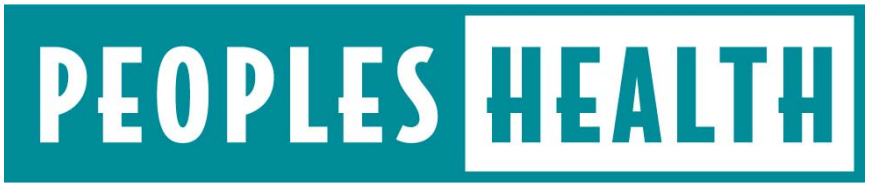

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

FOR

PHN EMPLOYEE PLAN

NEW ORLEANS REGIONAL PHYSICIAN HOSPITAL ORGANIZATION, INC.
D/B/A PEOPLES HEALTH

PHN EMPLOYEE PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description is intended to describe the provisions of PHN Employee Plan, which is a form of a group health plan sponsored and maintained by New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health. The terms of this Summary Plan Description have been updated and are being restated as of April 1, 2016, and govern the administration and payment of claims Incurred on or after that date. **Please review the following information carefully; it supersedes any prior written information about the Plan.**

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HIGHLIGHTS OF THE PHN EMPLOYEE PLAN

This Plan is maintained for the purpose of providing benefits for Eligible Employees and their Eligible Dependents. Although it has no present intention to do so, the Plan Sponsor has reserved the right to amend or even terminate the Plan. Examples of amendments include, but are not limited to, the inclusion of additional cost containment features, increases in deductibles and out-of-pocket expense amounts, and changes in the benefits provided under this Plan. In addition, your Employer may require you to pay a portion of the cost of coverage (employee only or family coverage). Your share of the cost is determined annually, or more frequently if deemed appropriate, by the Plan Administrator.

Eligible Employee

The term "Eligible Employee" shall include a full-time employee who worked or is regularly scheduled to work at least 30 hours per week for the Employer and who has completed a waiting period of 30 consecutive days while employed.

"Eligible Employee" shall also include a part-time employee who worked or is regularly scheduled to work at least 24 hours per week for the Employer and who has completed a waiting period of 30 consecutive days while employed.

In accordance with the Patient Protection and Affordable Care Act as well as IRS rules and guidelines in the Internal Revenue Code, Section 4980H (as amended), the Plan may use a monthly measurement method or a look-back measurement method, or a combination of the two methods for determining the full-time status of employees. All New Employees who are not expected to work full-time at the time of hire, including variable hour and seasonal workers, may be subject to an Initial Measurement Period not to exceed twelve months.

If the look-back measurement method is used, then the term "Eligible Employee" shall also include a Variable Hour Employee who has averaged at least 30 hours per week for a complete Measurement Period and is currently in a Stability Period, or Administrative Period (if applicable), as determined by the Plan Sponsor. An employee who continues employment during the Stability Period will remain eligible throughout the Stability Period and Administrative Period (if applicable), regardless of a change in employment status (including, but not limited to, a reduction in hours).

For details and information about the Measurement Periods and, if applicable, Stability Periods and Administrative Periods, see your Personnel or Human Resources department.

The Plan Administrator determines status as an Eligible Employee hereunder.

Eligible Dependent

The Plan Administrator determines status as an Eligible Dependent hereunder and reserves the right to require such documentation as it deems satisfactory that a dependent is an Eligible Dependent under the Plan. The term "Eligible Dependent" shall mean any one or more of the following except that no Participant covered as an employee shall also be covered as a dependent, regardless of eligibility.

1. The Spouse, as defined by the Plan in the Definitions section, of an Eligible Employee until the date of legal separation or divorce, whichever occurs first.

   A common law spouse is not eligible for coverage under the Plan, even in a state where common law marriage is recognized.

   A Domestic Partner is eligible for coverage under the Plan, if the employee resides in a state where domestic partnership is recognized.

2. Any Child of an Eligible Employee who is:

   a. under the age of 26; or

   b. incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age 26. Such Child must have had continuous coverage as a dependent prior to attainment of such age and have remained covered continuously thereafter. The Plan Administrator may require proof of prior coverage. Additionally, at reasonable intervals during the two years following the dependent's reaching limiting age, the Plan Administrator may require subsequent proof of the Child's disability and continued incapability of self-sustaining employment. After such two-year period, the Plan Administrator may not require proof more than once each year.

   "Child" includes:

   a. a natural child following birth; or

   b. a legally adopted child; or

   c. a child legally placed in the employee's home for the purpose of adoption by the employee; or

   d. a stepchild; or

   e. a child of a Domestic Partner; or

f. a child under the legal guardianship of the employee; or

g. a child of the employee for whom the employee is required to provide health benefits pursuant to a Qualified Medical Child Support Order (QMCSO) in accordance with procedures adopted by the Plan Administrator. (Special rules apply to QMCSOs. Contact the Plan Administrator in situations of divorce and child custody for information regarding QMCSOs.)

Eligibility Date
(See "Persons Covered and Effective Dates" section for enrollment details and effective dates.)

Employee: The first day of the month coinciding with or after you meet the Plan's definition of an Eligible Employee.

Dependent: The same as the employee's Eligibility Date, if you have Eligible Dependents when you first become eligible to participate in the Plan.

Open Enrollment
(See "Persons Covered and Effective Dates" section for enrollment details.)

The Open Enrollment period is during the months of November and/or December. Coverage for a Participant enrolling during Open Enrollment is effective on the first day of January following enrollment.

Schedule of Medical Benefits

This is only a summary of the Plan's benefits and is not intended to be all-inclusive. Important information is contained in other sections, including benefit exclusions and limitations. You may find the Definitions section helpful in understanding some of the capitalized terms used throughout this Summary Plan Description, and within certain sections where a term is defined and used there. In addition, the Plan has other requirements and provisions that may affect benefits, such as those described in the sections for Utilization Management and Using the Provider Network, and it is strongly recommended that you read the entire Summary Plan Description to ensure a complete understanding of the Plan provisions. You also may contact Gilsbar, L.L.C., the Benefit Services Manager, or the Plan Administrator for assistance. All maximums are per Participant, unless specifically noted as per family.

For any benefit subject to a Calendar Year and/or Lifetime maximum, Allowable Charges that accumulate toward the benefit limit include any ancillary Allowable Charges associated with that benefit, including but not limited to office visits, lab tests, X-rays, physician services, etc.

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
DEDUCTIBLE, PER CALENDAR YEAR		
Per Participant	$0	$250
Per Family	$0	$750
MAXIMUM OUT-OF-POCKET EXPENSES PER CALENDAR YEAR		
Out-of-pocket expenses are separate, that is, expenses applied toward the satisfaction of the PHN Employee Plan Network out-of-pocket amount will not be applied toward satisfaction of the Out-of-Network out-of-pocket amount, and vice versa.		
Per Participant	$1,500	Unlimited
Per Family	$4,500	Unlimited
NOTE: The following charges do not apply toward the out-of-pocket expense amount and are never paid at 100%: • Premiums • Balance-billed charges • Healthcare this Plan doesn't cover • Utilization Management penalties		
UTILIZATION MANAGEMENT PENALTY		
Expenses will not be covered if you fail to precertify the following: • Bariatric surgery • Brachytherapy • Diagnostic testing, including MRA scans, CTA scans, and angiograms • Dialysis • Durable medical equipment greater than $500 • Home Health Care Expenses • Hospice services • Home infusion in excess of $2,000 • Injectable drugs in excess of $2,000 • Inpatient admissions • Occupational therapy • Organ transplants • Orthotics • Outpatient surgery • Physical therapy • Prosthetics • Stereotactic/gamma knife procedures		

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
COPAYMENTS AND BENEFIT PERCENTAGES Copayments are the responsibility of the Covered Person. The benefit percentage is what the Plan will pay for covered expenses after you have satisfied any applicable deductible and copay.		
Ambulance	$50 copay, then 100%	$50 copay, then 100%, deductible waived
Behavioral/Mental Health and Substance Use Disorders – Inpatient (Includes Residential treatment) (Precertification required) (MHNet is the network and claims administrator for these services. All claims for these services must be filed with MHNet. You may contact MHNet toll-free at 1-866-301-8866 or via http://providersearch.mhnet.com)	100%	80% after deductible
Behavioral/Mental Health and Substance Use Disorders – Outpatient (Includes Partial Hospitalization) (MHNet is the network and claims administrator for these services. All claims for these services must be filed with MHNet. You may contact MHNet toll-free at 1-866-301-8866 or via http://providersearch.mhnet.com) Office Visits (Covered services rendered by a Mental Health or Substance Abuse professional, including psychotherapy) Services other than in a Physician's office	$10 copay, then 100% 100%	80% after deductible 80% after deductible
Blood and blood derivatives	100%	Not Covered
Chemotherapy & Radiation Therapy (If services are billed with an office visit, the office visit copay will apply)	100%	80% after deductible
Chiropractic Treatment	$10 copay, then 100%	80% after deductible
Diabetes Self-management Training (1 session Lifetime maximum, unless additional visits are coordinated with the Primary Care Physician)	100%	Not Covered
Diagnostic Testing (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.) (Precertification required for MRA, CTA, and CT scans)	100%	80% after deductible

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Diagnostic Testing (X-ray, lab) – Inpatient	100%	80% after deductible
Diagnostic Testing (X-ray, lab) – Outpatient Hospital (Services other than in a Physician's office)	100%	80% after deductible
Diagnostic Testing (X-ray, lab) – Stand-alone Facility (Services other than in a Physician's office)	100%	80% after deductible
Diagnostic Testing (X-ray, lab) – Office	100%	80% after deductible
Durable Medical Equipment (Precertification is required for equipment in excess of $500)	100%	80% after deductible
Emergency Room (Copay waived if admitted directly to Hospital from Emergency room within 24 hours) Emergency Services	$50 copay, then 100%	$50 copay, then 100%
Non-emergency services	$50 copay, then 100%	80% after deductible
If you are hospitalized for an Emergency, you, your family member, the medical care facility or attending Physician must contact the Utilization Management company within 48 hours of admission. If you are admitted to an Out-of-Network facility, the Plan reserves the right to require a transfer to a PHN Employee Plan Network Hospital and to transfer the responsibility for medical care to a Network provider. If it is determined you are able to transfer without medically harmful results, but you refuse to do so, you will pay for services at the Out-of-Network benefit level.		
Extended Care/Skilled Nursing Facility (60 days Calendar Year maximum) (Precertification required)	100%	80% after deductible
Hearing Aid (Limited to Participants under age 18; further limited to $1,400 per hearing aid for each hearing-impaired ear every 36 months)	100%	80% after deductible
Home Health Care (Precertification required)	100%	80% after deductible
Hospice Care (Precertification required)	100%	Not Covered

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Hospital / Facility Inpatient Expenses (Precertification required)	100%	80% after deductible
If you are hospitalized for an Emergency, you, your family member, the medical care facility or attending Physician must contact the Utilization Management company within 48 hours of admission. If you are admitted to an Out-of-Network facility, the Plan reserves the right to require a transfer to a PHN Employee Plan Network Hospital and to transfer the responsibility for medical care to a Network provider. If it is determined you are able to transfer without medically harmful results, but you refuse to do so, you will pay for services at the Out-of-Network benefit level.		
Hospital / Facility Outpatient Expenses (Precertification required for outpatient surgery)	100%	80% after deductible
Infertility/Sterility (Covered up to diagnosis only; diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography and diagnostic laparoscopy)	Refer to applicable service for benefit percentages	
Maternity Physician Office Services (Maternity related expenses for dependent Children are not covered, except as required by law for prenatal care) Prenatal care as required by federal law	See **Preventive Care**	See **Preventive Care**
Other Eligible Charges (Copay applies on first office visit only)	$50 copay, then 100%	80% after deductible
Newborn Care – Routine Inpatient	100%	80% after deductible
Organ Transplants (Out-of-Network services are covered only when pre-approved by the Plan)	Refer to applicable service for benefit percentages	
Orthotics/Prosthetics (Precertification required)	100%	80% after deductible
Physician Services		
Inpatient Visits	100%	80% after deductible
Inpatient Surgery	100%	80% after deductible
Outpatient Visits	100%	80% after deductible

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Physician Services (continued)		
Outpatient Surgery (Physician's fee for services not performed in a Physician's office) (Precertification required)	100%	80% after deductible
Office visits (Copay is per provider and applies to office visit charge, allergy testing, allergy treatment, injections, supplies, and minor office surgery, including vasectomies. The copay does not apply to allergy injections when no office visit is billed.) (Precertification is required for certain in-office surgeries. Members and providers may use the following link to determine whether the procedure to be performed is one that requires precertification: https://www.peopleshealth.com/for-providers/procedure-code-search/)	$10 copay, then 100%	80% after deductible
Prescription Drugs (Inpatient)	See **Hospital / Facility Inpatient Expenses**	
Prescription Drugs (Outpatient)	See the **Schedule of Prescription Drug Benefits** subsection	
Preventive Care	100%	80% after deductible*
This benefit includes Preventive Care, as defined in the Definitions section, as well as the following: • Colorectal screenings, including flexible sigmoidoscopy or screening barium enema, fecal occult blood test, and screening colonoscopy or screening barium enema (2 per Calendar Year) • Gynecological exam, and well woman visit (1 per Calendar Year) • Pap smear (1 per Calendar Year)* • Prostatic/testicular exam (1 per Calendar Year)* • Smoking cessation counseling and supplies • Immunizations and inoculations • Mammograms (1 per Calendar Year)*. Additional mammogram will be covered with precertification from the Plan. • Hearing screening (1 per Calendar Year) • Vision screening (1 per Calendar Year) • Contraceptives (no coverage for contraceptives received Out-of-Network)		

BENEFIT DESCRIPTION	PHN EMPLOYEE PLAN NETWORK	OUT-OF-NETWORK
Preventive Care (continued)		
• Osteoporosis screening, including bone mass measurement.* "Bone mass measurement" means a radiological or radioisotope procedure, or other scientifically proven technology performed on an individual for the purpose of identifying bone mass or detecting bone loss. To receive this benefit, the Participant must be one of the following: o An estrogen-deficient woman at clinical risk of osteoporosis who is considering treatment o A Participant being monitored to assess to response to or efficacy of approved osteoporosis drug therapies *The Out-of-Network deductible will not apply to services noted with the asterisk that are received out-of-network.		
Rehabilitation Services (Physical, Occupational, Speech, & Cardiac Rehab Therapies) (Precertification required for Occupational and Physical Therapy) (Cardiac Rehab is limited to Phases I and II only) (Physical, Occupational, and Speech Therapy are limited to a combined maximum of 60 visits per Calendar Year) (Additional visits may be approved if precertification is obtained)	$10 copay, then 100%	80% after deductible
Sterilization Vasectomy (Office visit copay applies if procedure is performed in the office) Female sterilization as required by federal law	100% See **Preventive Care**	80% after deductible See **Preventive Care**
Temporomandibular Joint Syndrome	Refer to applicable service for benefit percentage	
Urgent Care Facility (includes all covered charges billed by facility)	$35 copay, then 100%	$35 copay, then 100%, deductible waived
Other Covered Expenses	100%	80% after deductible

Schedule of Prescription Drug Benefits
The following schedule summarizes amounts paid by the Plan. Please refer to the Prescription Drug Benefits section for a description of covered expenses and benefit exclusions and limitations.

