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Plan Number_____

(Here in after called Employer Sponsor)

EMPLOYEE WELFARE BENEFIT PLAN

PLAN DOCUMENT

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Plan Document

SECTION 1 - DEFINITIONS AND EXCEPTIONS

The terms set out below, wherever used in this document, shall be construed as follows:

A. "ACCIDENTAL INJURY" means an injury happening unexpectedly and taking place not according to the usual course of events (for example, a motor vehicle accident). Accidental Injury does not include any damage caused by chewing or biting on any object.

B. "ACTIVE SERVICE." A covered person will be considered in Active Service on a day which is a scheduled work day if he is performing in the customary manner all of the duties of his employment on a full-time basis of thirty (30) hours per week either at his customary place of employment or some location at which that employment requires him to travel, or if he is absent from work solely by reason of paid vacation and at the time his coverage would otherwise become effective he has not been absent from work for a period of more than three consecutive weeks. A covered person will be considered in Active Service on a day which is not a scheduled work day only if he was performing in the customary manner all the regular duties of his employment on the last preceding scheduled work day. A dependent will be considered in Active Service on any day if he is then engaging in all the normal activities of a person in good health of the same age and sex, he is not confined in a medical facility, and if he is a student, he is attending school. This paragraph will not apply to a newborn child.

C. "CHRONIC" means any diagnosed condition for which a Member receives ongoing care, treatment or medication.

D. "CONTRACT YEAR" means the period of time from January 1 through December 31 of each year.

E. "CONSULTATION" means services rendered by a physician whose opinion or advice is requested by another physician in the evaluation and/or treatment of a patient's sickness or injury. When and if a consulting physician assumes the continuing care of the patient, any subsequent services rendered by him will no longer be considered to be a Consultation. Services of a consulting physician may include a limited or extensive examination, a diagnostic history work-up or preparation of a special report in or out of a hospital.

F. "COPAYMENT" means the amount of payment indicated in the Schedule of Copayments which is due and payable by the Member to a provider of care.

G. "COVERED DEPENDENT" means a member or members of the Subscribers family who meet the eligibility requirements of this Plan Document, have been enrolled by the Subscriber in accordance with the terms of this Plan, and for whom Employer Sponsor of the Plan or the Plan Supervisor has received applicable contribution payments.

H. "COVERED SERVICE(S)" means those medically necessary health services and benefits to which Members are entitled under the terms of this Plan Document.

I. "CRISIS INTERVENTION" means medically necessary care rendered during that period of time in which an individual exhibits symptoms which could result in harm to that individual or to others in his environment.

J. "DEPENDENT" includes the following:

1. an employee's spouse who is living with employee.

2. an employee's child who meets all the following criteria:

a. is unmarried or married,

b. is a natural child, stepchild, legally adopted child, foster child, or a child for whom the employee claims an exemption on his/her federal income tax return who is living with the employee in a normal parent/child relationship;

c. is a natural child living with one natural parent, but whose medical care is by law or by decree the responsibility of the other natural parent, the employee;

d. is less than 26 years old;

e. who may or may not be mentally or physically handicapped, incapable of self-sustaining employment and is chiefly dependent upon the employee for support and maintenance. Proof of incapacity must be furnished to Plan Supervisor within thirty-one (31) days of the date when dependent coverage would otherwise have been terminated; upon acceptance of proof and payment of applicable Contribution, the Plan Sponsor will continue coverage for such child so long as employee's coverage remains in force and such incapacity continues.

K. "DETOXIFICATION" means services rendered during the time interval necessary to achieve medical stabilization necessitated by the physiological effects produced by the withdrawal from drugs of abuse, including alcohol.

L. "DURABLE MEDICAL EQUIPMENT means equipment which:

1. Can withstand repeated use;

2. Is primarily and customarily used to serve a medical purpose;

3. Generally is not useful to a person in the absence of illness or injury; and

4. Is appropriate for use in the home.

M. "ELIGIBLE CHARGES" means those charges incurred by a covered person for any injury or sickness, subject to the following criteria:

1. They are necessary for the care and treatment of the injury or sickness and are incurred on the recommendation and while under the continuous care and regular attendance of a physician.

2. They are not in excess of charges listed in the fee schedule shown in Attachment A of this Plan Document for the services performed or the materials furnished.

3. They are not excluded charges as hereinafter defined.

4. They are incurred for one or more of the services or materials specified under the Schedule of Benefits contained herein.

N. "EMERGENCY MEDICAL CONDITION" means a sudden or unexpected onset of an acute condition requiring medical or surgical care and in the absence of such care the Member could reasonably be expected to suffer serious physical impairment or death. Heart attack, severe chest pain, stroke, hemorrhaging, poisoning, major bums, loss of consciousness, serious breathing difficulty, spinal injury, shock, and other acute conditions as Supervisor shall determine are Emergency Medical Conditions.

0. "EMERGENCY SERVICES" means services to treat Emergency Medical Conditions as described more fully in 'Basic Covered Services" of this Plan Document.

P. "EMPLOYEE" An Employee shall be a person who works at least thirty (30) hours a week for the Employer specifically excluding part-time and temporary employees.

Q. "EMPLOYER' means Employer Sponsor, the plan sponsor of this Employee Welfare Benefit Plan.

R. "EXCLUDED CHARGES" The term "Excluded Charges" means those charges which do not meet the definition of Eligible Charges as defined herein.

S. "EXTENDED CARE FACILITY" The term "Extended Care Facility" means an institution, or distinct part thereof, which meets the following criteria:

1. It is duly licensed pursuant to state or local law.

2. It is operated primarily for the purpose of providing skilled nursing care and treatment for persons convalescing from injury or sickness as an inpatient; and

a. has organized facilities for medical treatment and provides twenty-four hour nursing service under the full-time supervision of a physician or a graduate registered nurse;

b. maintains daily clinical records on each patient and has available the services of a physician under an established agreement;

c. provides appropriate methods of dispensing and administering drugs and medicines;

d. has transfer arrangements with one or more hospitals;

e. has a utilization review plan in effect and operational policies developed with the advice of, and reviewed by, a professional group including at least one physician;

f. excludes any institution which is other than incidentally a rest home, a home for the aged, or a place for the treatment of mental disease, drug addiction or alcoholism.

3. It is qualified to participate and is eligible to receive payments under and in accordance with the provisions of Medicare, Title XVIII, of the Social Security Act, as enacted and amended.

