Special Enrollment Rights

The Children's Health Insurance Program Reauthorization Act of 2009 (as amended) provides a special enrollment right in the following circumstances:

1. The employee or dependent covered under Medicaid or CHIP has coverage terminated as a result of loss of eligibility, or;

2. The employee or dependent becomes eligible for Medicaid or CHIP assistance.

To enroll under either of these special enrollment rights, you must notify your *employer* and complete and return any required forms within 60 days of the determination of eligibility. Coverage will generally begin on the first day of the calendar month following the timely enrollment request.

Late Enrollment

If you or your dependents do not timely enroll upon initial eligibility or a special enrollment right, you may enroll for coverage only during the annual open enrollment period.

Open Enrollment

Each *year*, during the month of October/November (as applicable), there is an open enrollment period designated by your *employer* during which you may change your benefit elections under the plan and eligible *employees* who previously declined to enroll in the plan may enroll themselves and any eligible dependents.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a change in status or a special enrollment right. Those who fail to make an election during open enrollment will automatically be enrolled in default coverage as indicated on the applicable Enrollment Form.

You will receive detailed information regarding open enrollment from your *employer*.

Pre-Existing Conditions

A pre-existing condition is any *illness* or *injury* (excluding pregnancy) for which medical advice, diagnosis, care or treatment (including prescribed drugs or medicines) has been recommended by or has been received from a *physician* or *practitioner* during the 6 months immediately prior to your *enrollment date*. Genetic information is not an excludable condition in the absence of a diagnosis of the condition related to the genetic information.

If you or your dependents have a pre-existing condition, related expenses will not be covered if they are incurred within 12 consecutive months or 18 consecutive months for late enrollees from your *enrollment date*.

The pre-existing condition limitation period will be reduced by any creditable coverage (not including any coverage preceding a break in coverage of 63 days or more) determined to exist under a previous health plan. The reduction of the pre-existing condition limitation period is illustrated by the following example:

Bob is a new employee who begins work after 14 days of unemployment and enrolls in this medical plan as outlined in the enrollment requirements. Bob was covered under his previous employer's medical plan for 4 ½ months (134 days, to be exact). Bob obtains a certificate of creditable coverage from his prior employer and submits it to his new employer, thus documenting his prior medical coverage. His new employer determines he indeed has prior

creditable coverage because he did not have a break in coverage greater than 63 days. Bob's pre-existing condition limitation under this plan is thus reduced by 4 ½ months (134 days).

The determination regarding the length of any pre-existing condition limitation period that applies to you and/or your dependents will be made within a reasonable time following receipt of a certificate of coverage or other accurate and reliable information relating to prior creditable coverage. You will be notified of this determination and the basis relied upon in support for such determination. Please see your *employer* for assistance in requesting and obtaining a certificate of coverage from any prior plan or issuer.

The pre-existing condition limitation does not apply to pregnancy. The pre-existing condition does not apply to newborn children or to a child who is adopted or placed for adoption before attaining age 18.

These limitations on coverage of pre-existing conditions are intended to comply with at least the minimum requirements of the Health Insurance Portability and Accountability Act of 1996 (H.R. 3103). If they are incomplete or in conflict with the Act in any way, the Act will prevail.

When Coverage Ends

Your coverage ends the earliest of the end of the month in which your employment with Employers Resource ends, the end of the month in which contributions cease, the date you are no longer eligible to participate in this plan, the date this plan ends or the date a Co-employer and Employers Resource cease to be parties to the Client Service Agreement or other written agreement through termination of such Agreement by any means whatsoever.

Coverage for your dependents ends the earliest of the end of the month in which your coverage ends, the end of the month in which a dependent no longer meets the eligibility requirements, the end of the month in which contributions cease, the date this plan ends or the date a Co-employer and Employers Resource cease to be parties to the Client Service Agreement or other written agreement through termination of such Agreement by any means whatsoever.

In certain circumstances, when you or an eligible dependent would otherwise lose coverage, you and/or they 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 "Optional Continuation of Coverage."

Special Situations, Extension of Coverage

Family And Medical Leave Act (FMLA)

If you qualify for an approved family or medical leave of absence (as defined in the Family Medical Leave Act of 1993, as amended), eligibility may continue for the duration of the leave if you pay any required contributions toward the cost of the coverage. Your *employer* has the responsibility to provide you with prior written notice of the terms and conditions under which payment must be made. Failure to make payment within 30 days of the due date established by your *employer* will result in the termination of coverage. Subject to certain exceptions, if you fail to return to work after the leave of absence, your *employer* has the right to recover from you any contributions toward the cost of coverage made on your behalf during the leave, as outlined in the FMLA.

If coverage is terminated for failure to make payments while you are on an approved family or medical leave of absence (as defined in the FMLA), coverage for you and your eligible dependents will be automatically reinstated on the date you return to employment if you and your dependents are otherwise eligible under the plan. The pre-existing condition limitation and any waiting periods will not apply. However, all accumulated annual and *lifetime* maximums will apply. Coverage continued under this provision is in addition to coverage described under the section entitled “Optional Continuation of Coverage (COBRA).”

The plan intends to comply with all existing FMLA regulations. The plan reserves the right to administer the FMLA in accordance with federal law. See Human Resources for complete detail on the FMLA leave policy and for all appropriate forms.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

As used in this provision, “Uniformed Services” means:

- The Armed Forces;
- The Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty (pursuant to orders issued under federal law);
- The commissioned corps of the Public Health Service; and
- Any other category of persons designated by the President in time of war or national emergency.

As used in this provision, “Service in the Uniformed Services” or “Service” means the performance of a duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes:

- Active duty;
- Active duty for training;
- Initial active duty training;
- Inactive duty training;
- Full-time National Guard duty,
- A period for which you are absent from your job for purpose of an examination to determine your fitness to perform any such duties;
- A period for which you are absent from your job for the purpose of performing certain funereal honors duty; and
- Certain service by intermittent disaster response appointees of the National Disaster Medical System (NDMS).

If you were covered under this plan immediately prior to taking a leave for Service in the Uniformed Services, you may elect to continue your coverage under USERRA for up to 24 months from the date your leave for uniformed service began, if you pay any required contributions toward the cost of the coverage during the leave. This USERRA continuation coverage will end earlier if one of the following events takes place:

- 1) You fail to make a premium payment within the required time;
- 2) You fail to report to work or to apply for reemployment within the time period required by USERRA following the completion of your service; or
- 3) You lose your rights under USERRA, for example, as a result of a dishonorable discharge.

If the leave is 30 days or less, your contribution amount will be the same as for active *employees*. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

Coverage continued under this provision runs concurrently with coverage described below under the section entitled “Optional Continuation Coverage (COBRA).”

If your coverage under the plan terminated because of your Service in the Uniformed Services, your coverage will be reinstated on the first day you return to employment if you are released under honorable conditions and you return to employment within the time period(s) required by USERRA.

When coverage under this plan is reinstated, all of the plan’s provisions and limitations will apply to the extent that they would have applied if you had not taken military leave and your coverage had been continuous. The eligibility waiting period will be waived and the pre-existing condition limitation will be credited as if you had been continuously covered under this plan from your original effective date. This waiver of limitations does not provide coverage for any *illness* or *injury* caused or aggravated by your military service, as determined by the VA. (For complete information regarding your rights under USERRA, contact your *employer*.)

The plan intends to comply with all existing regulations of USERRA. If for some reason the information presented in the plan differs from the actual regulations of USERRA, the plan reserves the right to administer the plan in accordance with such actual regulations.

Medical Plan Coverage for College Students on Leaves of Absence (Michelle’s Law)

Under a federal law, an employer’s health plan must allow a dependent student to remain eligible for health plan coverage during a qualified leave of absence from school, or other enrollment change, due to an illness or injury. Eligibility may be extended for up to one year. (The student’s coverage may terminate for other reasons during that time, for example, due to the employee’s termination of employment.)

COBRA will not be triggered when an ill or injured child is no longer a full-time student. The child simply will not lose coverage for up to one year while on a medical leave of absence or while enrolled less than full-time. You would continue to pay the usual cost for dependent coverage, not the more expensive COBRA rate. At the end of a one-year leave of absence, if the child still cannot reenroll as a full-time student, then the child loses coverage, and the plan will offer COBRA continuation for up to 36 months.

This continued coverage applies to a dependent child enrolled in college, a university, a vocational school, or other similar institution of higher learning. A medical leave of absence, or other change from full-time status, is considered “qualified” and extends eligibility when it is medically necessary due to the child’s illness or injury. The child’s treating physician must sign a statement that the student is taking a leave of absence that is medically necessary. The plan will take steps to protect the plan and to prosecute wrongdoing in the event of any misrepresentation by the physician, employee, or student, including termination of employment of the employee for gross misconduct.

Other Leave of Absence and Workers Compensation

If an employee ceases to be actively at work on a full time basis due to non FMLA issues, the employee’s coverage may be continued at the written option of the Co-employer until the employee recovers or returns to work, but not beyond (60) calendar days after the end of the month when cessation of active full-time employment occurs.

Rehiring a Terminated Employee

If you terminate employment for any reason and are rehired within 30 days, coverage may be reinstated on the date you are rehired, if the enrollment requirements are met. All accumulated annual and *lifetime* maximums will apply. If you terminate employment and are rehired more than 30 days after the date of the loss of benefits, you will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. The pre-existing condition limitation and all accumulated annual and *lifetime* maximums will apply.

DELTA TEAMCARE HEALTH CARE MANAGEMENT PROGRAM

Delta TeamCare

Your health benefit plan includes a comprehensive care management package provided to covered employees and covered dependents at no out-of-pocket expense. These services are referred to as Delta TeamCare.

The services provided to you through Delta TeamCare are an important part of your benefit plan. These services include:

- Resources, assistance, and information about your treatment options
- Help in understanding your benefits
- Help in reducing your out-of-pocket expenses
- Coordinating care with your *physician*

Delta TeamCare services are provided to empower you to make informed decisions about your own health care. The services are 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*. The final decision regarding health care always remains with you and your *health care provider*.

Professional Review Staff

The Delta TeamCare staff of *physicians, nurses, and other health care providers* is both clinically experienced and highly skilled in medical care/cost management. The staff works together, with you, your family participants, and your *health care providers* to ensure that the services you are receiving satisfy the plan's *medical necessity* requirement. In certain instances, a Case Management nurse will be available to assist you.

The Pre-certification Requirement

You or your provider must pre-certify the following services and supplies with Delta TeamCare at least 48 hours in advance of you or a covered dependent receiving them:

1. Hospital/Inpatient Admissions. All *inpatient* admissions to any *hospital or inpatient facility* (e.g., *community hospital, psychiatric hospital*).
 - Guidelines are:
 - i. Non-emergency hospital admissions (at least 7 days prior to admission);
 - ii. Emergency hospitalization (within 2 business days of admission).
2. *Outpatient Surgery* when performed at an outpatient *hospital* or surgical facility.
3. All MRIs and CT Scans.
4. *Durable Medical Equipment* over \$1,000.
5. Treatment for Treatment Excellence conditions as defined in the Schedule of Benefits.

Delta TeamCare will analyze your *physician's* plan of treatment as it applies to the plan's requirements (for example, the *medical necessity* requirement), and may be able to coordinate medical services and advise you regarding more appropriate use of your health benefits, which will help reduce your out-of-pocket expenses. The benefit payable will be reduced by \$500 if you do not follow the procedures outlined in the Delta TeamCare Health Care Management section of the plan. Penalties for failure to pre-certify will not apply to any out of pocket maximum.

How It Works

Pre-certification is required for Hospital/Inpatient Admissions and this includes all inpatient admissions to any *hospital* or *inpatient* facility (e.g., community hospital, psychiatric hospital, or residential treatment facility).

Guidelines are:

- * Non-emergency hospital admissions (at least 7 days prior to admission);
- * Emergency hospitalization (within 2 business days of admission).

Who should pre-certify depends on the facility. If it is an in-network facility the provider should pre-certify the stay. If it is an out-of-network facility you, the participant should pre-certify. It is always in the participant's best interest to make sure this is done regardless of the facility so that no reduced benefits apply due to not pre-certifying.

The number to call for pre-certification is: 800-922-1855.

Delta TeamCare will analyze your physician's plan of treatment as it applied to the plan's requirements (for example, the medical necessity requirement), and may be able to coordinate medical services and advise you regarding more appropriate use of your health benefits, which will help reduce your out-of-pocket expenses.

Continued Stay Review

During a hospitalization, a Delta TeamCare Nurse Reviewer will contact the *hospital* to check on your status and coordinate any needs you may have in your transition out of the *hospital*. Should you need to remain hospitalized longer than originally precertified, the *hospital* or your *physician* may be contacted for additional information. Any additional *hospital* days will be reviewed for *medical necessity*.

Penalty for Failure to Pre-certify

When the required review procedures are followed for pre-certifying *inpatient, outpatient and other procedures listed*, your benefits will be unaffected. **However, if you do not follow the pre-certification procedures outlined above, the benefit payment percentage indicated in the Schedule of Medical Benefits will be reduced by \$500 per admission.** Penalties for failure to precertify will not apply to any out of pocket maximum.