Prescription Coverage Options	Your copayment for a:	
	30-day supply	90-day supply
Network Retail Pharmacy Option		
Prescribed Preventive Medications and Contraceptives as required by federal law*	$0	$0
Tier 1 (includes preferred generic drugs)	$5	$10
Tier 2 (includes generic drugs)	$10	$20
Tier 3 (includes generic and preferred brand drugs)	$25	$50
Tier 4 (includes generic and non-preferred brand drugs)	$40	$80
Tier 5 (includes generic and specialty brand drugs)	$40	$80
Network Mail Order Option		
Prescribed Preventive Medications and Contraceptives as required by federal law*	n/a	$0
Tier 1 (includes preferred generic drugs)	n/a	$10
Tier 2 (includes generic drugs)	n/a	$20
Tier 3 (includes generic and preferred brand drugs)	n/a	$50
Tier 4 (includes generic and non-preferred brand drugs)	n/a	$80
Tier 5 (includes generic and specialty brand drugs)	n/a	$80

Prescribed Preventive Medications and Contraceptives as required by federal law includes prescribed preventive medications that are recommended by the United States Preventive Services Task Force (USPSTF), as well as all Food and Drug Administration (FDA)-approved, prescribed female contraceptives (including but not limited to injectable, implants, IUDs, oral, and transdermal) at the following member cost:

- $0 cost for Generic
- $0 cost if there is no Generic equivalent or when Physician does not authorize Generic
- $0 cost for over-the-counter with a prescription
- Otherwise, refer to other existing drug costs.
- If the Plan imposes a penalty for choosing Brand Name when Generic is available and authorized by the Physician, such penalty continues to apply.
- If not obtainable from an In-Network pharmacy, you may be required to pay in full then submit a claim form and receipt for full reimbursement.

Brand Name means a trade name medication.

Generic drug means a prescription drug that has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any FDA-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Preferred Brand Name drug means a trade name prescription medication that is included in Tier 3 of the formulary and the Schedule of Prescription Drug benefits (shown above).

Non-Preferred Brand Name drug means a trade name prescription medication that is included in Tier 4 of the formulary and the Schedule of Prescription Drug benefits (shown above).

Specialty drugs means prescription medications that require special handling, administration or monitoring. These drugs are high-cost injectable, infused, oral, or inhaled drugs that generally require special storage or handling and close monitoring of the patient's drug therapy. Specialty drugs are used to treat complex, chronic and often costly conditions, such as cancer, chronic kidney failure, post-transplant anti-rejection, multiple sclerosis, rheumatoid arthritis, hepatitis C, and hemophilia. These drugs may have a limited distribution or may need prior authorization to have them ordered through a specialty pharmacy.

DEFINITIONS

For this Summary Plan Description, the following terms have the meanings given them in this section, unless otherwise defined elsewhere in the Summary Plan Description for the purpose of specific provisions. **These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of this Summary Plan Description for that information.**

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily Injury for which medical treatment is required.

Actively at Work and Active Work: Actually performing the regular duties of the employee's occupation at an Employer-designated work site. For a vacation, holiday or scheduled non-working day (e.g., weekend, etc.), Actively at Work and Active Work mean the capacity to perform the regular duties of the employee's occupation at an Employer-designated work site. An employee will be deemed Actively at Work if the employee is absent from work due to a health factor.

Administrative Period: A period of time selected by the Employer beginning immediately following the end of the Measurement Period and ending immediately before the start of the associated Stability Period. This period of time may be used by the Employer to determine if a Variable Hour Employee averaged at least 30 hours per week during the Measurement Period and, if so, to make an offer of coverage. Any applicable Administrative Period will not exceed 90 days.

Allowable Charge: See the 'Reasonable and Customary and Allowable Charge' definition.

Benefit Services Manager: Gilsbar, L.L.C., the entity that performs certain contracted nondiscretionary administrative services for the Plan pursuant to the terms of the Benefit Services Management Agreement.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

Certificate of Coverage: A written certification provided by any source that offers medical care coverage, including the Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Chiropractic Treatment: Skeletal adjustments, modalities, spinal/cerebral manipulation or other treatment in connection with the detection and correction, by manual means, of structural imbalance or subluxation of the human body. Such treatment is done to remove interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Clinical Trial: An Approved Clinical Trial as defined by Patient Protection and Affordable Care Act (PPACA), and includes phase I, II, III or IV trials that are federally funded by specified Agencies (National Institutes of Health (NIH), the CDC, CMS, a cooperative group or center of any of the previous entities or the Dept. of Defense or Veterans Affairs, or a qualified non-governmental research entity identified by NIH guidelines) or are conducted under an investigational new drug application reviewed by the FDA (if such application is required).

COBRA: The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Continuous Period of Confinement: All periods of confinement due to the same or a related cause or condition, unless periods are separated by one month during which the Covered Employee or Covered Dependent was not confined in either a Hospital or an Extended Care Facility or Skilled Nursing Facility.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Covered Dependent: A dependent covered pursuant to the eligibility requirements of the Plan; however, a dependent eligible as a dependent of more than one Covered Employee may not be a Covered Dependent of more than one employee.

Covered Employee: An employee covered pursuant to the eligibility requirements of the Plan, except that no employee may be covered simultaneously as an employee and a dependent.

Custodial or Custodial Care: Care or confinement provided primarily for the maintenance of the Participant, essentially designed to assist the Participant, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, and supervision over medication which can normally be self-administered and all domestic activities.

Domestic Partner: A person of the opposite or same sex with whom the Eligible Employee has established a Domestic Partnership.

Domestic Partnership: A Domestic Partnership consists of an Eligible Employee and one other person of the same or opposite sex (a "Domestic Partner"). Such persons must satisfy the following requirements:

- Each partner must be the other's sole Domestic Partner and must intend to remain so indefinitely. The partners must have an exclusive mutual commitment similar to that of marriage;

- Each partner must be at least 18 years of age or, if lower, the age at which a person may be legally married in the state in which the partners share the same permanent address;
- The partners must share the same permanent residence and have done so for at least 12 months;
- The partners cannot be related by blood to a degree that would prohibit marriage;
- The partners cannot be legally married to anyone else or in a domestic partnership with another individual nor have had another domestic partner within the prior ***six*** months;
- The partners must share the same permanent address and must be able to provide their driver's licenses listing the common address;
- The partners must share joint financial responsibility for basic living expenses, including food, shelter and coverage expenses;
- The partners must each be mentally competent to consent to contract; and
- The partners must be financially interdependent, demonstrated by at least ***two*** of the following:
    - Ownership of a joint bank account; ownership of a joint credit account; or evidence of joint obligation on a loan;
    - Common ownership of a motor vehicle;
    - Joint ownership of a residence; or evidence of a joint mortgage or lease;
    - Evidence of common household expenses, e.g. utility, phone;
    - Execution of wills naming each other as executor and/or beneficiary;
    - Granting each other durable powers of attorney;
    - Designation of each other as beneficiary under a retirement benefit account; or
    - Evidence of other joint financial responsibility.

Notwithstanding the foregoing, a Domestic Partner of an Eligible Employee will be eligible for coverage under the Plan if the Domestic Partnership has been registered with any state or local government registry recognizing domestic partnerships (and the Domestic Partnership meets the requirements of such registry) or if the domestic partners have been legally married in any state recognizing such marriages.

The Eligible Employee and Domestic Partner must jointly sign the required affidavit of Domestic Partnership.

Elective Surgical Procedure: Any non-Emergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

Eligibility Date: The day on which employees and dependents of employees become eligible to participate in the Plan.

Eligible Dependent: (See Highlights section.)

Eligible Employee: (See Highlights section.)

Emergency Medical Condition: A severe medical condition of recent onset that would lead a reasonably prudent and knowledgeable layperson to believe that failure to obtain immediate medical attention could result in serious jeopardy to health or serious impairment to bodily function or to any bodily organ or part.

Examples of Emergency medical conditions are:

- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

If you believe you are having a medical emergency, call 911 (or the appropriate emergency number in your area) or go immediately to the nearest appropriate medical facility.

Emergency Services: Emergency Services means, with respect to an Emergency Medical Condition:

1. A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

2. Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient.

Employer: New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health, including any affiliate or subsidiary thereof.

ERISA: The Employee Retirement Income Security Act of 1974, as from time to time amended.

Essential Health Benefits: Under section 1302(b) of the PPACA, those health benefits to include at least the following general categories and the items and services covered within the categories:

ambulatory patient services; Emergency Services; hospitalization; maternity and newborn care; mental health and Substance Abuse disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

Experimental or Investigational: Any treatment, equipment, new technology, drug, procedure or supply which:

1. is not recognized by the state or national medical communities;

2. does not have final approval from the appropriate government regulatory bodies of the United States;

3. is not supported by conclusive, scientific evidence regarding the effect on health outcome; or

4. is not considered standard medical treatment for the patient's specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, even if a Physician has previously prescribed, ordered, recommended or approved such treatment. The Plan Administrator determines what is considered Experimental or Investigational. Routine patient costs associated with participation in approved Clinical Trials shall not be considered Experimental or Investigational for qualified individuals.

Extended Care or Skilled Nursing Facility: A licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Inpatient basis during the convalescent stage of Illness or Injury under 24-hour-a-day supervision of a Physician or registered graduate Nurse, and which maintains permanent facilities for the care of ten or more bed patients. Such a facility must maintain complete medical records on each patient and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

1. A rest home, retirement home or home for the aged;

2. A school or similar institution;

3. Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or

4. Engaged in Custodial Care.

Full-time Employee or Full-Time Employment: With respect to a calendar month, an employee who is employed an average of at least 30 hours of service per week with the Employer.

HIPAA: The Health Insurance Portability and Accountability Act of 1996, as amended.

Home Health Care Agency: An agency that:

1. Is primarily engaged in providing skilled nursing and other therapeutic services to the patient in his home;

2. Is duly licensed or approved by the appropriate governmental body if such licensing or approval is legally required;

3. Has policies established by a professional group associated with the organization, including at least one Physician and at least one registered Nurse to govern the services provided;

4. Provides for full-time supervision of such services by a Physician or by a registered Nurse; and

5. Maintains a complete medical record of each patient.

Home Health Care Expenses: The Allowable Charge made by a health care agency for the following necessary services or supplies furnished to the Covered Employee or Covered Dependent in such individual's home in accordance with the home health care plan for care for which the patient would otherwise have been hospitalized:

1. Part-time or intermittent nursing care by or under the supervision of a registered Nurse;

2. Part-time or intermittent home health care aide services that consist primarily of caring for the patient;

3. Physical therapy, Occupational Therapy and speech therapy provided by the Home Health Care Agency; and/or

4. Medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Care Agency, to the extent such items would have been covered under any other provisions of the Plan had the Covered Employee or Covered Dependent been confined in a Hospital.

Hospice: A licensed service that offers a coordinated program of home care and Inpatient care for a Terminally Ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social and economic stresses often experienced during the final stages of life.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It must also provide such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

1. A surgery center;

2. A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;

3. A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Illness: A bodily or Mental/Emotional Disorder of any kind of any Participant. Illness includes pregnancy for the purpose of benefit determination. Illness also includes Injury where appropriate to the context.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Injury: A bodily injury resulting from an Accident sustained by any Participant. All injuries sustained by a Participant in one Accident will be considered one Injury.

Inpatient: A person who is confined in a Hospital as a registered bed patient and who is charged at least one day's room and board by the Hospital.

Late Enrollee: A Participant who enrolls in the Plan other than:

1. during the first period in which the individual is eligible to enroll under the Plan; or

2. during a Special Enrollment Period.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the absolute limit on what this Plan will pay for each Participant's covered expenses, even if other provisions of the Plan appear to entitle the Participant to more. "Lifetime" shall mean while covered under this Plan or any other plan maintained by the Employer.

Marriage or Married: A union that is legally recognized as a marriage under the state law where such marriage was performed.

Measurement Period: A period of time selected by the Employer during which a Variable Hour Employee's hours of service are tracked to determine if they average at least 30 hours during this period. The beginning dates and the lengths of each Measurement Period are set by the Plan Sponsor and will be applied uniformly to each category of employees.

- Initial Measurement Period: For a newly-hired Variable Hour Employee, this Measurement Period may start at any time from the date of hire to the first day of the month after the employee begins working and end no later than after the first 12 months of service.

- Standard Measurement Period: For Ongoing Employees, this Measurement Period will start on the same day each year and will last no longer than 12 months.

Medically Necessary or Medical Necessity: Describes medical treatment, as determined by the Plan Administrator, that:

1. Is appropriate and consistent with the diagnosis;

2. In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;

3. Is not primarily Custodial Care; and

4. As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is "medically necessary." In addition, the fact that certain services are excluded from coverage under this Plan because they are not "medically necessary" does not mean that any other services are deemed to be "medically necessary."

Medicare: All parts of Health Insurance for the Aged provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

Mental/Emotional Disorder: Any disorder characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances are the dominant feature. Mental/Emotional Disorders include mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Network (sometimes referred to as "In-Network"): A network of providers offering discounted fees for services and supplies to Participants. The network will be identified on the Participant's Plan identification card.

New Employee: An employee who has not been employed for at least one complete Standard Measurement Period, or who is treated as a New Employee following a period during which the employee was credited with zero hours of service.

Nurse: A licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) who does not usually live with the patient and is not a member of his family.

Occupational Therapy: The therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

Ongoing Employee: An employee who has been employed by the Employer for at least one complete Standard Measurement Period.

Out-of-Network: Physicians, Hospitals, or other health care providers that do not have a contract with the Plan to provide services to Participants at negotiated rates.

Outpatient: A person who is not admitted as an Inpatient but who receives medical care.

Outpatient Surgery: Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, that meets all the following criteria:

1. Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;

2. Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;

3. Provides at least two operating rooms and one post anesthesia recovery room;

4. Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;

5. Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;

6. Maintains an adequate medical record for each patient. The medical record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Partial Hospitalization: A structured Hospital-based program. Patients receive intense treatment usually between the hours of 8 a.m. and 5 p.m., Monday through Friday, and are capable of remaining in their home environment in the evenings. Individual, group or family therapy is provided a minimum of four hours a day, three times a week.

Participant: Any Eligible Employee or Eligible Dependent who has elected coverage under this Plan. Participant, covered individual, covered person, and member have the same meaning.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

1. within the scope of the license; and

2. applicable state law requires such practitioner to be licensed.

Plan: The arrangement created by this Plan Document and Summary Plan Description, and which may be amended from time to time.

Plan Administrator: New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health.

Plan Document: This Plan Document and Summary Plan Description.

Plan Sponsor: New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health.

Plan Year: A period of twelve consecutive months commencing on either the effective date of the Plan or on the day following the end of the first Plan Year if the first Plan Year is a short year.

Preventive Care: Care consisting of measures taken to prevent diseases, rather than curing them or treating their symptoms. For purposes of the Plan, in order to comply with applicable law, and in accordance with recommendations and guidelines, Preventive Care consists of the following:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;

2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;

3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and

4. Comprehensive guidelines for women supported by the HRSA.

Reasonable and Customary and Allowable Charge:

Reasonable and Customary: For the purposes of the plan generally, a charge is considered Reasonable and Customary:

1. If the charge is made for medical or dental services or supplies essential to the care of the Participant; and

2. If the charge is in the amount normally charged by the provider for similar services and supplies; and

3. If the charge does not exceed the amount ordinarily charged by most providers of comparable services and supplies in the geographic area where the services or supplies are received.

