<EMPLOYER NAME>

EMPLOYEE HEALTH AND WELFARE BENEFIT PLAN

SUMMARY PLAN DESCRIPTION AND PLAN DOCUMENT

FOR

EMPLOYEE PARTICIPANTS

AND THEIR DEPENDENTS

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION - The Plan is a self-funded health plan and the administration is provided through the Plan Administrator. The funding for the benefits is derived from the funds of the Employer and any funds contributed by covered Employees, which are received at the individual Trust account established to fund eligible benefits payable under the Plan.

EMPLOYER NAME:	**<Employer Name>**
PLAN NAME:	**<Employer Name>** **Employee Health and Welfare Benefit Plan**
PLAN NUMBER:	**<XXXXXX>**
EMPLOYER TAX ID NUMBER:	**<XX-XXXXXXX>**
PLAN EFFECTIVE DATE:	**< >**
PLAN YEAR ENDS:	**< >**
SITUS OF TRUST:	**Ohio**
TRUST NAME:	**<Employer Name>** **Employee Health and Welfare Benefit Trust**
PLAN SPONSOR (Employer):	**<Employer Name>** Street City, State, Zip Code Phone: Fax:
PLAN ADMINISTRATOR:	**Simplicity Health Plans** 20600 Chagrin Blvd. Suite 450 Cleveland, OH 44122 Phone: (877) 747-1113 Fax: (216) 283-7931
CLAIM ADMINISTRATOR:	**<Third Party Administrator (TPA)>** Street City, State, Zip Code Phone: Fax:

CASE MANAGEMENT AND UTILIZATION REVIEW ADMINISTRATOR:

AdvoCare, Inc.
25001 Emery Road
Suite 300
Cleveland, OH 44128
Phone: (877) 747-1113
Fax: (216) 514-1227

PRESCRIPTION CARD SERVICE ADMINISTRATOR:

Partners Rx Management, L.L.C.
15950 North 76th Street
Suite 200
Scottsdale, AZ 85260
Phone: (800) 711-4550
Fax: (480) 624-9401

SCHEDULE OF BENEFITS

Verification of Eligibility: **1-877-747-1113** listed on Your Member Identification Card. Call this number to verify eligibility for Plan benefits **before** the charge is incurred.

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

Pre-authorization For Medical Care Facility and Physician: Prior to being admitted to any Medical Care Facility or Physician a pre-authorization must be obtained. Call the phone number as indicated on Your Member Identification Card.

Network Provider Plan: This Plan has entered into an agreement with certain Hospitals, Physicians and other health care Providers, which are called Network Providers or PPO. These Network Providers have agreed to accept pre-negotiated rates as payment for eligible charges.

Therefore, when a Covered Person uses a Network Provider (In-Network Provider), that Covered Person's claim will be paid at the In-Network Maximum Allowed Amount for eligible charges subject to any Deductible and/or Co-payment.

When a Covered Person uses a Non-network Provider (Out-of-Network Provider), the Covered Person may be balance billed by the Non-network Provider for the differences between what this Plan pays and the Provider charges.

It is the Covered Person's choice as to which Provider to use.

Additional information about this option, as well as a list of In-Network Providers is available on www.simplictyhealthplans.com.

Plan Administrator Discounts. The Plan Administrator reserves the right to negotiate on behalf of the Member for additional discounts with Providers for In-Network and Out-of-Network services. If a Provider agrees to the negotiated allowed amount, the Member will not be balance billed for the differences between what this Plan pays and the Provider charges. The Member will only be responsible for any applicable Deductible and/or Co-payment.

Preferred Provider Organization (PPO): listed on Your Member Identification Card.

Deductibles/Co-payments payable by Plan Participants: Deductibles/Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A deductible is an amount of money that is paid once a Plan Year per Covered Person. Typically, there is one deductible amount per Plan and it must be paid before any money is paid by the Plan for any covered services.

A co-payment is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments. A co-payment may be either a fixed amount or based on a percentage.

Eligibility Requirements for Employee Benefits: A person is eligible for Employee benefits if he or she:

1. Is a full-time, Active Employee of the Employer working _____hours or more per week;

2. Is in a class eligible for benefits; and

3. Completes the employment Waiting Period of _____, if applicable. A "Waiting Period" is the time between the first day of employment and the first day of benefits under the Plan.

Initial Plan Contribution Categories:

Employee Only:	**$**
Employee + Spouse:	**$**
Employee + Child(ren):	**$**
Family:	**$**

BENEFIT SUMMARY

***Note:** Here we will insert a copy of the HDHP Benefit Summary

TABLE OF CONTENTS

INTRODUCTION

This document is a Summary Plan Description of health benefits provided under the Employer's Employee Health and Welfare Benefit Plan (the Plan). The Plan is designed to protect Plan Participants and their Dependents against certain catastrophic health expenses by providing reimbursement for certain medical expenses described in this Plan.

Benefits under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents complete the Waiting Period and are properly enrolled through the Plan Administrator and satisfy all the eligibility requirements of the Plan. There will be no allowance for Employee benefits or refunds of contributions for any Employee that is not listed on the Plan's eligibility listing. If the Employee is not enrolled and accepted in writing, there will be no benefits paid on behalf of the Employee. **Further if the Employee is not deleted from the eligibility list and contributions are paid on behalf of that Employee; no refund can be made to the Employer if the Plan Administrator has paid for stop loss/excess loss coverage for that time frame**.

The Employer fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason.

Only changes made by the Employer and distributed to all Plan Participants as a written amendment to the Plan may occur in any or all parts of the Plan including, but not limited to benefits, Deductibles, maximums, Co-payments, exclusions, limitations, definitions, and eligibility. The written terms of the Plan will prevail over any oral representation or interpretations.

The Plan provides benefits only for the expenses incurred while the Plan is in effect. No benefits are payable for expenses incurred before the Plan began or after the Plan is terminated. An expense for a service or supply is incurred on the date the service or supply is performed or furnished.

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

This document summarizes the Plan rights and benefits for covered Employees and their Dependents. If the terms of this document conflict with the terms of the Plan Document, the terms of the Plan Document shall control.

DEFINED TERMS

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

Active Employee is an Employee who performs the duties of his or her job on the basis specified by the Employer/Sponsor for participation in the Employee Health and Welfare Benefit Plan.

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

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

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

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

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

Cosmetic Dentistry means any dental procedure that is not **Medically Necessary**.

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

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

Dependent is a covered Employee's lawful spouse and any unmarried children from birth to the limiting age of nineteen (19) years. Children must be dependent upon the covered Employee for support and maintenance. However, a Dependent child may continue to be covered after age nineteen (19), up to the limiting age of twenty-five (25), if the unmarried child is a full-time student at an accredited school, and still dependent upon the Employee for support and maintenance. When the child reaches either limiting age, benefits will end on the child's birthday.

Children include natural, step, adopted, foster, and those children placed with the Employee or lawful spouse for care as a Legal Guardian. Also included are children under a qualified medical child support order.

The Plan Administrator may require documentation proving dependency, including birth certificates, tax records or initiation of legal proceedings severing parental rights.

If a covered Dependent child is incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance, unmarried and covered under the Plan when reaching the limiting age, coverage may be continued beyond the limiting age if the Dependent child remains as a Disabled Dependent. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent's reaching the limiting age, subsequent proof of the child's disability and dependency.

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

Employee is a person who is on the payroll of the Employer and is in an Employee/Employer relationship.

Employer is named on the Cover Page of this document.

Enrollment Date is the first day under the Plan: or, if there is a Waiting Period, the first day of the Waiting Period. **Employees and their Dependents must be added/deleted within thirty (30) days of the addition or deletion.**

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

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services are rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator will be guided by a reasonable interpretation of Plan provisions. The decisions will be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. The Plan Administrator will be guided by the following principles:

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

2. If the drug, device, medical treatment or procedure has not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or illness to be treated; or

3. If the drug, device, medical treatment or procedure has not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or illness to be treated; or

4. If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

5. If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

6. If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure 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 a standard means of treatment or diagnosis.

Reliable Evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol(s) used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

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

Fertility means the evaluation and treatment of reproductive function in male and/or female to include ability to conceive and/or sustain a successful Pregnancy.

Generic Drug means a Prescription drug, which has the same use and metabolic disintegration equivalency as a brand name drug. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in

specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

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

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

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

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

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

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

Hospice Unit is a facility or separate Hospital Unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six (6) months.

Hospice is defined as follows:

An agency that provides outpatient counseling and medical services and may provide room and board to a terminally ill person and that meets all of the following tests:

1. It has obtained any required state or governmental certificate of need approval;
2. It provides service 24 hours a day, 7 days a week;
3. It is under the direct supervision of a Physician;

4. It has a nurse coordinator who is a registered nurse;
5. It has a social service coordinator who is licensed;
6. It is an agency that has as its primary purpose the provision of Hospice services;
7. It has a full-time administrator;
8. It maintains written records of services provided to the patient; and
9. It is licensed as a Hospice, if state law requires licensing.

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

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

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

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

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

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

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean during the lifetime of the Covered Person while covered under this Plan.

Maximum Allowed Amount is the portion of any charge for covered services and supplies that is considered eligible under this Plan. It will be determined at the time of claim submission and will be calculated based on either a percentage of the Medicare fee schedule as determined by the Plan Administrator or the negotiated PPO rate.

Medical Care means the diagnosis, cure, mitigation, treatment, or prevention of disease, for the purpose of affecting any structure or function of the body.

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

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate Medical Care and includes such conditions as heart attacks, cardiovascular incidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary care and treatment is: (1) recommended or approved by a Physician; (2) consistent with the patient's condition or accepted standards of good medical practice; (3) medically proven to be effective treatment of the condition; (4) not performed mainly for the convenience of the patient or provider of medical services; (5) not conducted for research purposes; and (6) the most appropriate level of services that can be safely provided to the patient.

All of these criteria must be met for care and treatment to be considered medically necessary.