No benefits will be provided for proposed procedures/supplies that are not *medically necessary* or do not otherwise satisfy plan requirements as determined by Delta TeamCare during the precertification process.

Not a Guarantee of Benefits

No benefits will be provided for proposed procedures/supplies that are not *medically necessary* or do not otherwise satisfy plan requirements as determined by Delta TeamCare during the precertification process.

Pre-certification by Delta TeamCare is not a guarantee of benefits. Related benefits are still subject to all of the other terms, conditions, limitations and exclusions of the plan.

Case Management Services

Case Management is a valuable resource that is a benefit to you through Delta TeamCare. The goal of Case Management is to help you achieve a positive health outcome through participant education, referral coordination, and individual treatment planning. A staff of registered *nurses* and *physicians* will assist you and/or a family participant in understanding the complexities of health care. You may contact your Case Management resources at any time. A case manager may also contact you (see Risk Indexing below). Case Management services are voluntary. If appropriate, and approved by your *plan administrator*, a case manager will be assigned to work with you and your *health care providers* to facilitate a treatment plan.

As part of the Case Management process, benefits may be modified by the *plan administrator* on an individual exception basis to permit a benefit not otherwise provided for by the plan, if the *plan administrator* determines, in its sole discretion, that such modification is *medically necessary* and is more cost-effective than the benefit to which you or your eligible dependents would otherwise be entitled. The *plan administrator* also reserves the right to limit payment for services to those amounts which would have been charged had the service been provided in the most cost-effective setting in which the service could safely have been provided.

Risk Indexing

Risk Indexing, a participant health management service, is an evaluation of claims and pharmacy data to identify those participants who could potentially benefit from case or disease management. Those identified are offered the opportunity to participate in these programs (See Case Management above). These programs promote quality care and access to *medically necessary* services throughout the course of healthcare treatment. Employers Resource will offer \$100 incentive if you choose to participate in the disease management program for 1 year.

Maternity Management – “Tomorrow’s Child” for High Risk Pregnancies only

Your health plan also includes maternity management services called Tomorrow’s Child. Tomorrow’s Child provides a prevention-focused approach to early identification, intervention and management of pregnancy complications, with the goal to help expectant women achieve a full-term pregnancy and improve newborn outcomes. Tomorrow’s Child’s nurses provide immediate consultation, education, referral and support services throughout the participant’s pregnancy. Each expectant woman is assigned a personal maternity case manager who is a registered nurse specializing in OB/GYN services. The program delivers:

- Maternity handbook

- Monthly personal telephone contact and follow-up
- Health and risk assessment with the mother and physician
- Coordination and collaboration with physician or health care provider
- Psychosocial support and referral
- Treatment compliance monitoring
- Information and referral to community resources
- Postpartum follow-up and assessment
- Lactation education and follow-up

Tomorrow's Child is available throughout your pregnancy via a toll-free line to answer your questions and listen to your concerns. You are encouraged to contact Tomorrow's Child at **800-922-1855, prompt 2**, as soon as your pregnancy is confirmed to enroll in this valuable program.

Newborns' and Mothers' Health Protection Act of 1996

In accordance with federal law, the plan does not restrict benefits for any *hospital* length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan may pay for a shorter stay if the attending provider (e.g., your *physician, nurse* midwife, or *physician* assistant), after consultation with the mother, discharges the mother or newborn earlier.

The plan does not set the level of benefits or out-of-pocket costs so that any later portion of the 48 hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, the plan does not require that a *physician* or other *health care provider* obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain precertification. For information on precertification, contact your *plan administrator*.

The Women's Health and Cancer Rights Act of 1998

In the case of an employee or dependent who receives benefits under the plan in connection with a mastectomy and who elects breast reconstruction (in a manner determined in consultation with the attending physician and the patient), coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Benefits will be subject to the same cost-sharing (deductible, co-payment, co-insurance) provisions as apply to the mastectomy.

PREFERRED PROVIDER ORGANIZATION (PPO)

What Is a PPO

A *preferred provider organization (PPO)* has made agreements with *hospitals, physicians* and other *health care providers* to discount the services they provide.

Who Is Your PPO

Employers Resource has chosen Arizona Foundation, BeechStreet, Idaho Physicians Network (IPN), Interplan, Valley Preferred, First Choice of the Midwest, MedCost and PHCS to provide *PPO* services for you and your eligible dependents. You can get more detailed information about this *PPO* and its most up-to-date list of participating *physicians* and *hospitals* at:

www.azfmc.com

www.beechstreet.com

www.ipnmd.com

www.interplanhealth.com

www.valleypreferred.com

www.1choicem.com

www.medcost.com

www.phcs.com

About Your PPO

BeechStreet, Idaho Physicians Network (IPN), Interplan, Multiplan, Valley Preferred, First Choice of the Midwest, MedCost and PHCS have selected the participating *physicians* and *hospitals* after carefully reviewing their qualifications. Each *health care provider* has agreed to reduced amounts in payment for their services. Consequently, you and your dependents will typically be provided care at a fee significantly less than is common in the geographic area in which you live and may enjoy a higher level of benefits under the plan. Additionally, when you utilize these *PPO* providers, you cannot be “balance billed” by your *PPO* provider for any amounts over the negotiated *PPO* rate.

The final choice of *health care providers* is yours. However, if you receive services from a *health care provider* included in the *PPO*, the plan's benefit percentage payable may be increased, which may decrease the amount you must pay.

The *PPO* benefits are outlined on the Schedule of Medical Benefits. *PPO* and non-*PPO* plan deductibles, out-of-pocket maximums, and plan benefit maximums are combined.

MEDICAL BENEFITS

Deductibles

A deductible is the amount of covered expenses you must pay during each *year* before the plan will consider expenses for reimbursement. The individual deductible applies separately to each covered person. The family deductible applies collectively to all covered persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family participant during the remainder of that *year*.

The annual individual and family deductible amounts are shown on the Schedule of Medical Benefits.

Benefit Percentage Payable

Benefit percentage payable represents the portion of covered expenses paid by the plan after you have satisfied any applicable deductible. These percentages apply only to covered expenses which do not exceed *usual and customary charges*. You are responsible for all remaining covered and non-covered expenses, including any amount which exceeds the *usual and customary charge* for covered expenses.

The benefit percentages payable are shown on the Schedule of Medical Benefits.

Co-Payments

Co-payments are the first-dollar amounts you must pay for certain covered services under the plan, which are usually paid at the time the service is performed (i.e. *physician* office visits or emergency room visits). These co-payments do not apply to your annual deductible or out-of-pocket maximum, unless specified on the Schedule of Medical Benefits.

The co-payment amounts are shown on the Schedule of Medical Benefits.

Out-Of-Pocket Maximums

An out-of-pocket maximum is the maximum amount of covered expenses you must pay during a *year*, including the deductible, before the plan's benefit percentage payable increases. The individual out-of-pocket maximum applies separately to each covered person. When a covered person reaches the annual out-of-pocket maximum, the plan will pay 100% of additional covered expenses for that individual during the remainder of that *year*.

The family out-of-pocket maximum applies collectively to all covered persons in the same family. When the annual family out-of-pocket maximum is reached, the plan will pay 100% of covered expenses for any covered family participant during the remainder of that *year*.

However, expenses for services, which do not apply to the out-of-pocket maximum, will never be paid at 100%.

The annual individual and family out-of-pocket maximum amounts are shown on the Schedule of Medical Benefits.

Claims Edit System and Industry Standard Modifiers

All claims will be sent through a claims edit system and plan payments will be based upon system review of the appropriateness of CPT coding including, but not limited to, bundling and unbundling of CPT code combinations, gender-appropriate procedure codes, appropriateness of multiple office visits on the same day, and *medical necessity*. Also, on occasion your *health care provider* will submit charges containing industry-standard modifiers along with certain procedure codes. When this occurs, the plan will reduce its payment for these charges by an industry-standard percentage of the negotiated *PPO* rate for *PPO* services and supplies or at a percentage of the *usual and customary charge* for non-*PPO* services and supplies.

Benefit Maximums

Total plan payments for each covered person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum amount also applies to a specific time period, such as annual or *lifetime*. Whenever, the word *lifetime* appears in this plan in reference to benefit maximums, it refers to the period of time you or your eligible dependents participate in this plan or any other plan sponsored by Employers Resource.

The benefit maximums applicable to this plan are shown on the Schedule of Medical Benefits.

COVERED MEDICAL EXPENSES

When all of the provisions of this plan are satisfied, the plan will provide benefits as outlined on the Schedule of Medical Benefits for the services and supplies listed in this section. To fully understand your benefits as well as plan rules, limitations and exclusions, you must read all applicable provisions of this plan including the Schedule of Benefits. This list is intended to give you a general description of expenses for services and supplies covered by the plan.

All benefits provided under this plan must satisfy some basic conditions. The following conditions are commonly included in health benefit plans but are often overlooked or misunderstood. See the “Definitions” section for more information about these important terms.

Health Care Providers

The plan provides benefits only for covered services and supplies rendered by a *physician, practitioner, nurse, hospital or specialized treatment facility* as those terms are specifically defined in the “Definitions” section.

Medical Necessity

The plan provides benefits only for covered services and supplies that are *medically necessary* for the treatment of a covered *illness or injury*. Also, the treatment must not be *experimental/investigational*.

Usual and Customary Charges (Non-PPO Claims)

The plan provides benefits only for covered expenses that are equal to or less than the *usual and customary charge* in the geographic area where services or supplies are provided. Any amounts that exceed the *usual and customary charge* are not recognized by the plan for any purpose and are the responsibility of the patient.

Hospital Services

- Semi-private room and board expenses.
- Private room and board expenses, limited to 80% of the facility’s private room rate.
- *Intensive care unit* and coronary care unit charges.
- Miscellaneous *hospital* services and supplies required for treatment.
- Plan pays the lesser of any contracted rate or invoice +20% of the cost for a surgically implanted device.
- Well-baby nursery, *physician* and initial exam expenses during the initial *hospital* confinement of a newborn. Expenses for the newborn will be considered separately from the mother's expenses.
- Expenses for treatment of a sick newborn during the initial *hospital* confinement. Expenses for the newborn will be considered separately from the mother's expenses.
- *Outpatient hospital* services, including lab and x-ray services.

Emergency Services

- Treatment in a *hospital* emergency room or other emergency care facility for a condition that can be classified as a *medical emergency*. Use of an emergency room for treatment of a condition other than a *medical emergency* is not covered under this plan.
- Ground or air transportation provided by a professional ambulance service to and from (limited to one return trip per *year*) a *hospital* or emergency care facility which is equipped to treat a condition that can be classified as a *medical emergency*.
- Treatment of an *accident* in a *hospital* or other emergency care facility.

Specialized Treatment Facilities

- A *skilled nursing facility*, limited to 90 days per *year*, as outlined on the Schedule of Medical Benefits.
- A *rehabilitation facility*.
- An *ambulatory surgical facility*.
- An *urgent care facility*.
- A *birthing center*.
- A *hospice facility*.

Surgical Services

- Surgeon's expenses for the performance of a surgical procedure, subject to the following:
 1. Procedures requiring the skill of co-surgeons. The amount eligible for consideration is 125% of the eligible charge divided evenly between the two surgeons (each surgeon will receive **62.5%** of the eligible charge).
 2. Multiple surgical procedures performed by the same *physician* during the same surgical session. The amount eligible for consideration is 100% of the maximum eligible charge for the primary procedure, 50% for the secondary procedure, and 25% for all subsequent procedures. The *surgery* with the greatest eligible charge on the claim is considered the primary surgical procedure, the next highest is the secondary surgical procedure, etc. Procedures that are performed concurrently with and are clinically an integral part of the primary procedure will not be reimbursed separately. The fees for any incidental procedure will be denied.
 3. Two or more surgical procedures performed during the same session through different incisions, natural body orifices or operative fields. The amount eligible for consideration is the sum of eligible charges for each procedure performed. 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.
 4. If two or more surgical procedures are performed by two (2) or more surgeons on separate operative fields, benefits will be based on the eligible 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 eligible charge allowed for that procedure.
- Assistant surgeon's expenses not to exceed 20% of the eligible charge of the surgical procedure.
 - Anesthetic services, when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.
 - *Oral surgery*, only if medically necessary and not covered under dental plan.
 - *Reconstructive surgery* when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part, in connection with mammoplasty, or for an accidental *injury*, unless specifically excluded elsewhere in this plan.
 - Breast reconstruction following a total or partial mastectomy. Benefits include prostheses and reconstruction of the non-diseased breast to restore symmetry.
 - *Medically necessary* removal of breast or other prosthetic implants, only if they were not inserted in connection with *cosmetic surgery*.
 - Surgical reproductive sterilization.
 - Human organ and tissue transplants, if the transplant is *medically necessary* and not *experimental/investigational*, limited to heart, heart/lung, liver, kidney, kidney/pancreas, allogeneic and autologous bone marrow transplants (but with respect to allogeneic and autologous bone marrow transplants only in connection with treatment for leukemia). All organ and tissue transplants must be performed in a Life Trac facility and are subject to the following limitations:
 - a) The maximum benefit for all transplant procedures performed during a covered person's lifetime is shown in the Schedule of Medical Benefits.
 - b) Charges for obtaining donor organs or tissues are covered charges under the plan when the recipient is a covered person. When the donor has medical coverage, his or her plan will pay first. The benefits under this plan will be reduced by those payable under the donor's plan. Donor charges include those for:
 - evaluating the organ or tissue;
 - removing the organ or tissue from the donor; and
 - transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.
 - c) If both the donor and the recipient are covered under this plan, eligible medical expenses incurred by each person will be treated separately for each person.
 - d) No amounts shall be payable by the plan for travel or lodging involved in the transplant, except as provided under the ambulance benefit of the plan.
 - Expenses related to insertion or maintenance of an artificial heart, only if not *experimental/investigational*.
 - Circumcision.