Whether a charge is Reasonable and Customary may be established by the Plan Administrator by use of any customary or accepted method.

Allowable Charge: The following are Allowable Charges under this plan and are agreed to be Reasonable and Customary:

1. A contracted rate of a Network provider servicing the Plan with the agreement of the Plan Administrator is an Allowable Charge.

2. A charge billed by an Out-of-Network provider is determined to be an Allowable Charge under the following rules applied in the order of priority as they are listed:

    a. If the Plan Administrator determines that the Allowable Charge is a lower amount than is otherwise applicable under the following rules, then that lower amount is the Allowable Charge;

b. If the billed charge is discounted according to an agreement negotiated specifically for the patient by the Plan Administrator directly with the provider, the Allowable Charge is the discounted charge;

c. If the billed charge is discounted according to an agreement with a repricing service that covers the Plan, the Allowable Charge is the discounted amount;

d. If the medical or dental service, supply, facility charge, or any other ancillary charge appears on the Reasonable and Customary Table utilized by the Plan Administrator (including, but not limited to Medicare pricers, MDCR, and Medicare fee schedules), then the Allowable Charge is the lesser of the billed charge or the amount as listed on the Table;

e. If none of the foregoing applies, the Allowable Charge is the billed charge.

Reconstructive Surgery: Surgery performed to restore function by reshaping abnormal structures of the body caused by Illness, Injury, congenital defects or developmental abnormalities.

Residential Treatment Center: A facility that provides treatment 24 hours a day and can usually serve more than twelve people at a time. Treatment may include individual, group and family therapy; behavior therapy; special education; recreation therapy; or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent mental illness that results in the person being unable to maintain independent functioning without support and continued treatment for an indefinite period of time or (2) substance abuse in which the patient is at a high risk for relapse.

Routine Physical Exam: Exam by doctor not required because of Illness or Injury.

Second Surgical Opinion: A written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future surgical procedure that was recommended by another Physician. This will include all Outpatient tests and diagnostic procedures Medically Necessary to render such opinion.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multi-surface restoration or a tooth that has had root canal therapy.

Spouse: An individual who is legally Married to a Covered Employee.

Stability Period: A period selected by the Employer that immediately follows, and is associated with, a Standard Measurement Period or an Initial Measurement Period (and, if elected by the Employer,

the Administrative Period associated with that Standard Measurement Period or Initial Measurement Period), and is used by the Employer as part of the Look-back Measurement Method. The Stability Period is a period of time equal to the Measurement Period in which the Variable Hour Employee's eligibility status is fixed.

Substance Abuse: The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results 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: This Plan Document and Summary Plan Description.

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

Terminally Ill: Someone who has a life expectancy of approximately six months or less, as certified in writing by the Physician who is in charge of the patient's care and treatment.

Variable Hour Employee: An employee is considered a Variable Hour Employee if, based on the facts and circumstances at the employee's start date, the Employer cannot determine whether the employee is reasonably expected to be employed on average at least 30 hours of service per week during the Initial Measurement Period because the employee's hours are variable or otherwise uncertain.

PERSONS COVERED AND EFFECTIVE DATES

Election of Coverage

If you are an Eligible Employee as defined by the Plan in the Highlights section, you may elect coverage under the Plan by submitting a completed, valid enrollment form which you may obtain from the Plan Administrator. You may elect coverage for yourself only, you and your Spouse or Domestic Partner, you and your dependent children, or your whole family. The application process involves electing coverage and paying the required contribution, if any, for the type of coverage you've chosen. The Plan Administrator determines annually or more frequently if deemed appropriate, whether (and to what extent) employees will be required to contribute towards the cost of coverage under the Plan. Contributions may be required to obtain employee and/or dependent coverage.

Effective Date of Employee Coverage

Your Eligibility Date is listed in the Highlights section. This is the earliest date that you may become covered under the Plan. If you choose not to enroll within 30 days of your Eligibility Date, you will be considered a Late Enrollee. You will also be considered a Late Enrollee if you do not enroll within 30 days of a Special Enrollment event described later in this section.

However, if you were covered under the prior plan when this Plan became effective, your Eligibility Date is the effective date of the Plan.

Your coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on your Eligibility Date, if you enroll within 30 days of becoming eligible; or

2. If you are a Late Enrollee, at 12:01 A.M. on the first day of January following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling during a Special Enrollment period, see Special Enrollment Periods later in this section.

If you are not required to make a contribution to the cost of your coverage (that is, it is non-contributory), it is effective at 12:01 A.M. on your Eligibility Date. However, you must complete an enrollment form in order for your claims to be paid promptly.

If, for reasons not related to a health condition, you are not Actively at Work on the date you would otherwise become covered under the Plan, your coverage will not begin until the day you return to Active Work.

Effective Date of Dependent Coverage

Your dependents may be covered under the Plan only if you are a Covered Employee and if the dependents meet the Plan's requirements for Eligible Dependents. If you have Eligible Dependents when you first become eligible to participate in the Plan, the Eligibility Date for these dependents is the same as your Eligibility Date. Any dependent not enrolled within 30 days of the Eligibility Date is considered a Late Enrollee. A dependent will also be considered a Late Enrollee if not enrolled within 30 days of a Special Enrollment event described later in this section.

Dependent coverage is effective as follows:

1. If you are an Eligible Employee, at 12:01 A.M. on the Eligibility Date, if you apply for dependent coverage within 30 days of becoming an Eligible Employee; or

2. If you or your dependent is a Late Enrollee, at 12:01 A.M. on the first day of January following the date of the request for enrollment (see Open Enrollment Period later in this section).

If you are enrolling your dependent during a Special Enrollment period, see Special Enrollment Periods later in this section.

If dependent coverage is non-contributory, coverage is effective at 12:01 A.M. on the Eligibility Date. Your dependents must be listed on your enrollment form in order for claims to be paid promptly.

If you did not have an Eligible Dependent when you first became eligible to participate in the Plan, but you later acquire one, coverage for this dependent is effective as described above. However, in this case the Eligibility Date is the date the Eligible Dependent was acquired. For a newborn child, the Eligibility Date is the date of birth. For an adopted child (under age 18), the Eligibility Date is the date of adoption or the date of placement in your home while you are covered under this Plan.

Contributory coverage for a newborn child is effective on the date of birth only if application is made within 30 days after this date. Contributory coverage for an adopted child (under age 18) is effective on the date of adoption or the date of placement in your home if application is made within 30 days after this date. These are exceptions to provision (1) above.

Special Enrollment Periods

The employee must make a request for special enrollment to the Plan Administrator within 30 days of Marriage, birth, adoption or the loss of other coverage (other than Medicaid or a State Children's Health Insurance Program). The request must be made in writing to the Plan Administrator.

Coverage is effective as follows:

1. For Marriage, the date the completed enrollment form is received;

2. For loss of other coverage, the date the completed enrollment form is received;

3. For birth or adoption, the date of birth or adoption, or the date the child is placed in the home for adoption.

Special enrollment rights are also available for employees and/or their dependents who lose coverage under Medicaid or a State Children's Health Insurance Program (SCHIP) or become eligible for a premium assistance subsidy from Medicaid or SCHIP as provided for in the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). In these cases, the employee must make a request for special enrollment to the Plan Administrator within 60 days of loss of Medicaid or SCHIP coverage, or notice of eligibility for a premium assistance subsidy, whichever applies. Coverage will become effective no later than the first day of the month after application is made to the Plan Administrator.

If an employee or a dependent does not enroll within 30 days of Marriage, birth or adoption or the loss of other coverage, and requests coverage later, he is considered a Late Enrollee and may enroll only during the Open Enrollment Period.

Open Enrollment Period

The Open Enrollment Period and the corresponding coverage effective date are shown in the Highlights section. During the Open Enrollment Period only, the Plan allows an Eligible Employee (and/or his Eligible Dependents) who is not currently enrolled and who has completed any waiting period (i.e., a Late Enrollee) to elect coverage.

During the Open Enrollment period only, Eligible Employees who are currently enrolled may also elect to add or drop dependents, or drop coverage altogether.

Change in Family Status

Once you are in the Plan, you must notify the Plan Administrator within 30 days of <u>any</u> family status change, such as a newborn baby, or when your first family member becomes eligible, or when you no longer need coverage for a certain family member, or when they are no longer eligible as defined in the Plan.

Change in Coverage Status
If your coverage status changes from dependent to employee or from employee to dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses or Domestic Partners Are Covered Employees
When both you and your Spouse or Domestic Partner are Covered Employees and you have family coverage for dependent children, one Spouse or Domestic Partner will be treated as a dependent for billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses or Domestic Partners are Covered Employees to get the full benefit of their family coverage. The Spouse or Domestic Partner who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

Alternately, each Spouse or Domestic Partner may decide to enroll separately. In this situation, eligible dependent Children may be covered under one Spouse's or Domestic Partner's enrollment. They may not be enrolled under both parents' coverage if both parents are Eligible Employees who have enrolled separately.

Election of Coverage Regarding Medicare
Medicare regulations applicable to employers with twenty or more employees require that any active Participant who has reached age 65 and is eligible for Medicare must choose one of the following coverage options:

1. Primary coverage under this Plan (Plan benefits will be paid without regard to Medicare), or

2. Sole coverage under Medicare (coverage under this Plan will terminate).

When eligible, Plan Participants must enroll in Medicare coverage in a timely manner in order to assure maximum coverage.

Court-ordered Coverage for a Child
Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below. Be sure you read them carefully.

The Plan Administrator shall enroll for immediate coverage under this Plan any alternate recipient who is the subject of a "medical child support order" ("MCSO") or "national medical support notice" ("NMSN") that is a "qualified medical child support order" ("QMCSO") if the child named in the MCSO is not already covered by the Plan as an

eligible dependent, once the Plan Administrator has determined that the order or notice meets the standards for qualification set forth below.

"Alternate recipient" shall mean any child of a Covered Employee who is recognized under an MCSO as having a right to enrollment under this Plan as the Covered Employee's Eligible Dependent. "MCSO" shall mean any judgment, decree or order (including approval of a domestic relations settlement agreement) issued by a court of competent jurisdiction that:

1. Provides for child support with respect to a Covered Employee's child or directs the Covered Employee to provide coverage under a health benefits plan pursuant to a state domestic relations law (including a community property law); or

2. Enforces a law relating to medical child support described in Social Security Act §1908 with respect to a group health plan.

"NMSN" shall mean a notice that contains the following information:

1. Name of an issuing state agency;

2. Name and mailing address (if any) of an employee who is a Participant under the Plan;

3. Name and mailing address of one or more Alternate Recipients (i.e., the child or children of the Covered Employee or the name and address of a substituted official or agency that has been substituted for the mailing address of the alternate recipients(s)); and

4. Identity of an underlying child support order.

"QMCSO" is an MCSO that creates or recognizes the existence of an Alternate Recipient's right to, or assigns to an Alternate Recipient the right to, receive benefits for which a Covered Employee or Eligible Dependent is entitled under this Plan. In order for such order to be a QMCSO, it must clearly specify the following:

1. The name and last known mailing address (if any) of the Covered Employee and the name and mailing address of each Alternate Recipient covered by the order;

2. A reasonable description of the type of coverage to be provided by the Plan to each Alternate Recipient, or the manner in which such type of coverage is to be determined;

3. The period of coverage to which the order pertains; and

4. The name of this Plan.

In addition, an NMSN shall be deemed a QMCSO if it:

1. Contains the information set forth above in the definition of "NMSN";

    a. Identifies either the specific type of coverage or all available group health coverage. If the Employer receives an NMSN that does not designate either specific type(s) of coverage or all available coverage, the Employer and the Plan Administrator will assume that all are designated; or

    b. Informs the Plan Administrator that, if a group health plan has multiple options and the Eligible Dependent is not enrolled, the issuing agency will make a selection after the NMSN is qualified, and, if the agency does not respond within 20 days, the child will be enrolled under the Plan's default option (if any); and

2. Specifies that the period of coverage may end for the Alternate Recipient(s) only when similarly situated dependents are no longer eligible for coverage under the terms of the Plan, or upon the occurrence of certain specified events.

However, such an order need not be recognized as "qualified" if it requires the Plan to provide any type or form of benefit, or any option, not otherwise provided to Participants without regard to this section, except to the extent necessary to meet the requirements of a state law relating to MCSOs, as described in Social Security Act §1908.

Upon receiving an MCSO, the Plan Administrator shall, as soon as administratively possible:

1. Notify the Covered Employee and each Alternate Recipient covered by the order (at the address included in the order) in writing of the receipt of such order and the Plan's procedures for determining whether the order qualifies as a QMCSO; and

2. Make an administrative determination if the order is a QMCSO and notify the Participant and each affected Alternate Recipient of such determination.

Upon receiving an NMSN, the Plan Administrator shall:

1. Notify the state agency issuing the notice with respect to the child whether coverage of the child is available under the terms of the Plan and, if so:

    a. Whether the child is covered under the Plan; and

    b. Either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent or by the official of a state or political subdivision to effectuate the coverage; and

2. Provide to the custodial parent (or any state official serving in a substitute capacity) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

3. Permit any Alternate Recipient to designate a representative for receipt of copies of the notices that are sent to the Alternate Recipient with respect to the order.

"GINA"

"GINA" shall mean the Genetic Information Nondiscrimination Act of 2008 (Public Law No. 110-233), which prohibits group health plans, issuers of individual health care policies, and employers from discriminating on the basis of genetic information.

The term "genetic information" means, with respect to any individual, information about:

1. Such individual's genetic tests;

2. The genetic tests of family members of such individual; and

3. The manifestation of a disease or disorder in family members of such individual.

The term "genetic information" includes participating in clinical research involving genetic services. Genetic tests would include analysis of human DNA, RNA, chromosomes, proteins, or metabolite that detects genotypes, mutations, or chromosomal changes.

Therefore, this Plan will not discriminate in any manner with its Participants on the basis of such genetic information.

USING THE PROVIDER NETWORK

The PHN Employee Plan Network (also referred to as "In-Network" or "Network") is a network of local Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Participants at reduced rates. As a Participant in the Plan, you will receive a list of providers that belong to the PHN Employee Plan network. It is the Participant's choice as to which provider to use.

If you choose the Network option, please follow the procedures for its use carefully. When medical care is needed, be sure the provider is still under contract with the Network shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the Network before services are rendered.

Eligible expenses for services rendered in an In-Network Hospital by an Out-of-Network provider, including, but not limited to, an anesthesiologist, radiologist or pathologist, will be payable at the same benefit level that an In-Network provider would be paid for such services if you did not have the option of choosing an In-Network provider. However, those Out-of-Network providers may bill you for any amount above what the Plan pays. All other charges by Out-of-Network providers will be payable at the Out-of-Network benefit level shown in the Schedule of Medical Benefits, even if you are referred to the Out-of-Network provider by an In-Network provider.

The copayment amount and the applicable benefit percentage for Physician office visits are shown in the Highlights section. A Participant is required to pay only the listed copay amount for same-day office visit services by an In-Network Physician and, if applicable, the copay amount for same-day services by an In-Network laboratory. The copay applies to the services outlined in the Schedule of Medical Benefits.

Any In-Network charge (1) for a service rendered on a different day, (2) for a service rendered outside the Physician's office (except as otherwise listed in the Schedule of Medical Benefits), or (3) billed as a separate facility fee is specifically excluded from the copay benefit associated with the original office visit. Such charges will be considered for payment by other applicable benefit provisions of the Plan. After the copay, the Plan will apply the applicable benefit percentage to the remaining covered expenses up to the maximum office visit limit, if any, and then the appropriate deductibles, benefit percentages and other Plan limits apply.