The Plan Administrator has the discretionary authority to decide whether care or treatment is medically necessary.

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

Member is any Employee or Dependent who is eligible to receive benefits under the Plan.

Member Identification and Prescription Drug Card. The identification card provided by the Plan Administrator/Claim Administrator for each eligible Plan Participant.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the

current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity is a diagnosed condition in which the body weight exceeds the medically recommended weight by either one hundred (100) pounds or is twice the medically recommended weight in the most recent industry recognized actuarial tables for a person of the same height, age, and mobility as the Covered Person.

Outpatient Surgical Facility means a licensed public or private medical facility that has an organized staff of Physicians, and permanent facilities that are equipped and operated primarily to perform surgery. The facility must provide continuous Physician and registered professional nursing services whenever a patient is in the facility. Outpatient Surgical Facility includes a facility that is operated by a Hospital that provides scheduled, non-emergency and outpatient surgical care. It does not include a Hospital emergency room, trauma center, Physician's office, or clinic.

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

Plan means the Employer's Employee Health and Welfare Benefit Plan, which is a benefits plan for certain Employees of the Employer named on the cover page and is described in this document.

Plan Administrator is named on the second page to administer the Plan for the Employer Sponsor.

Plan Participant is any Employee or Dependent who is eligible to receive benefits under the Plan.

Plan Sponsor is the Employer, which directs the establishment of the Plan, **appoints the Plan Administrator and the Trustee which may appoint the Custodian; and, funds the Plan on behalf of the Plan Participants.**

Plan Year is the twelve (12) month period beginning on the effective date of the Plan.

Plan Year Maximum is a term that appears in this Plan in reference to benefit maximums and limitations that apply during each twelve (12) month period beginning on the effective date of the Plan.

Pre-Existing Condition is a condition for which medical advice; diagnosis, care or treatment was recommended or received within six (6) months of the person's Enrollment Date under this Plan. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

If an otherwise Eligible Employee or Dependent enrolls for coverage under the Plan after the Effective Date of this Plan, the Covered Person shall not be entitled to benefits for expenses incurred as the result of Injuries or illnesses for which the Covered Person has consulted with a Physician, taken medication or received any Medical Care or services within a six (6) month period immediately prior to his Enrollment Date until the expiration of a period of twelve (12) consecutive months from the Covered Person's Enrollment Date in the Plan. This Pre-Existing Conditions Limitation provision does not apply to a newborn child enrolled within thirty (30) days of his/her birth, or to an adopted child under age eighteen (18) who is enrolled within thirty (30) days of his/her adoption or placement for adoption, or to expenses due to Pregnancy which would otherwise have been eligible for benefits under the Plan.

Any period of time during which Creditable Coverage, as defined, was in effect will carry over to offset or reduce the Pre-Existing Conditions Limitation of twelve (12) months as long as no break in coverage of sixty-three (63) days or more has occurred. Any Waiting Period for coverage is not considered a break in coverage. Certification of Creditable Coverage must be supplied indicating the exact time period such coverage was in effect. The employer, insurance company or other organization under which the Creditable Coverage occurred supplies this certification.

Furthermore, a Pre-Existing Condition is also a Sickness or Injury which was diagnosed or treated, or which produced signs or symptoms that would cause an ordinary, prudent person to seek treatment, during the six (6) month period before the Covered Person's effective date of coverage. Benefits for Pre-Existing Conditions are not payable until the Covered Person's coverage has been in force for twelve (12) consecutive months with this Employer’s Employee Health and Welfare Benefit Plan.

Primary Care Physician means a Family Practitioner, General Practitioner, Internist, Pediatrician or OB/GYN chosen by the Covered Person to provide general and routine care services.

Prior Creditable Coverage means the aggregate period of time after any break in coverage during which You were covered under another group health plan, health insurance, public health service plan, Medicare Part A or Part B, Medicaid, a Medical Care program of the Indian Health Service or of a tribal organization, a State health benefits risk pool, or other statutorily mandated coverage’s such as those covering military personnel, veterans, and Peace Corps workers. A break in coverage is a continuous period of at least sixty-three (63) days during

which You were not covered under any of the aforesaid types of plans. A Waiting Period that You must satisfy in order to enter a plan, including this Plan, is not a break in coverage.

Preferred Provider Organization is a PPO. When the Employer selects a plan of benefits which utilizes a PPO, every effort will be made to contract with that Provider Network offering services to the Employees and Dependents based on Provider choices, discounts, and customer service. National and Regional networks are usually available in most areas and the PPO Provider will be listed on the Member ID card. An Employer may need to utilize more than one PPO Network when Employees are in different locations. PPO access is granted on a capitated basis; therefore, when more than one PPO is used, the Employees only have access to the PPO which is best for them.

Pregnancy is childbirth and conditions associated with pregnancy, including complications for any Plan Participant.

Prescription Drug means any of the following: a Food and Drug Administration approved drug or medicine that, under federal law, is required to bear the legend: "Caution - Federal Law prohibits dispensing without prescription".

Sickness is an illness or disease.

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

1. It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician.
3. It provides 24 hours per day nursing services by licensed nurses, under the direction of a full-time registered nurse.
4. It maintains a complete medical record on each patient.
5. It has an effective utilization review plan.
6. It is not, other than incidentally, a place for rest care, convalescence, care of the aged, drug addiction, alcoholism, mental retardation or illness, or Mental Disorders, or custodial or educational care.
7. It is approved and licensed by Medicare.

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

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

Single Employer Trust is the Employee Health and Welfare Benefit Plan under ERISA developed exclusively for a single Employer. Each Employer must have a Trust, which is used exclusively for the benefits of the Employees and the Dependents of the Employees of the Employer.

Substance Abuse is the condition characterized by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that result in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Summary Plan Description means the document that each Employee receives to explain the level of benefits provided to Plan Participants under the Employee Health and Welfare Benefit Plan sponsored by their Employer.

Urgent Care Services are Medically Necessary services that are required for an illness or Injury that would not result in further disability or death if not treated immediately, but require professional attention and have the potential to develop such a threat if treatment is delayed longer than 24 hours. An urgent care condition could be a sprain, sore throat or rising temperature.

Waiting Period means the number of days after the first day of employment as an Active Employee that must pass before You and Your Dependents are eligible for benefits under this Plan. The waiting period does not apply to existing Employees who have been actively at work for a period of time greater than the established waiting period, initially waived benefits, but are then added to the Plan after a qualifying event.

ELIGIBILITY AND EFFECTIVE DATES

Eligible Classes of Employees. Active Employees of the Employer.

Eligibility Requirements for Employee Benefits. A person is eligible for Employee benefits if he or she:

1. Is an Active Employee of the Employer meeting the definition specified by the Employer for participation in the Employee Health and Welfare Benefit Plan;

2. Is in a class eligible for benefits; and all Employees in a classification are offered the same level of benefits;
3. Completes the employment Waiting Period as noted in the Schedule of Benefits. A "Waiting Period" is the time between the first day of employment and the first day of benefits under the Plan;
4. Has submitted to the Employer Sponsor a complete and accepted Employee Questionnaire applying for benefits.

Eligible Classes of Dependents. All Dependents as defined in the Plan.

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

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

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

Eligibility Requirements for Dependent Benefits. A family member of an Employee will become eligible for Dependent benefits on the first day that the Employee is eligible for Employee benefits and the family member satisfies the requirements for Dependent benefits. At any time, the Plan may require proof that a spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

EFFECTIVE DATES

Effective Date of Employee Benefits. An Employee will be eligible for benefits under this Plan as of the first day of the calendar month following the date that the Employee satisfies all of the following:

1. The Eligibility Requirement.
2. The Active Employee Requirement.
3. The Enrollment Requirements of the Plan.

Effective Date of Dependent Benefits. A Dependent's benefits will take effect on the day that; (1) the Eligibility Requirements are met; (2) the Employee is covered under the Plan; and (3) all Enrollment Requirements are met.

IDENTIFICATION CARD

Your ID Card identifies You as a participant in the Network Plan. You are responsible for showing Your ID Card to the Provider before receiving any medical services. If You fail to show Your Card before receiving any medical services, the benefits described in this section as Network benefits may be payable as if they were Non-Network/Out-of-Network benefits.

In-Network Providers are constantly changing and You will get the most up-to-date information by referring to the internet listing of Providers on the Simplicity Health Plans' website.

There may be times when You need care and the type of Provider is not listed in the Network Provider directory. There may also be times when You are away from home and need non-emergency medical attention. If this happens, please call the number listed on Your ID Card for assistance. **IT IS YOUR RESPONSIBILITY TO DETERMINE IF THE PROVIDER RENDERING THE SERVICES IS AN IN-NETWORK PROVIDER WHEN SUCH SERVICES ARE RENDERED.**

ENROLLMENT

Enrollment Requirements. An Employee must enroll for benefits under this Plan by filling out and signing an Employee Questionnaire form. The covered Employee is required to enroll for any Dependent benefits by completing and signing an Employee Questionnaire form for the Dependents to be covered. If the covered Employee already has Dependent benefits, a newborn, newly adopted or newly placed child will be automatically enrolled from the date of birth, adoption, or placement; otherwise, separate enrollment for such child is required.

Enrollment Requirements for Newborn, Newly Adopted, or Newly Placed Children. For benefits of Sickness or Injury, including Medically Necessary care and treatment of congenital defects, birth abnormalities or complications resulting from prematurity, if the newborn, newly adopted, or newly placed child is required to be enrolled, he or she must be enrolled as a Dependent under this Plan within thirty (30) days of the child's birth, adoption, or placement in order for non-routine benefits to take effect from the date of birth, adoption, or placement.

If the child is required to be enrolled and is not enrolled within thirty (30) days of birth, adoption, or placement, the enrollment will be considered a late enrollment.