T. "GRACE PERIOD" means a period of ten (10) days after the last day of the month preceding the month of coverage during which period Contributions may be paid to Employer Sponsor or the Plan Supervisor without lapse of coverage.

U. "GRIEVANCE PROCEDURE" means the process for resolving problems and disputes set forth in this Plan Document.

V. "GROUP OPEN ENROLLMENT PERIOD" means those periods of time (at least 30 working days but not less than that required by applicable law) established by Employer from time to time but no less frequently than once in any 12 consecutive months during which Eligible Employees who have not previously enrolled in the Employee Welfare Benefit Plan may do so.

W. "HOME HEALTH AGENCY" means an organization licensed by the State which has entered into an agreement with the Plan Administrator or Plan Supervisor to render home health services to Members and has been approved as a participating Home Health Agency under the federal Medicare program.

X. "HOSPICE" The term 'Hospice" means a facility or agency primarily engaged in providing skilled nursing services and other therapeutic services for terminally ill patients and which:

1. Is licensed in accordance with State law (where such licensing is provided); and

2. Is certified by Medicare as a provider of Hospice Care; and

3. Is approved by the applicable State Medical Foundation as a Hospice.

Y. "HOSPITAL" means an institution which meets the following criteria:

1. It operates in accordance with the law of the jurisdiction in which it is located.

2. It is primarily engaged in providing, for compensation from its patients on an inpatient basis, diagnosis, care and treatment of injured or sick persons.

3. It continuously provides 24 hour nursing service by registered nurses.

4. It is under the supervision of a staff of physicians or surgeons, one or more of which is available at all times.

5. It is not primarily a clinic and it is not, other than incidentally, a place for rest, convalescents, alcoholics, drug addicts, mentally ill or tubercular patients.

6. It is accredited by the American Hospital Association.

7. If it is a Psychiatric hospital, then as defined by Medicare.

Z. "HOSPITAL CONFINEMENT" means the period of time during which a person is admitted as a patient upon the recommendation of a physician, is confined as a bed-paying patient, is charged for room and board in a hospital as defined herein.

AA. "HOSPITAL SERVICES" means those acute-care services furnished and billed by a Hospital which are authorized by a Participating Physician.

AB. "INITIAL ACQUISITION" means the first purchase whether obtained while a participant of this Employee Welfare Benefit Plan or prior to enrollment in this Employee Welfare Benefit Plan.

AC. 'INJURY' means bodily injury caused solely by and resulting solely from a non-occupational accident sustained while the injured person is covered by the plan.

AD. "INTENSIVE CARE UNIT" means a section, ward, or wing within the hospital which is separated from other hospital facilities and

1. is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

2. has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use;

3. provides constant observation and treatment by registered nurses or other specially trained hospital personnel.

AE. "MAXIMUM FEE SCHEDULE" means a schedule of fees shown in Attachment A of this Plan Document established by Employer Sponsor for payment to providers for Covered Services, and which may be less than actual charges billed by the providers.

AF. "MEDICAL DIRECTOR" means a Physician designated by Employer Sponsor and the Plan Supervisor to monitor and review the provision of Covered Services to Members or such person or persons as the Medical Director shall designate.

AG. "MEDICALLY NECESSARY" means services or supplies provided by a Hospital, Skilled Nursing Facility, Home Health Agency, Physician or other health care provider which are determined by the Plan's Medical Director or its utilization review committee to be:

1. Consistent with the symptoms or diagnosis and treatment of the Member's condition, disease, ailment or injury;

2. Appropriate with regard to standards of good medical practice;

3. Not solely for the convenience of the Member, his or her Physician, Hospital, or other health care provider; and

4. The most appropriate supply or level of service which can be provided to the Member.

For inpatient services and supplies, it further means that the Member's medical symptoms or condition requires that the diagnosis or treatment cannot be safely provided to the Member as an outpatient.

AN. "MEDICARE" means Title XVIII of the Social Security Act and all amendments thereto.

Al. "MEMBER" means any person enrolled in this Employee Welfare Benefit Plan as a Subscriber or Covered Dependent.

AJ. "MENTAL CONDITION" means any mental, emotional, or behavioral condition, disorder, or disease, including mental retardation or deficiency.

AK. "MIDWIFE" means a person certified to practice as a nurse-midwife and fulfills both of these requirements:

1. A person licensed by a board of nursing as a registered nurse.

2. A person who has completed a program approved by the state for the preparation of nurse-midwives.

AL. "NURSE" The term "nurse" means a Registered Graduate Nurse (RN), a Licensed Vocational Nurse (LVN), or a Licensed Practical Nurse (LPN) not related to or residing with the Covered Individual being cared for.

AM. "ONE CONTINUOUS PERIOD OF HOSPITAL CONFINEMENT means a period of time during which an insured individual is confined in a hospital as a registered bed patient. Successive periods of Hospital Confinement due to the same or related cause or causes will be considered one period of hospital confinement unless they are separated by:

1. With respect to an employee, two or more weeks of continuous employment with the Employer on an active full-time basis, or

2. With respect to a Covered Dependent, a period of three or more months during which the Covered Dependent has not been hospital confined due to the same or related cause or causes.

AN. "OUTPATIENT SURGICAL FACILITY" means a legally operated institution which is primarily operated to provide facilities for performing surgery, and which has:

1. Permanent operating rooms, a recovery room and all medical equipment necessary for surgery;

2. A medical staff including registered nurses for patient care;

3. A contract with a hospital for immediate acceptance of patients requiring post-operative confinement.

It does not include a private office or clinic of one or more doctors.

AO. "OUT OF AREA SERVICES" means those services provided outside the Service Area defined for this Employee Welfare Benefit Plan. Covered “Out of Area Services” are more fully described in "Basic Covered Services.

AP. "PARTICIPATING PHYSICIAN" means a Physician who, at the time of providing or authorizing services to a Member, is under contract with Employer Sponsor and the Plan Supervisor through an Association or Accountable Care Organization to provide Professional Services to Members.

AQ. "PARTICIPATING PROVIDER" means a Participating Physician, a Participating Specialist, a Hospital, Skilled Nursing Facility, Home Health Agency or any other duly licensed institution or health professional under contract with Employer Sponsor and the Plan Supervisor through an Association or an Accountable Care Organization to provide Professional Services, Hospital Services or other Covered Services to Members. A list of Participating Providers is available to each Subscriber upon enrollment. Such list shall be

revised by the Plan Supervisor from time to time as deemed necessary by Employer Sponsor and the Plan Supervisor.