- *Outpatient surgery.*
- Podiatry *surgery*, limited to open cutting procedures of the foot.
- Plan pays the lesser of any contracted rate or invoice +20% of the cost for a surgically implanted device.

Medical Services

- *Physician office visits.*
- *Inpatient physician visits.*
- *Second surgical opinions.*
- Treatment Excellence opinions.
- Pregnancy-related care for a female employee or spouse. Pursuant to federal law, the plan does not restrict benefits for any *hospital* length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section.
- Treatment of *complications of pregnancy* for a female employee or spouse.
- Termination of pregnancy, for a female employee or spouse, only when the life of the mother would be endangered if the fetus were carried to term.
- *Chiropractic services/alternative care services*, including related x-rays, limited to a combined 12 visits per *year*. Chiropractic services from any licensed chiropractic practitioner. Benefits include related x-rays. Alternative care, oriental medicine, acupuncture, Chinese herbology through an accredited practitioner. Benefit includes practitioner fee only, no supplies.
- Radiation therapy.
- Chemotherapy.
- Physical therapy from a qualified *practitioner*.
- Non-custodial services of a *nurse* which are not billed by a *home health care agency*. Benefits include *inpatient* private-duty nursing, if *medically necessary*.
- Home health care provided by a *home health care agency*, limited to 100 visits per *year*, as outlined on the Schedule of Medical Benefits.
- *Home hospice.*
- Physical therapy.
- Speech therapy from a qualified *practitioner* to restore speech loss due to an *illness, injury* or surgical procedure.

- Occupational therapy.
- Treatment of diabetes. Diabetic education and nutritional counseling limited to a \$500 annual maximum.
- Dialysis.
- Treatment of sleep apnea.
- Biofeedback, only when performed by a *physician*.
- Bereavement counseling.
- *Medically necessary*, non-surgical treatment of the feet, including treatment of metabolic or peripheral-vascular disease. Refer to Medical Expenses Not Covered for exclusions.
- Allergy injections, including serum.
- Smoking cessation services or supplies as outlined on the schedule of medical benefits.
- Covered Supplements, as follows:

The Plan reimburses natural supplements as listed in the Schedule of Medical Benefits. This includes nutrients and food extracts such as vitamins, minerals, essential fatty acids, nutraceuticals (ie. Vitamin C), botanical or herbal medicines, extracts, phytochemicals and homeopathic remedies as listed in the publications: Physicians Desk Reference, Physicians Desk Reference for herbal Medicine and/or Homeopathic Pharmacopeia- United States (HPUS).

This benefit DOES NOT include nutritional bars or drinks, sports drinks, weight loss powders/liquids/pills or similar products.

Some natural supplements available to plan participants that are covered, and may be alternatives to prescription drugs not covered by the medical plan's prescription formulary, are listed below to assist participants. Note, this is simply a sampling of supplements that may be mentioned in plan materials or health newsletters and this serves as a guide, but is not meant to be medical advice nor all-inclusive. Also, some or all of these supplements may or may not be covered by your respective Flexible Spending Account, Health Reimbursement Arrangement, Health Savings Account or other similar reimbursement plans.

Natural supplements available at many health food or drug stores (condition that typically is applicable is indicated in parenthesis):

- Pantethine (cholesterol)
- Inositol Hexaniacinate (cholesterol)
- Policosanol (cholesterol)
- Orange Peel Extract (Heartburn/GERD/Acid Reflux)
- Mastic Gum (Heartburn/GERD/Acid Reflux)
- MigraClear (migraines)

Natural supplements available via a specific distributor (check with Employers Resource) (condition that typically is applicable is indicated in parenthesis):

- Integra-Lean Irvingia (Life Extension; www.lef.org)
 - Mix™ Tabs (Life Extension; www.lef.org)
 - Super Mega EPA/DHA (360 mg EPA; 240 mg DHA; Life Extension; www.lef.org)
 - Super-Absorbable CoQ10 with d-Limonene (Life Extension; www.lef.org)
 - Vitamin C with Dihydroquercetin (Life Extension; www.lef.org)
 - D3-5 (Bio-Tech; www.bio-tech-pharm.com)
 - EpiCor (Vitamin Research Products, www.vrp.com)
 - Ultra Vir-X (Biotics Research; www.bioticsresearch.com)
-
- Glucotor 2 (diabetes; Baseline Nutritionals, www.baselinenutritionals.com)
 - Iodoral (iodine deficiency; Vitamin Research Products, www.vrp.com)
 - Maximum Vitality (multivitamin; Rejuvenation Science, <http://www.rejuvenation-science.com/multivitamin.html>)
 - Silver Biotics (American Biotech Labs, www.americanbiotechlabs.com)
 - ASAP (American Biotech Labs, www.americanbiotechlabs.com)
 - EmPowerPlus (TrueHope, www.truehope.com)
 - Krill Oil (Various distributors, including www.swansonvitamins.com)
 - Rescue Remedy (Bach, www.bachflower.com)

Diagnostic Services Including X-Ray and Laboratory

- *Diagnostic charges* for x-rays.
- *Diagnostic charges* for laboratory services.
- Pre-admission testing (PAT).
- Amniocentesis, including any testing performed in connection with the procedure.
- Ultrasounds.
- Allergy testing.
- Magnetic Resonance Imaging (MRI).
- Mammograms:
 - One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
 - A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
 - A mammogram every year for any woman who is fifty (50) years of age or older.
 - A mammogram for any woman desiring a mammogram for medical cause.
- Computed Tomography (CT).
- Positron Emission Tomography (PET).

Routine and Preventive Services -- (Will only be covered as Routine or Preventive if identified by your physician as Routine services upon claim submission.)

- PAP tests, including the exam.
- Mammograms, including the office visit.
 - One (1) baseline mammogram for any woman who is thirty-five (35) through thirty-nine (39) years of age.
 - A mammogram every two (2) years for any woman who is forty (40) through forty-nine (49) years of age, or more frequently if recommended by the woman's physician.
 - A mammogram every year for any woman who is fifty (50) years of age or older.
 - A mammogram for any woman desiring a mammogram for medical cause.
- Physicals for covered participants over age 6 (excluding chest x-rays and electrocardiograms "EKG's").
- Well-child checkups, through age 6.
- Prostate exams.
- Colorectal exams.
- Thermograms (limited to \$200 per scan).
- Bloodwork for hormone replacement therapy or as part of a routine physical.
- Vaccinations, inoculations and immunizations.
- Toobox prevention education and assistance services as defined and covered in the Schedule of Benefits

Equipment and Supplies

- *Durable medical equipment*, including expenses related to necessary repairs and maintenance. A statement is required from the prescribing *physician* describing how long the equipment is expected to be necessary. This statement will determine whether the equipment will be rented or purchased. Replacement equipment will be covered if the replacement equipment is required due to a change in the patient's physical condition; or purchase of new equipment will be less expensive than repair of existing equipment. For purposes of this plan, *durable medical equipment* includes insulin infusion pumps and related supplies. Purchase of *durable medical equipment* is not a covered expense unless (1) the *plan administrator* determines that purchase of the equipment should be less expensive than rental, based on the *physician's* statement of expected duration of the patient's need as well as the rental costs versus the purchase costs, or (2) rental by the *plan* is not possible. Such equipment will not be covered under the plan if it could be useful to a person in the absence of an *illness* or *injury* and could be purchased without a *physician's* prescription.
- Artificial limbs and eyes and replacement of artificial limbs and eyes if required due to a change in the patient's physical condition and if replacement is less expensive than repair or alteration of existing equipment.
- Original fitting, adjustment and placement of orthopedic braces, casts, splints, crutches, cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in

their function when impaired. Replacement of such devices only will be covered if the replacement is necessary due to a change in the physical condition of the covered person.

- Oxygen and rental of equipment required for its use.
- Orthotics, orthopedic or corrective shoes and other supportive appliances for the feet.
- Blood and/or plasma and the equipment for its administration.
- Contraceptive devices and injections, including related *physician* expenses.
- Initial prescription contact lenses or eyeglasses, including the examination and fitting of the lenses, to replace the human lens lost through intraocular *surgery*, limited to \$100 per *lifetime*.
- Sterile surgical supplies after *surgery*.

MEDICAL EXPENSES NOT COVERED

The plan will not provide benefits for any of the items listed in this section, regardless of *medical necessity* or recommendation of a *health care provider*, and even if the type of charge is listed on the Schedule of Medical Benefits. This list is intended to give you a description of expenses for services and supplies not covered by the plan.

1. Expenses exceeding the *usual and customary charge* for the geographic area in which services are rendered.
2. Services rendered by anyone other than a covered *health care provider*.
3. Treatment not prescribed or recommended by a *health care provider*.
4. Services, supplies or treatment not *medically necessary*.
5. Services or supplies for which there is no legal obligation to pay, or expenses which would not be made, except for the availability of benefits under this plan.
6. *Experimental/investigational* treatment, medications, equipment, services or supplies.
7. Complications arising from any non-covered *surgery* or treatment, except as required by law.
8. Services furnished by or for the United States Government or any other government, unless payment is legally required by federal law.
9. Services received as a result of *illness* or *injury* caused or contributed to by the covered person committing or attempting to commit any of the following or engaging in conduct which would amount to any of the following if a charge had been made, regardless, in either case, of whether a charge was filed or guilt was determined:
 - A felony;
 - Any illegal occupation;
 - A misdemeanor or other offense involving theft, fighting, disorderly conduct, or other breach of the peace; or
 - A misdemeanor or other offense involving the use of alcohol or drugs, including, but not limited to any crime or offense involving driving or being in actual physical control of a motor vehicle or any other means of conveyance propelled in part or in whole by an engine or motor, for example, a boat or ATV while under the influence of alcohol or drugs.

A person will be conclusively presumed to be under the influence of alcohol or drugs and such influence will be conclusively presumed to be a cause of the *illness*, condition, *accident*, or *injury* for purposes of this exclusion if either the person's blood alcohol level was equal to or greater than the legal limit for driving in the state where the *accident* occurred, or if a blood, urine, or other medically reliable test determines that there was any amount of illegal drugs in the person's system at the time of the cause or occurrence of the *illness*, condition, or *accident*. The presence of alcohol or drugs may be determined by tests performed by or for law enforcement authorities, by tests performed in the course of treating the person, or by other reliable means, such as, but not limited to, the testimony of witnesses to the person's conduct.

The plan sponsor in its sole discretion shall determine whether a claim is excluded under these rules and there need not be a determination or action by any other person or party as to criminal fault.

This exclusion does not apply if the services resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

10. Any condition, disability or expense sustained as a result of: duty as a participant of the armed forces of any state or country; engaging in a war or act of war, whether declared or undeclared; participation in a civil revolution or riot; or an intentional or accidental atomic explosion or other release of nuclear energy, whether in peacetime or wartime.
11. Any condition or disability sustained as a result of being engaged in any activity primarily for wage, profit or gain.
12. No benefits are payable for any expenses incurred while a person is involuntarily incarcerated in any correctional, penal, rehabilitative, mental illness, or similar facility, regardless of age, the type of offense, pleas made or any other circumstances.
13. Educational, vocational or training services and supplies, except as specified in Covered Medical Expenses.
14. Expenses for preparing or copying medical reports, itemized bills or claim forms.
15. Mailing and/or shipping expenses.
16. Handling expenses for laboratory fees.
17. Sales tax.
18. Expenses for broken appointments, telephone calls, or telephone or E-mail consultations.
19. Services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family participant in the armed forces of a government.
20. Travel expenses of a *physician* or a covered person.
21. Maintenance care.
22. Sanitarium, rest or *custodial care*.
23. Expenses eligible for consideration under any other plan of the *employer*.
24. Treatment or services rendered outside the United States of America or its territories, except for an accidental *injury* or a *medical emergency*.
25. Coverage while on a religious mission, in the Peace Corps, or while engaged in any similar activity or assignment.
26. Emergency room care for a non-*medical emergency*.
27. Treatment of an *injury* sustained while participating in a hazardous hobby or activity (to include skydiving, auto racing, hang gliding, and bungee jumping, and other activities as amended by the plan).
28. Personal comfort or service items while confined in a *hospital*, such as, but not limited to, radio, television, telephone and guest meals.