TIMELY ENROLLMENT

1. **Timely Enrollment.** The timely enrollment period is thirty (30) days from the date the person becomes eligible for benefits under this Plan, either initially or under a special enrollment period, in which the Plan Administrator must receive a completed Employee Questionnaire form and the Member ID card is issued. Exceptions to this procedure must be approved in advance by the Plan Administrator.

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

a. The Employee or Dependent was covered under a group health plan or had health coverage at the time benefits under this Plan were previously offered to the individual.
b. If required by the Plan Administrator, the Employee stated in writing at the time that benefits were offered that the other health coverage was the reason for declining enrollment.
c. The benefits of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated.
d. The Employee or Dependent requests enrollment in this Plan not later than thirty (30) days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above.
e. If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or for cause as defined by their former plan's requirements (such as making a fraudulent claim), that individual does not have a special enrollment right.

3. Dependent Beneficiaries. If:

a. The Employee is a participant under this Plan (or is eligible to be enrolled under this Plan, but for a failure to enroll during a previous enrollment period), and
b. A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, and then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the spouse is otherwise eligible for coverage.

The Dependent special enrollment period must be a period of not less than thirty (30) days and must begin on the date of the marriage, birth, adoption or placement for adoption.

The benefits of the Dependent enrolled in the special enrollment period will be effective:
1. In the case of marriage, not later than the first day of the first month beginning after the date of the completed request for enrollment is received;
2. In the case of a Dependent's birth, as of the date of birth; or in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

FUNDING

Contributions to the Plan. The Employer may share the cost of Employee and Dependent benefits under this Plan with the covered Employees. The Plan Sponsor/Employer sets the amount of any Employee contributions.

TERMINATION PROVISIONS

When Employee Benefits Under the Plan Terminate. Employee benefits will terminate on the earliest of these dates:

1. The date the Plan is terminated.
2. The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee.
3. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

Except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled COBRA Continuation Options.

Continuation during Periods of Employee-Certified Disability. A person may remain eligible for a limited time if active, full-time work ceases due to disability. This continuance will end as follows:

For disability leave only: the end of the three (3) calendar month period that next follows the month in which the person last worked as an Active Employee.

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

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

During any leave taken under the FMLA, the Employer will maintain benefits under this Plan on the same conditions as benefits would have been provided if the covered Employee had been continuously employed during the entire leave period.

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

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment requirements.

Employees on Military Leave. Employees going into or returning from military service will have Plan rights mandated by the Uniformed Services Employment and Reemployment Rights Act. These rights include up to eighteen (18) months of extended health care benefits upon payment of the entire cost of benefits plus a reasonable administration fee and immediate benefits with no Pre-Existing Condition exclusions applied in the Plan upon return from service. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

Plan exclusions and Waiting Periods may be imposed for any Sickness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

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

1. The date the Plan or Dependent benefits under the Plan is terminated.
2. The date that the Employee's benefits under the Plan terminate for any reason including death. (See the COBRA Continuation Options.)
3. The date a covered Dependent loses benefits due to loss of dependency status. (See the COBRA Continuation Options.)
4. The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the benefit charges of a Plan Participant that are in excess of the Deductible and any Co-payment if applicable. Payment will be made according to the Schedule of Benefits. No benefits will be paid in excess of the Maximum Allowed Amount or maximum benefit limit of the Plan for eligible charges.

COVERED CHARGES

Covered Charges are the Maximum Allowed Amounts for Medically Necessary care or treatment for an Injury or Sickness that are incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

1. **The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center**. Covered Charges for room and board will be payable as shown in the Schedule of Benefits.

   Room charges made by a Hospital for private rooms will be paid when Medically Necessary.

If a private room is chosen when not Medically Necessary, the Plan payment will not exceed the Maximum Allowed Amount for the semi-private room rate.

2. **The Maximum Allowed Amount for the care and treatment of Pregnancy** is covered the same as any other Sickness for any Plan Participant.

   Benefit for a Hospital stay following a normal vaginal delivery will be forty-eight (48) hours for both the mother (if a covered Plan Participant) and the newborn child unless a shorter stay is agreed to by both the mother and her attending Physician. Benefits for a Hospital stay in connection with childbirth following a Cesarean section will be ninety-six (96) hours for both the mother and the newborn child, unless a shorter stay is agreed to by both the mother and her attending Physician.

3. **Extended Care Services. Charges furnished by a Skilled Nursing Facility; or, for Rehabilitative Therapy.** Covered Charges for a Covered Person's extended care services are limited to the charge limit shown in the Schedule of Benefits.

   Skilled Nursing Facility. The room and board and other charges furnished by a Skilled Nursing Facility will be payable if and when:
   a. The patient is confined as a bed patient in the facility;
   b. The confinement starts within fourteen (14) days of a Hospital confinement;
   c. The attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
   d. The attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment, and the projected date of discharge from the Skilled Nursing Facility.

   Rehabilitative Therapy. Specialized treatment for an Injury, or physical defect related to an illness or Injury, which: 1) is an intense, comprehensive program of therapies and services provided by a multi-disciplinary team; 2) is designed to restore the patient's maximum function and independence; 3) is under the direction of a qualified Physician; 4) meets the definition of Medically Necessary; and, 5) can be provided in both an inpatient and outpatient setting. Rehabilitative Therapies include physical therapy, occupational therapy and speech therapy.

4. **The professional services of a Physician for multiple surgical procedures will be payable subject to the following provisions**:

   a. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the Maximum Allowed Amount for the primary procedure; 50% of the Maximum Allowed Amount will be considered on each additional procedure performed through the same incision; and 50% of the Maximum Allowed Amount will be considered for each additional procedure performed through a separate incision. Any procedure that would 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.
   b. If two (2) or more surgeons on separate operative fields perform multiple unrelated surgical procedures, benefits will be based on the Maximum Allowed

Amount for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the Maximum Allowed Amount for that procedure; and

c. If an assistant surgeon is required, the assistant surgeon's Covered Charge will not exceed 20% of the surgeon's Maximum Allowed Amount.

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

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

6. **Charges for Hospice Care Services and Supplies** are covered only when the attending Physician has diagnosed the Covered Person's condition as being terminal, determined that the person is not expected to live more than six (6) months, and placed the person under a Hospice Care Plan.

7. **Other services and supplies, not otherwise included in the items above, are covered as follows**:

   a. Local Medically Necessary professional land or air ambulance service. A charge for this item will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where necessary treatment can be provided, unless the Plan Administrator finds a longer trip was Medically Necessary.
   b. Anesthetic; oxygen; blood and blood derivatives that are not donated or replaced; intravenous injections and solutions. Administration of these items is included.
   c. **Cardiac rehabilitation as deemed Medically Necessary,** provided services are rendered: (1) under the supervision of a Physician; (2) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (3) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (4) in a Medical Care Facility as defined by this Plan.
   d. **Radiation or chemotherapy and treatment with radioactive substances.** The materials and services of technicians are included.
   e. **Initial contact lenses or glasses** required following cataract surgery.
   f. **Rental of durable medical or surgical equipment** if deemed Medically Necessary. These items may be bought rather than rented, with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator.
   g. **Treatment of Mental Disorders and Substance Abuse.** Covered Charges for care, supplies, and treatment of Mental Disorders and Substance Abuse will be limited as follows: (1) All treatment is subject to the benefit payment maximums shown in the Schedule of Benefits; and (2) Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental

health practitioners must be under the direction of, and must bill the Plan through, these professionals.

h. **Injury to or care of mouth, teeth and gums.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under medical benefits only if that care is for the following oral surgical procedures: (1) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth; (2) Emergency repair due to Injury to sound natural teeth (this repair must be made within twelve (12) months from the date of an accident); (3) Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth; (4) Excision of benign bony growths of the jaw and hard palate; (5) External incision and drainage of cellulitis; (6) Incision of sensory sinuses, salivary glands or ducts; (7) Removal of impacted teeth; and (8) Treatment of conditions directly related to underlying medical and surgical procedures for which this Plan has provided coverage. No charge will be covered under medical benefits for dental and oral surgical procedures involving orthodontic care of the teeth, periodontal disease, and preparing the mouth for the fitting of or continued use of dentures.

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

j. **Organ Transplant Benefit.** The Plan will cover charges for any In-Network organ, tissue or cellular transplants reviewed and approved through Utilization Review or by the Case Management department prior to transplantation evaluation, testing, or donor search. The maximum benefit for potential donor and actual donor expenses is $10,000 for each transplant. All transplant related claims apply toward the lifetime maximum benefit.

Covered Charges include the following solid organ transplants and marrow reconstitution or support:

<u>Solid Organ Transplants</u>

- Heart
- Lung
- Combined Heart/Lung
- Combined Kidney/pancreas
- Liver (Candidates for liver transplantation must have abstained from alcohol for one year immediately prior to transplantation.)

Marrow reconstitution or support (often called bone marrow transplant or stem cell transplant) is a transplantation procedure in which human blood precursor cells are administered to a patient following myelosuppressive or ablative therapy. Such cells may be derived from bone marrow or circulating blood, obtained from the patient in autologous harvest, or from a matched donor for an allogenic transplant. The marrow reconstitution and support procedure includes all chemotherapy, the harvesting, and reinfusion of the marrow or blood precursor cells.

The Plan will not cover charges:

- For multiple organ, tissue and cellular transplants during one operative session, except for a heart/lung, double lung or simultaneous kidney/pancreas transplant;
- For transplants approved for a specific medical condition, but applied to another condition;
- For the purchase of an organ or tissue; or
- For any transplant determined by the Plan to be Experimental or Investigational or not Medically Necessary;
- For any non-human (including animal or mechanical) organ transplant.