AR. "PARTICIPATING SPECIALIST" means a Participating Physician who, at the time of providing or authorizing services to a Member, practices a particular medical specialty and is under contract with Employer Sponsor and the Plan Supervisor through an Association or Accountable Care Organization to provide services to Members as a Participating Specialist.

AS. "PHYSICIAN" means a duly licensed Doctor of Medicine (MD), Osteopath (DO), Podiatrist (DPM), Chiropractor, Master of Oriental Medicine and Acupuncture (MAOM,LAc), or Clinical Psychologist, Dentist or any other practitioner providing a Covered Service and acting within the scope of his or her license who is required to be recognized as such by an applicable State code.

AT. "PLAN" means the employee welfare benefit plan which has been established by Employer Sponsor and through which benefits are provided, in whole or in part, through this Plan Document.

AU. "PLAN ADMINISTRATOR" is Employer Sponsor, which has ultimate responsibility for management of the Plan, and for performing, or having performed, such tasks as maintaining contributions on deposit for claim payments, paying claims as they come due, preparing claim reports and other necessary data for the Plan, and preparing any necessary government reports. The Plan Administrator is not responsible, in any manner, for the guarantee of claim payments for which there are no contributions or funds. The Plan Administrator may employ persons or firms to process claims and perform other Plan-connected services.

AV. "PLAN SPONSOR" is Employer Sponsor, the entity responsible for the establishment of the Plan.

AW. "PLAN SUPERVISOR" means a company or entity engaged by the Plan Administrator for the purposes of billing, accounting, payments of claims and expenses and other such duties as may be specified by the Plan Administrator.

AX. "PRIMARY CARE PHYSICIAN" means a Participating Physician (M.D., D.O., NP, MAOM, Lac), chosen by a Member to provide Professional Services and coordinate health care services for the Member.

AY. "PROFESSIONAL SERVICES" means services performed by Physicians and health professionals which are Medically Necessary, generally recognized as appropriate care within the Service Area, and which are performed, prescribed, directed, or authorized by a Participating Physician.

AZ. "PROTHESIS" means an artificial device which replaces a missing part of the body.

BA. "PRONOUNS." Masculine pronouns used in this document shall apply to both sexes.

BB. "REASONABLE AND CUSTOMARY" means the charge made by an individual, group, or other entity rendering or furnishing services, treatment, or materials not exceeding the schedule of fees included in this plan document as Attachment A for services, treatments, or materials in which treatment is provided for injuries and sicknesses treated.

BC. "SERVICE AREA" means those counties in states where Employer Sponsor, the Plan Supervisor, and any insurers, health maintenance organizations, Accountable Care Organizations, and service providers from whom the Plan purchases coverage are authorized to operate.

BD. "SICKNESS" means a bodily disorder, a disease, or mental infirmity, pregnancy and complications thereof. A recurrent sickness shall be considered as one sickness. Concurrent sicknesses shall be deemed to be one sickness unless they are totally unrelated or separated by a period of six weeks.

BE. "SIGNIFICANT IMPROVEMENT" means substantial ongoing positive changes in the condition of the patient as determined by the Plan's Medical Director.

BF. "SKILLED NURSING CARE" means care provided by a registered nurse (R.N.) or a licensed practical nurse (L.P.N.) under the supervision of an R.N. if all of the following conditions are met:

1. The services are required on an intermittent or part-time basis.
2. The services must require the skills of a R.N. or L.P.N. under the supervision of an R.N.
3. The services must be reasonable and necessary to the treatment of an illness or injury.

BG. "SKILLED NURSING FACILITY" means an institution which is licensed by the State in which it is situated to provide skilled nursing services and which has been approved as a participating Skilled Nursing Facility under the Medicare program.

BH. "SOUND NATURAL TEETH" means teeth free from active or Chronic clinical decay, having at least fifty percent (50%) bony support and having not been weakened by multiple dental procedures.

BI. "SUBSCRIBER" means a person who meets all applicable eligibility requirements of this Plan Document, whose enrollment form has been accepted by the Plan Administrator and Plan Supervisor in accordance with the Plan, and for whom the Plan Supervisor has received Contribution payments for the applicable period of coverage.

BJ. "TOTAL DISABILITY" means a state of incapacity due to a bodily injury or sickness which requires the regular and personal attendance of a physician and prevents the individual from performing or engaging in any gainful occupation for which he is reasonably fitted by education, training, or experience, and is not performing work of any kind for wage or profit. A Covered Dependent will be considered to be totally disabled if, because of a non-occupational injury or disease, he is prevented from engaging in all the normal activities of a person of the same age and sex who is in good health. If he is a student, he will not be considered to be disabled if he is attending school.

SECTION 2 - ELIGIBILITY

A. EMPLOYEE

1. A person eligible for coverage under this Plan shall:

a. Be an employee of Employer Sponsor who is employed on a permanent, full-time basis for at least twenty (20) hours per one week pay period;

b. Be actively at work at the customary place of employment with Employer Sponsor and in performance of regular duties on the day coverage is to be effective;

c. Submit satisfactory evidence of insurability in the form of a health statement at his or her own expense if application is not made within 31 days after satisfaction of the waiting period;

d. Authorize contributions for coverage where appropriate.

2. EFFECTIVE DATE: Coverage for an eligible employee becomes effective on:

a. The first of the month coincident with or next following 1 month of active full-time employment if evidence of insurability is not required; or

b. The first of the month coincident with or next following approval of application and health statement; or

c. The first of the month coincident with or next following authorization of necessary contributions;

d. However, if on the day the employee's coverage would otherwise become effective, the employee were by reason of injury or sickness unable to perform active work on a full-time basis, whether or not that employee were scheduled to work on such day, coverage would not become effective until such time as the employee returned to active work on a full-time basis.

e. Reinstatement of coverage:

(1) Coverage terminated with respect to a person formerly covered under this Plan may be reinstated by written consent of the Plan Administrator and Plan Supervisor within 6 months after the date of termination. Coverage reinstated accordingly, shall be treated as if coverage first became effective on the first day of the month following his return to work unless the agreement explicitly stipulates otherwise.