29. *Hospital* confinement expenses for dental services.
30. *Inpatient* and *outpatient* treatment of a *Mental Health disorder*, including *residential facility* treatment.
31. *Inpatient* and *outpatient* substance abuse treatment.
32. Treatment of or related to eating disorders.
33. Treatment of or related to attention deficit disorder (A.D.D.) and attention deficit hyperactive disorder (ADHD).
34. Marital counseling.
35. Family counseling.
36. Sex counseling.
37. *Mental Health treatment facility*, *substance abuse treatment facility*, *psychiatric day treatment facility* or chemical dependency/substance abuse day treatment facility expenses for *inpatient* treatment of substance abuse or a *Mental Health disorder*.
38. Use of an emergency room for treatment of a condition other than a *medical emergency*.
39. *Cosmetic surgery*.
40. Surgical and non-surgical treatment of obesity.
41. Surgical and non-surgical treatment of temporomandibular joint dysfunction (TMJ).
42. Surgical and non-surgical orthognathic treatment.
43. Kerato-refractive eye *surgery* (*surgery* to improve nearsightedness, farsightedness and/or astigmatism by changing the shape of the cornea including, but not limited to, radial keratotomy and keratomileusis *surgery*).
44. Reversal of any reproductive sterilization procedure.
45. Surgical impregnation procedures.
46. Surgical and non-surgical treatment for the correction of infertility, including any and all testing to establish or diagnose the condition of infertility.
47. Treatment of impotence.
48. Sex change *surgery*.
49. Penile prosthetic implants.
50. Expenses for education, counseling, job training or care for learning disorders or behavioral problems, whether or not services are rendered in a facility that also provides medical and/or Mental Health treatment.

51. Treatment of behavioral or conduct disorders.
52. Treatment of or related to an overdose of drug or medication. This exclusion will not apply if the overdose results from a medical condition such as depression and the benefits for the resultant *injuries* are normally covered under the plan.
53. Massage therapy or Rolfing.
54. Eye examinations for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses, orthoptics, vision therapy or supplies.
55. Hearing aids, *surgery* or implants involving hearing improvements or hearing devices, including but not limited to cochlear implants.
56. Dental services.
57. Adoption expenses.
58. Surrogate expenses.
59. Treatment, instructions, activities or drugs (including diet programs) for weight reduction or control.
60. Expenses incurred for non-surgical treatment of the feet, including treatment of corns, calluses and toenails, or other routine foot care, except as specified in Covered Medical Expenses. Refer to Covered Medical Expenses for covered expenses.
61. Hypnosis.
62. Genetic testing and genetic counseling.
63. Elective surgical procedures performed as a result of discovery through genetic testing.
64. Prescription drugs and medicines, vitamins and nutritional supplements (including prenatal vitamins), and insulin and insulin syringes.
65. B-12 injections.
66. Infertility drugs, whether or not a *physician's* prescription is required.
67. Drugs, medicines or supplies that do not require a *physician's* prescription.
68. Wigs and artificial hairpieces.
69. Jobst garments.
70. Equipment such as air conditioners, air purifiers, dehumidifiers, heating pads, hot water bottles, water beds, swimming pools, hot tubs and any other clothing or equipment which could be used in the absence of an *illness* or *injury*.

COORDINATION OF BENEFITS

General Provision

When you and/or your dependents are covered under more than one group health plan, the combined benefits payable by this plan and all other group plans will not exceed 100% of the eligible expense incurred by the individual. The plan assuming primary payor status will determine benefits first without regard to benefits provided under any other group health plan.

When this plan is the secondary payor, it will reimburse, subject to all plan provisions, the balance of remaining eligible expenses, not to exceed normal plan liability if this plan had been primary.

For purposes of coordination, eligible expense means any *usual and customary charge* considered in part or in full by this plan.

A plan may consider the benefit paid or provided by another plan only when it is secondary to the other plan.

Government Programs and Other Group Health Plans

The term group health plan, as it relates to coordination of benefits, includes the government programs *Medicare, Medicaid* and TRICARE. The regulations governing these programs take precedence over the determination of benefits under this plan. For example, in determining the benefits payable under the plan, the plan will not take into account the fact that you or any eligible dependent(s) are eligible for or receive benefits under a *Medicaid* plan.

The term group health plan also includes all group insurance and group subscriber contracts, such as union welfare plans.

Automobile Insurance

This plan provides benefits relating to medical expenses incurred as a result of an automobile *accident* on a secondary basis only. Benefits payable under this plan will be coordinated with and secondary to benefits provided or required by any no-fault automobile insurance statute, whether or not a no-fault policy is in effect, and/or any other automobile insurance.

Any benefits provided by this plan will be subject to the plan's reimbursement and/or subrogation provisions.

Order of Payment When Coordinating with Other Group Health Plans

Any group health plan which does not contain a coordination of benefits provision will be considered primary. There are two exceptions:

- i. Coverage that is obtained by virtue of being a participant in a group and designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to

any other parts of the plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a closed panel plan to provide out-of-network benefits.

ii. Individual plans as they shall always be secondary to group plans.

When all plans covering you and/or your dependents contain a coordination of benefits provision, the first of the following rules that describes which plan will pay benefits before another plan is the rule to follow:

1. The plan covering an individual other than as dependent (for example, as an active employee or retiree) will be primary to a plan covering the same individual as a dependent. However, if the individual is covered by two group health plans and *Medicare*, and under federal law *Medicare* is:
 - a. secondary to the plan covering the individual as a dependent; and
 - b. primary to the plan covering the individual as other than a dependent (for example, a retiree);

then, the order of payment is reversed so the plan covering the individual as an employee or retiree is secondary and the other plan is primary.

2. If a dependent child is covered under more than one plan, the primary plan is the plan of the parent whose birthday is earlier in the calendar year if:
 - a. the parents are married; or
 - b. the parents are not separated (regardless of whether they ever have been married); or
 - c. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage.

If both parents have the same birthday, the plan that has covered either of the parents longer is primary.

If the specific terms of a court decree state that one of the parents is responsible for the child's health care coverage or expenses and the plan of that parent has actual knowledge of those terms, that plan is primary. If the parent designated by the decree has no coverage for the child but that parent's spouse does, the spouse's plan is primary.

If the parents are not married or are separated (regardless of whether they were ever married), or are divorced and there is no court decree allocating responsibility for the child's health care coverage or expenses, the order of benefit determination among the plans of the parents and the parents' spouses (if any) is:

- the plan of the custodial parent;
 - the plan of the spouse of the custodial parent;
 - the plan of the noncustodial parent; then
 - the plan of the spouse of the noncustodial parent.
3. Active/inactive employee: The plan that covers an individual as an employee who is neither laid-off nor retired (or as that employee's dependent) is primary. However, the order of benefit determination for an individual covered both as a retiree and as a dependent of that individual's spouse will be determined under section No. 1b above.

4. The plan covering the individual as an employee or retiree (or as that individual's dependent) will be primary to the plan providing continuation coverage under federal (COBRA) or state law.
5. Longer/shorter length of coverage: If none of the above rules determines the order of benefits, the plan that has covered the individual as an employee, participant, subscriber or retiree for the longer period of time is primary.
 - a. To determine the length of time a person has been covered under a plan, two (2) plans shall be treated as one (1) if the person was eligible under the second within twenty-four (24) hours after the first ended.
 - b. The start of a new plan does not include:
 - i. A change in the amount or scope of a plan's benefits;
 - ii. A change in the entity that pays, provides or administers the plan's benefits; or
 - iii. A change from one type of plan to another (such as from a single employer plan to that of a multiple employer plan).
 - c. The person's length of time covered under a plan is measured from the person's first date of coverage under that plan. If that date is not readily available for a group plan, the date the person first became a participant of the group shall be used as the date from which to determine the length of time the person's coverage under the present plan has been in force.
6. If none of the above rules determines the primary plan, the allowable expenses will be shared equally between the plans.

Right to Make Payments to Other Organizations

Whenever payments that should have been made by this plan have been made by any other plan(s), this plan has the right to pay the other plan(s) any amount necessary to satisfy the terms of this coordination of benefits provision. Amounts paid will be considered benefits paid under this plan and, to the extent of such payments, the plan will be fully released from any liability regarding the person for whom payment was made.

OTHER IMPORTANT PLAN PROVISIONS

Assignment of Benefits

All benefits payable by the plan are automatically assigned to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. Payments made in accordance with an assignment are made in good faith and release the plan's obligation to the extent of the payment. Payments will also be made in accordance with any assignment of rights required by a state *Medicaid* plan.

Special Election for *Employees and Spouses Age 65 and Over*

If you remain actively employed after reaching the Medicare eligible age of 65, you or your spouse may choose to remain covered under this plan. If you choose to remain covered under this plan, and your specific co-employer has less than 20 or more employees for each working day in each of 20 or more calendar weeks in the current calendar year or the preceding calendar year, this plan will be the secondary payer of benefits and Medicare will be primary. If, however, you choose to remain covered under this plan, and your specific co-employer has 20 or more employees for each working day in each of 20 or more calendar year weeks in the current calendar year or the preceding calendar year, this plan will be the primary payer of benefits and Medicare will be secondary.

If you are under age 65 and your spouse is over age 65, he or she can make his or her own choice.

Restitution to the Plan

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent, by settlement, verdict or otherwise, for an *illness* or *injury*. In that case, you or your dependent (or the legal representatives, estate or heirs of either you or your dependent), must promptly provide equitable restitution to the plan for any benefits it paid relating to that *illness* or *injury*, up to the full amount of the compensation received from the other party (regardless of how that compensation may be characterized and regardless of whether you or your dependent have been made whole). The plan has first priority over any money received. You or your dependent must repay to the plan the benefits out of the recovery you or your dependent receive from a third party and/or any insurer including your own insurer. If the plan has not yet paid benefits relating to that *illness* or *injury*, the plan may reduce or deny future benefits on the basis of the compensation received by you or your dependent.

Benefits relating to such *illness* or *injury* will not be payable by the plan until you sign and return a statement, provided by the plan, acknowledging your obligation to provide equitable restitution to the plan under this provision. (That obligation will arise upon the payment of any plan benefits relating to the *illness* or *injury*, whether or not you sign such a statement).

You or your dependent must cooperate with the plan and its agents, and must sign and deliver such documents as the plan or its agents reasonably request to protect the plan's right of restitution. You or your dependent must also provide any relevant information, and take such actions as the plan or its agents reasonably request to assist the plan in making a full recovery of the reasonable value of the benefits provided. You or your dependent must not take any action that prejudices the plan's right of restitution.

In order to secure the rights of the plan under this section, you or your dependent hereby: (1) grant to the plan a first priority lien against the proceeds of any such settlement, verdict or other amounts received by you or your dependent; and (2) assign to the plan any benefits you or your dependent may have under any automobile policy or other coverage, to the extent of the plan's claim for restitution.

Any funds recovered by you or your dependent by way of settlement, judgment, or other award from a third party or from your/their own insurance due to an *accident, illness, injury*, or other condition involving a third party as described in this provision shall be held by you or your dependent (or your/their agent or attorney) in a constructive trust for the benefit of the plan until its equitable restitution interest has been satisfied.

The equitable restitution required under this provision will not be reduced to reflect any costs or attorneys' fees incurred in obtaining compensation unless separately agreed to, in writing, by the *plan administrator*, in the exercise of its sole discretion.

Subrogation

This section applies whenever another party (including your own insurer under an automobile or other policy) is legally responsible or agrees to compensate you or your dependent for your or your dependent's *illness or injury* and the plan has paid benefits related to that *illness or injury*.

The plan is subrogated to all of the rights of you or your dependent against any party liable for your or your dependent's *illness or injury* to the extent of the reasonable value of the benefits provided to you or your dependent under the plan. The plan may assert this right independently of you or your dependent.

You or your dependent are obligated to cooperate with the plan and its agents in order to protect the plan's subrogation rights. Cooperation means providing the plan or its agents with any relevant information requested by them, signing and delivering such documents as the plan or its agents reasonably request to secure the plan's subrogation claim, and obtaining the consent of the plan or its agents before releasing any party from liability for payment of medical expenses.

If you or your dependent enter into litigation or settlement negotiations regarding the obligations of other parties, you or your dependent must not prejudice, in any way, the subrogation rights of the plan under this section.

The costs of legal representation of the plan in matters related to subrogation will be borne solely by the plan. The costs of legal representation of you or your dependent must be borne solely by you or your dependent.

Recovery of Excess Payments

Whenever payments have been made in excess of the amount necessary to satisfy the provisions of this plan, the plan has the equitable right to recover (receive restitution of) these excess payments from any individual (including yourself), insurance company or other organization to whom the excess payments were made or to withhold payment, if necessary, on future benefits until the overpayment is recovered. Any such excess payments shall be held by the individual (including yourself), insurance company or other organization to whom the excess payments were made in a constructive trust for the benefit of the plan until its equitable restitution interest has been satisfied.

If excess payments were made for services rendered to your dependent(s), the plan has the right to withhold payment on your future benefits until the overpayment is recovered.