Charges otherwise covered under the Plan that are incurred for the care and treatment due to an organ or tissue transplant are subject to these limits: (1) The transplant must be performed to replace an organ or tissue of the Covered Person; and (2) 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 benefits, 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.

k. **The initial purchase**, fitting, repair, and replacement of orthotic appliances such as braces, splints, or other appliances, which are required for support for an injured or deformed part of the body as a result of a disabling congenital condition or an Injury or Sickness.

l. **Physical Therapy** by a licensed physical therapist. The therapy must be in accord with a Physician's exact orders as to type, frequency, and duration, and to improve a body function.

m. **Prescription Drugs,** if coverage is included in the benefits of the Plan**.**

n. **Routine preventive care** by a Physician that is not for an Injury or Sickness. Routine charges include well adult and childcare. Well childcare includes routine pediatric care and immunizations as stated in the Schedule of Benefits.

o. **The initial purchase,** fitting, repair, and replacement of fitted prosthetic devices**,** which replace body parts.

p. **Speech Therapy** by a licensed speech therapist. Therapy must be ordered by a Physician and follow either: (1) surgery for correction of a congenital condition of the oral cavity, throat, or nasal complex (other than a frenectomy) of a person; (2) an Injury; or (3) a Sickness that is other than a learning or Mental Disorder.

q. **Spinal Manipulation/Chiropractic** services by a licensed M.D., D.O., or D.C. The maximum benefit and the number of visits per month, per Plan Year is as stated in the Schedule of Benefits. This Plan only covers the office visit charges. Charges for related labs, x-rays and any other services are excluded.

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

s. **Benefits for well newborn nursery** Physician care includes room, board, and other normal care for which a Hospital makes a charge. This benefit is only provided if the Employee or spouse is the Covered Person at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill. Benefits for a Hospital stay following a normal vaginal delivery may not be limited to less than forty-eight (48) hours for both the mother and the newborn child. Benefits for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to less than ninety-six (96) hours for both the mother and the newborn child.

t. **Diagnostic X-rays.**

PLAN EXCLUSIONS

For all medical benefits shown in the Schedule, a charge for the following is not covered:

1. Expenses incurred before the effective date or after the date coverage terminated.
2. Services not Medically Necessary or which are Experimental, Investigational or for research purposes.
3. Services while confined in a Hospital or other facility owned or operated by the United States government, provided by a person who ordinarily resides in the Covered Person's home or who is a family member, or that are performed in association with a service that is not covered under the Plan.
4. Charges incurred for which the Plan has no legal obligation to pay.
5. Charges caused by war, declared or undeclared, or any act of war.
6. Charges incurred while on full-time active duty in the armed forces of any country, combination of countries, or international authority.
7. Injury or Sickness arising out of or in the course of any occupation, employment or activity for compensation, profit or gain, whether or not benefits are available under Workers' Compensation. This exclusion does not apply to a Covered Person qualifying as a sole proprietor, officer or partner under state law, and such benefits are not covered under any Workers' Compensation plan, provided the Covered Person is not covered under a Workers' Compensation plan, except for certain professions or activities as stated in the Plan.
8. Care and treatment for which there would not have been a charge if no coverage had been in force.
9. Care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
10. Charges in excess of the Maximum Allowed Amount or which exceed any maximum Plan benefit.
11. Any loss due to attempted suicide or intentionally self-inflicted Injury when sane.
12. Care or treatment resulting from the voluntary taking of or while under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances.
13. Services not authorized or prescribed by a health care practitioner or for which no charge is made.

14. Charges resulting from or occurring during the commission of a crime by the Covered Person, or while engaged in an illegal act, illegal occupation, aggravated assault, or participating in a riot or public disturbance.
15. Charges incurred for Experimental procedures, drugs, or research studies, or for any services or supplies not considered legal in the United States. Any drug, medicine or device that is not FDA approved.
16. Charges incurred for drugs, devices, medical treatments or procedures that have not received the approval or endorsement of the American Medical Association (AMA) for the specific Injury or illness to be treated.
17. Charges incurred for drugs, devices, medical treatments or procedures that have not received the approval or endorsement of the National Institutes of Health (NIH) or its affiliated institutes for the specific Injury or illness to be treated.
18. Contraceptives other than oral, including implant systems and devices regardless of the purpose for which prescribed.
19. Medications, drugs or hormones to stimulate growth.
20. Charges related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility, artificial insemination, or in-vitro fertilization or charges resulting from or in connection with the sterilization or reversal of a sterilization procedure.
21. Care, services, or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
22. Any surgical procedure for the correction of a visual refractive problem, including radial keratotomy. Lenses for the eyes and examinations for their fitting. This exclusion does not apply to aphakis patients and soft lenses or sclera shells intended for use as corneal bandages.
23. Vision therapy; all types of refractive keratoplasties or any other procedures, treatments or devices for refractive correction; eyeglasses; contact lenses. Hearing aids and examinations for their fitting.
24. Dental services (except for dental Injury), appliances or supplies.
25. Cosmetic dentistry. Dental services or x-ray examinations involving one or more teeth, the tissue or structure around them, the alveolar process or the gums. All diagnostic and treatment services related to the treatment of jaw joint problems, including temporomandibular joint syndrome in excess of $1,500.00 for any Plan Year. This exclusion does not apply to charges made for treatment or removal of a malignant tumor, for treatment of conditions directly related to underlying medical and surgical procedures for which this Plan has provided coverage, or for the following dental services received within twelve (12) months after an accident: treatment by a doctor, dentist or dental surgeon for Injuries to natural teeth including replacement of such teeth and related x-rays.
26. Routine or periodic examinations, screening examinations, evaluation procedures, preventive Medical Care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness, or Pregnancy-related condition, unless such care is specifically covered in the Schedule of Benefits. Routine physical examinations for occupation, employment, school, travel, purchase of insurance or premarital tests are excluded.
27. Services or supplies provided mainly as a rest cure, maintenance, or Custodial Care.
28. Any treatment for the purpose of reducing obesity, or any use of obesity reduction procedures to treat Sickness or Injury caused by, complicated by, or exacerbated by obesity, including but not limited to surgical procedures.
29. Charges for treatment of nicotine habit or addiction; expenses incurred for educational or vocation therapy, services and schools; light treatment for Seasonal Affective Disorder

(S.A.D.); alternative medicine; marital counseling; genetic testing, counseling or services; sleep therapy or services rendered in a premenstrual syndrome clinic or holistic medicine clinic.

30. Care and treatment for hair loss, including hair prosthesis, implants, wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician. Wigs will be covered if the hair loss is directly related to underlying medical and surgical procedures for which this Plan has provided coverage.
31. Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan. Charges for health clubs or health spas, aerobic and strength conditioning, work hardening programs and related material and products for these programs; personal computers and related or similar equipment; communication devices other than due to surgical removal of the larynx or permanent lack of function of the larynx.
32. Care and treatment of an Injury or Sickness that results from engaging in a Hazardous Hobby. A hobby is hazardous if it is an unusual activity, which is characterized by a constant threat of danger or risk of bodily harm. Examples of hazardous hobbies are horseback riding, skydiving, auto racing, hang gliding, and bungee jumping.
33. Services, supplies, care or treatment in connection with an abortion, unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
34. Charges for elective medical or surgical procedures; sterilization, including tubal ligation and vasectomy; reversal of sterilization; gender change or sexual dysfunction.
35. Care and treatment, which has not been pre-authorized, billed by a Hospital for non-emergency admissions. This does not apply if surgery or significant treatment as prescribed by an attending Physician is performed within 24 hours of admission.
36. Charges for standby Physician or assistant surgeon, unless Medically Necessary; private duty nursing; communication or travel time; lodging or transportation, except as stated in the Plan.
37. Charges for non-medical purposes or used for environmental control or enhancement (whether or not prescribed by a health care practitioner). Any personal comfort items, elective expenses, or other equipment, such as, but not limited to: air conditioners, humidifiers, blood pressure instruments, scales, shoes, inserts, ankle pads, printed material, arch supports, elastic stockings, fluoride, vitamins, nonprescription drugs, nutritional or dietary counseling, or food supplements.
38. Blood or blood plasma that is replaced on a discretionary basis by or for the patient. This exclusion in no way limits the coverage for blood or blood plasma used in a covered procedure.
39. Expenses applied toward satisfaction of the Deductible.
40. Routine foot care services and services performed by a podiatrist. Treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, or bunions, except open cutting operations. Charges for corns, calluses, or toenails, except the removal of nail roots and necessary services in the treatment of metabolic or peripheral-vascular disease.
41. Cosmetic procedures and any related complications, except cosmetic surgery for: (1) charges to repair or alleviate damage incurred within two years of an accident; (2) surgery to restore bodily function or to correct deformity resulting from a disease, trauma, congenital birth defects, or previous therapeutic process; or (3) reconstructive surgery following a mastectomy.
42. Organ transplants not approved based on established criteria or Investigational, Experimental or for research purposes. Organ transplants except as allowed in the Covered Charges and Schedule of Benefits sections.

43. Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
44. Care or treatment for which there would have been no benefit Plan issued or benefits available if complete details and information would have been disclosed at the time of the original Employee and Employer's Questionnaires/Applications. Any material misrepresentation provided for underwriting and stop loss/excess loss insurance/reinsurance in the Questionnaires/Applications could cause the cancellation of the stop loss/excess loss policy/treaty purchased and issued to the Trust.
45. Services received in an emergency room unless required because of emergency care.
46. Inpatient services when in an observation status or when the stay is due to behavioral, social maladjustment, lack of discipline or other antisocial actions not a result of a Mental Disorder.
47. Charges incurred for a Hospital stay beginning on a Friday or Saturday unless due to emergency care or surgery is performed on the day admitted.
48. Charges covered by another plan sponsor or payor.
49. Charges incurred as a result of radioactive contamination or the hazardous properties of nuclear material.

PRESCRIPTION BENEFITS

Drugs, biologicals and compounded prescriptions that can be dispensed only pursuant to a written prescription given by a Physician, that are listed and accepted in the United States Pharmacopeia, National Formulary, or AMA Drug Evaluations published by the American Medical Association, that are prescribed for human consumption, and that are required by law to bear the legend: "Caution - Federal Law prohibits dispensing without prescription."