(2) Provisions for reinstatement of an individual whose coverage terminated more than 6 months prior to the written request for reinstatement will be the same as those required of a new applicant.

3. TERMINATION DATE: Coverage for an employee shall terminate automatically on the earliest of the following dates, except as provided in COBRA or Extension of Benefits provisions herein:

a. The end of the month following date employment is terminated;

(1) Cessation of Active Service shall be deemed termination of employment;

(2) Coverage for an employee who ceases to be actively at work on a full-time basis by reason of an injury or sickness which renders the employee totally disabled may be continued by the Employer, on a basis precluding individual selection, by continuing Contribution payments for a period of not more than twelve months.

(3) Coverage for an employee who ceases to be actively at work on a full-time basis by reason of a temporary layoff or approved leave of absence may be continued by the Employer, on a basis precluding individual selection, by continuing Contribution payments for a period no longer than three months beyond the date coverage would otherwise have been terminated.

b. The date employee ceases to be an eligible employee as defined herein;

c. The date the Plan is terminated;

d. The date the Employer terminates employee coverage;

e. The date the employee dies.

B. DEPENDENT SPOUSE:

a. A spouse and any unmarried children of an eligible employee not otherwise enrolled for benefits under this Plan and who satisfy the qualifications as defined in SECTION 1 shall be eligible for coverage under this Plan.

b. Notwithstanding anything to the contrary, coverage is also extended to a newborn child of a covered employee from the moment of birth with the proviso that written notice of the birth is received by the Plan Supervisor within 31 days from the moment of birth.

4. EFFECTIVE DATE:

a. Coverage for an eligible dependent will be effective on the date the employee becomes eligible for coverage:

(1) if the employee applies for dependent coverage at the time of original enrollment in the Plan,

(2) if the dependent is not disabled on the date coverage would otherwise become effective.

b. In the event a child is born to a covered employee already having enrolled dependents, that newborn child will automatically become a Covered Dependent beginning with the moment of birth. Written notice of such birth must be made to the Plan Supervisor within thirty-one (31) days after the date of birth.

c. If on the effective date of coverage the employee did not have a dependent and later acquires one or more dependents, the employee may enroll the dependent(s) in this Plan by written notice to the Plan Supervisor within thirty-one (31) days after acquiring that dependent. Coverage for that dependent becomes effective on the date the dependent was acquired provided required contributions (if any) are made.

d. An employee who does not apply for dependent coverage within thirty-one (31) days of the date he acquires a dependent but who applies for coverage at a subsequent date:

(1) Must submit satisfactory evidence of good health to the Plan Supervisor for each and every dependent he has who would be eligible for coverage by terms of SECTION 1 herein.

(2) Coverage for that dependent becomes effective on the first day of the month coincident with or next following approval of evidence of good health.

e. If a dependent (other than a newborn child) is disabled on the date coverage would otherwise be effective, that dependent's coverage would not be effective until the earlier of

(1) the date immediately following the completion of a period of thirty-one (31) consecutive days during which that dependent was not disabled, or

(2) the date twelve (12) months after the date he would have been eligible if he were not disabled.

5. TERMINATION DATE: Dependent coverage with respect to all dependents of a covered employee shall terminate automatically on the earliest of the following dates except for the COBRA provisions as described hereinafter:

a. the date the employee requests that dependent coverage be terminated;

b. the date the dependent is no longer eligible for dependent coverage under the terms of this Plan;

c. the date the dependent enters the armed forces of any country;

d. the date of termination of this Plan;

e. the date the employee's coverage terminates;

f. the date the employee dies;

g. the date employee fails to make any required contribution for coverage.

SECTION 3 - BASIC COVERED SERVICES

A. PROFESSIONAL AND HOSPITAL SERVICES

1. Professional Services Performed Within the Service Area

a. Physician Services. The following are Covered Services when provided by the Member’s Primary Care Physician. These services are also covered when furnished by a Participating Specialist (upon proper referral by the Primary Care Physician) or by a non-participating Specialist (upon proper referral by the Primary Care Physician with pre-authorization by the Plan's Medical Director. Services are furnished at the Physician's office, Hospital, Skilled Nursing Facility, or at the Members home (when the Member’s health so requires and as authorized by the Members Primary Care Physician):

(1) diagnosis and treatment of illness or injury;

(2) physical examinations, including routine examinations and pap smears, as determined to be Medically Necessary by a Participating Physician;

(3) usual and customary pediatric and adult immunizations in accordance with accepted medical practice;

(4) pre- and post-operative care;

(5) prenatal care, delivery and postnatal care of mother;

(6) consultant and referral services;

(7) pediatric care, including newborn care (if the child has been enrolled as required);

(8) family planning services (including the provision of intrauterine devices), except for subcutaneous implants for contraception;

(9) examinations to determine the need for hearing correction.

b. Surgery and Anesthesia. These services include surgical services performed at inpatient and outpatient surgical facilities that are Participating Providers and anesthesia administered in conjunction with such surgery. Some limitations apply to transplants (refer to "Limitations").

c. Laboratory Procedures and X-ray Examinations. Diagnostic and therapeutic radiology services; diagnostic laboratory services in support of other basic services prescribed by the Primary Care Physician or the Participating Physician to whom the patient was referred by the Primary Care Physician.

d. Home Health Care. The services include:

(1) Medically Necessary short term Skilled Nursing Care, provided at a Member's home through a Home Health Agency by a Registered Nurse or Licensed Practical Nurse duly licensed by the applicable state. Coverage is limited to sixty (60) consecutive days per illness per lifetime; prior authorization must be obtained from the Primary Care Physician and the Plan's Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable time. During treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full 60-day period; and

(2) Medically Necessary short-term rehabilitation services upon referral from the Primary Care Physician or a Participating Physician and with prior approval of the Medical Director. Coverage is limited to sixty (60) consecutive days per illness per lifetime; prior authorization must be obtained from the Primary Care Physician and the Plan's Medical Director certifying that Significant Improvement is expected in a relatively limited and predictable time. During treatment, documentation of continuing Significant Improvement is required in order for benefits to be provided for the full 60-day period. Short-term rehabilitation services are limited to those set forth in Limitations and are counted against the sixty (60) day treatment period contained therein.