Further, whenever payments have been made based on fraudulent information provided by you, the plan will exercise all available legal rights, including its right to withhold payment on future benefits, until the overpayment is recovered.

Right to Receive and Release Necessary Information

The plan may, without the consent of or notice to any person, release to or obtain from any organization or person, information needed to implement plan provisions, including your protected health information, subject to the protections of applicable law, including the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations. When you request benefits, you must either furnish or authorize the release of all the information required to implement plan provisions. Your failure to fully cooperate will result in a denial of the requested benefits and the plan will have no further liability for such benefits.

Alternate Payee Provision

Under normal conditions, benefits are payable to the provider of services or supplies, unless evidence of previous payment is submitted with the claim form. If conditions exist under which a valid release or assignment cannot be obtained, the plan may make payment to any individual or organization that has assumed the care or principal support for you and is equitably entitled to payment. The plan must make payments to your separated/divorced spouse, state child support agencies or *Medicaid* agencies if required by a qualified medical child support order (QMCSO) or state *Medicaid* law.

The plan may also honor benefit assignments made prior to your death in relation to remaining benefits payable by the plan.

Any payment made by the plan in accordance with this provision will fully release the plan of its liability to you.

Reliance on Documents and Information

Information required by the *plan administrator* may be provided in any form or document that the *plan administrator* considers acceptable and reliable. The *plan administrator* relies on the information provided by you and others when evaluating coverage and benefits under the plan. All such information, therefore, must be accurate, truthful and complete. The *plan administrator* is entitled to conclusively rely upon, and will be protected for any action taken in good faith in relying upon, any information provided to the *plan administrator*. In addition, any fraudulent statement, omission or concealment of facts, misrepresentation, or incorrect information may result in the denial of the claim, cancellation or rescission of coverage, or any other legal remedy available to the plan. Any such action by you will result in prosecution to the fullest extent of the law and any termination of employment as a result will be considered termination for gross misconduct and COBRA continuation will not be available.

No Waiver

The failure of the *plan administrator* to enforce strictly any term or provision of this plan will not be construed as a waiver of such term or provision. The *plan administrator* reserves the right to enforce strictly any term or provision of this plan at any time.

Physician/Patient Relationship

This plan is not intended to disturb the *physician/patient* relationship. *Physicians* and other *health care providers* are not agents or delegates of the *employer*, *plan administrator* or the third party *contract administrator*. Nothing contained in this plan will require you or your dependent to commence or continue medical treatment by a particular provider. Further, nothing in this plan will limit or otherwise restrict a *physician's* judgment with respect to the *physician's* ultimate responsibility for patient care in the provision of medical services to you or your dependent.

Plan Is Not a Contract of Employment

Nothing contained in this plan will be construed as a contract or condition of employment between the *employer* and any employee. All employees are subject to discharge to the same extent as if this plan had never been adopted.

Right to Amend or Terminate Plan

The *plan sponsor* reserves the right to amend, modify or terminate the plan in any manner, for any reason, at any time.

CLAIMS AND APPEALS

The plan's representatives will follow administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated *claimants*. In addition to italicized terms defined in the "Definitions" section, this section uses the following terms:

Adverse Benefit Determination

The term adverse benefit determination means any of the following: a denial, reduction, or termination of a claim for benefits, or a failure to provide or make payment for such a claim (in whole or in part) including determinations of a *claimant's* eligibility, the application of any review under the Delta TeamCare Health Care Management Program, and determinations that an item or service is *experimental/investigational* or not *medically necessary* or appropriate.

Authorized Representative

To designate an authorized representative a claimant must provide written authorization on a form provided by the plan, and clearly indicate on the form the nature and extent of the authorization. However, where an *urgent care claim* is involved, a health care professional with knowledge of the medical condition will be permitted to act as a claimant's authorized representative without a prior written authorization.

Benefit Determination

A benefit determination is the plan's decision regarding the acceptance or denial of a claim for benefits under the plan.

Claimant

A claimant is any plan participant or beneficiary making a claim for benefits. Claimants may file claims themselves or may act through an authorized representative. In this document, the words "you" and "your" are used interchangeably with claimant.

Concurrent Care Decision

A concurrent care decision is a decision by the plan regarding coverage of an ongoing course of treatment that has been approved in advance by the plan.

Notice/Notify/Notification

The terms notice, notify or notification refer to the delivery or furnishing of information to a *claimant* as required by federal law.

Post-Service Claim

A post-service claim is any claim for a benefit under the plan related to care or treatment that the participant or beneficiary has already received.

Pre-Service Claim

A pre-service claim is any claim that requires plan approval prior to obtaining medical care for the *claimant* to receive full benefits under the plan. For example, a request for pre-certification under the Delta TeamCare Health Care Management Program is a pre-service claim.

Urgent Care Claim

An urgent care claim is any claim for medical care or treatment which, if subject to the normal timeframes for plan determination, could seriously jeopardize the *claimant's* life, health or ability to regain maximum function or which, 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. Whether a claim is an urgent care claim will be determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, any claim that a *physician* with knowledge of the *claimant's* medical condition determines is an urgent care claim as described herein shall be treated as an urgent care claim under the plan. Urgent care claims are a subset of *pre-service claims*.

Filing Non-Urgent Pre-Service Claims

Procedures for filing pre-service claims are discussed in the Delta TeamCare Health Care Management Program section of this plan.

Under certain circumstances provided by federal law, if you or your *authorized representative* fail to follow the plan's procedures for filing a *pre-service claim*, the plan will provide *notice* of the failure and the proper procedures to be followed. This *notification* will be provided as soon as reasonably possible, but not later than 5 days after receipt of the claim. You will then have up to 45 days from receipt of the notice to follow the proper procedures.

Filing Urgent Care Claims

In order to file an *urgent care claim*, you or your *authorized representative* must call **800-922-1855, prompt 2** and provide the plan: 1) information sufficient to determine whether, or to what extent, benefits are covered under the plan and 2) a description of the medical circumstances that give rise to the need for expedited review.

If you or your *authorized representative* fail to provide the plan with the above information, the plan will provide *notice* as soon as reasonably possible, but not later than 24 hours after receipt of your claim. You will be afforded a reasonable amount of time under the circumstance, but not less than 48 hours, to provide the specified information.

Filing Post-Service Claims

In order to file a post-service claim, you or your *authorized representative* must submit the claim in writing on a form pre-approved by the plan. Pre-approved claim forms are available from your *employer*.

All claims must be received by the plan within a **12-month** period from the date of the expense and must include the following information:

- plan participant's name, Social Security number and address;
- patient's name, Social Security number and address if different from the participant's;
- provider's name, tax identification number, address, degree and signature;
- date(s) of service;
- diagnosis;
- procedure codes (describes the treatment or services rendered);
- assignment of benefits, signed (if payment is to be made to the provider);
- release of information statement, signed;
- coordination of benefits (COB) information if another plan is the primary payor; and
- sufficient medical information to determine whether and to what extent the expense is a covered benefit under the plan.

Send complete information to:

P5 Health Plan Solutions
P.O. Box 9554
Salt Lake City, UT 84109-0554

Status of Benefit Verifications

Please note that oral or written communications with P5 Health Plan Solutions regarding a participant's or beneficiary's eligibility or coverage under the plan are not claims for benefits, and the information provided by P5 or other plan representative in such communications does not constitute a certification of benefits or a guarantee that any particular claim will be paid.

Benefits are determined by the plan at the time a formal claim for benefits is submitted according to the procedures outlined above.

Notification of Benefit Determinations

The plan will *notify* you or your *authorized representative* of its *benefit determinations* as follows:

Urgent care claims: Notice of a *benefit determination* (whether adverse or not) will be provided as soon as possible, taking into account the medical circumstances, but not later than 72 hours after receipt of the claim. However, if the plan gives you *notice* of an incomplete claim, the *notice* will include a time period of not less than 48 hours for you to respond with the requested specified information. The plan will then provide you with the *notice of benefit determination* within 48 hours after the earlier of: receipt of the specified information, or the end of the period of time given you to provide the information. If the *benefit determination* is provided orally, it will be followed in writing no later than three days after the oral *notice*.

If the *urgent care claim* involves a *concurrent care decision*, *notice* of the *benefit determination* (whether adverse or not) will be provided as soon as possible, but not later than 24 hours after receipt of your claim for extension of treatment or care, as long as the claim is made at least 24 hours before the prescribed period of time expires or the prescribed number of treatments ends.

Other pre-service claims: Notice of a *benefit determination* (whether adverse or not) will be provided in writing within a reasonable period appropriate to the medical circumstances, but not later than 15 days after receipt of the claim. However, this period may be extended one time by the plan for up to an additional 15 days if the plan both determines that such an extension is necessary due to matters beyond its control and provides you written notice, prior to the end of the original 15-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. If such an extension is necessary due to your failure to submit the information necessary to decide the claim, the *notice* of extension will specifically describe the required information, and you will be given at least 45 days from your receipt of the *notice* to provide the specified information.

Notice of an *adverse benefit determination* regarding a *concurrent care decision* will be provided sufficiently in advance of any termination or reduction of benefits to allow you to appeal and obtain a determination before the benefit is reduced or terminates.

Post-service claims: Notice of *adverse benefit determinations* will be provided, in writing within a reasonable period of time, but not later than 30 days after receipt of the claim. However, this period may be extended one time by the plan for up to an additional 15 days if the plan both determines that such an extension is necessary due to matters beyond its control and provides you written *notice*, prior to the end of the original 30-day period, of the circumstances requiring the extension and the date by which the plan expects to render a decision. If an extension is necessary due to your failure to submit the information necessary to decide the claim, the *notice* of extension will specifically describe the required information, and you will be given at least 45 days from your receipt of the notice to provide the specified information.

The applicable time period for the *benefit determination* begins when your claim is filed in accordance with the reasonable procedures of the plan, even if you haven't submitted all the information necessary to make a *benefit determination*. However, if the time period for the *benefit determination* is extended due to your failure to submit information necessary to decide a claim, the time period for making the *benefit determination* will be suspended from the date the *notice* of extension is sent to you until the earlier of: 1) the date on which you respond to the request for additional information, or 2) the date established by the plan for the furnishing of the requested information (at least 45 days).

If your claim is denied based on your failure to submit information necessary to decide the claim, the plan may, in its sole discretion, renew its consideration of the denied claim if the plan receives the additional information within 180 days after original receipt of the claim. In such circumstances, you will be *notified* of the plan's reconsideration and subsequent *benefit determination*.

Notification of Adverse Benefit Determination

If your claim is subject to an *adverse benefit determination*, you will receive a *notification* that includes:

- the specific reason(s) for the *adverse benefit determination*;
- reference to the specific plan provisions on which the *adverse benefit determination* was based;
- a description of any additional information or material needed from you to complete the claim and an explanation of why it is necessary;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the *adverse benefit determination*, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in the *adverse benefit determination* and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- if the *adverse benefit determination* was based on a *medical necessity, experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
- if an *urgent care claim* was denied, a description of the expedited review process applicable to the claim; and
- a description of the plan's review or appeal procedures, including applicable time limits, and a statement of your right to bring suit under ERISA §502(a) with respect to any claim denied after an appeal.

Appeals

General Procedures

You or your *authorized representative* may appeal any *adverse benefit determination* to the *plan administrator*. The *plan administrator* is the sole fiduciary of the plan, and exercises all discretionary

authority and control over the administration of the plan and has sole discretionary authority to determine eligibility for plan benefits and to construe the terms of the plan.

The *plan administrator* will conduct a full and fair review of all benefit appeals, independently from the individual(s) who made the *adverse benefit determination* or anyone who reports to such individual(s) and without affording deference to the *adverse benefit determination*. You will, upon request and free of charge, be given reasonable access to, and copies of, all documents, records, and other information relevant to your claim for benefits. You or your *authorized representative* will also have the opportunity to submit to the *plan administrator* written comments, documents, records and other information relating to your claim for benefits. The *plan administrator* will take into account all this information regardless of whether it was considered in the *adverse benefit determination*.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *plan administrator* 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 benefit determination* nor is a subordinate of any such individual.

Upon request, you will be provided the identification of the medical or vocational expert(s) whose advice was obtained on behalf of the plan in connection with the *adverse benefit determination*, whether or not the advice was relied upon to make the *adverse benefit determination*.

Form and Timing

All requests for a review of a denied pre-service claim (other than *urgent care claim*) must be in writing and should include a copy of the *adverse benefit determination*, if applicable, and any other pertinent information that you wish the *plan administrator* to review in conjunction with your appeal. Send all information to:

Employers Resource Benefit Trust and American Guaranty Title and Trust Inc.
1301 South Vista Ave, Ste 250
Boise, ID 83705

P5 Health Plan Solutions
Attention: Appeals Coordinator
2455 E. Parleys Way, Suite 300
Salt Lake City, UT 84109-1217

You or your *authorized representative* may appeal an *adverse benefit determination* of an *urgent care claim* on an expedited basis, either orally or in writing. You may appeal orally by calling the *plan administrator's* health care management program at **800-922-1855, prompt 2**. All necessary information, including the *plan administrator's* benefit determination on review, will be transmitted between the *plan administrator* and you by telephone, facsimile, or other available similarly expeditious method.