OUTPATIENT PRESCRIPTION DRUG BENEFITS PAYMENT OF BENEFITS

Subject to the Plan Exclusions section in the medical benefit portions of the Plan, the Charges Not Covered section which follows and all other conditions, terms, and limitations of the Plan, We will pay for outpatient prescription drug benefits for covered outpatient prescription drug charges that You or Your covered Dependents incur.

To obtain benefits at a Member Pharmacy, present Your ID card. Certain drugs require pre-authorization prior to dispensing and review for possible coverage. Once You pay any applicable Deductible and/or the prescription drug Co-payment, We will pay benefits up to a thirty (30) consecutive days' supply for each prescription, or, if mail order service is available, up to a ninety (90) consecutive days' supply for each maintenance medication prescription covered by and through the mail order pharmacy service unless restricted by the manufacturer's packaging or the prescription order. Some drugs or drug categories may be subject to additional supply, quantity, Plan sponsorship or Plan cost share limits. If two or more covered drug products are packaged and/or manufactured together, You may be required to pay a Co-payment for each drug product in the packaging and/or in the combination product. If a covered medication is taken on an as-needed basis, the Plan may cover enough medication for a single episode of care per Co-payment charge. If two or more products are packaged and/or manufactured together, and one or more of the active ingredients in the product(s) are

not covered, then the entire packaged and/or manufactured combination product is not covered.

When a Member Pharmacy is used, the following provisions apply for covered outpatient prescription drug charges. You pay any applicable Deductible. After the Deductible has been satisfied, You pay the applicable Co-payment.

1. When a covered Generic Drug is available, and You receive that Generic Drug, You pay the Generic Drug Co-payment.
2. When a Generic Drug is not available, and You receive a Brand Drug, You pay the applicable Brand Drug Co-payment.
3. If You receive a Brand Drug when a Generic Drug is available, then You will pay the applicable Brand Drug Co-payment plus the difference in cost between the Brand Drug and the Generic Drug.

When You have prescriptions filled at a pharmacy that is not a Member Pharmacy, You must pay for the prescription in full and then follow the instructions for filing a claim as outlined in the claim procedures section. You will be reimbursed at the Maximum Allowed Amount that would have been paid to a Member Pharmacy for the cost of the drug minus any applicable Deductible and/or Co-payment.

Amounts not paid by Us due to the difference between the billed amount at any pharmacy and what We pay do not count toward any Out-of-Pocket Limit or Deductible and will continue after these amounts are met. Prescription Co-payments count toward the Out-of-Pocket Limit and will cease when the Out-of-Pocket Limit is met. Benefits paid under this section will be applied toward any applicable maximum benefit limit, the Plan Year Maximum and Lifetime maximum benefit.

For purposes of this section, the following definitions shall apply:

"Brand Drug" means any medicinal substance that may only be dispensed pursuant to a prescription order from a Physician or other authorized prescriber under state or federal regulations. Additionally, it means a drug for which a pharmaceutical company has received a patent or trade name. Additionally, compounded medications and combination medications manufactured and/or packaged together are considered non-formulary/non-preferred brand name drugs. A Brand Drug may be a Non-Preferred Brand or a Non-Preferred Brand as defined in the Drug Formulary provided as Appendix to the Plan Document.

"Compounded Medications" means a drug product made up of two or more active parts or ingredients that must be specifically prepared by a licensed pharmacist pursuant to a prescription order. Compounded medications are considered to be non-formulary/non-preferred Brand Drugs.

"Co-payment" (for purposes of the outpatient prescription drug benefits only) means an amount, as shown on the Schedule of Benefits, for which You are responsible after the Deductible has been satisfied. When a Member Pharmacy is used, You pay any applicable Co-payment directly to the Member Pharmacy each time a prescription is filled.

"Drug Formulary" means a preferred drug list that We approve. We will periodically update the list that is available on www.simplicityhealthplans.com.

"Generic Drug" means a drug that has the same active ingredients as an equivalent brand name drug, does not carry a drug manufacturer's brand name on the label, and is not protected by a patent. It must be listed as a generic drug by Our national drug data bank. Compounded medications and combination medications manufactured and/or packaged together are not considered to be generic drugs under these Plan provisions.

"Member Pharmacy" means a pharmacy that is currently participating in the pharmacy network of this Plan. A complete listing of the Member Pharmacies for this Plan, and future updates to such listing, will be available to You.

"PCSA" (Prescription Card Service Administrator) means a pharmacy benefit manager that administers prescription claim processing for the Plan.

COVERED OUTPATIENT PRESCRIPTION DRUG CHARGES

Subject to the Charges Not Covered section that follows, other exclusion/charges not covered sections of the Plan, and all the terms, conditions, and other limitations of the Plan, covered outpatient prescription drug charges include only charges for:

1. Brand Drugs and medicines, in dosages, dosage forms, and durations of treatment that are Medically Necessary for the care and treatment of a covered illness or Injury;
2. Drugs and medicines fully approved by the U.S. Food and Drug Administration;
3. Brand Drugs and drug products, if all active ingredients are covered;
4. Self-injectable insulin, on prescription only, up to a quantity of three vials of one type of insulin for each Co-payment charge, or up to a thirty (30) consecutive days' supply, whichever is less;
5. Disposable insulin syringes, disposable blood/urine, glucose/acetone testing agents or lancets on prescription only, up to a quantity of one hundred (100), or up to a thirty (30) consecutive days' supply, whichever is less;
6. Drugs and medicines used for outpatient care for the treatment of Mental Disorder or Substance Abuse;
7. Drugs and medicines used in the treatment of gastroesophageal reflux disease, heartburn, esophagitis, or related conditions;
8. Drugs and medicines used in the treatment of colds, hay fever, allergies and related conditions;
9. Other drugs that, under applicable state or federal law, may only be dispensed upon written prescription from a Physician or other lawful prescriber; and
10. Those which do not exceed the Maximum Allowed Amount, as determined by the Plan, provided that each prescription and each refill do not exceed a thirty (30) consecutive days' supply or other quantity, supply, or Plan-share limits We determine for a drug or drug therapy class.

Payment for a prescription drug does not constitute any assumption of liability for any illness, Injury or condition under the medical benefits section of this Plan. When a covered prescription drug is available under two or more names, dosages, dosage forms or manufacturers' packaging or when more than one covered drug may be used to treat a condition, the Plan reserves the right to consider benefits only for the least expensive drug or drug formulation, or

the pharmacy network cost thereof, that will, in Our opinion, produce a professionally adequate result, subject to all of the terms, limitations, and conditions of the Plan. Certain drugs may require pre-authorization prior to dispensing and/or review for possible coverage by the Plan. Subject to applicable state and federal law, You may be required to submit complete medical history and all pertinent medical office records prior to consideration for possible coverage of a drug.

When a covered condition may be effectively treated through medical therapy or pharmacological (drug therapy) interventions, the Plan reserves the right to consider benefits for the least expensive therapy alternative, subject to all the terms, conditions, and limitations of the Plan.

Manufacturer product discounts, also known as rebates, may be sent back to the Plan Sponsor pursuant to certain drug purchases through the Plan. Those amounts will be retained by the Plan Administrator as part of its administration fees.

CHARGES NOT COVERED

In addition to other exclusion/charges not covered sections of the Plan, covered outpatient prescription drug charges do not include any charges:

1. For drugs prescribed for a Pre-Existing Condition or for drugs covered under another plan sponsor or payor.
2. For drugs prescribed for care, services or treatment which are not covered medical charges, or for drugs determined to be not Medically Necessary as determined by the Plan.
3. For drugs not listed as formulary medications in the Drug Formulary or as preferred medications on the Plan's preferred drug list.
4. For drugs administered or dispensed by a Physician, a Hospital, rest home, sanitarium, extended care facility, convalescent care facility, nursing home facility or similar institution.
5. For infertility drugs, regardless of intended use, or for any drugs used in the treatment of infertility or to facilitate Pregnancy.
6. For over-the-counter ("OTC") drugs available without a prescription (other than injectable insulin); and for drugs that the Plan determine have one or more over-the-counter equivalents or contain the same active ingredient(s) as over-the-counter medication.
7. Drugs available in prescription strength without a prescription EXCEPT AS NOTED AS TIER 1 DRUGS.
8. For compounded medications not containing all covered active ingredients; for Combination drugs or drug products manufactured and/or packaged together and containing one or more not-covered active ingredients; drugs prescribed by a dentist or prescribed for dental services and unit-dose drugs.
9. For injectable drugs which the Plan does not authorize to be paid under this benefit and the administration or injection of any drug.
10. For drugs limited by federal law to Investigational use; drugs used experimentally or investigationally; Experimental or Investigational drugs, even when a charge is made; drugs with no U.S. Food and Drug Administration ("FDA") approved indications for use, FDA approved drugs used for indications, dosage or dosage regimens or administration

outside FDA approval, and drugs determined by the FDA as lacking in substantial evidence of effectiveness for a particular condition, disease, or for symptom control.