e. Hospice Services. When a Member is diagnosed with a covered illness, and therapeutic intervention directed toward the cure of the covered illness is no longer appropriate, and the Member's medical prognosis is one in which there is a life expectancy of six months or less as a direct result of the covered illness, the Plan will pay for services and supplies for

hospice care prescribed by a Participating Physician and provided by a licensed hospice agency, organization or unit. The maximum lifetime benefit is as shown in the Schedule of Benefits. This benefit does not cover non-terminally ill patients who may be confined in: a convalescent home, rest home or nursing facility; a Skilled Nursing Facility; a rehabilitation unit or a facility that provides treatment for persons suffering from mental disease or disorders, or care for the aged, drug addicts, or alcoholics. For this benefit to be payable, the Plan Administrator must be furnished with a written statement from the attending Participating Physician that the Member is terminally ill within the terms of this benefit and a written statement from the hospice certifying the days on which services were provided.

f. Care of Newborns. Care of newborn child of Subscriber or Subscriber's spouse will be provided by the newborn's Primary Care Physician if the following conditions are met:

(1) Subscriber paying single coverage or couple coverage Contribution: The newborn child of a Subscriber paying single coverage or couple coverage Contributions will be covered at birth only if the Subscriber has pre-enrolled the new born prior to birth. Pre-enrollment shall mean that the Subscriber has submitted written proof of intent to enroll newborn in this Plan, which has been received by the Plan Administrator or Plan Supervisor or post-marked prior to newborn's date of birth. In addition to Pre-enrollment, the Subscriber must formally enroll the newborn within thirty-one days after birth. The newborn who is not enrolled prior to birth must wait until the next Group Open Enrollment Period. Increased Contributions will be payable according to the Employer's agreement for Contribution rates with dependent coverage.

(2) Subscriber paying family coverage or Subscriber and child(ren) coverage Contributions: Pre-enrollment is not required if family coverage Contributions including the contributions for the newborn are being paid at the time of the birth. Subscriber is required to formally enroll the newborn within sixty (60) days after birth.

(3) The care provided under this benefit includes preventive health care services as well as coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of coverage described in "Basic Covered Services", Part 5, necessary transportation costs from the place of birth to the nearest specialized treatment center.

(4) All services related to care of a newborn or child of a Covered Dependent other than Subscriber or Subscriber's spouse are excluded unless the Subscriber or Subscriber's spouse has adopted the child or is the court-appointed legal guardian of the child.

g. Services for Infertility. Diagnostic services, counseling and developing a plan of treatment for infertility are Covered Services when determined to be Medically Necessary by Member's Primary Care Physician. Diagnostic procedures are limited to one of each of the following: semen analysis, pelvic ultrasound, hormone levels, hysterosalpingogram, post coital test, and endometnal biopsy. **Treatment for infertility is not a Covered Service**.

h. Care of Alcohol and Drug Abuse Conditions. Detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis when determined by the Plan's Mental Health Coordinator (a qualified mental health provider appointed by the Plan’s Medical Director) to be Medically Necessary and appropriate are covered the same as Mental Health

Services. "Detoxification" means services rendered during the time interval necessary to achieve medical stabilization necessitated by the physiological effects produced by the withdrawal from drugs of abuse, including alcohol. Detoxification services shall be limited to seventy-two (72) hours or as otherwise approved by the Plan's Mental Health Coordinator.

i. Oral Surgery. Only the following procedures are covered:

(1) surgical removal of partial or bony impacted teeth;

(2) removal of tumors;

(3) cysts of the jaws, cheeks, lip, tongue and roof of the mouth;

(4) treatment of fractured facial bones;

(5) external and internal incision and drainage;

(6) cutting of salivary glands or ducts;

(7) frenectomy, and

(8) treatment of non-dental birth defects (such as cleft lip or cleft palate) which have resulted in a severe functional impairment.

j. Extraction and Replacement of Teeth. Extraction and replacement of Sound Natural Teeth are covered if due to Accidental Injury which occurred while a Member of the Plan. "Accidental Injury" does not include any damage caused by chewing or biting on any object. In order to be covered, treatment must begin within ninety (90) days after the accident and must be completed by six (6) months from date of injury.

2. Hospital Services. All Hospital Services, except in the case of Emergency Services, must be provided in a Participating Hospital, must be Medically Necessary, and the admitting provider must obtain pre-certification authorization from the Plan Administrator or Plan Supervisor prior to the admission. Failure to obtain pre-certification authorization shall result in a reduction of benefits available under the Plan.

a. Inpatient Services.

(1) semi-private room, if available (private room only if Medically Necessary and authorized by the Members Primary Care Physician and the Plan's Medical Director);

(2) general nursing care; special-duty nursing (when Medically Necessary and authorized by the Members Primary Care Physician and the Plan's Medical Director);

(3) meals (special diets when Medically Necessary);

(4) use of operating room and related facilities;

(5) use of Intensive Care Unit or Cardiac Care Unit and related services;

(6) diagnostic and therapeutic x-ray;

(7) laboratory;

(8) other diagnostic testing;

(9) drugs, medications, biologicals, anesthesia, and oxygen services;

(10) physical therapy;

(11) speech therapy;

(12) radiation therapy;

(13) occupational therapy;

(14) chemotherapy;

(15) inhalation therapy;

(16) administration of whole blood and blood derivatives (but not the whole blood itself);

(17) hospital social services;

(18) detoxification for substance abuse, as limited in "Basic Covered Services"; and

(19) rehabilitation services during a hospital stay in an acute facility (except for alcohol and substance abuse) with the prior approval of the Plan's Medical Director.

b. Outpatient Services. When authorized by Member's Primary Care Physician, outpatient services shall include diagnostic services, radio- and chemotherapy and x-ray services which can be provided in a non-hospital based health care facility or at a Hospital outpatient department for Members who are ambulatory.

3. Extended Care Facility and Skilled Nursing Facility Services. Skilled Nursing Facility services are covered up to a maximum of 100 days per illness per lifetime of a Member, (including semi-private room, board and general skilled nursing care) at a Skilled Nursing Facility approved by the Plan Administrator or Plan Supervisor if the primary purpose of such institutionalization is care by health professionals for the medical condition(s) requiring such Skilled Nursing Facility care. In all instances, care must be Medically Necessary, ordered by the Member's Primary Care Physician, and have prior approval by the Plan's Medical Director.