All requests for a review of a denied *post-service claim* must be in writing and should include a copy of the *adverse benefit determination* and any other pertinent information that you wish the plan administrator to review in conjunction with your appeal. Send all information to:

P5 Health Plan Solutions
Attention: Appeals Coordinator
2455 E. Parleys Way, Suite 300
Salt Lake City, UT 84109-1217

You or your *authorized representative* must file any appeal of an *adverse benefit determination* within 180 days after receiving *notification* of the *adverse benefit determination*.

Requests for appeal which do not comply with the above requirements will not be considered.

Time Period for Deciding Appeals

Appeals will be decided by the *plan administrator* as follows:

Urgent care claims: Appeals of *urgent care claims* will be decided by the *plan administrator* as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the *plan administrator* receives the appeal. A decision communicated orally will be followed-up in writing.

Other pre-service claims: Appeals of *pre-service claims* will be decided by the *plan administrator* within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the *plan administrator* receives the appeal. The *plan administrator's* decision will be provided to you in writing.

Post-service claims: Appeals of post-service claims will be decided by the *plan administrator* within a reasonable period of time, but not later than 30 days after the *plan administrator* receives the appeal. The *plan administrator's* decision will be provided to you in writing.

Notification of Appeal Denials

If your appeal is denied, the *plan administrator's* written *notification* will include:

- the specific reason(s) for the *adverse benefit determination*;
- reference to the specific plan provisions on which the *adverse benefit determination* was based;
- a statement regarding your right, upon request and free of charge, to access and receive copies of documents, records and other information that are relevant to the claim;
- if an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the appeal, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline protocol, or other similar criterion was relied upon in denying the appeal and that a copy of the rule, guideline, protocol, or other criterion will be provided free of charge to you upon request;
- if the denied appeal was based on a *medical necessity, experimental/investigational* or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the denial, applying the terms of

the plan to your medical circumstances, or a statement that such an explanation will be provided free of charge upon request; and

- a statement describing any additional appeal procedures offered by the plan and your right to obtain information about such procedures, and a statement of your right to bring suit under ERISA §502(a).

Notification of the decision on an urgent care claim may be provided orally, but a follow-up written notification will be provided no later than three days after the oral notice.

Second Level Appeal of Post-Service Claims

If your appeal of a *post-service claim* is denied, you or your *authorized representative* may request further review by the *plan administrator*. This request for a second-level appeal must be made, in writing, within 60 days of the date you are notified of the original appeal decision. For *post-service claims*, this second-level review is mandatory, i.e., you are required to undertake this second-level appeal before you may pursue civil action under Section 502(a) of ERISA.

The *plan administrator* will promptly conduct a full and fair review of your appeal, independently from the individual(s) who considered your first level appeal or anyone who reports to such individual(s) and without affording deference to the initial denial. You will again have access to all relevant records and other information and the opportunity to submit written comments and other information, as described in more detail under the section entitled “General Procedures” above.

If the *adverse benefit determination* was based, in whole or in part, on a medical judgment, including determinations that treatments, drugs, or other services are *experimental/investigational*, or not *medically necessary* or appropriate, the *plan administrator* 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 consulted neither in connection with the *adverse benefit determination* nor the initial appeal denial and who is not a subordinate of any such individuals.

Second-level appeals of *post-service claims* will be decided by the *plan administrator* within a reasonable period of time, but not later than 30 days after the *plan administrator* receives the appeal. The *plan administrator’s* decision will be provided to you in writing, and if the decision is a second denial, the *notification* will include all of the information described in the section entitled “Notification of Appeal Denials” above.

If you remain dissatisfied with the outcome of the second-level review, you may pursue civil action under Section 502(a) of ERISA.

Dispute Resolution

As an option in lieu of civil action (or any statutory administrative procedure, if applicable) for claims review and determination, the plan provides for dispute resolution as set forth herein.

Each, every, and all claims, disputes and/or controversies, now existing or hereafter arising, whether known or unknown, may be resolved, as follows:

- a) through mediation utilizing the Rules and Mediator provided by Truce, LLC, a neutral entity, or its successor, at ERBT or the plan's expense;
- b) and, failing settlement by mediation, the parties agree that all claims and disputes, including those of jurisdiction and arbitrability, may be resolved by neutral binding arbitration conducted by the National Arbitration Forum (NAF), under the NAF Code of Procedure in effect at the time any claim is made. Each party shall pay its own costs of arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court of competent jurisdiction.

OPTIONAL CONTINUATION OF COVERAGE

Continuation of Coverage Under Federal Law (COBRA)

As mandated by federal law (COBRA), the plan offers optional continuation coverage to you and/or your dependents if coverage would otherwise end due to one of the following qualifying events:

- Termination of your employment for any reason except gross misconduct. Coverage may continue for you and your eligible dependents.
- A reduction in hours worked by you. Coverage may continue for you and your eligible dependents.
- Your death. Coverage may continue for your eligible dependents.
- Divorce or legal separation from your spouse. Coverage may continue for that spouse and your other eligible dependents. Also, if you reduce or eliminate your spouse's or eligible dependents' group health coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a qualifying event for your spouse or other eligible dependents even though the coverage was reduced or eliminated before the divorce or separation.
- You become entitled to *Medicare*. Coverage may continue for eligible dependents.
- Loss of eligibility of a covered dependent child. Coverage may continue for that dependent.
- Your *employer* files a Title 11 bankruptcy petition. Coverage may continue for retirees and their beneficiaries if the plan covers such retirees and beneficiaries within one year of the date of the bankruptcy petition and if such retiree coverage ends or is substantially reduced within one year before or after the filing for bankruptcy. (Please note that the plan may not cover retirees, in which case *employer* bankruptcy is not a qualifying event.)

NOTE: To choose this COBRA coverage, an individual must be a covered person under the plan on the day before the qualifying event. You can also obtain COBRA coverage for children born to, adopted by or placed for adoption with you during the period of your COBRA coverage if they are timely enrolled under the terms of the plan. In the case of bankruptcy, an individual must have retired on or before the date coverage was substantially reduced, or be a beneficiary of the retired employee on the day before the bankruptcy.

COBRA eligibility and coverage is available during the period the Client Service Agreement or other written agreement between the Co-Employer and ERM is in effect. Termination of the Client Service Agreement by any means whatsoever terminates COBRA eligibility and coverage. Additionally, should underwriting practices result in the cessation of health benefits for your company (by the client or by ERM/ERBT), that event alters the terms of the Client Service Agreement. The changing or termination of a contract, like the Client Service Agreement, is not among the "qualifying events" designated by COBRA. For that reason, continuation coverage is not available in conjunction with the change in underwriting.

Notification Requirement

You or other qualifying individual(s) have the responsibility to inform the *plan administrator* in writing of a divorce, legal separation or a child losing dependent status under the plan within 60 days of the qualifying event or, if later, the date coverage under the plan would end. Failure to provide this written notification within 60 days will result in the loss of COBRA coverage rights.

Your *employer* has the responsibility of notifying the *plan administrator* of your death, termination of employment, reduction in hours, entitlement to *Medicare* or the *employer's* bankruptcy within 30 days of the qualifying event.

Electing COBRA Coverage

Subject to the *plan administrator* being timely informed of the qualifying events described in the above paragraphs, the plan will promptly notify you and other qualifying individual(s) of their COBRA coverage rights. You and any other qualifying individuals must elect COBRA coverage within 60 days after plan coverage would otherwise end, or, if later, within 60 days after the date of the notice of COBRA coverage rights. Failure to elect COBRA coverage within this 60-day period will result in loss of COBRA coverage rights.

Notice of Unavailability of COBRA Coverage

If the *plan administrator* receives notice of a qualifying event and determines that the individual is not entitled to COBRA coverage, the *plan administrator* will provide to such individual an explanation as to why the individual is not entitled to COBRA coverage. This notice will be provided within the same time frame that the *plan administrator* would have provided the notice of right to elect COBRA coverage.

Maximum Period of COBRA Coverage

Except as described below, the maximum period of COBRA coverage for individuals who qualify due to the *employee's* termination of employment or reduction in hours worked is 18 months from the date of the qualifying event.

If a qualifying individual is disabled (as determined under the Social Security Act) at the time of your termination or reduction in hours or becomes disabled at any time during the first 60 days of COBRA coverage, COBRA coverage for the qualifying individual and any non-disabled family members who are also entitled to COBRA coverage may be extended to 29 months provided the qualifying individual or family member, if applicable, notifies the *plan administrator* within the 18-month COBRA coverage period and within 60 days after you receive notification of determination of disability.

The maximum period of COBRA coverage for individuals who qualify due to any other described qualifying event, except bankruptcy, is 36 months from the date of the qualifying event.

Qualifying retirees and widows or widowers of retirees who died before bankruptcy are entitled to lifetime COBRA coverage. However, if a retiree dies after bankruptcy, the surviving spouse and dependent children may only elect an additional 36 months of COBRA coverage after the death.

If a second qualifying event occurs (for example, your death or divorce) during the 18 or 29 month coverage period resulting from a termination of employment or reduction in hours, the maximum period of coverage will be computed from the date of the first qualifying event, but will be extended to the full 36 months if required by the subsequent qualifying event.

A special rule applies if the qualifying individual is your spouse or dependent child whose qualifying event was the termination or reduction in hours of your employment and you became entitled to *Medicare* within 18 months before such qualifying event. In that case, the qualifying individual's maximum period of COBRA coverage is the longer of 36 months from the date of your *Medicare* entitlement or their otherwise applicable maximum period of coverage.

Cost of COBRA Coverage

The cost of COBRA coverage is determined by your *employer* and paid by the qualifying individual. If the qualifying individual is not disabled, the applicable premium cannot exceed 102% of the plan's cost of providing coverage. The cost of coverage during a period of extended COBRA coverage due to a disability cannot exceed 150% of the plan's cost of coverage.

Premium payments for COBRA coverage for your or your dependent's "initial premium month(s)" are due by the 45th day after electing COBRA coverage. The "initial premium month(s)" are any month that ends on or before the 45th day after you or the qualifying individual elects COBRA coverage. All other premiums are due on the 1st of the month for which coverage is sought, subject to a 30-day grace period. Premium rates are established by your *employer* and may change when necessary due to plan modifications. The cost of COBRA coverage is computed from the date coverage would normally end due to the qualifying event.

Failure to make payment for the initial premium month(s) within 45 days or any subsequent monthly premium payment within 30 days of the established due date will result in the permanent cancellation of COBRA coverage.

When COBRA Coverage Ends

Continuation of coverage ends on the earliest of:

- The date the maximum period of COBRA coverage expires.
- The date the qualifying individual becomes entitled to coverage under *Medicare*, if the *Medicare* entitlement date is after the date that the individual elected COBRA coverage.
- The last period for which payment was made when coverage is canceled due to non-payment of the required cost.
- The date the *employer* no longer offers a group health plan to any of its employees.
- The date the qualifying individual becomes covered under any other group health plan that does not exclude or limit coverage for a pre-existing condition the qualifying individual may have.

- The first day of the month that begins more than 30 days after the qualifying individual who was entitled to a 29-month maximum continuation period is subject to a final determination under the Social Security Act that he or she is no longer disabled.

NOTE: If a Client Service Agreement (CSA) is terminated by a client, no COBRA benefits will be extended for the Sensible Basic self-funded medical plan to currently enrolled COBRA participants for that client or anyone active with such plan after the end of the month in which the CSA is terminated.

Notice of Termination Before Maximum Period of COBRA Coverage Expires

If COBRA coverage for a qualifying individual terminates before the expiration of the maximum period of COBRA coverage, the *plan administrator* will provide notice to the qualifying individual of the reason that the COBRA coverage terminated, and the date of termination. The notice will be provided as soon as practicable following the *plan administrator's* determination regarding termination of the COBRA coverage.

COBRA Subsidy

Certain persons will have the right to a premium subsidy equal to 65% of your COBRA (continued medical plan coverage) premiums, provided you meet all required conditions stated in this section, applicable federal law, and guidance from the enforcing federal agencies. This subsidy applies to you and your qualified beneficiaries.

Under the American Recovery and Reinvestment Act of 2009 (as amended), enacted on February 17, 2009, most persons who were or are terminated involuntarily between September 1, 2008 and February 28, 2010 are eligible for a subsidy of 65% of the cost of COBRA coverage. This subsidy is available for up to fifteen months, beginning from the first month the person was eligible for the subsidy. If you believe you are qualified to elect coverage under this subsidy, your election materials are due within 60 days of the date of notification.

Dates of Termination

If you were terminated after September 1, 2008 and prior to February 17, 2009, you are entitled to reconsider whether you want to elect COBRA if you are not currently covered by the plan through COBRA. You may have even previously elected but failed to pay your monthly premiums. Now you may elect to begin COBRA coverage again as of March 1, 2009 with the government subsidizing 65% of the cost. Your coverage will be effective as of the first of the next monthly period (generally March 1, 2009). You are not eligible for coverage or the subsidy prior to that date. The length of your COBRA coverage (generally 18 months) will be determined starting with your termination date, not the date you now elect to continue coverage.