11. Drugs prescribed for intended use other than for indications approved by the FDA or recognized off-label indications through peer-review medical literature or by the commissioner.
12. For immunization agents, biological sera, blood, blood plasma or other blood products, self-injectables or other prescriptions requiring parental administration or use, except insulin or Imitrex.
13. For nonprescription supplements, dietary products, vitamins and minerals other than legend prenatal vitamins prescribed during Pregnancy.
14. For prescriptions refilled in excess of the number specified by the Physician's original order.
15. For prescriptions dispensed after one year from the Physician's original order.
16. For drugs delivered or administered by the prescriber; take-home prescriptions.
17. For any drug used for Cosmetic purposes as determined by Us, for growth hormone and its derivatives; for any drug used to stimulate or to promote growth; botulinum toxin and its derivatives; or onychomycosis (nail fungus). For drugs used in the treatment of chronic fatigue or related syndromes or conditions.
18. For herbal or homeopathic medicines or products, and nutraceuticals.
19. For Retin-A (tretinoin) and other drugs used in the treatment or prevention of acne or related conditions for a Covered Person age thirty (30) and older.
20. For medications used to treat, impact or influence "quality of life" or "lifestyle" concerns including but not limited to: smoking deterrence or cessation; obesity; weight management; prevention or treatment of hair loss; prevention or treatment of excessive hair growth or abnormal hair patterns, sexual function, dysfunction, performance or inadequacy; conscious or unconscious sexual energy or desire; skin coloring or pigmentation; social phobias; slowing the normal processes of aging; memory improvement or cognitive enhancement, daytime drowsiness, overactive bladder, athletic performance, body conditioning, strengthening, or energy; drymouth, excessive salivation, or hyperhidrosis (excessive sweating).
21. For DDAVP (desmopressin acetate) or other drugs used in the treatment of nocturnal enuresis (bedwetting) for a Covered Person under the age of eight; for drugs used to treat hyperactivity, attention deficit and related disorders.
22. For drugs in connection with an accidental Injury or illness that arises out of, or is the result of, any work for wage or profit; except that this exclusion will not apply to:
    a. The sole proprietor, if the Employer is a proprietorship; or
    b. A partner of the Employer, if the Employer is a partnership; or
    c. An executive officer of the Employer, if the Employer is a corporation;
    d. for any such charges that result from accidental Injury or illness that arises out of or is a result of any work for the Employer and then only if he or she is not required to have coverage under any Workers Compensation Act or similar law and does not have such coverage.
23. For drugs used for outpatient care for the treatment of Mental Disorder in excess of the limits reflected in the covered outpatient prescription drugs charges section; for other drugs or drug categories with limited coverage, when used in excess of the limits.
24. For charges in excess of the Generic Drug prescription.
25. For more than the Plan determines to be an average quantity of medication required to treat an immediate condition or symptom on an "as needed" basis or which the Plan determines to be excessive in scope, duration or intensity of drug therapy needed for safe, adequate and appropriate care.

26. For prescriptions, dosages or dosage forms issued principally for the convenience of the Covered Person or the Covered Person's family or Physician.
27. For duplicate prescriptions, replacement of lost, stolen, destroyed or damaged prescriptions or prescriptions refilled more frequently than the prescribed dosage indicates.
28. For drugs designed or used to diagnose, treat, alter, impact, or differentiate a Covered Person's genetic make-up or genetic predisposition unless specifically authorized by the Plan for a specified period of time under a medical plan and medical plan provisions.
29. For any drug payable under the medical benefit portions of this Plan.

ADDITIONAL PROVISIONS

Drugs and medicines, which are covered under this outpatient prescription drug benefit, will be excluded under any medical benefits for which You are also covered under this Plan. Any drug which is a metabolite, isomer, extended release or other dosage form, or other direct or indirect derivative of a drug approved by the FDA may be subject to similar terms, limitations and conditions of coverage or non-covered by the Plan as the original drug.

Charges which are payable under the medical benefit portions of the Plan are not payable under the outpatient prescription drug benefit. No benefits are payable under this benefit section for charges incurred on or after the date Your Plan and/or outpatient prescription drug benefits terminate.

If the Plan determines that You or Your covered Dependent(s) are engaged in activities that could be deemed inappropriate or misuse of services, We reserve the right to terminate Your coverage under the Plan. Alternatively, We reserve the right to limit covered outpatient services to a single pharmacy to help ensure the quality provision of services for You and Your covered Dependents.

IDENTIFICATION CARDS

In connection with this benefit, You will receive an ID card or cards for Your use, while covered, as explained in the claim procedures section.

You are required to turn in Your ID card or cards to Your Employer at the time coverage terminates. If You fail to do so and use Your card after coverage ends for You or Your Dependents, You are responsible for all drug claims made after the termination date. Your Employer will also be responsible for any claim payment made after such termination date. In either event, Your Employer may also hold You liable for the amount of charges You incur or that are paid on You or Your Dependent's behalf, after the termination date of coverage.

CLAIM PROVISIONS

When You go to a Member Pharmacy for Your covered outpatient prescription drugs, You need to:

1. Present Your ID card to the pharmacist with Your prescription each time You need to have a prescription filled;

2. Pay to the pharmacist the difference between the charge for the prescription and the amount the Plan pays.

The above applies to each prescription filled.

When You go to a pharmacy that is not a Member Pharmacy for Your covered outpatient prescription drugs, You need to:

1. Pay the pharmacist the amount charged for the prescription;
2. Have a prescription drug claim form completed and signed by You and the pharmacist; Claim Forms can be printed from www.simplicityhealthplans.com; and
3. Forward the completed prescription drug claim form and payment receipt to the address shown on the form for reimbursement of benefits payable.

You will be reimbursed at the Maximum Allowed Amount that would have been paid to a Member Pharmacy for the cost of the drug minus any applicable Deductible and/or Co-payment.

MAIL ORDER PHARMACY SERVICES

Outpatient prescription drug benefits include coverage for home delivery of Prescription Maintenance Drugs.

"Prescription Maintenance Drugs" means drugs that are:
1. Covered under this outpatient prescription drug benefit; taken regularly to treat a chronic health condition; and approved by the Plan for coverage under the mail order pharmacy services provision; and
2. Oral contraceptives.

Under this provision, prescription drugs will be covered in amounts of up to a ninety (90) consecutive days' supply for each prescription and each refill.

If You choose home delivery of Prescription Maintenance Drugs, You or Your Dependent must mail the prescription, a completed order form and any applicable Deductible, Co-payment, and/or other charges required by the Plan to the Plan's mail order pharmacy services provider. The name and address of the mail order pharmacy services provider along with order forms and additional service details are available on www.simplicityhealthplans.com.

The following provisions apply for covered outpatient prescription drug charges when You choose home delivery of Prescription Maintenance Drugs. You pay any applicable Deductible, and/or Co-payment and postage and handling charges, and:

If You receive a Brand Drug when a Generic Drug is available, then You will pay the difference in cost between the Brand Drug and the Generic Drug.

The provider will fill the prescription and mail it along with a replacement order form to You or Your Dependent. It will be mailed to Your home or other location You designate.

PRE-EXISTING CONDITIONS LIMITATION

Covered Charges incurred under medical benefits for Pre-Existing Conditions are not payable unless incurred twelve (12) consecutive months or eighteen (18) months if a Late Enrollee, after the person's Enrollment Date. This time may be offset if the Employee has Creditable Coverage from his or her previous plan.

The length of the Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has Creditable Coverage from another health plan.

An eligible person may request a certificate of Creditable Coverage from his or her prior plan and the Employer will assist any eligible person in obtaining a certificate of Creditable Coverage from a prior plan. If, after Creditable Coverage has been taken into account, there will still be a Pre-Existing Conditions Limitation imposed on an individual, that individual will be so notified.

Creditable Coverage - The Covered Person will be given credit towards any Pre-Existing Conditions for the time he was covered under qualifying prior coverage if: (1) that coverage was for a period of at least eighteen (18) months; and (2) if he makes application for coverage under the Plan within sixty-three (63) days of termination of the qualifying prior coverage.

Waiting Periods do not count towards a break in coverage, nor as creditable coverage.

Qualifying prior coverage means:

1. Any individual or group insurance policy, contract, or program that is written or administered by a disability insurer, nonprofit Hospital service plan, health care service plan, fraternal benefits society, self-insured employer plan or any other entity, and that arranges or provides medical, Hospital, and surgical coverage not designed to supplement other private or governmental plans. The term includes continuation or conversion coverage, but does not include accident only, credit, disability income, Medicare supplement, long-term care, dental, vision, coverage issued as a supplement to liability insurance, workers' compensation or coverage under a similar law, automobile medical payment insurance, or statutorily required "no fault" insurance;
2. Medicare;
3. Medicaid; and
4. Any other publicly sponsored program of medical, Hospital, and surgical care.

COST MANAGEMENT SERVICES

Pre-authorization Services: Telephone number as indicated on Your Identification Card. The patient or family member must call the Pre-authorization telephone number to receive certification of certain Cost Management Services. This call must be made at least two (2) days in advance of services being rendered or within forty-eight (48) hours after an emergency.

UTILIZATION REVIEW PROGRAM - Utilization Review is a program designed to help insure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses. The program consists of:

1. Pre-authorization of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:
   - ♦ Hospitalizations
   - ♦ Skilled Nursing Facility stays
   - ♦ Home Health Care
   - ♦ Hospice Care
   - ♦ Outpatient surgical procedures
   - ♦ Knee Arthroscopy, Upper Stomach Scope, Myringotomies, Carpal Tunnel Surgery
   - ♦ Tonsillectomy/Adenoidectomy, Heart Catheterization
   - ♦ Intestinal Bypass
   - ♦ Rhinoplasty

2. Retrospective review of the Medical Necessity of the listed services provided on an emergency basis.

3. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician; and,

4. Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

5. Requirement for Second or Third Opinion for specified services.

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

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

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

PRE-AUTHORIZATION

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

Note: The following services must be pre-authorized or reimbursement from the Plan will be reduced. Please see the Cost Management Services section for details.

23-Hour Observation
Hospitalizations
Organ and Tissue Transplants
Skilled Nursing Facility stays
Home Health Care
Hospice Care
Durable Medical Equipment, Prosthetic and Orthotic Devices
Upper Stomach Scope
Biopsies
ALL Outpatient Surgeries (OR charges)

The Utilization Review Program is set in motion by the Covered Person with a telephone call **at least two (2) days before** services are scheduled to be rendered with the following information:

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

If there is an emergency admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or attending Physician must contact the Utilization Review Administrator **within forty-eight (48) hours** of the first business day after the admission.

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

If the Covered Person does not receive authorization as explained in this section, the benefit payment may be reduced.

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

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

SECOND AND/OR THIRD OPINION PROGRAM. Certain surgical procedures may be performed either inappropriately or unnecessarily. In some cases, surgery is only one of several treatment options. In other cases, surgery will not help the condition. In order to prevent unnecessary or potentially harmful surgical treatments, the Second and/or Third Opinion Program fulfills the dual purpose of protecting the health of the Plan's Covered Persons and protecting the financial integrity of the Plan.