When you receive care from an In-Network provider, the Plan will pay the higher benefit percentage shown in the Highlights section for your covered expenses. When you receive care from an Out-of-Network provider, the Plan will pay the lower benefit percentage shown in the Highlights section. This lower percentage will apply to any expenses covered by the Plan if you had the option of using an In-Network provider and chose instead to use an Out-of-Network provider. The lower percentage will not apply if you must use an Out-of-Network provider in an Emergency or if the care you need is not available at an In-Network provider.

You will pay more out of your pocket if you Incur expenses at an Out-of-Network provider. There is no out-of-pocket limit for Out-of-Network expenses, so the Plan will not increase its benefit percentage to 100% for these expenses.
When you receive care from an In-Network provider, there is no Calendar Year deductible. When you receive care from an Out-of-Network provider, the Calendar Year deductible will apply.

MHNet is the network and claims administrator for Behavioral Health and Substance Use Disorder services. You may contact them toll-free at 1-866-301-8866 and obtain a list of providers through the website http://providersearch.mhnet.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer.

A current list of all other Network providers is available, without charge, through the website www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer.

This Plan requires the designation of a primary care provider. You have the right to designate as your primary care provider any Family Practitioner, Internist, or General Practitioner who participates in the PHN Employee Plan Network and who is available to accept you or your family members. If you do not make this designation, the Plan designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact the Plan Administrator.

For Children, you may designate a pediatrician as the primary care provider.

You do not need precertification from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the PHN Employee Plan Network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining precertification for certain services, following a pre-approved treatment plan, or following procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the Plan Administrator.

Each Participant has a free choice of any provider, and the Participant, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Network provider.

DEDUCTIBLES AND OUT-OF-POCKET EXPENSES

Deductibles and out-of-pocket expenses represent the portion that the Participant pays of covered expenses. This section describes generally these cost-sharing provisions of the Plan. The Plan Sponsor determines these amounts.

Calendar Year Deductible

The Calendar Year deductible is the amount of covered expenses Incurred by an individual during the Calendar Year for which no benefits will be paid. After you or a Covered Dependent has satisfied the Calendar Year deductible, the Plan pays a certain percentage of the covered expenses for that individual that are Incurred during the rest of the Calendar Year. Deductible accumulation period is January 1 through December 31. Copayments do not accrue toward the deductible. No Calendar Year deductible applies for services received from Network providers.

Family Calendar Year Deductible

If the dollar amount of the family Calendar Year deductible, shown in the Highlights section, is satisfied by the combined covered expenses applied to the individual deductibles of several Participants in a family, no additional Calendar Year deductible amount is required to be satisfied by the Participants of that family for covered expenses Incurred during the remainder of the Calendar Year. Once a Participant has satisfied the individual deductible, no additional covered expenses for that person will be counted toward the family deductible. No Calendar Year deductible applies for services received from Network providers.

Calendar Year Deductible Credit

Any portion of the Calendar Year deductible for 2016 satisfied under the plan of the Employer in effect immediately prior to the effective date of this Plan will be credited toward the 2016 Calendar Year deductible for this Plan.

Out-of-Pocket Expense

Out-of-pocket expense is the amount of covered expenses you must pay before certain benefits begin to be paid at 100%.

If during the Calendar Year your out-of-pocket covered expenses satisfy the out-of-pocket expense amount, the rate of payment by the Plan for certain covered charges will be increased to a full 100%. The 100% will continue for covered expenses Incurred during the remainder of that Calendar Year. You must satisfy your out-of-pocket amount before these benefits will be paid at

100%. There is no out-of-pocket limit for Out-of-Network expenses, so the Plan will not increase its benefit percentage to 100% for these expenses.

NOTE: See the Highlights section for a list of charges that do not apply to the out-of-pocket expense amount.

Family Out-of-Pocket Expense

If the dollar amount of the family out-of-pocket expense amount, shown in the Highlights section, is satisfied by the combined covered expenses applied to the individual out-of-pocket expense amount of several Participants in a family, no additional out-of-pocket expense amount is required to be satisfied by the Participants of that family for covered expenses Incurred during the remainder of the Calendar Year. Once a Participant has satisfied the individual out-of-pocket expense amount, no additional covered expenses for that person will be counted toward the family out-of-pocket expense amount.

Out-of-Pocket Expense Credit

Any portion of a Participant's out-of-pocket expense for 2016 satisfied under the plan of the Employer in effect immediately prior to the effective date of this Plan will be credited toward this Plan's out-of-pocket expense amount for 2016.

Calendar Year and Lifetime Maximum Carryover

A Participant's Calendar Year and Lifetime maximums under this Plan will be reduced by any amount paid for that Participant's expenses under the Employer's prior plan.

MEDICAL BENEFITS

Covered Medical Expenses

Covered expenses (sometimes identified as covered charges, eligible charges, eligible expenses or similar terms) include only the Allowable Charges that:

1. Are Medically Necessary for the care and treatment of Illness or Injury of a Participant; and

2. Are recommended by an attending Physician; and

3. Do not exceed the Reasonable and Customary charge; and

4. Are not excluded by other provisions applicable to this coverage.

The following expenses are covered by the Plan provided they meet the requirements for covered medical expenses described above and are not excluded elsewhere in the Plan. Reimbursement is based upon the Lifetime and Calendar Year limits, benefit percentages and other limitations previously described in the Highlights section.

1. Transportation by a professional **ambulance** service to a local Hospital or convalescent facility for Inpatient care, if Medically Necessary, or to the nearest Hospital for Emergency care. Transportation by ambulance to a non-medical facility will be covered only if Medically Necessary. Expenses for transportation by air will be covered only if an air ambulance is Medically Necessary. Expenses will also be covered for an ambulance transfer during hospitalization when requested by the Plan.

2. Services and supplies used in the administration of **anesthesia**, when not duplicated in the Hospital charges.

3. Services and supplies for treatment of **attention deficit**/hyperactivity disorder.

4. **Blood** and blood derivatives that are not donated or replaced.

5. **Cardiac rehabilitation**.

6. **Chiropractic** treatment.

7. Routine patient costs associated with a qualified individual's participation in a **Clinical Trial**, as defined by the Plan, for the prevention, detection or treatment of cancer or other life-threatening condition or disease (or other condition described in the PPACA. A life-threatening condition is a disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted.

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided by the Plan that is typically covered for a qualified individual who is not enrolled in a Clinical Trial. If one or more In-Network providers are participating in a Clinical Trial, the Plan may require that the qualified individual participate in the Clinical Trial with an In-Network provider. The Plan will cover Out-of-Network providers outside the state in which the qualified individual resides only if there is not an In-Network provider conducting the same trial in state.

Routine patient costs do not include (a) the investigational item, device or service itself; (b) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; (c) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular diagnosis; and (d) the cost of a health care service that is specifically excluded by the Plan.

8. **Contraceptive procedures and medications** other than those considered preventive services, including but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants, and any related office visit. Some contraceptives may be available under the Prescription Drug Benefit. The Plan does not cover contraceptive supplies or devices available without a Physician's prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

9. **Diabetes** self-management training.

10. Rental of **durable medical equipment** when such equipment is deemed Medically Necessary, including, but not limited to, a wheelchair, hospital-type bed, respirator, and equipment for the administration of oxygen. Such equipment may be purchased if, in the judgment of the Plan Administrator, purchase of the equipment would be less expensive than rental or the equipment is not available for rental. If purchased, the Plan will cover replacement only after a five-year period.

11. Room, board and supplies (other than drugs and medicines) billed by an **Extended Care Facility** or Skilled Nursing Facility. Benefits are payable only if the confinement is required due to a need for extended medical care and not for Custodial Care.

12. **Hearing aids** for Participants under age 18, subject to the limitations listed in the Schedule of Medical Benefits.

13. **Home health** care, if prescribed by a Physician as a plan of treatment. The Physician must certify that the proper treatment of the Injury or Illness would require continued confinement as an Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

14. **Hospice** care for Terminally Ill Participants. Covered charges are as follows:

    a. Inpatient Hospice care;

    b. Services of a Physician;

    c. At-home care including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds; and

    d. Emotional support services and physical/chemical therapies.

15. **Hospital** room and board, at the semi-private Hospital room and board rate. If confinement is in a Hospital providing private rooms only, the covered expense shall be no greater than the rate listed in the Schedule of Benefits. If Medical Necessity requires an intensive care unit or intermediate care unit, the Plan will cover the room and board up to the maximum listed in the Schedule of Benefits.

    If you are hospitalized for an Emergency, you, your family member, the medical care facility or attending Physician must contact the Utilization Management company within 48 hours of admission. If you are admitted to an Out-of-Network facility, the Plan reserves the right to require a transfer to a PHN Employee Plan Network Hospital and to transfer the responsibility for medical care to a Network provider. If it is determined you are able to transfer without medically harmful results, but you refuse to do so, you will pay for services at the Out-of-Network benefit level.

16. Other **Hospital** services and supplies furnished by the Hospital for medical care during confinement, exclusive of Physician's and other professional services.

17. Diagnostic testing to determine **infertility** or sterility. Diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography and diagnostic laparoscopy.

18. **Qualified interpreter/translator services**: Expenses Incurred by any hearing-impaired Participant for services performed by a qualified, contracted interpreter or translator, when such services are used by the Participant in connection with medical treatment or diagnostic

consultations performed by a healthcare provider, are only covered at the In-Network benefit level.

19. Medical **laboratory** charges in connection with treatment of an Illness or Injury.

20. Treatment of **Mental/Emotional Disorders**, including Severe Mental Illness and autism spectrum disorder services. Only the following diagnosed disorders are considered a Severe Mental Illness:

    a. Schizophrenia or schizo-affective disorder
    b. Bi-polar disorder
    c. Pervasive development disorder or autism
    d. Panic disorder
    e. Obsessive-compulsive disorder
    f. Major depressive order
    g. Anorexia/bulimia
    h. Asperger's disorder
    i. Intermittent explosive disorder
    j. Post-traumatic stress disorder
    k. Psychosis NOS (not otherwise specified), when diagnosed in a child under 17 years of age
    l. Rett's disorder
    m. Tourette's disorder

    Autism spectrum disorder services are psychiatric services for autism spectrum disorders that are both of the following:

    a. Provided by or under the direction of an experienced psychiatrist or an experienced licensed psychiatric provider; and

    b. Focused on treating maladaptive or stereotypic behaviors that are posing danger to self, others and property, and impairing daily functioning.

    Enhanced autism spectrum disorder are services that are focused on educational or behavioral intervention that are habilitative in nature and that are backed by credible research demonstrating that the services or supplies have a measurable and beneficial effect on health outcomes. Benefits are provided for intensive behavioral therapies (educational or behavioral services that are focused on primarily building skills and

capabilities in communication, social interaction and learning such as Applied Behavioral Analysis (ABA)).

21. Routine Hospital and Physician care for a **newborn child** prior to discharge from the Hospital. Such care may not be less than 48 hours following a normal delivery or 96 hours following a cesarean section. Refer to "Pregnancy" later in this section for details of the Newborns' and Mothers' Health Protection Act of 1996. The maximum benefit is also 48 hours and 96 hours, respectively. For a newborn child to receive this benefit, the child must be enrolled in the Plan within 30 days after birth. Charges for circumcision of a Child born while covered under the Plan will be covered prior to and after discharge from the Hospital.

22. **Occupational therapy** performed by a licensed occupational therapist and ordered by a Physician. The therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury. It must be considered progressive therapy, not maintenance therapy, and must not be performed for the purpose of vocational rehabilitation. Covered expenses do not include either recreational programs or supplies used in Occupational Therapy.

23. Covered medical expenses Incurred for care and treatment due to an **organ transplant** are subject to the following:

    a. The recipient must be a Participant in the Plan;

    b. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow and/or stem cell, heart, heart/lung, liver, lung, and pancreas or other organ transplant approved by the FDA that is not Experimental or Investigational. Bone marrow and/or stem cell transplants are considered organ transplants for the purposes of this Plan;

    c. Charges for obtaining donor organs are not covered under the Plan;

    d. Organ procurement does not include donor-related expenses while the Participant is awaiting the transplant, unless the donor is covered under this Plan.

    Prior to undergoing the procedures, the Participant who is the recipient of the transplant must receive two opinions with regard to the need for transplant surgery. Each opinion must be in writing by a board-certified specialist in the involved field of surgery. The specialist must certify that alternative procedures, services, or course of treatment would not be effective in the treatment of the Participant's condition.

24. The initial purchase, fitting and repair of an **orthotic appliance** such as a brace, splint or other appliance required for support of a malfunctioning or deformed limb as a result of Injury, Illness or a disabling congenital condition. The Plan will cover subsequent repair,

modification or replacement of the appliance only if the attending Physician certifies in writing that it is Medically Necessary due to:

a. a physical change in the condition of the patient's site of attachment;

b. the normal, physical growth of a dependent child; or

c. the fact that the existing orthosis is unusable and cannot be repaired or modified to achieve proper fit and function.

Corrective or orthopedic shoes, arch supports or other similar, corrective foot devices or appliances are not covered unless they are an essential part of a leg brace and are included in the orthopedist's charge, or if they are therapeutic shoes prescribed for Participants suffering from severe diabetes.

25. **Outpatient Surgery** charges for necessary services and supplies for surgical procedures performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.

26. **Physician's** fees for medical care and treatment of an Illness or Injury covered under the terms of this Plan.

27. **Physical therapy** by a licensed physical therapist. The therapy must be to restore or rehabilitate due to an Illness or Injury or due to surgery for an Illness or Injury.

28. **Preadmission testing** ordered by a Physician, done on an Outpatient basis and related to the condition for which the patient is to be hospitalized. These tests must be performed at a Hospital, ambulatory surgical facility, or Physician's office prior to confinement as an Inpatient. No benefits will be payable if the same tests are repeated after Hospital admission, unless Medically Necessary.

29. **Pregnancy** expenses, except for those Incurred by a dependent child (however, prenatal care is covered for a dependent child as required by federal law). Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain precertification

from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

30. **Prescription drugs** necessary for the treatment of an Illness or Injury, if obtainable only on a Physician's written prescription and dispensed by a licensed pharmacist (see Prescription Drug Benefits section).

31. **Preventive Care** services and prescription drugs, as listed in the Schedule of Medical Benefits and the Schedule of Prescription Drug Benefits, also including breastfeeding equipment and supplies, subject to the following:

    a. Rental of a Hospital-grade electric pump while the baby is Hospital confined; and

    b. Purchase of a standard (non-Hospital grade) electric pump or manual breast pump if requested while the baby is still breastfeeding, provided the Participant has not received either a standard electric breast pump or a manual breast pump within the last three Plan Years;

    c. For women electing to use a breast pump from a prior pregnancy, one (1) new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

    A detailed list of all covered Preventive Services is available, free of charge, by visiting www.healthcare.gov/coverage/preventive-care-benefits or by requesting a list from the Plan Administrator. Note that compliance with changes to the recommendations or guidelines is not required under the Plan until the Plan Year beginning one year or later after the recommendation or guideline is issued.

32. Replacement of a natural eye or limb with an artificial one (**prosthesis**), and subsequent repair, modification or replacement if it is Medically Necessary. Subsequent replacement is covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.