If you are terminated involuntarily after February 17, 2009 and prior to February 28, 2010, you may elect COBRA as well and will receive a subsidy from the government of 65% of the cost.

Conditions for Subsidy Eligibility

The federal government pays for the subsidy at great cost to taxpayers and imposes certain conditions on eligibility. You are not eligible for the subsidy if:

1. You voluntarily terminated. You are asked to sign a binding statement regarding the circumstances of your termination, and your employer will verify this statement against the records they have kept on your employment history. Failure to answer this question honestly generally results in a penalty owed by you to the U.S. government under federal law.
2. You (or a covered family member) are eligible for any other group health plan coverage such as through your own employment, your spouse's employment, or (if you are young) perhaps your parents' plans. (Note you cannot claim the subsidy if you are *eligible* for the other coverage -- you need not be enrolled in the other coverage to lose your eligibility for paying the reduced cost of COBRA.)
3. You (or a covered family member) are eligible for Medicare. (Note you cannot claim the subsidy if you are *eligible* for Medicare --you need not be enrolled in Medicare to lose your eligibility for paying the reduced cost of COBRA.)
4. You experienced an event other than termination of employment that resulted in your loss of medical coverage. Again, the federal government and IRS will impose penalties when persons who are offered this subsidy by mistake take improper advantage.

You must cooperate with your employer in providing all the required information for the government subsidy to apply. You are required to sign a statement provided by your plan sponsor indicating you are not ineligible for coverage due to one of the four reasons stated above.

An individual will no longer be eligible for the subsidy and must then begin paying 100% of the cost of your coverage as of the earliest of the date:

1. You (or a covered family member) are *eligible* for other group health plan coverage such as through your own employment, your spouse's employment, or (if you are young) perhaps your parents' plans.
2. You (or a covered family member) are *eligible* for Medicare.

If you lose eligibility for the subsidy for one of these reasons, you can remain on COBRA continuation until it terminates due to the end of your continuation period measured from the date of your termination (generally 18 months) or earlier if you lose COBRA coverage for other reasons prior to its expiration.

You must immediately notify the Plan if you are no longer eligible for the subsidy.

The federal government imposes a penalty of 110% of the amount of the subsidy you improperly received after the date you should have been ineligible. The government may forgive you if you had reasonable cause for not notifying them, but not if you failed to do so due to willful neglect.

HIPAA

The federal Health Insurance Portability and Accountability Act (HIPAA) requires that medical plans grant credit for prior coverage called creditable coverage. Under HIPAA, your creditable coverage from this plan may reduce the exclusion period, if any, for a pre-existing medical condition under a new health plan. The law requires that each employee and dependent for whom coverage terminates for any reason be provided with a certificate indicating the length of time an individual was covered under the health plan. Employers Resource will issue you a certificate to provide you with evidence of your medical plan

coverage shortly after your coverage termination date. Check with your new plan administrator to see if you need to provide this certificate. This certificate may also be required to buy a private insurance policy. When you receive this certificate, keep it in a safe place until you are ready to use it.

PROVISION OF PROTECTED HEALTH INFORMATION TO THE PLAN SPONSOR

This plan complies with the Health Insurance Portability and Accountability Act of 1996 (the "HIPAA Privacy Rule" and/or "HIPAA Security Rule" as applicable) by establishing the conditions under which the *plan sponsor* will receive, use and/or disclose *protected health information*. All terms in this section that are defined in the HIPAA Privacy Rule or HIPAA Security Rule shall have the same meaning set forth therein. Provisions related to the HIPAA Security Rule take effect as of the effective date of the HIPAA Security Rule for the plan.

Permitted Disclosures of Protected Health Information to the Plan Sponsor

Subject to the conditions described below under "No Disclosure of Protected Health Information to the Plan Sponsor Without Certification by Plan Sponsor" and "Conditions of Disclosure of Protected Health Information to the Plan Sponsor," the plan (and any health insurance issuer or business associate acting on behalf of the plan) may disclose individuals' *protected health information* to the *plan sponsor* for the *plan sponsor* to carry out plan administration functions performed by the *plan sponsor*. The plan (and any health insurance issuer or business associate acting on behalf of the plan) may not 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*.

No Disclosure of Protected Health Information to the Plan Sponsor Without Certification by Plan Sponsor

Except as provided below in "Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the Plan Sponsor," with respect to the plan's disclosure of summary health information and enrollment/disenrollment information, the plan will not disclose *protected health information* to the *plan sponsor* unless the *plan sponsor* certifies that:

- a. the plan has been *amended* to incorporate the provisions set forth below under "Conditions of Disclosure of Protected Health Information to the Plan Sponsor" (the requirements of 45 CFR Section 164.504(f)(2)(ii)); and
- b. the *plan sponsor* agrees to comply with the provisions set forth below under "Conditions of Disclosure of Protected Health Information to the Plan Sponsor."

Conditions of Disclosure of Protected Health Information to the Plan Sponsor

The *plan sponsor* agrees to the following restrictions and conditions of receiving *protected health information* (other than summary health information or enrollment/disenrollment information as explained in "Disclosures of Summary Health Information and Enrollment/Disenrollment Information to the Plan Sponsor" below). The *plan sponsor* shall:

1. Not use or further disclose the *protected health information* other than as permitted or required herein or as required by law.

2. Ensure that any agent(s), including a subcontractor, to whom it provides *protected health information* received from the plan agrees to the same restrictions and conditions that apply to the *plan sponsor* with respect to such *protected health information*.
3. Not use or disclose *protected health information* for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the *plan sponsor*.
4. Report to the plan any use or disclosure of *protected health information* that is inconsistent with the uses or disclosures provided for of which the *plan sponsor* becomes aware.
5. Make available *protected health information* to comply with an individual's right to access *protected health information* in accordance with 45 C.F.R. Section 164.524.
6. Make available *protected health information* for amendment and incorporate any amendments to *protected health information* in accordance with 45 C.F.R. Section 164.526.
7. Make available the information required to provide an accounting of disclosures in accordance with 45 C.F.R. §164.528.
8. Make its internal practices, books and records relating to the use and disclosure of *protected health information* received from the plan available to the Secretary of the Department of Health and Human Services for purposes of determining compliance by the plan with the HIPAA Privacy Rule.
9. If feasible, return or destroy all *protected health information* received from the plan that the *plan sponsor* still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if 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.
10. Ensure that the required adequate separation, described in "Required Separation Between the Plan and the Plan Sponsor" below, is established and maintained.

The *plan sponsor* further agrees that if it creates, receives, maintains, or transmits any electronic *protected health information* (other than enrollment/disrollment information and summary health information, which are not subject to these restrictions) on behalf of the plan, it will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic *protected health information*, and it will ensure that any agents (including subcontractors) to whom it provides such electronic *protected health information* agree to implement reasonable and appropriate security measures to protect the information. *Plan sponsor* will report to the plan any security incident of which it becomes aware.

Disclosures of Summary Health Information and Enrollment/Disrollment Information to the Plan Sponsor

1. The plan (or a health insurance issuer with respect to the plan) may disclose summary health information to the *plan sponsor* without the need to comply with the conditions and restrictions set forth above under "No Disclosure of Protected Health Information to the Plan Sponsor Without Certification by Plan Sponsor" and "Conditions of Disclosure of Protected Health Information to the Plan Sponsor," if the *plan sponsor* requests the summary health information for the purpose of:

- a. Obtaining premium bids from health plans (including health insurance issuers) for providing health insurance coverage under the plan; or
 - b. Modifying, amending, or terminating the plan.
2. The plan (or a health insurance issuer with respect to the plan) may disclose information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer offered by the plan without the need to comply with the conditions and restrictions set forth above under “No Disclosure of Protected Health Information to the Plan Sponsor Without Certification by Plan Sponsor” and “Conditions of Disclosure of Protected Health Information to the Plan Sponsor.”

Required Separation Between the Plan and the Plan Sponsor

1. The following classes of *employees* or other persons under the control of the *plan sponsor* will have access to protected health information received from the plan (or from a health insurance issuer with respect to the plan):
 - a. Benefits Manager
 - b. Sr. Benefits Specialist
 - c. Benefits Specialist
2. No other persons shall have access to *protected health information*. The listed classes of *employees* or other persons under the control of the *plan sponsor* will have access to *protected health information* solely to perform the plan administration functions that the *plan sponsor* performs for the plan. They will be subject to disciplinary action and/or sanctions (including termination of employment or affiliation with the *plan sponsor*) for any use or disclosure of *protected health information* in violation of the provisions of this plan. The *plan sponsor* will ensure that the provisions of this paragraph are supported by reasonable and appropriate security measures to the extent that the classes or *employees* or other persons have access to electronic *protected health information*.

DEFINITIONS

The following terms define specific wording used in this plan. These definitions should not be interpreted to extend coverage unless specifically provided for under previously explained provisions of this plan.

Accident

An unforeseen and unavoidable event resulting in an *injury*.

Ambulatory Surgical Facility

A public or private facility, licensed and operated according to the law, which does not provide services or accommodations for a patient to stay overnight. The facility must have an organized medical staff of *physicians*; maintain permanent facilities equipped and operated primarily for the purpose of performing surgical procedures; supply registered professional nursing services whenever a patient is in the facility; and be *Medicare* approved or accredited as an ambulatory surgical facility by the Joint Commission on Accreditation of Healthcare Organizations.

Benefit Year

The 12-month period beginning January 1 and ending December 31. All annual deductibles and benefit maximums accumulate during the benefit year.

Birthing Center

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

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

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

Chiropractic Services

The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column.

Complications of Pregnancy

Conditions (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but which are adversely affected by pregnancy or caused by pregnancy such as: acute nephritis, nephrosis,

cardiac decompensation, missed abortion and similar medical and surgical conditions of comparable severity. Complications of pregnancy also include a non-elective cesarean section, an ectopic pregnancy which is terminated or spontaneous termination of pregnancy which occurs during a period of gestation when a viable birth is not possible; and pernicious vomiting (hyperemesis gravidarum) and toxemia with convulsions (eclampsia of pregnancy) and puerperal infection.

Complications of pregnancy do not include false labor, occasional spotting, physician prescribed rest during the period of pregnancy, morning sickness and similar conditions which, although associated with the management of a difficult pregnancy, are not medically classified as distinct complications of pregnancy.

Contract Administrator

P5 Health Plan Solutions/JSA P5 Utah, LLC. has been hired as the third party contract administrator by the *plan administrator* to perform claims processing and other specified administrative services in relation to the plan. The contract administrator is not an insurer of health benefits under this plan, is not a fiduciary of the plan and does not exercise any of the discretionary authority and responsibility granted to the *plan administrator*. The contract administrator is not responsible for plan financing and does not guarantee the availability of benefits under this plan.

Cosmetic Surgery

A procedure performed primarily for psychological purposes or to preserve or improve appearance rather than to restore the anatomy and/or functions of the body which are lost or impaired due to an *illness* or *injury*.

Custodial Care

Services and supplies furnished primarily to assist an individual in the activities of daily living. Activities of daily living include such things as bathing, feeding, administration of oral medicines, or other services that can be provided by persons without the training of a *health care provider*.

Diagnostic Charges

Charges for x-ray or laboratory examinations made or ordered by a *physician* or *practitioner* in order to detect a medical condition.

Durable Medical Equipment

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

Employee

A person who is a regular employee of the *employer* on the *employer's* W-2 payroll. It does not include any person classified by the *employer* as a leased *employee*, contract worker, independent contractor, or temporary *employee*, whether or not any such persons are on the *employer's* W-2 payroll or are determined by the IRS or others to be common-law *employees* of the *employer*. Determination of *employee* status is to be made by the *employer*, and is made without regard to any classification by any

other person or entity, including but not limited to state or federal agencies, courts of law, etc. “Employee” does not include any person who is not legally able to work in the United States. Any person enrolled in the plan who misrepresents that status on the INS Form I-9 shall be retroactively removed from coverage under the plan, any claim paid must be repaid to the plan and that person shall be considered terminated from the plan for gross misconduct.

Employer

Whenever the word “employer” appears in this document the term may mean either Employers Resource Management Company or Co-employer, or both, as the context may require.

Enrollment Date

The earlier of the day coverage begins or, if there is a waiting period, the first day of the waiting period. For late enrollees and special enrollees, the enrollment date is the date coverage begins.

Experimental/Investigational

A treatment, procedure, device or drug that the *plan administrator* determines, in the exercise of its discretion:

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

“Reliable evidence” includes anything determined to be such by the *plan administrator*, in the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the national medical professional community.

A treatment, procedure, device or drug that meets any of the criteria listed above is considered experimental/investigational and is not eligible for coverage under this plan.

Health Care Provider

A *physician, practitioner, nurse, hospital or specialized treatment facility* as those terms are specifically defined in this section.

Home Health Care Agency

A public or private agency or organization, licensed and operated according to the law, that specializes in providing medical care and treatment in the home. The agency must have policies established by a professional group; at least one *physician* and one registered graduate nurse to supervise the services

provided; and be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Home Hospice

A program, licensed and operated according to the law, which is approved by the attending *physician* to provide palliative, supportive and other related care in the home for a covered person diagnosed as terminally ill.