Benefits will be provided for a Second (and Third, if necessary) Opinion consultation to determine the Medical Necessity of an elective surgical procedure. An elective surgical procedure is one that can be scheduled in advance; that is, it is not an emergency or of a life-threatening nature.

The patient may choose any board-certified specialist who is not an associate of the attending Physician and who is affiliated in the appropriate specialty.

While any eligible surgical treatment is allowed a Second Opinion, the following elective, non-emergency procedures are ones for which surgery is often performed when other treatments are available and for which the Plan will require a Second Opinion:

~ Cataract surgery

~ Cholecystectomy (gall bladder removal)

~ Deviated septum (nose surgery)

~Hemorrhoidectomy

~Hernia surgery

~Hysterectomy

~ Intestinal Bypass

~Mastectomy surgery

~ Prostate surgery

~Salpingo-oophorectomy (Removal of tubes/ovaries)

~Spinal surgery

~ Surgery to knee, shoulder, elbow or toe

~Tonsillectomy and adenoidectomy

~Tympanotomy (inner ear)

~Varicose vein ligation

If the Covered Person does not receive a Second Opinion as explained in this section, the benefit payment may be reduced.

CASE MANAGEMENT

When a catastrophic condition, such as a spinal cord Injury, cancer, transplants, AIDS or a premature birth occurs, a person may require long-term, perhaps Lifetime care. After the person's condition is diagnosed, he or she might need extensive services or might be able to be moved into another type of care setting even to his or her home.

Case Management is a program whereby a case manager monitors these patients and explores, discusses, and recommends coordinated and/or alternate types of appropriate

Medically Necessary care. The case manager consults with the patient, the family, and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

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

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

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

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

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate. Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

HOW TO SUBMIT A CLAIM

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

1. Obtain a standard claim form from the Provider or have the Provider submit the claim on-line at www.simplicityhealthplans.com.

2. For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
   a. Name of Plan
   b. Employee's name
   c. Name of patient
   d. Name, address, telephone number, and tax identification number of the provider of care
   e. Diagnosis
   f. Type of services rendered, with diagnosis and/or procedure codes
   g. Date of services
   h. Charges

3. For claims submitted by mail, send the above information to:
   Simplicity Health Plans – Claim Submissions
   25001 Emery Road
   Suite 300
   Cleveland, OH 44128

4. For claims submitted on-line, follow the instructions on www.simplicityhealthplans.com.

WHEN CLAIMS SHOULD BE FILED

Claims must be filed with the Plan Administrator/Claim Administrator within ninety (90) days of the date charges for the service were incurred. Benefits are based on the Plan's Provisions at the time the charges were incurred. Claims filed later than that date will be declined unless:

1. It is not reasonably possible to submit the claim in that time; and
2. The ninety (90) day period will not apply when the person is not legally capable of submitting the claim.

The Plan Administrator/Claim Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.

A request for Plan benefits will be considered a claim for Plan benefits, and it will be subject to a full and fair review. If a claim is wholly or partially denied, the Plan Administrator/Claim Administrator will furnish the Plan Participant with a written notice of this denial. This written notice will be provided within ninety (90) days after receipt of the claim. The written notice will contain the following information:

1. the specific reason or reasons for the denial;
2. specific reference to those Plan provisions on which the denial is based;
3. a description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
4. appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

A Plan Participant will be notified within ninety (90) days of receipt of the claim as to the acceptance or denial of a claim and if not notified within ninety (90) days, the claim will be deemed denied.

If special circumstances require an extension of time for processing the claim, the Plan Administrator/Claim Administrator will send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of ninety (90) days from the end of the initial ninety (90) day period.

CLAIMS APPEAL PROCEDURE

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

1. Request from the Plan Administrator a review of any claim for benefits. Such request must include: the name of the Employee, his or her Social Security number, the name of the patient and the Employer name.
2. File the request for review in writing, stating in clear and concise terms the reason or reasons for this disagreement with the handling of the claim.

The request for review must be directed to the Plan Administrator within sixty (60) days after the claim payment date or the date of the notification of denial of benefits.

A review of the denial will be made by the Plan Administrator and the Plan Administrator will provide the Plan Participant with a written response within sixty (60) days of the date the Plan Administrator receives the Plan Participant's written request for review and if not notified, the Plan Participant may deem the claim denied. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within sixty (60) days, the Plan Administrator will notify the Plan Participant of the delay within the sixty (60) day period and will provide a final written response to the request for review within one hundred twenty (120) days of the date the Plan Administrator received the Plan Participant's written request for review.

The Plan Administrator’s written response will include specific reasons for the decision and will cite the specific Plan provision(s) upon which the decision is based.

COORDINATION OF BENEFITS

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

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

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

1. Group or group-type plans, including franchise or blanket benefit plans.
2. Blue Cross and Blue Shield group plans.
3. Group practice and other group prepayment plans.
4. Federal government plans or programs. This includes Medicare.
5. Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
6. No Fault Auto Insurance, by whatever name it is called, when not prohibited by law.

Allowable Charge. For a charge to be allowable, it must be covered under this Plan and not exceed this Plan's Maximum Allowed Amount.

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

Benefit Plan Payment Order. When two or more plans provide benefits for the same Allowable Charge, benefit payment will follow these rules.

1. Plans that do not have a coordination provision, or one like it, will pay first. Plans with such a provision will be considered after those without one.
2. Plans without a coordination provision will pay their benefits by these rules up to the Allowable Charge.
3. Plans with a coordination provision will pay their benefits by the following rules, up to the Allowable Charge:
    a. The benefits of the plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the plan that covers the person as a dependent ("Plan B"). Special Rule. If: (i) the person covered directly is a Medicare beneficiary; and (ii) Medicare is secondary to Plan B; and (iii) Medicare is primary to Plan A (for example, if the person is retired); THEN Plan B will pay before Plan A.
    b. The benefits of a benefit plan which covers a person as an employee who is neither laid-off nor retired are determined before those of a benefit plan, which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid-off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid-off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
    c. The benefits of a benefit plan which covers a person as an employee who is neither laid-off nor retired or a dependent of an employee who is neither laid-off nor retired are determined before those of a plan which covers the person as a COBRA beneficiary.
    d. When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
        i. The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
        ii. If both parents have the same birthday, the benefits of the benefit plan, which has covered the patient for the longer time, are determined before those of the benefit plan, which covers the other parent.
    e. When a child's parents are divorced or legally separated, these rules will apply:
        i. This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
        ii. This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.

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

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

f. If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first.

4. Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
5. If a Plan Participant is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claim Determination Period. Benefits will be coordinated on a Calendar Year basis. This is called the claim determination period.

Right to Receive or Release Necessary Information. This Plan retains the right to receive or release necessary information. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of Allowable Charges.

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

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

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

THIRD PARTY RECOVERY PROVISION
RIGHT OF SUBROGATION AND REFUND

The Covered Person may incur medical or dental charges due to Injuries, which may be caused by the act, or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against that third party, or insurer, for payment of the medical or dental charges. Accepting benefits under this Plan for those incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim that the Covered Person has against any third party, or insurer,

whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien will remain in effect until the Plan is repaid in full.

The Covered Person:

1. automatically assigns to the Plan his or her rights against any third party or insurer when this provision applies; and
2. must repay to the Plan the benefits paid on his or her behalf out of the recovery made from the third party or insurer.

The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement. These rights provide the Plan with a priority over any funds paid by a third party to a Covered Person relative to the Injury or Sickness, including a priority over any claim for non-medical or dental charges, attorney fees, or other costs and expenses.

Notwithstanding its priority to funds, the Plan's subrogation and refund rights, as well as the rights assigned to it, are limited to the extent to which the Plan has made, or will make, payments for medical or dental charges as well as any costs and fees associated with the enforcement of its rights under the Plan.

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

Defined terms: "Recovery" means monies paid to the Covered Person by way of judgment, settlement, or otherwise to compensate for all losses caused by the Injuries or Sickness whether or not said losses reflect medical or dental charges covered by the Plan.

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

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

Recovery from another plan under which the Covered Person is covered also applies when a Covered Person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renters plan, medical malpractice plan or any liability plan.

PLAN ADMINISTRATION

PLAN ADMINISTRATOR. The Employer’s Employee Health and Welfare Benefit Plan is the benefit Plan of the Employer named on the Cover Page. The Plan Administrator will administer the Plan in accordance with the provisions of ERISA. An entity may be appointed by the Employer to be the Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies, or is otherwise removed from the position, the Employer will appoint a new Plan Administrator as soon as reasonably possible.

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

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant's rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claim Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator is paid compensation; including all expenses for Plan Administration. Compensation for all hired services from other vendors will be paid by the Plan.

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

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

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the Plan documents to the extent that they agree with ERISA.

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

1. The named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or
2. The named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

CLAIM ADMINISTRATOR IS NOT A FIDUCIARY. A Claim Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan or Plan Administrator.

FUNDING THE PLAN

The cost of the Plan is funded as follows:

FOR EMPLOYEE AND DEPENDENT BENEFITS: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The Plan Sponsor will set the level of any Employee contributions. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction. The Plan Administrator may determine that the Plan Sponsor and/or any personnel of the Sponsor and/or Employer that handles such Employee contributions may be deemed a person that is exercising Trustee powers and should be Bonded for such activities in accordance with ERISA. If so determined, the cost of such Bond will be secured by the Plan Administrator on behalf of those deemed Trustees.

The Claim Administrator pays benefits directly from the Trust established by the Plan.