33. **Radiological tests** (X-rays), radium treatments, and treatments with other radioactive substances.

34. **Reconstructive surgery** of the breast on which a **mastectomy** was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant. Reimbursement will be made according to the Schedule of Medical Benefits section by type of service.

35. **Rehabilitation Hospital** charges, provided all the following conditions are met:

    a. The Participant has a physical disability, and his medical condition and functional performance can realistically be improved through the intensive rehabilitation program offered by the Hospital;

    b. Other treatment programs offering less intensive care or Outpatient treatment would not achieve the realistic goals sought by the Participant through the Hospital's rehabilitation program; and

    c. The Participant requires close medical care by a Physician and 24-hour-a-day nursing supervision.

    The Utilization Management company should be notified of the intended stay.

36. **Second Surgical Opinion** charges to confirm that recommended surgery is needed. The Physician who provides the second opinion must be board-certified for the medical condition for which surgery is advised. He must not be scheduled to perform the surgery or be in partnership with or have any financial affiliation with the first Physician in order for the surgical opinion benefit to be paid. If the second Physician disagrees with the first Physician, the Plan will cover a third surgical opinion.

37. Treatment of **sleep disorders**.

38. **Speech therapy** by a qualified speech therapist, when it is determined by the Plan that such therapy can be expected to result in significant improvement of the member's condition within a period of 60 days.

39. Elective surgery for **sterilization**, including tubal ligation female sterilization by any other FDA-approved method, and vasectomy.

40. Treatment of **Substance Abuse**.

41. Medical **supplies** that are Medically Necessary for treatment, including, but not limited to, an electronic heart pacemaker, surgical dressings, casts, splints, and crutches.

42. **Surgeon's** fees for the performance of surgical procedures, including necessary related postoperative care by a Physician, subject to the Reasonable and Customary fees in his area.

43. Treatment of **Temporomandibular Joint syndrome**, whether surgical or nonsurgical.

44. **Urgent care** center facilities and services.

UTILIZATION MANAGEMENT

Utilization Management Company Phone Number

Please refer to the Employee ID card for the Utilization Management company's phone number.

The Participant or family member must call this number to receive precertification of certain medical services. This call must be made in advance of services being rendered, or within 48 hours or on the first business day after an Emergency.

Failure to precertify required medical services will result in the application of the Utilization Management Penalty, shown in the Schedule of Medical Benefits.

Utilization Management

Utilization Management ("UM") is a program designed to help ensure that all Participants receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

(a) Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

- Bariatric surgery
- Brachytherapy
- Diagnostic testing, including MRA scans, CTA scans, CT scans, and angiograms
- Dialysis
- Durable medical equipment greater than $500
- Home health
- Home infusion in excess of $2,000
- Hospice services
- Injectable drugs in excess of $2,000
- Inpatient admissions
- Occupational therapy
- Organ transplants
- Outpatient surgery (including certain surgeries performed in the Physician's office)
- Physical therapy
- Prosthetics and orthotics
- Stereotactic/gamma knife procedures

(b) Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician;

(c) Certification of services and planning for discharge from a medical care facility or cessation of medical treatment; and

(d) Retrospective review of the Medical Necessity when precertification or concurrent review/discharge planning has not been secured.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

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

The UM organization's staff cannot and does not verify benefits or eligibility. The UM organization's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The UM program's purpose is strictly the verification of Medical Necessity and the appropriateness of care.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize your benefits, please read the following provisions carefully.

Here's how the program works.

Precertification
Before a Participant enters a medical care facility on a non-emergency basis, the Utilization Management company 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.

The Utilization Management program is set in motion by a telephone call from the Participant or the Participant's attending Physician. Contact the Utilization Management company at the telephone number on the Participant's ID card **before** services are scheduled to be rendered with the following information:

- The name of the Participant and relationship to the Covered Employee;
- The name, Social Security number and address of the Covered Employee;
- The name of the Employer;
- The name and telephone number of the attending Physician;

- The name of the medical care facility, proposed date of admission and proposed length of stay; and
- The diagnosis and/or type of surgery.

If there is an **emergency** admission to the medical care facility, the Participant, Participant's family member, medical care facility or attending Physician must contact the Utilization Management company **within 48 hours** or on the first business day after the admission.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life, there is no need to contact the Plan for prior approval. The Participant should obtain such care without delay.

The Utilization Management company will determine the number of days of medical care facility confinement authorized for Medical Necessity.

Precertification is designed to assist with your hospital stay, not to determine which benefits will be payable. To find out which benefits are payable, please refer to the appropriate sections of this Summary Plan Description.

Under the Newborns' and Mothers' Health Protection Act of 1996, plans and issuers may not, under federal law, require that a provider obtain precertification from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours following a vaginal delivery, or 96 hours following a cesarean section. Notification is still encouraged at the time of admission, and is **required** for any Hospital stay that is in excess of the minimum length of stay. Failure to notify the Utilization Management administrator of any stay that is in excess of the minimum length of stay will result in application of the penalty shown in the Highlights section to the Hospital expenses for the excess days not certified.

Concurrent Review and Discharge Planning

Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Management program. The Utilization Management company will monitor the Participant's medical care facility stay or use of other medical services and coordinate with the attending Physician, medical care facilities, and Participant 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 Participant to receive additional services or to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician must request the additional services or days.

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

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

Case Management occurs when this alternate benefit will be beneficial to both the Participant 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 will consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the Participant. The objective of this service is to direct the Participant toward the most appropriate care in a cost-effective environment. The Plan Administrator, attending Physician, Participant and, in some circumstances, the Participant's family must all agree to the alternate treatment plan.

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

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

Retrospective Utilization Management
When Hospital precertification or continued stay review/discharge planning has not been secured, the Utilization Management company may elect to use Retrospective Utilization Management. Retrospective Utilization Management is the process in which the Utilization Management company evaluates Inpatient, acute care hospitalizations which were not reviewed during the confinement. Using the established medical criteria for Hospital precertification and concurrent review/discharge planning, the Utilization Management company will determine retrospectively the Medical Necessity and appropriateness of Inpatient hospitalization and treatment plan.

PRESCRIPTION DRUG BENEFITS

Using Your Prescription Drug Benefits

As a Participant in the Plan, you will receive an ID card that allows you to purchase prescription drugs through the pharmacy benefits manager. If you present this card to a participating retail pharmacy when buying prescription drugs covered by the Plan or purchase eligible prescription drugs through a Network mail-order pharmacy, you will be charged as shown in the Highlights section. The per Participant, per Calendar Year deductible applicable to Out-of-Network medical expenses does not apply to these prescription drug expenses.

A current list of Network pharmacies is available, without charge, through www.myGilsbar.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer. If you do not have your prescription drug card with you when buying eligible prescription drugs from a Network pharmacy, you must pay the full price of the prescription drug and submit a claim form to the pharmacy benefit manager for reimbursement. These expenses are reimbursable only by the prescription drug card company. These claim forms may be obtained from the pharmacy benefits manager. Any claim submitted to Gilsbar, L.L.C. for these expenses will be returned to you.

Outpatient prescription drugs purchased from an Out-of-Network pharmacy are not covered under the Plan.

Covered Prescription Drug Expenses

Covered prescription drug expenses are the Reasonable and Customary charges for prescription drugs purchased from a Network pharmacy. Such drugs and medicines are eligible for coverage only if they are used to treat an Illness or Injury of a Participant in the Plan and can be obtained from a licensed pharmacist with a written prescription from a Physician and do not exceed the Allowable Charge. They are limited to the following:

1. Prescription drugs, including, but not limited to, pre-natal vitamins and vitamins with fluoride;

2. Compounded medications of which at least one ingredient is a prescription drug in a therapeutic amount;

3. Injectable insulin, including insulin syringes and needles, and diabetic supplies furnished on written prescription of a Physician.

Covered expenses may not exceed a 30-day supply when you purchase prescription drugs from a retail Network pharmacy, or a 90-day supply when you are purchasing a maintenance drug through the Network mail-order pharmacy or through a retail Network pharmacy. The amount may not be more than the amount normally prescribed by your Physician.

An expense will be considered to be Incurred, for purposes of this benefit, at the time the drug or medication is received from the pharmacist.

Exclusions and Limitations
Charges for the following are excluded unless specifically covered by the Plan or as required by federal law:

1. **Administration**: Any charge for the administration or injection of any drug or medication.

2. **Anorexiants** or any drug or medication used as an appetite suppressant.

3. **Blood** or blood plasma.

4. **Consumed on site**: Any drug or medication which is consumed or administered at the place where it is dispensed.

5. **Cosmetic purposes**: Drugs used for cosmetic purposes, such as hair growth stimulants or growth hormones.

6. **Devices** of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).

7. **Diagnostic** agents.

8. **Experimental/investigational**: Drugs labeled: "Caution–limited by federal law to investigational use," or experimental drugs even though a charge is made to the Participant.

9. **FDA**: Any drug that is not approved by the Food and Drug Administration or that is prescribed for non-FDA-approved uses.

10. **Impotence**: Drugs for erectile dysfunction or organic impotence.

11. **Immunizations** or biological sera, except for those covered as Preventive Care.

12. **Infertility**: Any drug or medication related to or used in the treatment of infertility.

13. **Injectables** & supplies: A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or

treatment other than insulin, as specifically covered under the Specialty Drug benefit, or otherwise herein.

14. **Inpatient medication**: Any drug or medication which is to be taken by or administered to the Participant, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing or Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

15. **Medical exclusions**: Any drug or medication otherwise excluded by the medical plan.

16. **No charge**: Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker's Compensation.

17. **No prescription**: Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.

18. **Refills**: Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.

19. **Smoking** deterrents or smoking cessation medications or supplies, other than those required by federal law.

20. **Vitamins**, except pre-natal vitamins and vitamins with fluoride that require a prescription.

GENERAL EXCLUSIONS AND LIMITATIONS

Note: See the Prescription Drug Benefits section for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description. This Plan excludes or limits coverage as described for the following, unless specifically covered by the Plan or as required by federal law:

Occupational Illness or Injury

Any Illness or Injury arising out of, or in the course of, employment with the Participant's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation, are excluded.

Government Plan

Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Participant is or could be covered, unless payment of the charge is legally required.

Unnecessary Services or Supplies

Any services or supplies not Medically Necessary for the care of the Participant's Illness or Injury are excluded. Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the Participant are also excluded. The Plan Administrator determines whether a service, treatment or supply is Medically Necessary.

Weekend Admissions

If admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an Emergency or if surgery is performed within 24 hours of admission.

Excess of Reasonable and Customary

The portion of any charge for any services or supplies that are in excess of the Reasonable and Customary charge or the Allowable Charge, as determined by the Plan Administrator, is excluded.

Mouth and Teeth Conditions
Medical Benefits for mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following:

1. Treatment or removal of malignant or benign tumors;

2. Treatment of an accidental Injury to a Sound, Natural Tooth, or for the setting of a jaw or facial bone fracture or dislocation if the treatment begins within three months of the Accident; or

3. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

Dental splints, dental prosthesis or any dental treatment for the teeth, gums or jaw is excluded, except as required for the treatment of temporomandibular joint syndrome (TMJ).

Foot Conditions
Physicians' services in connection with corns, calluses or toenails are excluded, unless the charges are for the partial or complete removal of the nail roots or unless associated with diseases affecting the lower limbs, such as severe diabetes, which requires the care of a podiatrist or a Physician.

Charges for corrective or orthopedic shoes, arch supports or other corrective devices or appliances are excluded, unless they are an essential part of a leg brace and are included in the orthopedist's charge, or if they are therapeutic shoes prescribed for Participants suffering from severe diabetes.

Vision Care
Medical benefits for Physicians' services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of, eyeglasses or contact lenses are excluded, unless for the initial examination following cataract surgery. The charges for eyeglasses or contact lenses are excluded, unless for the initial set following cataract surgery. radial keratotomy, LASIK, and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This exclusion does not apply to any services otherwise covered under vision benefits, if any.

Cosmetic or Cosmetic Surgery
Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:

1. Incurred as a result of accidental Injury;

2. For correction of a congenital anomaly; or

3. For reconstruction of the breast on which a mastectomy was performed, or for surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Participant.

Injury Due to Act of War
Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

Hearing Aids
Examinations to determine the need for, or the proper adjustments of, hearing aids are excluded. Also, the purchase of hearing aids is excluded. This exclusion does not apply to services that are otherwise specifically listed and included for coverage in the Medical Benefits section.

Routine or Preventive Care
Routine or Preventive Care is excluded, except as otherwise specifically listed and included for coverage under this Plan.

Other General Exclusions
Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Abortion**: Elective abortions unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. However, complications from abortions, whether elective or non-elective, are covered.

2. **Acupuncture/Acupressure**: Needle puncture or application of pressure at specific points, whether used to cure disease, to relieve pain or as a form of anesthesia for surgery.

3. **Administrative fees**, interest or penalties.

4. **Bariatric surgery**: A charge for bariatric surgery (including, but not limited to, gastric bypass, intestinal bypass, lap band, Roux-en-Y gastroenterostomy, adjustable gastric restrictive procedure, sleeve gastrectomy, gastroplasty, liposuction, or similar surgeries, including the normal pre-surgery and post-surgery care related to those procedures), unless the Plan Administrator itself, or through its delegee, such as a utilization review company, determines that the procedure is Medically Necessary to treat a medical condition in addition to obesity and gives documented confirmation of the determination to the provider.

5. **Behavioral health services as follows**:
   - Any care in lieu of legal involvement or incarceration
   - Conditions without a recognizable DSM IV diagnostic classification (such as adult child of alcoholics, ACOA, co-dependency) and self-help programs
   - Court-ordered examinations or care, or other similar arrangements, unless considered Medically Necessary by the mental health/substance use disorder designee
   - Dementias or amnesiac disorders
   - Habilitative as opposed to rehabilitative services, i.e., services to achieve a level of functioning the individual has never attained, except as provided for in connection with autism spectrum disorders
   - Learning disorders
   - Methadone treatment, L.A.A.M., cyclazocine, or their equivalents
   - Services related to mental retardation
   - Sexual dysfunctions and behavioral disorders such as anti-social personality disorders, paraphilia, gender identity disorders, sexual deviation or dysfunction, or social maladjustment

6. **Blood** and blood derivatives that are donated or replaced, including fees for administration.

7. **Claim filed late**: Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

8. **Claim form**: Completion of a claim form.

9. **Complications from non-covered services**: Charges that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure. However, complications from abortions, whether elective or non-elective, are covered.

10. **Coordination of benefits**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits or subrogation rules.

11. **Coverage not in force**: Charges incurred while coverage is not in force under the Plan.

12. **Custodial** care.

13. **Deductible**: Charges that are not payable due to the application of any specified deductible, copayment, or coinsurance provision of this Plan.

14. **Durable medical equipment**: Replacement of durable medical equipment within five years unless approved by the Plan Administrator.

15. **Education**, training, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns, except for diabetes self-management training and treatment of autism spectrum disorders, as listed in the Medical Benefits section.

16. **Electrical power**, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.

17. **Equipment**: Air conditioners, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves and any equipment or supplies not Medically Necessary.

18. **Experimental or Investigational**: Treatment, services, equipment, new technology, drugs, procedures or supplies considered Experimental or Investigational at the time the procedure is performed or service or supply is provided. Routine patient costs associated with participation in approved Clinical Trials shall not be considered Experimental or Investigational for qualified individuals.