B. Emergency Services.

1. Emergency medical care, including hospital emergency room services and emergency ambulance services will be covered twenty-four (24) hours per day, seven (7) days per week, if provided by an appropriate health professional whether in or out of the Service Area if the following conditions exist:

a. the Member has an Emergency Medical Condition; and

b. treatment is Medically Necessary; and

c. treatment is sought immediately after the onset of symptoms (within twenty-four (24) hours of occurrence); OR referral to a hospital emergency room is made by Member's Primary Care Physician.

d. There is a Deductible for each Emergency room visit as specified in the Schedule of Benefits.

2. Notification to the Plan Administrator. Member must notify the Plan Administrator or Plan Supervisor as soon as possible, but in no event later than twenty-four (24) hours after the provision of Emergency Services. If the Member is unable to contact the Plan Administrator or Plan Supervisor within twenty-four (24) hours due to shock or unconsciousness, the Member must, at the earliest time reasonably possible, contact the Plan Administrator or Plan Supervisor to receive authorization for care.

3. Payment to non-participating Providers. Payment for services of non-participating Providers shall be limited to expenses for such care required before the Member can, without medically harmful or injurious consequences, utilize the services of a Participating Provider and shall be limited to the fee schedule in Attachment A of this plan document.

4. Follow-up Care. Follow-up care must be provided by a participating Physician, unless otherwise authorized by Member's Primary Care Physician or the Plan's Medical Director. Benefits for continuing or follow-up treatment are otherwise provided only in the Service Area, subject to all provisions of the Plan Document.

C. Ambulance Services. Medically Necessary ambulance service or appropriate emergency transportation to or from a hospital for treatment of Emergency Medical Conditions or between hospitals. Transport between hospitals requires the approval of a Participating Physician. Air ambulance transportation will be provided and covered in the continental United States when authorized and arranged in advance by the Primary Care Physician and the Plan's Medical Director or his/her designee.

E. Durable Medical Equipment and Prosthetics. The following benefits are provided if Medically Necessary and approved by the Members Primary Care Physician and the Plan Administrator Medical Director PRIOR to acquisition:

1. The cost of Initial Acquisition or rental (whichever is the most cost effective as determined by the Medical Director) from approved providers of the following Durable Medical Equipment subject to Copayments and/or limitations defined in your Schedule of Copayments:

a. Hospital type beds

b. Manual wheelchairs

c. Crutches/walkers, canes

d. Braces (limb or back only)

e. Traction devices

f. Infant apnea monitors

g. Blood glucose monitors for insulin dependent diabetics

h. C-PAP (if documented obstructive sleep apnea)

i. Nebulizers

2. Initial Acquisition of Prostheses after Accidental Injury or surgical removal which occurred while a Member of this Plan. Replacement of a Prostheses is a Covered Service only when the body's growth necessitates the replacement. All maintenance, replacements and repairs of Durable Medical Equipment and Prostheses are the responsibility of the Member.

Dental Services listed are subject to fee limitations as shown in Paragraph N below

F. Preventive Dental Services include the following:

1. (Non-Orthodontic) Prophylaxis (one treatment per six months) including examination, scaling, polishing and topical application of fluoride.

2. Space maintainers (limited to persons under age 16 and initial appliance only) including all adjustments in the first six months after installation.

3. Diagnostic services including examination and diagnosis X-rays - full mouth (limited to once in each 36-month period.

4. Bitewing films (limited to four films in any consecutive six-month period.

5. Other intraoral periapical or occlusal films - single films.

6. Extraoral superior or inferior maxillary film.

7. Panoramic film, maxilla and mandible (limited to once in any 36-consecutive month period).

8. Office visits and examinations (limited to one examination in any six-consecutive month period)

9. Emergency palliative treatment and other non-routine, unscheduled visits.

G. Basic Dental Services (Non-Orthodontic) include the following:

1. Office visits and Examinations

2. Diagnostic services diagnostic casts

3. Biopsy and examination of oral tissue

H. Restorative dental services - including the following:

1. Amalgam, Synthetic (silicate cement, acrylic or plastic, composite resin)

2. Crowns (acrylic or plastic, without metal, stainless steel)

3. Pins (pin retention, exclusive of restorative material) _

4. Recementation (inlay or onlay, crown, bridge)

5. Endodontic services - (pulp capping-direct, remineralization, vital pulpotomy, apexification)

6. Root Canal therapy of non-vital teeth- (traditional therapy, medicated paste therapy, N2 Sargenti) _

7. Apicoectomy, as a separate procedure or in conjunction with other endodontic procedures

I. Periodontic Services - including the following:

1. Gingivectomy or gingivoplasty, per quadrant, Gingivectomy, per tooth (fewer than six)

2. Subgingival curettage and root planing, per quadrant (limited to a maximum of four quadrants in any 12 consecutive month period)

3. Pedicle or free soft tissue grafts including donor sites

4. Osseous surgery including flap entry and closure per quadrant

5. Osseous grafts including flap entry closure and donor sites

6. Muco-gingival surgery

7. Occlusal adjustment not involving restorations and done in conjunction with periodontic surgery per quadrant and limited to a maximum of four quadrants in any consecutive 12 month period

J. Oral Surgery - including the following:Extractions and other surgical procedures - alveolectomy, stomatoplasty, excision of pericoronal gingiva, removal of palatal torus, removal of mandibular tort excision of hyperplastic tissue, removal of cyst or tumor, incision and drainage of abscess, closure of oral fistula of maxillary sinus, reimplantation of tooth, frenectomy, suture of soft tissue injury, sialolithotomy for removal of salivary calculus, closure of salivary fistula, dilation of salivary duct, sequestrectomy for osteomyelitis or bone abscess - superficial, maxillary sinusotomy for removal of tooth fragment or foreign body.