Hospice Facility

A public or private organization, licensed and operated according to the law, primarily engaged in providing palliative, supportive and other related care for a covered person diagnosed as terminally ill.

The facility must have an interdisciplinary medical team consisting of at least one *physician*, one registered nurse, one social worker, one volunteer and a volunteer program. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A hospice facility is not a facility or part thereof which is primarily a place for rest, *custodial care*, the aged, drug addicts, alcoholics or a hotel or similar institution.

Hospital

A public or private facility, licensed and operated according to the law, which provides care and treatment by *physicians* and *nurses* at the patient's expense of an *illness* or *injury* through medical, surgical and diagnostic facilities on its premises.

The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

A hospital does not include a facility or any part thereof which is, other than by coincidence, a place for rest, the aged or convalescent care.

Illness

Any bodily sickness, disease or *Mental Health disorder*.

Injury

A condition which results independently of an *illness* and all other causes and is a result of an externally violent force or *accident*.

Inpatient

Treatment in an approved facility during the period when charges are made for room and board.

Intensive Care Unit

A section, ward or wing within a *hospital* which is operated exclusively for critically ill patients and provides special supplies, equipment and constant observation and care by registered graduate nurses or other highly trained personnel. This excludes, however, any *hospital* facility maintained for the purpose of providing normal post-operative recovery treatment or service.

Lifetime

The period of time you or your eligible dependents participate in this plan or any other plan sponsored by Employers Resource.

Maintenance Care

Services and supplies provided primarily to maintain a level of physical or mental function.

Medicaid

Title XIX (Grants to states for Medical Assistance Programs) of the United States Social Security Act as amended.

Medical Emergency

A sudden, serious, unexpected and acute onset of an *illness* or *injury* where a delay in treatment would cause irreversible deterioration resulting in a threat to the patient's life or a body part, or an organ not returning to full, normal function.

Such conditions include, but are not limited to, suspected heart attack or stroke, loss of consciousness, actual or suspected acute poisoning, acute appendicitis, toxicity due to drugs or alcohol, acute renal failure, heat exhaustion, convulsive disorder, severe hemorrhage/allergic reaction, airway obstruction or aspiration, emergency medical care rendered for an accidental *injury* and other acute conditions.

Medically Necessary (Medical Necessity)

Treatments, procedures, services or supplies that the *plan administrator* determines, in the exercise of its discretion:

- are expected to be of clear clinical benefit to the patient; and
- are appropriate for the care and treatment of the *injury* or *illness* in question; and
- conform to standards of good medical practice as supported by applicable medical and scientific literature.

A treatment, procedure, service or supply must meet all of the criteria listed above to be considered medically necessary and to be eligible for coverage under this plan. In addition, the fact that a *health care provider* has prescribed, ordered or recommended a treatment, procedure, service or supply does not, in itself, mean that it is medically necessary as defined above.

Medicare

Title XVIII (Health Insurance for the Aged and Disabled) of the United States Social Security Act as amended.

Mental Health Disorder

For purposes of this plan, a Mental Health disorder is any diagnosed condition listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM, most recent edition, revised), except as specified in Medical Expenses Not Covered, for which treatment is commonly sought from a psychiatrist or mental health provider. The DSM is a clinical diagnostic tool developed by the American Psychiatric Association and used by mental health professionals. Diagnoses described in the DSM will be considered Mental Health in nature, regardless of etiology.

Mental Health Treatment Facility

A public or private facility, licensed and operated according to the law, which provides a program for diagnosis, evaluation and effective treatment of *Mental Health disorders*; and professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility must also have a *physician* on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Nurse

A person acting within the scope of his/her license and holding the degree of Registered Graduate Nurse (R.N.), Licensed Vocational Nurse (L.V.N.) or Licensed Practical Nurse (L.P.N.).

Oral Surgery

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

Outpatient

Treatment either outside of a *hospital* setting or at a *hospital* when room and board charges are not incurred.

Partial Hospitalization

A distinct and organized intensive ambulatory treatment service, less than 24-hour daily care specifically designed for the diagnosis and active treatment of a *Mental Health disorder* when there is a reasonable expectation for improvement or to maintain the individual's functional level and to prevent relapse or hospitalization.

Partial hospitalization programs must provide diagnostic services; services of social workers; psychiatric *nurses* and staff trained to work with psychiatric patients; individual, group and family therapies; activities and occupational therapies; patient education; and chemotherapy and biological treatment interventions for therapeutic purposes.

The facility providing the partial hospitalization must prepare and maintain a written plan of treatment for each patient. The plan must be approved and periodically reviewed by a *physician*.

Physically or Mentally Disabled

The inability of a person to engage in substantial gainful activity because of a mental or physical condition as certified by a physician and which has lasted or is expected to last at least 12 months or result in death.

Physician

A person acting within the scope of his/her license and holding the degree of Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) and who is legally entitled to practice medicine in all its branches under the laws of the state or jurisdiction where the services are rendered.

Plan Administrator

Employers Resource Benefit Trust and American Guaranty Title and Trust Inc.

Plan Sponsor

Employers Resource Benefit Trust and American Guaranty Title and Trust Inc.

Plan Year

The 12-month fiscal period for Employers Resource beginning January 1 and ending December 31.

Practitioner

A *physician* or person acting within the scope of applicable state licensure/certification requirements and holding the degree of Doctor of Dental Surgery (D.D.S.), Doctor of Dental Medicine (D.M.D.), Doctor of Podiatry Medicine (D.P.M.), Doctor of Chiropractic (D.C.), Doctor of Optometry (O.D.), Optician, Certified Nurse Midwife (C.N.M.), Certified Registered Nurse Anesthetist (C.R.N.A.), Registered Physical Therapist (R.P.T.), Psychologist (Ph.D., Ed.D., Psy.D.), Licensed Clinical Social Worker (L.C.S.W.), Master of Social Work (M.S.W.), Marriage, Family, Child Counselor (M.F.C.C.), Speech Therapist, Occupational Therapist, Acupuncturist, Physician's Assistant, Registered Respiratory Therapist, Nutritionist, Chemical Abuse Dependency Counselor (C.A.D.C.), Alcohol and Chemical Dependency Counselor (A.C.D.C.), Nurse Practitioner or Licensed Clinical Practitioner (L.C.P.), oriental medicine/acupuncture/Chinese herbology NCCAOM or ACAM accredited practitioner.

Preferred Provider Organization (PPO)

Arizona Foundation, BeechStreet, Idaho Physicians Network (IPN), Interplan Multiplan, Valley Preferred and First Choice of the Midwest and MedCost, including those health care providers who have agreed to discount the services they provide.

Protected Health Information

Information that is created or received by the plan and relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual.

Psychiatric Day Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than 8 hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a *physician* certified in psychiatry by the American Board of Psychiatry and Neurology.

The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Healthcare Organizations, or be *Medicare* approved.

Reconstructive Surgery

A procedure performed to restore the anatomy and/or functions of the body which are lost or impaired.

Rehabilitation Facility

A legally operating institution or distinct part of an institution which has a transfer agreement with one or more *hospitals*, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute *hospital* and rehabilitative *inpatient* care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, *custodial care*, ambulatory or part-time care services, or an institution which primarily provides treatment of *Mental Health disorders*, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of Mental Health conditions or substance abuse in the jurisdiction where it is located, *Medicare* approved, or is accredited as such a facility by the Joint Commission for the Accreditation of Healthcare Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Residential Treatment Facility

A child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be *Medicare* approved or accredited as a residential treatment facility by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Second Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Skilled Nursing Facility

A public or private facility, licensed and operated according to the law, which provides: permanent and full-time facilities for 10 or more resident patients; a registered nurse or *physician* on full-time duty in charge of patient care; at least one registered nurse or licensed practical nurse on duty at all times; a daily medical record for each patient; transfer arrangements with a *hospital*; and a utilization review plan.

The facility must be primarily engaged in providing continuous skilled nursing care for persons during the convalescent stage of their *illness* or *injury*, and is not, other than by coincidence, a rest home for *custodial care* or for the aged. The facility must be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Specialized Treatment Facility

Specialized treatment facilities as the term relates to this plan include *birthing centers, ambulatory surgical facilities, urgent care facilities, hospice facilities, skilled nursing facilities, Mental Health treatment facilities, substance abuse treatment facilities, psychiatric day treatment facilities, chemical dependency/ substance abuse day treatment facilities, residential treatment facilities, rehabilitation facilities* and *urgent care treatment facilities* as those terms are specifically listed in Covered Medical Expenses.

Substance Abuse Treatment Facility

A public or private facility, licensed and operated according to the law, which provides: a program for diagnosis, evaluation and effective treatment of substance abuse; detoxification services; and professional nursing services provided by licensed practical nurses who are directed by a full-time R.N. The facility also must have a *physician* on staff or on call.

The facility must prepare and maintain a written plan of treatment for each patient. The plan must be based on medical, psychological and social needs. The facility must also be *Medicare* approved or accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Surgery

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

Third Surgical Opinion

Examination by a *physician* who is certified by the American Board of Medical Specialists in a field related to the proposed *surgery* to evaluate the medical advisability of undergoing a surgical procedure.

Urgent Care Facility

A public or private facility, licensed and operated according to applicable state law, where ambulatory patients can receive immediate, non-emergency care for mild to moderate *injuries* and/or *illnesses* without scheduling an appointment.

Usual and Customary Charge

The charge most frequently made to the majority of patients for the same service or procedure. The charge must be within the range of the charges most frequently made in the same or similar medical service area for the service or procedure as billed by other *physicians* or *practitioners*.

Year

See *benefit year*.

RIGHTS OF PLAN PARTICIPANTS

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the *plan administrator's* office and at other specified locations (such as work sites and union halls) all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Administration.

Obtain, upon written request to the *plan administrator*, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The *plan administrator* may make a reasonable charge for the copies. Receive a summary of the plan's annual financial report. The *plan administrator* is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as the result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation rights.

Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the *plan administrator* and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the *plan administrator* to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the *plan administrator*.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees.

If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if the court finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the *plan administrator*. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the *plan administrator*, you should contact the nearest office of the Employee Benefits Security Administration (formerly Pension and Welfare Benefits Administration), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

GENERAL INFORMATION

Name of Plan

Employers Resource Management Employee Benefit Plan

Type of Plan

A welfare benefit plan, providing medical, and prescription drug benefits

Name and Address of the *Plan Sponsor*

Employers Resource Benefit Trust and American Guaranty Title and Trust Inc.
1301 South Vista Ave, Ste 250
Boise, ID 83705

The plan sponsor has the right to amend, modify or terminate the plan in any manner, at any time, regardless of the health status of any plan participant or beneficiary.

Name, Address and Telephone Number of the *Plan Administrator*

Employers Resource Benefit Trust and American Guaranty Title and Trust Inc.
1301 South Vista Ave, Ste 250
Boise, ID 83705
(208) 426-8006

The plan administrator is the sole fiduciary of the plan, and exercises all discretionary authority and control over the administration of the plan and the management and disposition of plan assets. The plan administrator shall have the sole discretionary authority to determine eligibility for plan benefits or to construe the terms of the plan, and benefits under the plan will be paid only if the plan administrator decides, in its discretion, that the participant or beneficiary is entitled to such benefits.

The plan administrator may hire someone to perform claims processing and other specified services in relation to the plan. Any such contractor will not be a fiduciary of the plan and will not exercise any of the discretionary authority and responsibility granted to the plan administrator, as described above.

Name and Address of the Designated Agent for Service of Legal Process

Alkine and Company PLLC
205 North 10th Street, Ste 300
Boise, ID 83702

In addition, service of process may be made upon the *plan administrator* or a plan trustee.

Name and Address of the Third Party *Contract Administrator*

P5 Health Plan Solutions/JSA P5 Utah, LLC.
P.O. Box 9554
Salt Lake City, UT 84109-9554

Internal Revenue Service

The corporate tax identification number assigned by the Internal Revenue Service is 82-0443852.

Plan Identification Number

The plan number is 502.

Plan Year

The *plan year* is the 12-month fiscal period for Employers Resource Benefit Trust and American Guaranty Title and Trust Inc. beginning January 1 and ending December 31.

Method of Funding Benefits

Benefits are self-funded from the general assets of the *plan sponsor* and contributions from participating employees (if required). The *plan sponsor* may purchase excess risk insurance coverage which is intended to reimburse the *plan sponsor* for certain losses incurred and paid under the plan by the *plan sponsor*. Such excess risk coverage, if any, is not part of the plan.

Payments out of the plan to *health care providers* on behalf of the covered person will be based on the provisions of the plan.

SIGNATURE PAGE

The effective date of the Employers Resource Management Employee Benefit Plan is January 1, 2010.

It is agreed by Employers Resource Management that the provisions of this document are correct and will be the basis for the administration of the Employers Resource Management Employee Benefit Plan.

Dated this _____ day of _____, _____

BY

TITLE

BY

TITLE