19. **Family member**: Services or supplies provided by a member of the Participant's immediate family or by an individual residing in the Participant's home.

20. **Fertilization**: Any means of artificial fertilization, including but not limited to artificial insemination, in-vitro fertilization or gamete intra-fallopian transfer. Services of a surrogate mother are also excluded.

21. **Foreign travel**: Care, treatment or supplies out of the U.S. if travel is for the purpose of obtaining medical services.

22. **Genetic testing** or treatment, unless the results are specifically required for a medical treatment decision on the member.

23. **Hair loss**: Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

24. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.

25. **Infertility**: All specific treatments to correct or treat infertility and sterility.

26. **Marriage** counseling.

27. **Maternity**-related expenses for a dependent child, except as required by federal law for prenatal care.

28. **Medicare**: Benefits available under the Plan that may be reduced or eliminated based upon the coordination of benefits with Medicare when Medicare is the primary payor. This limitation may apply to Participants 65 or older, and is subject to federal regulation.

29. **Not legally required to pay**: Any item for which the Participant is not legally required to pay, or for which a charge would not have been made if the Participant did not have this coverage.

30. **Not listed**: Any items not listed in the Covered Medical Expenses subsection.

31. **Not necessary**: Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.

32. **Oral statements**: Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.

33. **Organ transplants**: Organ transplants other than those specified as covered under the Plan; or organ transplants that are Experimental or Investigational or which are not approved by the FDA; and

    Donor-related health care services and supplies, except as otherwise specifically listed and included for coverage under the Plan or unless the donor is a covered Participant under the Plan.

34. **Pain management**: All services for pain management.

35. **Personal** or convenience items.

36. **Physical fitness**: Programs, services or equipment related to physical conditioning or weight loss (including but not limited to, weight control/loss programs, dietary regimens and

supplements, appetite suppressants and other medications, food or food supplements, exercise programs, or exercise-related equipment, and other services or supplies that are primarily intended to control weight).

37. **Prior to or after coverage**: Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.

38. **Prison**: Charges for services received while confined in a prison, jail or other penal institution.

39. **Private duty nursing**.

40. **Radioactive contamination**: An Injury or Illness caused as a result of radioactive contamination.

41. **Room and board** for any other room at the same time the Participant is being charged for use of a special care unit.

42. **Sales tax** on prescription drugs or on any other covered items.

43. **Scheduled visit**: Failure to keep a scheduled medical visit.

44. **Sexual dysfunctions**, impotence, penile implants, sex transformations, gender dysphoria or inadequacies, and sex therapy.

45. **Sterilization reversal**: Reversal of previous sterilization treatments or surgeries.

46. **Telephone** conversations with a Physician.

47. **Travel expenses**, even if prescribed by a Physician.

48. **VAX-D therapy**.

49. **Violation of law**: The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

50. **Vision therapy**.

51. **Vitamins** (except pre-natal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over-the-counter items, whether or not prescribed by a Physician, unless specifically covered herein.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

WHEN YOU HAVE A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

The Benefit Services Manager may periodically request a General Information Verification Form to verify continued eligibility for benefits. If you need a General Information Verification Form, you may download one from www.myGilsbar.com or you may notify your Personnel or Human Resources Department.

If you or a Covered Dependent has to go to the Hospital, get duplicate Medical/Dental Family Claim Forms from your Personnel Department or Gilsbar's web site in advance. Sign the forms and send them to the Benefit Services Manager at the address listed on your ID card.

Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the Participant's full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

All claims, including those first mailed to a participating Network, must be received by Gilsbar, L.L.C. no later than 365 days after the date the expense is Incurred. A claim received after this deadline may be covered only if the Plan Administrator, or Benefit Services Manager acting on the instructions of the Plan Administrator, finds that there was a reasonable cause for the delay. Contact Gilsbar, L.L.C. to be sure the Claims Department has received all submitted claims.

CLAIMS PAYMENT AND APPEALS

Assignability

Benefits for covered expenses may be assigned by a Participant to the provider; however, if those benefits are paid directly to the Participant, the Plan will have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Participant and the assignee, has been received before the proof of loss is submitted.

Claims Procedure

A description of the Plan's process for handling claims and appeals for health benefits follows. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Plan's procedures, which are described below. "Days" means calendar days.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials: Pre-service Claim, Concurrent Claim, and Post-service Claim. The definitions and procedures for the three types of health claims are:

Pre-service Claim – a claim for a benefit under the Plan where prior approval for any part of the benefit is a condition to receiving the benefit. If a Participant makes a request for information on a charge or benefit (or a request for a determination of Medical Necessity) for which prior approval is not required by the Plan, that informational request or determination is not a pre-service claim. If a Participant needs medical care for a condition which could seriously jeopardize his life, health or ability to regain maximum function or which would subject him to severe pain that cannot be adequately managed without care or treatment, there is no need to seek or obtain approval in advance of obtaining medical care. The Participant should obtain such care without delay and contact the Utilization Management (UM) organization within 48 hours, or on the first business day following a Hospital admission.

Concurrent Claim – a claim that arises when the Plan has approved the Medical Necessity of an on-going course of treatment to be provided over a period of time or number of treatments, and either:

1. the Plan determines that the course of treatment should be reduced or terminated; or
2. the Participant requests extension of the course of treatment beyond that which was approved.

Remember, if the Plan does not require approval, then there is no need to contact the UM organization to request an extension of that treatment.

Pre-service and Concurrent Claims are deemed to be filed with the Plan when the request for approval is made and received by the UM organization or Benefit Services Manager in accordance with the Plan's procedures.

Post-service Claim – a request for a Plan benefit or benefits that is a request for payment under the Plan for covered medical services already received by the Participant.

If the Plan contracts with a network and you receive care through an In-Network provider, you will not need to file a medical claim. On your first visit to your In-Network provider, you will sign a form to assign benefits to that provider, and they will file the claims on your behalf.

You will be responsible for filing your own claims if you use providers that do not participate in the network, although some Out-of-Network providers may file claims on your behalf.

A Post-service Claim is deemed to be filed with the Plan on the date it is received by the Benefit Services Manager, containing the following information:

1. A properly completed Form HCFA or Form UB92 or successor forms, or an Electronic Data Interchange (EDI) file or other standard billing format;
2. The date of service;
3. The name, address, telephone number and tax identification number of the provider of the services or supplies;
4. The place where the services were rendered;
5. The diagnosis and procedure codes;
6. The amount of charges and repricing information;
7. The name of the Plan;
8. The name of the Covered Employee;
9. The name of the patient; and
10. Any Physician's notes, accident details, employment status, coordination of benefits information, or other information needed to adjudicate the claim.

When the information referenced above is provided, the claim is considered a "Clean Claim". The Plan will determine if enough information has been submitted to enable proper consideration of the claim. If the claim is not a Clean Claim, the Plan may deny the claim or may take an extension of time in order to request additional information. This additional information must be received by the Benefit Services Manager within 45 days from the date the Participant or the authorized representative receives the request. **Failure to respond within this time period may result in claims being denied or reduced.**

"Adverse Benefit Determination" is defined as a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit. This includes any reduction or failure to make payment based on the determination of a Participant's ineligibility or a rescission of coverage due to fraud or intentional misrepresentation of material fact. It includes any reduction or failure to make payment resulting from the application of any utilization review, the application of any Plan exclusions, and the failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary.

Timing of Notice of Benefit Determinations:
Pre-service Claim:

1. If the Participant has provided all the information needed to determine the Medical Necessity of the treatment, the Plan will notify the Participant of a benefit determination in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to determine the Medical Necessity of the treatment, the Participant may be notified as to what specific information is needed as soon as possible, but not later than 15 days after receipt of the claim. The Participant will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan and the Participant (if additional information was requested during the extension period).

3. If the Participant has failed to follow the Plan's procedures for filing a Pre-service Claim, the Participant will be notified of the failure and the proper procedures to be followed as soon as possible, but not later than 5 days following the failure.

4. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Concurrent Claim:

1. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), it will do so before the end of such period of time or number of treatments.

The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that Adverse Benefit Determination before the benefit is reduced or terminated.

2. Request by Participant for Extension of Treatment. If the Plan Administrator receives a request from the Participant to extend the course of treatment beyond the period of time or number of treatments, the request will be treated as a new Pre-service Claim or Post-service Claim and decided within the timeframe appropriate to that type of claim.

Post-service Claim:

1. If the Participant has provided all the information needed to process the claim, the Plan will notify the Participant of an Adverse Benefit Determination in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.

2. If the Participant has not provided all the information needed to process the claim and additional information is requested during the initial processing period, the Participant may be notified of an Adverse Benefit Determination prior to the end of the extension period, unless additional information is requested during the extension period; then, the Participant will be notified of the determination by a date agreed to by the Plan Administrator and the Participant.

3. Extensions. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Participant, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

Form of Notice to Participant of Adverse Benefit Determinations

Once the claim has been decided, the Plan Administrator will provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

1. The reason or reasons for the Adverse Benefit Determination;
2. Reference to the Plan provisions on which the determination was based;
3. A description of any additional material or information necessary for the Participant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the Plan's appeal procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the Participant's right to bring a civil action following a denial of the appeal;

5. A statement that the Participant is entitled to request the diagnostic and treatment codes used and their meaning;
6. A statement that any rule, guideline, protocol, or criterion that was relied upon in making the Adverse Benefit Determination will be provided free of charge to the Participant upon request;
7. If the denial is based on Medical Necessity, Experimental/Investigational Treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request.

Procedure for Internal Appeals

When a Participant receives an Adverse Benefit Determination, the Participant has the right to a full and fair review of the claim and Adverse Benefit Determination. More specifically, the Participant has 180 days following receipt of the notification in which to appeal the decision. The Participant must submit a written request for appeal to the Benefit Services Manager, including any written comments, documents, records, and other information relating to the claim. If the Participant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim that is in the possession of the Plan Administrator or the Benefit Services Manager.

A document, record, or other information will be considered relevant to a claim if it:

1. Was relied upon in making the benefit determination;
2. Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. Demonstrates compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all Participants; or
4. Constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the individual's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is deemed to be filed in accordance with the procedures of the Plan, which are described in this section. It is the Participant's responsibility to submit proof that the claim for benefits is covered and payable under the Plan's provisions. Any appeal must include the following:

1. The name of the Covered Employee/Participant;

2. The Covered Employee's/Participant's Social Security number or Participant ID number (PID);
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits, whether or not presented or available at the initial benefit decision. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Participant will lose the right to raise factual arguments and theories which support this claim if the Participant fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Participant has which indicates that the Participant is entitled to benefits under the Plan.

The review shall take into account all comments, documents, records, and other information submitted by the Participant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not rely on the initial Adverse Benefit Determination and will be conducted by an independent party who is neither the individual who made the Adverse Benefit Determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the Benefit Services Manager will consult with a health care professional who was not involved in the original benefit determination or the subordinate of that individual. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified upon request.

In the event of an Adverse Benefit Determination on review, the Participant will receive written or electronic notice of determination. The notice will meet the requirements as described above.

The Plan Administrator will notify the Participant of the Plan's benefit determination on review within the following timeframes:

Pre-service and Concurrent Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.

This Plan does not require prior approval for a Participant to receive urgent care; therefore, all urgent care claims will be handled as Concurrent or Post-service claims.

Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.

Procedure for External Review

If the Participant's claim continues to be denied or if the Participant does not receive a timely decision, he or she may request an external review of the claim by an independent review organization (IRO), except where such request is limited by applicable law, that will review the denial and issue a final decision. This request for external review must be made within 4 months from the date of receipt of the notice of final internal Adverse Benefit Determination or by the first of the fifth month following receipt of such notice, whichever occurs later.

In order for a claim to be eligible for external review, it must be a claim that involves:

1. Medical judgment (excluding those that involve only contractual or legal interpretation without any use of medical judgment) as determined by the external reviewer; or

2. A rescission of coverage.

The Participant will be notified in writing within six business days as to whether their request is eligible for external review and whether additional information is necessary to process the request. If the Participant's request is determined ineligible for external review, the notice will include the reasons for ineligibility and contact information for the appropriate oversight agency. If additional information is required to process the Participant's request, he or she may submit the additional information within the four-month filing period, or within 48 hours, whichever occurs later.

The Participant will receive written notice from the assigned IRO of the Participant's right to submit additional information to the IRO and the time periods and procedures to submit this additional information. The IRO will make a final determination and provide written notice to the Participant and the Plan no later than 45 days from the date the IRO receives a request for external review. The notice from the IRO will contain the reason(s) for the decision, including any applicable evidence-based standards used, and references to evidence or documentation considered in reaching its decision.

If the IRO decides the claim is payable, the Plan will pay the claim but may seek later judicial review.

Responsibility for Deciding Claims and Appeals

The Plan Administrator shall be ultimately and finally responsible for adjudicating claims and for providing full and fair review of the decision on such claims in accordance with the provisions in this section and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Participant is entitled to them or to the extent the above IRO decision

determines the claim is payable. Processing claims in accordance with the Plan Document and Summary Plan Description may be delegated to Gilsbar, L.L.C.

Decision on Appeal to be Final

The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law.

No suit concerning the claim may be commenced until the appeal process set forth herein has been completed and the decision on the appeal has been rendered by the Plan Administrator or the IRO. The Participant has one year from that time to file suit. Suit may not be brought after the one-year period has passed.

Summary of Claims Procedure Timetables

This chart of the timetables is included for your convenience only. Details concerning any applicable time limits are contained elsewhere in this section, and we recommend that you review this section and applicable subsections carefully for complete information regarding the timetables that apply to your claim.

Time Limits	Type of Claim			
	Pre-service	**Concurrent: To end or reduce treatment prematurely**	**Concurrent: To deny your request to extend treatment**	**Post-service**
You'll be notified of determination as soon as possible, but no later than…	15 days from receipt of claim	Notification to end or reduce will allow time to finalize appeal before end of treatment	Treated as any other Pre-service or Post-service claim	30 days from receipt of claim
Extension period allowed for circumstances beyond the Benefit Services Manager's control…	15 days	n/a	Treated as any other Pre-service or Post-service claim	15 days
If additional information is needed, you must provide it within…	45 days of date of extension notice	n/a	Treated as any other Pre-service or Post-service claim	45 days of date of extension notice
You must file your appeal within…	180 days of claim denial	Denial letter will specify filing limit	Treated as any other Pre-service or Post-service claim	180 days of claim denial
You'll be notified of the appeal decision as soon as possible but no later than…	30 days from receipt of appeal	15 days from receipt of appeal	Treated as any other Pre-service or Post-service claim	60 days from receipt of appeal

Time Limits	Type of Claim			
	Pre-service	**Concurrent: To end or reduce treatment prematurely**	**Concurrent: To deny your request to extend treatment**	**Post-service**
If your claim is eligible for external review, you must file the request within…	4 months from the date of receipt of the notice of final internal Adverse Benefit Determination	4 months from the date of receipt of the notice of final internal Adverse Benefit Determination	Treated as any other Pre-service or Post-service claim	4 months from the date of receipt of the notice of final internal Adverse Benefit Determination
You'll be notified of a final decision by the IRO as soon as possible but no later than…	45 days from the date the IRO receives a request for external review	45 days from the date the IRO receives a request for external review	Treated as any other Pre-service or Post-service claim	45 days from the date the IRO receives a request for external review

Appointment of Authorized Representative

A Participant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Participant to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Participant must complete a form which can be obtained from Gilsbar, L.L.C. In the event a Participant designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Participant, unless the Participant directs the Plan Administrator, in writing, to the contrary.