K. Prosthodontic Services - including the following:

1. Denture repair, acrylic and metal Denture duplication jump case (limited to one denture in 36 consecutive month period)

2. Denture reline (limited to once per denture in any 12 month consecutive period)

3. Tissue conditioning (limited to two treatments per arch in any 12 month consecutive period)

4. Adding teeth to partial dentures to replace extracted natural teeth, repairs to crowns and bridges.

L. Other services - including the following:

1. General anesthesia in conjunction with surgical procedures only

2. Injectable antibiotics needed solely for treatment of a dental condition.

M. Major Dental Services, include the following:

1. Restorative services (cast restorations and crowns only when needed because of decay or injury and only when the tooth cannot be restored with routine filing material)

2. Inlays

3. Onlays (in addition to inlay allowance)

4. Crowns and Posts (acrylic with metal, porcelain, porcelain with metal, full cast metal other than stainless steel, 3/4 cast metal other than stainless steel, cast post and core in addition to crown but not a thimble coping, steel post and composite or amalgam core in addition to crown, cast dowel pin one piece cast with crown)

5. Prosthodontic Services - (specialized techniques and characterizations are not covered)

6. Fixed bridges (each abutment and each pontic makes up a unit in a bridge)

7. Bridge Abutments

8. Bridge Pontics (cast metal,plastic, porcelain with metal, slotted facing, slotted pontic)

9. Simple stress breakers

10. Removable bridges (unilateral partial, one piece chrome casting, clasp attachment including pontics

11. Dentures (allowance includes all adjustments done by dentist furnishing denture in the first six months after installation)

12. Full dentures upper and lower, partial dentures (allowance includes base, all clasps, rests and teeth).

N. Fee Limitation Schedule. The above stated dental services (Paragraphs F. – M.) are paid by the patient based on a discounted fee schedule gotten by the Patient Physician Cooperatives of which the participants of this Trust Plan are members.

0. Vision Care. Routine refractions by a participating ophthalmologist or optometrist once every twenty-four (24) months are covered, and referral from the Primary Care Physician is not required. Other visits require referral from the Primary Care Physician. Glasses or contact lenses are available at the discounted rate specified in Schedule of Copayments when purchased from participating optometrists and participating optical suppliers that are members of the Patient Physician Cooperatives.

P. Mental Health Services.

1. Outpatient Mental Health Services, including Professional Services, are provided for short-term evaluation or Crisis Intervention when care is Medically Necessary and authorized by the Plan's Mental Health Coordinator. Coverage is subject to a graduated copayment schedule.

2. Inpatient Mental Health Services. Medically Necessary inpatient mental health services, including Professional Services, appropriate for short-term evaluation or Crisis

Intervention for up to a maximum of $10,000 per Contract Year will be provided when authorized by the Plan's Mental Health Coordinator.

3. Mental health services required by a court order are specifically excluded from coverage.

4. Care of Alcohol and Drug Abuse Conditions - Detoxification for alcoholism or drug abuse on either an outpatient or inpatient basis when determined by the Plan's Mental Health Coordinator to be Medically Necessary and appropriate are covered as a Mental Health Service.

Q. LIMITATIONS

1. SERVICES AND TREATMENTS OTHERWISE COVERED MAY BE LIMITED OR MODIFIED UNDER CERTAIN CONDITIONS:

a. Major Disaster or Epidemic. If a major disaster or epidemic occurs, physicians and hospitals will render medical services (and arrange for extended care services and home health services) as is practical according to their best medical judgment, within the limitation of available facilities and personnel. Neither the Plan, the Plan Administrator, the Plan Supervisor nor any Participating Physician or Provider has any liability or obligation for delay or failure to provide or arrange any such services to the extent the disaster or epidemic causes unavailability of facilities or personnel.

b. Circumstances Beyond the Plan's Control. Services and other covered benefits could be delayed or made impractical by circumstances not reasonably within the control of the Plan, the Plan Administrator, or the Plan Supervisor such as: complete or partial destruction of facilities, war, civil insurrection, labor disputes, disability of a significant part of hospital or medical group personnel, or similar causes. If so, participating Physicians and Providers will make a good faith effort to provide services and other benefits covered hereunder. But neither the Plan, the Plan Administrator, the Plan Supervisor nor any Provider shall have any other liability or obligation on account of such delay or such failure to provide services or other benefits.

c. Refusal to Accept Treatment. Certain members may, for personal reasons, refuse to accept procedures or treatment recommended by physicians. In such case, neither the Plan, the Plan Administrator, the Plan Supervisor nor any Member Physician or Provider shall have any further responsibility to provide care for the condition under treatment, unless the member at some future time shall recant the refusal and agree to follow the recommended treatment or procedure.

2. SPECIFIC LIMITATIONS ON CERTAIN SERVICES:

a. Accident Benefits. When a covered employee or his eligible dependents sustains an injury as result of a non-occupational accident and receives treatment therefor commencing within 72 hours after the accident occurs, the Plan will pay those covered expenses defined in the Plan. However, no Accident Benefits are provided for:

(1) treatment rendered more than ninety (90) days following the date of the accident;

(2) an accident occurring prior to the time coverage is effective under this Plan;

(3) expenses incurred after the date that coverage terminates.

3. EXTENSION OF MAJOR MEDICAL BENEFITS PROVISION. If accidental bodily injury is sustained or sickness commences while these major medical benefits are in force as to the covered person, covered expenses otherwise payable under this Plan will be paid for any such expenses incurred as the result of such injury or sickness after the termination of coverage of a covered person if from the date of such termination of coverage to the date such expenses are incurred the covered person is wholly and continuously disabled by reason of such accidental bodily injury or sickness. Such benefits shall be payable only during the continuance of such disability, but not beyond the earliest of the following dates:

a. Three months from the date the coverage of the covered person terminated;

b. The date on which the Plan is terminated, either voluntarily or involuntarily;

c. On the date the covered person becomes covered or insured under any other group policy (whether issued by the sponsor or any insurer) or any group service or pre-payment plan.

d. The date on which the Plan changes reinsurance carriers.

4. Physical, and Speech Therapy; Inpatient Rehabilitation in a Rehabilitation Facility: Inpatient rehabilitation in a rehabilitation facility or outpatient short-term services for treatment of those conditions which, in the judgment of the attending physician, are expected to show Significant Improvement from relatively short-term (less than sixty (60) days) therapy. Length of coverage up to sixty (60) days is contingent upon documentation of Significant Improvement. The sixty (60) day treatment period begins on the first day any rehabilitative services are provided.

a. Inpatient rehabilitation must be upon referral by the Primary Care Physician and requires PRIOR approval by the Plan's Medical Director.

b. Outpatient physical therapy and occupational therapy must be authorized by the Primary Care Physician, and more than ten (10) visits require the approval of the Plan's Medical Director.

c. Outpatient speech therapy is limited to the treatment of significant speech dysfunction of sudden onset, caused by an illness (such as stroke, meningitis), trauma, or which results from a surgical procedure. Referral from the Primary Care Physician and PRIOR approval by the Plan's Medical Director is required.