CERTAIN EMPLOYEE RIGHTS UNDER ERISA

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

1. Examine, without charge, at the Plan Administrator's office, all Plan documents and copies of all documents filed by the Plan;
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

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

If a Plan Participant's claim for a benefit is denied, in whole or in part, the Plan Participant must receive a written explanation of the reason for the denial. The Plan Participant has the right to have the Plan review and reconsider the claim. Under ERISA there are steps that the Plan Participant can take to enforce the above rights. For instance, if the Plan Participant requests materials from the Plan and does not receive them within thirty (30) days, that person may file suit in federal court. In such a case, the court may require the Plan Administrator to provide the materials and to pay the Plan Participant up to $100 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits that is denied or ignored, in whole or in part, that Plan Participant may file suit in state or federal court.

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

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

THE TRUST AGREEMENT

This Plan is established under and funded through a Trust Agreement. That agreement is made a part of the Plan. A copy of the appropriate agreement is available for examination by Employees and their Dependent(s) at the office of the Plan Administrator or the Employer during normal business hours. Also, upon written request, the following items will be furnished to an Employee or Dependent:

1. A copy of the Trust Agreement.
2. A copy of the Employer/Sponsor Application and Plan Directive.

PLAN IS NOT AN EMPLOYMENT CONTRACT. The Plan is not to be construed as a contract for or of employment.

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

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money overpaid. In the case of a

Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable. If no future benefits are continuing, then the Plan Participant will return the money.

GRACE PERIOD. Contributions as determined by the Plan Administrator are to be paid by the Sponsor on or before the first day of each month. If contributions are not received by the first day of the month, claim payments, including prescription drugs, may be suspended until contributions are received. A grace period of thirty (30) days will be allowed. If the Employer pays the contribution that is past due during the grace period, coverage under this Plan will continue without a lapse in coverage and pended claims will be processed. If payment of contribution is not made within the grace period, coverage for benefits will terminate as of the last day of the last month for which contributions were paid and if any stop loss/excess loss coverage is likewise terminated due to a contribution not being paid during a grace period, payments of benefits for claims prior to the termination date may be required to be paid by the Sponsor.

REINSTATEMENT of Stop Loss/Excess Loss Coverage. Reinstatement of stop loss/excess loss, after coverage has been terminated due to nonpayment of a contribution, is effective only by written approval of the stop loss/excess loss insurer/reinsurer or its designated representative. The Employer may also be responsible to pay any reinstatement charges if assessed, have Employees provide new underwriting information; and, otherwise comply with the provisions of the stop loss/excess loss policy/treaty regarding reinstatements. If the stop loss/excess loss premium is increased at reinstatement, the monthly contributions required for the balance of the Plan Year may be increased accordingly. If stop loss/excess loss cannot be reinstated, any and all eligible claims of the Plan remain the sole responsibility of the Sponsor.

AMENDING AND TERMINATING THE PLAN. If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

COBRA CONTINUATION OPTIONS

Federal law gives certain persons the right to continue their health care benefits beyond the date that they might otherwise terminate. The entire cost (plus the administration fee allowed by law) must be paid by the continuing person. Health care benefits will end if the covered individual fails to make timely payment of contributions or premiums (within a maximum of forty-five (45) days during initial premium/contribution and thirty (30) days thereafter). This law is referred to as "COBRA," which stands for the Consolidated Omnibus Budget Reconciliation Act of 1985.

The Plan Administrator will provide complete instructions on COBRA to Plan Participants who become qualified beneficiaries under COBRA.

BENEFITS AFFECTED BY COBRA

There are two categories of benefits that may be continued under COBRA.

1. "Core benefits" are medical benefits. Any COBRA continuance option must include the offering of core benefits for which the person was covered just prior to the COBRA "qualifying event" (an event which qualifies a person for continued coverage under COBRA). A child born to or placed for adoption with the covered Employee during the period of COBRA coverage must also be offered these core benefits.
2. "Non-core benefits" include dental benefits (if applicable).

If the "qualified beneficiary" (a person eligible for COBRA continuance) was covered by these core and non-core benefits prior to termination, the individual may, but is not required to, continue them under COBRA. Which benefits, if any, are to be continued will be indicated by the qualified beneficiary at the time of COBRA enrollment.

Life insurance, accidental death, and dismemberment benefits and weekly income or long term disability benefits (if a part of the Employer's Plan) are not considered for continuance under COBRA.

Maximum Time Periods. Continuation will be available for a qualified beneficiary up to the maximum time period shown in item (1), (2) or (3) below. Combined qualifying events will not continue a beneficiary's benefits for more than thirty-six (36) months beyond the date of the original qualifying event.

1. Up to eighteen (18) months for an Employee and his covered Dependent(s) when benefits terminate due to reduction of hours worked, or termination of employment for reasons other than gross misconduct. Note: An individual who is disabled may have COBRA coverage extended (and an extra fee charged) from eighteen (18) months to twenty-nine (29) months provided that:
    a. The individual is determined as being disabled for Social Security purposes on the date of the qualifying event or within the first sixty (60) days of COBRA coverage; and
    b. The individual notifies the Plan Administrator within sixty (60) days of the Social Security Administration's determination of disability and within the original eighteen (18) month COBRA period, which applies to the person.
2. Up to thirty-six (36) months for:
    a. a covered child who ceases to be an eligible Dependent;
    b. a covered Dependent of a deceased Employee;
    c. a former covered spouse whose benefits cease due to divorce or legal separation; or
    d. a covered Dependent when the Employee's benefits cease due to entitlement for Medicare.
3. There is a special continuation period for retired Employees and their Dependents when the Employer declares bankruptcy under Title 11 of the United States Code and the retired Employees and their Dependents lose substantial benefits within one year before or after the date that the bankruptcy proceedings commenced. Benefits will be continued for each person until the date of that person's death. However, the surviving spouse or children of a deceased retired Employee may continue benefits for up to a

maximum of thirty-six (36) months following the retired Employee's death. For this item 3, benefits do not terminate when the person becomes eligible for Medicare.

Continued benefits may also cease before the end of the maximum period on the earliest of:

1. The date that the Employer ceases to provide a group health plan to any Employee; or

2. The date that the qualified beneficiary first becomes, after the date of election, (a) covered under any other group health plan (as an Employee or otherwise), or (b) entitled to benefits under Medicare (except as stated in item 3 above). However, a qualified beneficiary who becomes covered under a group health plan which has a Pre-Existing Conditions limit must be allowed to continue COBRA coverage for the length of a Pre-Existing Condition or to the COBRA maximum time period, if less. COBRA coverage may be terminated if the qualified beneficiary becomes covered under a group health plan with a Pre-Existing Conditions limit, if the Pre-Existing Conditions limit does not apply to (or is satisfied by) the qualified beneficiary by reason of the group health plan portability, access and renewability requirements of the Health Insurance Portability and Accountability Act, ERISA or the Public Health Services Act.

3. The date the cost of continued benefits is not paid by the due date.

4. For an individual who has extended COBRA coverage of twenty-nine (29) months due to disability, COBRA coverage will end in the month that begins more than thirty (30) days after a final determination has been made by the Social Security Administration that the individual is no longer disabled.

Notice Requirements. When benefits terminate due to an Employee's death, termination or eligibility for Medicare, the Employer has thirty (30) days in which to notify the Plan Administrator of the qualifying event.

When benefits terminate due to divorce, legal separation or change of Dependent status, the qualified beneficiary has sixty (60) days from the qualifying event or from the date benefits terminate in which to notify the Plan Administrator that the qualifying event has occurred.

Complete instructions on how to elect continuation will be provided by the Plan Administrator within fourteen (14) days of receiving notice of the qualifying event. Covered Persons then have sixty (60) days in which to elect continuation. The sixty (60) day period is measured from the later of the date benefits terminate or the date notice of the right to continue is sent. If continuation is not elected in that sixty (60) day period, then the right to elect continuation ceases.

Appendix A

PREVENTIVE BENEFITS

HEALTH MAINTENANCE EXAMS & SPECIFIC ACCOMPANYING TESTS/PROCEDURES
(limited to one per Plan Year, Employee & Spouse)

99385 – 99387	Initial comprehensive evaluation & exam (new patient)
99395 – 99397	Periodic comprehensive evaluation & exam (established patient)
80061	Lipid Panel
82270	Guaiac

ROUTINE PEDIATRIC EXAMS
(well child care, 6 visits per Plan Year up to age 2. From age 2 forward, one visit per Plan Year for eligible Dependent children)

99381 – 99384	Initial comprehensive pediatric evaluation & exam, (new patient)
99391 – 99394	Periodic comprehensive pediatric evaluation & exam (established patient)

ROUTINE IMMUNIZATIONS, TRAVEL INOCULATIONS

90476 – 90749	Includes DtaP, DT, Tdap, Td, Hib, HepA, HepB, HPV, LAIV, TIV, MMR, MCV, MPSV, PCV, PPSV, IPV, Rotavirus, Varicella, Zoster, Flu
90470-90474	Administration of vaccine-payable if no other office visit charged at time of service

ROUTINE PERIODIC GYNECOLOGICAL EXAMS & SPECIFIC ACCOMPANYING TESTS/PROCEDURES (Pap)

S0610, S0612, S0613	Annual gynecological exam: new; established; breast exam without pelvic
99385 – 99387	Initial comprehensive evaluation & exam (new patient)
99395 – 99397	Periodic comprehensive evaluation & exam (established patient)
88141-88155	Pap test
36415	Blood Collection Venipuncture

MAMMOGRAPHY
77057

PSA SCREENING (PROSTATE)
84152

COLONOSCOPY SCREENING
(starting at age 50, then one every 10 years)

45378 Screening Colonoscopy
45380 Screening Colonoscopy with Biopsy Single or Multiple

ALL OTHER SERVICES SUBJECT TO DEDUCTIBLE, PRE-AUTHORIZATIONS AND/OR PLAN LIMITS AND/OR PLAN EXCLUSIONS

Appendix B

DRUG FORMULARY

For the most up-to-date Drug Formulary, please go to www.simplicityhealthplans.com.

Appendix C

LIFE INSURANCE COVERAGE (*IF APPLICABLE*)

Appendix D

DENTAL INSURANCE COVERAGE (*IF APPLICABLE*)