An Appointment of Authorized Representative Form may be obtained from www.myGilsbar.com or by calling the number below. Forms must be submitted to:

Gilsbar, L.L.C.
Attention: Claims Dept.
P.O. Box 998
Covington, LA 70433
Phone: 1-888-472-4352
Fax: 985-898-1529

Right of Recovery

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, or are not paid according to the Plan's terms, conditions, limitations or exclusions. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the covered person on whose behalf such payment was made.

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

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum or deducted from future claims presented by the covered person for processing.

Providers and any other person or entity accepting payment from the Plan, in consideration of such payments, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their state's health care practice acts, ICD-10 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If court action is necessary to recover any erroneous payment, the Plan shall be entitled to recover its litigation costs and actual attorneys' fees incurred.

Subrogation, Reimbursement, and Third Party Recovery Provision

Payment Condition

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

2. Participant(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Participant(s) and/or their attorney from any source and said funds shall be held in trust until such time as the

obligations under this provision are fully satisfied. The Participant(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Participant(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Participant(s) shall be a trustee over those Plan assets.

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

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

Subrogation

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

2. If a Participant(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Participant(s) may have against any Coverage and/or party causing the sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Participant(s) is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Participant(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

4. If the Participant(s) fails to file a claim or pursue damages against:
    a. The responsible party, its insurer, or any other source on behalf of that party;
    b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    c. Any policy of insurance from any insurance company or guarantor of a third party;
    d. Workers' Compensation or other liability insurance company;
    e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Participant(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Participant(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Participant are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Participant(s)' obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Participant(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Participant(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any

lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery, will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

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

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

Participant is a Trustee Over Plan Assets

1. Any Participant(s) who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. By virtue of this status, the Participant(s) understands that he/she is required to:

   a. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

   b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

   c. in circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

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

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

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

Excess Insurance

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

   The Plan's benefits shall be excess to any of the following:

   a. The responsible party, its insurer, or any other source on behalf of that party;
   b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   c. Any policy of insurance from any insurance company or guarantor of a third party;
   d. Workers' Compensation or other liability insurance company;
   e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the Participant(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

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

b. To provide the Plan with pertinent information regarding the sickness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

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

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

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

f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

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

h. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

i. In circumstances where the Participant is not represented by an attorney, instruct the insurance company or any third party from whom the Participant obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft;

j. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Participant over settlement funds is resolved.

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

3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Participant(s)' cooperation or adherence to these terms.

Offset

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

Minor Status

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

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

Language Interpretation

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

Severability

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

COORDINATION WITH OTHER PLANS

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with other similar plans under which a Participant is covered, so the total benefits available will not exceed 100% of the Allowable Charge. The expenses for services and supplies must be covered, at least in part, by one of the coordinating plans. This provision is commonly called "coordination of benefits." Benefits payable under other similar plans include the benefits that would have been payable had proper claim been made for them.

If this Plan provides for coverage for eligible retirees, and you are a covered retiree, and you or a Covered Dependent are entitled to Medicare coverage (whether or not you are enrolled for such coverage), this Plan will be the secondary payor and will coordinate its benefits (as described in this section) with Medicare benefits as permitted by law.

As permitted by law, this Plan also will be the secondary payor and will coordinate its benefits with Medicare for Participants who are eligible to enroll in Medicare due to disability or end stage renal disease (whether or not you are enrolled for such coverage). For Participants with end stage renal disease, the Plan will pay the Allowable Charge for the first 90 days. After the first 90 days, the Plan will pay according to Medicare's published fee schedule.

For the purposes of this coordination provision, the term "plan" means the following types of medical care benefits:

1. Coverage under a governmental plan or required or provided by law, including no fault coverage to the extent required in policies or contracts by a motor vehicle insurance statute or similar legislation; and

2. Group insurance or other coverage for a group of individuals, other than school accident-type coverage for elementary school, high school and college students. This does not include any law or plan where benefits are provided after those provided by other plans;

3. Non-group insurance contracts, hospital indemnity benefits in excess of $300 per day, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage.

In the event of a motor vehicle Accident, this Plan shall not be primary to any auto coverage such as medical, no fault, casualty or liability insurance that by its terms is immediately payable without the necessity of a finding of liability on the part of a third party. The Participant shall be responsible for identifying the motor vehicle Accident as the source of the Injury and completing any requested Accident report forms.

When a claim is made, the primary plan (as described below) pays its benefits without regard to any other plans. The secondary plans adjust their benefits so that the total benefits available will not exceed the Allowable Charge. No plan pays more than it would otherwise pay without this coordination provision.

A plan without a coordination of benefits provision is always the primary plan. If all plans have such a provision:

1. The plan covering the patient as an active Participant (e.g., employee, member, subscriber) or a dependent of an active Participant, rather than as an inactive Participant (e.g., COBRA beneficiary, retiree, or TRICARE participant) or a dependent of an inactive Participant, is primary and the others are secondary (if the other plan does not have this provision and, as a result, the plans do not agree on the order of benefits, this provision is ignored);

2. If a child is covered under both parents' plans, the parent whose birthday falls earlier in the Calendar Year is primary, or, if both parents have the same birthday, the plan covering the parent longer is primary; but when the parents are separated or divorced, their plans pay in this order:

    a. the plan of the parent with custody of the child;

    b. the plan of the Spouse of the parent with custody of the child;

    c. the plan of the parent not having custody of the child; and

    d. the plan of the Spouse of the parent not having custody of the child.

However, if a Qualified Medical Child Support Order (QMCSO) has established financial responsibility for the child's health care expenses, the benefits of that plan are determined first.

If none of the preceding provisions determine the order of benefits, the benefits of the plan that covered a Participant longer are determined first.

If none of the preceding provisions of this section make it able to determine which plan is primary, the Allowable Charge shall be shared equally between the plans.

TERMINATION OF COVERAGE

Coverage will terminate for an employee at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Date employment terminates;

3. Date the employee ceases to be an Eligible Employee (unless the employee is in a Stability Period or Administrative Period);

4. Last day of the employee's current Stability Period or the Administrative Period (if applicable), if the employee does not meet the requirements for future coverage as determined by the current Standard Measurement Period;

5. Date the employee chooses Medicare as his sole coverage;

6. The end of the last period for which any required contribution was received;

7. Date of the employee's death; or

8. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Coverage for a dependent will cease at 11:59 P.M. on the earliest of the following:

1. Date the Plan terminates;

2. Date the employee's coverage terminates;

3. Date the dependent enters active service with armed forces of any country;

4. Date the dependent ceases to be an Eligible Dependent (for any reason other than attaining the applicable age limit);

5. Date the dependent chooses Medicare as his sole coverage;

6. For a dependent Spouse, on the date of divorce, legal separation, or the termination of the Domestic Partnership;

7. For a dependent child/children, the end of the month of attainment of the applicable age limit;

8. The end of the last period for which any required contribution was received; or

9. The date on which an employee or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

An employee or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.

CONTINUATION OF BENEFITS

Reinstatement of Coverage

A terminated employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if the employee is returning to work directly from COBRA coverage, the waiting period will not apply provided he meets all the other requirements of the definition of an Eligible Employee. Participants whose coverage is reinstated under this provision will receive credit for any portion of the Calendar Year deductible and other cost sharing amounts that were met for that year while previously covered under the Plan. Benefit maximums for such Participants will be reduced by any amount paid by the Plan while the Participants were previously covered.

Continuation During Family and Medical Leave

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide unpaid, job-protected leave during any 12-month period to eligible employees for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage

The right to COBRA Continuation Coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"). COBRA Continuation Coverage can become available to you when you otherwise would lose your group health coverage. It also can become available to other members of your family who are covered under the Plan when they otherwise would lose their group health coverage. The entire cost (plus a reasonable administration fee) must be paid by the Covered Employee. Coverage will end in certain instances, including if you or your dependents fail to make timely payment of premiums. You should check with your Employer to see if COBRA applies to you and your dependents.

What is COBRA Continuation Coverage?

"COBRA Continuation Coverage" is a continuation of Plan coverage when coverage otherwise would end because of a life event known as a "Qualifying Event." Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if a part of your employer's plan) are not considered for continuation under COBRA.

What is a Qualifying Event?

Specific Qualifying Events are listed below. After a Qualifying Event, COBRA Continuation Coverage must be offered to each person who is a "Qualified Beneficiary." You, your Spouse, and your

dependent children could become Qualified Beneficiaries if coverage under the Plan is lost because of the Qualifying Event.

If you are a Covered Employee (meaning that you are an employee and are covered under the Plan), you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following Qualifying Events happens:

1. Your hours of employment are reduced; or

2. Your employment ends for any reason other than your gross misconduct.

If you are the Spouse of a Covered Employee, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events happens:

1. Your Spouse dies;

2. Your Spouse's hours of employment are reduced;

3. Your Spouse's employment ends for any reason other than his or her gross misconduct;

4. Your Spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or

5. You become divorced or legally separated from your Spouse.

Your dependent children will become Qualified Beneficiaries if they lose coverage under the Plan because any of the following Qualifying Events happens:

1. The parent-Covered Employee dies;

2. The parent-Covered Employee's hours of employment are reduced;

3. The parent-Covered Employee's employment ends for any reason other than his or her gross misconduct;

4. The parent-Covered Employee becomes entitled to Medicare benefits (Part A, Part B, or both);

5. The parents become divorced or legally separated; or

6. The child stops being eligible for coverage under the plan as a "dependent child."

The Employer must give notice of some Qualifying Events
When the Qualifying Event is the end of employment, reduction of hours of employment, death of the Covered Employee, or the Covered Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the Qualifying Event.

You must give notice of some Qualifying Events
Each Covered Employee or Qualified Beneficiary is responsible for providing the Plan Administrator with the following notices, in writing, either by U.S. First Class Mail, hand delivery, or by facsimile to (504) 849-6963:

1. Notice of the occurrence of a Qualifying Event that is a divorce or legal separation of a Covered Employee (or former employee) from his or her Spouse;

2. Notice of the occurrence of a Qualifying Event that is an individual's ceasing to be eligible as a dependent under the terms of the Plan;

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

4. Notice that a Qualified Beneficiary entitled to receive Continuation Coverage with a maximum duration of 18 months has been determined by the Social Security Administration ("SSA") to be disabled at some time before the 60th day of Continuation Coverage; and

5. Notice that a Qualified Beneficiary, with respect to whom a notice described in paragraph (4) above has been provided, has subsequently been determined by the SSA to no longer be disabled.

The Plan Administrator is:

Peoples Health
Plan Administrator
3838 N. Causeway Blvd., Suite 2200
Metairie, Louisiana 70002
(504) 849-4500

A form of notice is available, free of charge, from the Plan Administrator and must be used when providing the notice.

Deadline for providing the notice

For Qualifying Events described in (1), (2) or (3) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date on which the relevant Qualifying Event occurs;

2. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

3. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

For the disability determination described in (4) above, the notice must be furnished by the date that is 60 days after the latest of:

1. The date of the disability determination by the SSA;

2. The date on which a Qualifying Event occurs;

3. The date on which the Qualified Beneficiary loses (or would lose) coverage under the Plan as a result of the Qualifying Event; or

4. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

In any event, this notice must be furnished before the end of the first 18 months of Continuation Coverage.

For a change in disability status described in (5) above, the notice must be furnished by the date that is 30 days after the later of:

1. The date of the final determination by the SSA that the Qualified Beneficiary is no longer disabled; or

2. The date on which the Qualified Beneficiary is informed, through the furnishing of the Plan's summary plan description or the general notice, of both the responsibility to provide the notice and the Plan's procedures for providing such notice to the Plan Administrator.

The notice must be postmarked (if mailed), or received by the Plan Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA

Continuation Coverage is lost, and if you are electing COBRA Continuation Coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan, or if you are extending COBRA Continuation Coverage, such coverage will end on the last day of the initial 18-month COBRA coverage period.

Who can provide the notice

Any individual who is the Covered Employee (or former employee), a Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the Covered Employee (or former employee) or Qualified Beneficiary may provide the notice, and the provision of notice by one individual shall satisfy any responsibility to provide notice on behalf of all related Qualified Beneficiaries with respect to the Qualifying Event.

Required contents of the notice

The notice must contain the following information:

1. Name and address of the Covered Employee or former employee;

2. If you already are receiving COBRA Continuation Coverage and wish to extend the maximum coverage period, identification of the initial Qualifying Event and its date of occurrence;

3. A description of the Qualifying Event (for example, divorce, legal separation, cessation of dependent status, entitlement to Medicare by the Covered Employee or former employee, death of the Covered Employee or former employee, disability of a Qualified Beneficiary or loss of disability status);

4. In the case of a Qualifying Event that is divorce or legal separation, name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan, date of divorce or legal separation, and a copy of the decree of divorce or legal separation;

5. In the case of a Qualifying Event that is Medicare entitlement of the Covered Employee or former employee, date of entitlement, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

6. In the case of a Qualifying Event that is a dependent child's cessation of dependent status under the Plan, name and address of the child, reason the child ceased to be an eligible dependent (for example, attained limiting age);

7. In the case of a Qualifying Event that is the death of the Covered Employee or former employee, the date of death, and name(s) and address(es) of Spouse and dependent child(ren) covered under the Plan;

8. In the case of a Qualifying Event that is disability of a Qualified Beneficiary, name and address of the disabled Qualified Beneficiary, name(s) and address(es) of other family members covered under the Plan, the date the disability began, the date of the SSA's determination, and a copy of the SSA's determination;

9. In the case of a Qualifying Event that is loss of disability status, name and address of the Qualified Beneficiary who is no longer disabled, name(s) and address(es) of other family members covered under the Plan, the date the disability ended and the date of the SSA's determination; and

10. A certification that the information is true and correct, a signature and date.

If you cannot provide a copy of the decree of divorce or legal separation or the SSA's determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline; however, you must submit a copy of the decree of divorce or legal separation or the SSA's determination within 30 days after the date you have provided the notice. The notice will be timely if you do so. However, no COBRA Continuation Coverage, or extension of such coverage, will be available until you have provided a copy of the decree of divorce or legal separation or the SSA's determination.

Please note, if the notice does not contain all of the required information, the Plan Administrator may request additional information. If the individual fails to provide such information within the time period specified by the Plan Administrator in the request, the Plan Administrator may reject the notice if it does not contain enough information for the Plan Administrator to identify the plan, the Covered Employee (or former employee), the Qualified Beneficiaries, the Qualifying Event or disability, and the date on which the Qualifying Event, if any, occurred.

Electing COBRA Continuation Coverage

Complete instructions on how to elect COBRA Continuation Coverage will be provided by the Plan Administrator within 14 days of receiving the notice of your Qualifying Event. You then have 60 days in which to elect COBRA Continuation Coverage. The 60-day period is measured from the later of the date coverage terminates or the date of the notice containing the instructions. If COBRA Continuation Coverage is not elected in that 60-day period, then the right to elect it ceases.

Each Qualified Beneficiary will have an independent right to elect COBRA Continuation Coverage. Covered Employees may elect COBRA Continuation Coverage on behalf of their Spouses, and parents may elect COBRA Continuation Coverage on behalf of their children.

In the event that the Plan Administrator determines that the Participant is not entitled to COBRA Continuation Coverage, the Plan Administrator will provide to the Participant an explanation as to why he or she is not entitled to COBRA Continuation Coverage.

How long does COBRA Continuation Coverage last?
COBRA Continuation Coverage will be available up to the maximum time period shown below. Multiple Qualifying Events which may be combined under COBRA will not continue coverage for more than 36 months beyond the date of the original Qualifying Event. When the Qualifying Event is "entitlement to Medicare," the 36-month continuation period is measured from the date of the original Qualifying Event. For all other Qualifying Events, the continuation period is measured from the date of the Qualifying Event, not the date of loss of coverage.

When the Qualifying Event is the death of the Covered Employee (or former employee), the Covered Employee's (or former employee's) becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA Continuation Coverage lasts for up to a total of 36 months.

When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, and the Covered Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, COBRA Continuation Coverage for Qualified Beneficiaries other than the Covered Employee lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA Continuation Coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the Qualifying Event (36 months minus 8 months).

Otherwise, when the Qualifying Event is the end of employment (for reasons other than gross misconduct) or reduction of the Covered Employee's hours of employment, COBRA Continuation Coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA Continuation Coverage can be extended.

Disability extension of 18-month period of COBRA Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the SSA to be disabled and you notify the Plan Administrator as set forth above, you and your entire family may be entitled to receive up to an additional 11 months of COBRA Continuation Coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of COBRA Continuation Coverage. An extra fee may be charged for this extended COBRA Continuation Coverage.

Second Qualifying Event extension of 18-month period of COBRA Continuation Coverage
If your family experiences another Qualifying Event while receiving 18 months of COBRA Continuation Coverage, the Spouse and dependent children in your family can get up to 18 additional months of COBRA Continuation Coverage, for a maximum of 36 months, if notice of the

second Qualifying Event properly is given to the Plan as set forth above. This extension may be available to the Spouse and any dependent children receiving COBRA Continuation Coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the Spouse or dependent child to lose coverage under the Plan had the first Qualifying Event not occurred. An extra fee may be charged for this extended COBRA Continuation Coverage.

Does COBRA Continuation Coverage ever end earlier than the maximum periods above?
COBRA Continuation Coverage also may end before the end of the maximum period on the earliest of the following dates:

1. The date your Employer ceases to provide a group health plan to any employee;

2. The date on which coverage ceases by reason of the Qualified Beneficiary's failure to make timely payment of any required premium;

3. The date that the Qualified Beneficiary first becomes, after the date of election, covered under any other group health plan (as an employee or otherwise), or entitled to either Medicare Part A or Part B (whichever comes first). However, a Qualified Beneficiary who becomes covered under a group health plan which has a pre-existing condition limit must be allowed to continue COBRA Continuation Coverage for the length of a pre-existing condition or to the COBRA maximum time period, if less; or

4. The first day of the month that begins more than 30 days after the date of the SSA's determination that the Qualified Beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA Continuation Coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not postmarked (if mailed) or received by the Plan Administrator (if hand delivered) within 30 days of the due date, COBRA Continuation Coverage will be canceled and will not be reinstated.

Two provisions under the Trade Act affect the benefits received under COBRA. First, certain eligible individuals who lose their jobs due to international trade agreements may receive a 72.5% tax credit for premiums paid for certain types of health insurance, including COBRA premiums. Second, eligible individuals under the Trade Act who do not elect COBRA Continuation Coverage within the

election period will be allowed an additional 60-day period to elect COBRA Continuation Coverage. If the Qualified Beneficiary elects COBRA Continuation Coverage during this second election period, the coverage period will run from the beginning date of the second election period. You should consult the Plan Administrator if you believe the Trade Act applies to you.

Additional Information
Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator, who is:

Peoples Health
Plan Administrator
3838 N. Causeway Blvd., Suite 2200
Metairie, Louisiana 70002
(504) 849-4500, ext. 8669

Current Addresses
In order to protect your family's rights, you should keep the Plan Administrator (who is identified above) informed of any changes in the addresses of family members.

USERRA Continuation of Coverage

May I continue participation while I am absent under USERRA?
The Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA") is a federal law, under which you may elect to continue coverage under the Plan for yourself and your Covered Dependents, where:

1. They were Participants in the Plan immediately prior to your leave of absence for uniformed service; and

2. The reason for your leave of absence is due to active service in the uniformed services.

In addition, you must meet the following requirements:

1. You (or an appropriate officer of the uniformed service) must give advance written or verbal notice of your service to your Employer. This notice will not be required if giving it is precluded by military necessity or is otherwise impossible or unreasonable;

2. The cumulative length of this absence and all previous absences with your Employer by reason of your service in the uniformed service does not exceed five years (although certain exceptions apply to this five-year maximum requirement); and

3. You comply with the notice requirements set forth in "When will coverage continued through USERRA terminate?"

The law requires your Employer to allow you to elect coverage which is identical to similarly situated employees who are not on USERRA leave. This means that if the coverage for similarly situated employees and dependents is modified, coverage for the individual on USERRA leave will be modified.

What is the cost of continuing coverage under USERRA?
The cost of continuing your coverage will be:

1. For leaves of 30 days or less, the same as the contribution required from similarly situated employees;

2. For leaves of 31 days or more, up to 102% of the contribution required from similarly situated employees and your Employer.

Continuation applies to all coverage provided under this Plan, except for short and long-term disability, and life insurance, coverage.

When will coverage continued through USERRA terminate?
Continued coverage under this provision will terminate on the earlier of the following events:

1. The date you fail to apply for, or return to, work for your Employer following completion of your leave. You must notify your Employer of your intent to return to employment within:

    a. For leaves of 30 days or less, or if you are absent from employment for a period of any length for the purposes of an examination to determine your fitness to perform service in the uniformed service, by reporting to the Employer:

        i. Not later than the beginning of the first full regularly scheduled work period on the first full calendar day following the completion of your period of service and the expiration of eight hours after a period allowing for your safe transportation from the place of service to your residence; or

ii. If reporting within such period is impossible or unreasonable through no fault of yours, then as soon as possible after the expiration of the eight-hour period referred to above.

b. For leaves of 31 to 180 days, by submitting an application for reemployment with your Employer:

   i. Not later than 14 days after completing uniformed service; or

   ii. If submitting such application within that period is impossible or unreasonable through no fault of yours, then the next first full calendar day when submission of such application becomes possible.

c. For leaves of more than 180 days, by submitting an application for reemployment with your Employer not later than 90 days after completing uniformed service.

d. If you are hospitalized for, or convalescing from, an illness or injury incurred in, or aggravated during, the performance of service in the uniformed service, by reporting to, or submitting an application for reemployment with, your Employer (depending upon the length of your leave as indicated above), at the end of the period that is necessary for you to recover from such illness or injury. This period may not exceed two years, except if circumstances beyond your control make reporting to your Employer impossible or unreasonable, then the two-year period may be extended by the minimum time required to accommodate such circumstances.

Continued coverage provided under this provision will reduce the maximum period allowed for continuation provided under COBRA.

How will my coverage be reinstated on return from USERRA leave?

The law also requires, regardless of whether continuation of coverage was elected, that your coverage and your dependents' coverage be reinstated immediately upon your return to employment, so long as you comply with the requirements set forth above in "May I continue participation while I am absent under USERRA?" and, if your absence was more than 30 days, you have furnished any available documents requested by your Employer to establish that you are entitled to the protections offered by USERRA. Further, your separation from service or discharge may not be dishonorable or based upon bad conduct, on grounds less than honorable, absent without leave (AWOL), or ending in a conviction under court martial.

Upon reinstatement, an exclusion or waiting period may not be imposed if that exclusion or waiting period would not have been imposed had your coverage (or your dependents' coverage) not terminated as a result of your service in the uniformed service. However, this does not apply to

coverage of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred in, or aggravated during, performance of your service in the uniformed services.

NOTE: For complete information regarding your rights under USERRA, contact your Employer.

PLAN ADMINISTRATION

The Plan Administrator

The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of Gilsbar, L.L.C., as the Benefit Services Manager to provide certain claims processing and other ministerial services, which the Benefit Services Manager may further delegate to others. The Plan Administrator's relationship with Gilsbar, L.L.C. is governed by the Benefit Services Management Agreement. The Benefit Services Manager has no responsibility or obligation to Plan Participants, but only to the Plan and the Plan Administrator, as set forth in the Benefit Services Management Agreement.

An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor 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 which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Medically Necessary or Experimental and what charges are Reasonable and Customary), to decide disputes which may arise relative to a covered person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the covered person is entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;

2. To determine all questions of eligibility, status and coverage under the Plan;

3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;

4. To make factual findings;

5. To decide disputes which may arise relative to a covered person's rights;

6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;

7. To keep and maintain the Plan documents and all other records pertaining to the Plan;

8. To appoint and supervise a benefit services manager to pay claims;

9. To perform all necessary reporting as required by ERISA;

10. To establish and communicate procedures to determine whether MCSOs and NMSNs are QMCSOs;

11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and

12. To perform each and every function necessary for or related to the Plan's administration.

Amendment and Termination

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan.

Any such amendment, suspension or termination shall be enacted by the authority of the Chief Executive Officer of the Plan Sponsor, or an officer of the Plan Sponsor that has been delegated the authority to act on the Chief Executive Officer's behalf. Notice shall be provided as required by ERISA.

If the Plan is terminated, the rights of covered persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Expenses

All claims, expenses, or charges for the administration and operation of the Plan will be paid by the Plan and the trust, if any, that funds the Plan, or in the absence of a trust, by the Employer, as the Plan Sponsor.

Notices

All payments or notices of any kind to an employee, Participant, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Participant must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Invalidity

In the event that any provision in this Plan is deemed to be invalid or unenforceable, no other provision of this Plan shall be affected.

Other Statements

This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.

HIPAA PRIVACY

The following is a description of certain uses and disclosures that may be made by the Plan of your health information:

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA's Standards for Privacy of Individually Identifiable Health Information (the "Privacy Standards"), the Plan may disclose Summary Health Information to the Plan Sponsor, if the Plan Sponsor requests the Summary Health Information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

2. Modifying, amending or terminating the Plan.

"Summary Health Information" may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

Disclosure of Protected Health Information ("PHI") to the Plan Sponsor for Plan Administration Purposes
In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan documents or as required by law (as defined in the Privacy Standards);

- Ensure that any agents to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

- Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or group employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;

- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;

- Make available PHI in accordance with section 164.524 of the Privacy Standards (45 CFR 164.524);

- Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the Privacy Standards (45 CFR 164.526);

- Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the Privacy Standards (45 CFR 164.528);

- Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services ("HHS"), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with part 164, subpart E, of the Privacy Standards (45 CFR 164.500 et seq);

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and

- Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:

  - The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the PHI to be disclosed:

    Appropriate personnel of Human Resources

    Appropriate personnel of Actuary Services

    Appropriate personnel of Finance

    Appropriate personnel of Audit & Compliance

    Appropriate personnel of Pharmacy

    Appropriate personnel of Corporate

    Appropriate personnel of Operations

  - The access to and use of PHI by the individuals described above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

  - In the event any of the individuals described above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

"Plan Administration" activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. "Plan Administration" functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

- The Plan documents have been amended to incorporate the above provisions; and
- The Plan Sponsor agrees to comply with such provisions.

Disclosure of Certain Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage
The Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Benefit Services Manager, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters ("MGUs") for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the Privacy Standards.

Other Disclosures and Uses of PHI
With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

HIPAA SECURITY

Effective April 20, 2005 (April 20, 2006 for small health plans as defined by 45 C.F.R. § 160.103), the following section will be added to the Plan. It is intended to bring the Plan into compliance with the requirements of 45 C.F.R. § 164.314(b)(1) and (2) of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, 45 C.F.R. parts 160, 162 and 164 (the regulations are referred to herein as the "HIPAA Security Standards") by establishing Plan Sponsor's obligations with respect to the security of Electronic Protected Health Information.

Accordingly, the following is hereby included in the Plan effective on the applicable date shown above:

1. Definitions

   Electronic Protected Health Information – The term "Electronic Protected Health Information" has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted or maintained in any electronic media.

   Security Incident – The term "Security Incident" has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

2. Plan Sponsor Obligations

   Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

   - Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that the Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;

   - Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

- Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

- Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware as described below:

    - Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan's Electronic Protected Health Information; and

    - Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis at renewal, or more frequently upon the Plan's request.

ERISA RIGHTS

As a Participant in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a Medical Child Support Order or a National Medical Support Notice, you may file suit in federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor (listed in your telephone directory) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

OTHER INFORMATION

Plan Name	PHN Employee Plan
Plan Number	501
SFP Number	S2790
State of Organization	Peoples Health is organized under the laws of the State of Louisiana.
Plan Sponsor	New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health 3838 N. Causeway Blvd., Suite 2200 Metairie, Louisiana 70002 (504) 849-4500
Tax Identification Number	72-1267232
Plan Administrator	New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health 3838 N. Causeway Blvd., Suite 2200 Metairie, Louisiana 70002 (504) 849-4500
Plan Affiliates/Subsidiaries	Capital City Medical Group, LLC d/b/a Primary Care Plus
Benefit Services Manager	Gilsbar, L.L.C. P.O. Box 998 Covington, LA 70434 Telephone (985) 892-3520 or (800) 445-7227 Fax (985) 898-1500
Type of Plan and Administration	This Plan is a self-funded group medical cost indemnity plan; claims are processed by a claims payment company (the Benefit Services Manager), separate from the Plan Sponsor but under the direction of the Plan Administrator.
Plan Year Ends	December 31

Plan Cost	Employer shares the cost of employee and dependent coverage under this Plan with the Covered Employees. The level of any employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of employee contributions.
Benefits	Plan benefits are provided by New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health.
Agent for Service of Legal Process	Service of legal process may be made upon the Plan Administrator.
Plan is Not an Employment Contract	The Plan shall not be deemed to constitute a contract between the Employer and any employee or to be a consideration for, or an inducement of, or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any employees.
Effective Date	This Plan was adopted by New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health effective January 1, 2005, and has been restated in this updated Plan Document and summary Plan description. The effective date of this amendment of the Plan is April 1, 2016.

NEW ORLEANS REGIONAL PHYSICIAN HOSPITAL ORGANIZATION, INC. D/B/A PEOPLES HEALTH

PHN EMPLOYEE PLAN

PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION

New Orleans Regional Physician Hospital Organization, Inc. d/b/a Peoples Health a corporation having established a group employee benefit plan for the benefit of Eligible Employees on the terms and conditions described in the Plan Document and Summary Plan Description originally effective January 1, 2005, hereby amends and restates that group employee benefit plan, including any amendments that were effective at the time of this restatement, to read as stated in this updated Plan Document and Summary Plan Description.

The effective date of this restatement as established herein is April 1, 2016.

NOW, THEREFORE, PHN Employee Plan is hereby adopted to read as described in the following attached exhibit:

PHN Employee Plan, Plan Document and Summary Plan Description

IN WITNESS WHEREOF, this adoption document has been executed by or on behalf of the Plan Sponsor, duly authorized, effective on the day and year stated above.

NEW ORLEANS REGIONAL PHYSICIAN HOSPITAL ORGANIZATION, INC. D/B/A PEOPLES HEALTH, PLAN SPONSOR

WITNESS: Anne Hasselbach

BY: [signature]

DATE: 1/17/17

TITLE: President & CEO

GILSBARDM-#2823352-v8-Medical_Plan_eff_20160401