5. Treatment for manual manipulation of subluxations and all related services such as lab and x-ray is limited to the Maximum Fee Schedule and visits are limited to six (6) visits per illness Per Contract Year for an acute episode.

6. Plastic/Reconstructive Surgery. Plastic/Reconstructive surgery will be covered if Medically Necessary and with the prior approval of the Plan's Medical Director only if:

a. Surgery is incidental to treatment of disease (such as breast reconstruction following mastectomy if reconstruction is a planned second Stage procedure); or

b. Surgery is necessary to correct a congenital disease or defect which causes a severe FUNCTIONAL IMPAIRMENT; or

c. Treatment follows surgery which results from Accidental Injury which occurred while a Member of this Plan.

7. Transplants. The transplant benefit is subject to a maximum allowable amount as set forth in the Schedule of Copayments. Authorized medical hospital expenses of a recipient and a donor (or prospective donor) are covered only when the recipient is a Member and when the services are authorized by the Members Primary Care Physician and the Plan's Medical Director. If the donor is not a Member, Covered Services for the donor are limited to those services and supplies directly related to the transplant procedure itself and are covered only to the extent that those services are not covered by other health insurance. If the recipient is not a Member, no donor expenses are covered. Living donor transportation costs are not covered even when the donor is a Member. Cadaver organ transportation costs are covered even when the donor is not a Member.

8. Temporomandibular Joint Disorders. Non-surgical and surgical management of temporomandibular joint (TMG) disorders, including office visits, and adjustments to the orthopedic appliance, physical therapy, joint splint, all hospital related services (including but not limited to room and board, general anesthesia and outpatient surgery services) are subject to a lifetime maximum dollar amount as set for in the Schedule of Copayments. All surgical services must have pre-certification authorization from the Plan Administrator or Plan Supervisor prior to the surgical procedure.

9. Mental Retardation is not covered, other than to make the primary diagnosis.

10. Chronic physical health problems which have also produced psychological problems, the mental health services will be limited to consulting on inpatient and outpatient services.

11. Eating disorders, gambling and stress management rehabilitation are not covered benefits under Hospital Inpatient Services. These disorders may be treated under sub-acute care or outpatient care when pre-authorized by the Plan's Mental Health Coordinator.

12. Experimental or nontraditional use of medication unless pre-authorized by the Plan's Mental Health Coordinator.

13. When parent(s) or guardian(s) are not actively involved in a dependent child's course of treatment for mental or nervous disorders/substance abuse, benefits will be reduced from those shown in the Basic Covered Services in the following way: (a) Hospital Inpatient Services shall be limited to 50% of contracting provider charges up to a maximum benefit of $3,000 per calendar year (b) Outpatient Care Services shall be limited to 50% of contracting provider charges up to a maximum of $25 per visit and a calendar year maximum of $500; (c) Sub Acute Care shall not be covered. Active participation will be determined within the concurrent review part of the utilization review program. Parents active involvement in the course of treatment will vary according to the particular patient or treatment plan. In each case the parent or guardian will be presented with the recommended participation, their participation will be discussed, explained, and negotiated with them. Active participation may include attending family sessions at the program that is treating the dependent child, attending self-help groups and participating in individual conjoint or family therapy. The treatment plan for parents

or guardians will be presented to parents or guardians for their signature. Refusal to follow the treatment plan for parents or guardians shall result in the reduction in benefits as detailed above.

14. Bio-feedback is not covered unless pre-authorized by the Plan's Mental Health Coordinator.

15. Court-ordered inpatient treatment is not a covered benefit. Court ordered Outpatient treatment will require, if approved, a copayment of $40 per visit for all outpatient, conjoint or day treatment and is limited to the fee schedule in attachment A.

16. Inpatient MD (Psychiatrist/Additionologist) professional services will be paid at 80% of allowed charges as listed in Attachment A.

17. Emergency Mental Health Hospitalization is not a covered benefit unless there is eminent danger of homicide or suicide necessitating a legal hold (as may be applicable). Maximum benefit under these conditions is $500 per day for hospital and $75 per day for attending physician. The yearly maximum for all charges under these conditions is $3,000 total for non-participating hospitals and non-participating attending physicians.

R. EXCLUSIONS: Like most other health plans, there are SOME SERVICES THE PLAN DOES NOT COVER under the basic benefits. Services which are not covered include but are not limited to:

1. CARE WHICH IS NOT MEDICALLY NECESSARY:

a. Any service not reasonably and medically necessary in accordance with accepted standards of medical, surgical, or psychiatric practice;

b. Provision for personal convenience items or services (e.g., telephone or TV charged to your hospital bill or housekeeping services charged as part of home health care);

c. Physical examinations required by Employer, insurer, licensing agent or other third party or required by school or summer camp;

d. Expenses for medical report preparation and presentation when not required by Participating Physicians;

e. Travel and transportation to receive consultation or treatment, except for approved emergency ambulance service;

f. Transsexual related services, supplies, surgery or therapy; and

g. Cosmetic surgery for enhancement of features.

2. CARE WHICH IS NOT AUTHORIZED:

a. Any inpatient or outpatient service or supply not properly referred by the Primary Care Physician and properly pre-certified by or otherwise authorized by the Plan Administrator or Plan Supervisor in accordance with its regular policies and procedures, except for Emergency Services.

b. Services rendered outside the Service Area, the need for which could have been reasonably foreseen by the Member prior to leaving the Service Area, except for Emergency Services or except as approved by the Plan Administrator or Plan Supervisor.

c. Health and benefit expenses incurred prior to membership in the Plan or services rendered after the Plan coverage or eligibility terminates.

d. Care for conditions which state or local law require to be treated in a public facility, care for military service connected disabilities for which the Member is entitled to service and for which facilities are reasonably available to the Member.

e. Service for pregnancy and/or delivery outside the Service Area except in case of an Emergency Medical Condition.

f. All charges associated with non-covered services.

g. Any other services and/or supplies that are not specifically included in the Plan Document or otherwise required by State or Federal statute or regulation.

h. Mental health services (including substance abuse services) which are not specifically pre-authorized by the Plan's Mental Health Coordinator.

i. Mental health services (including substance abuse services) of any kind provided by non-contracting providers.

j. Mental health services (including substance abuse services) with participating providers in excess of the services authorized by the Plan's Mental Health Coordinator.

k. Services or treatment paid for by other group health insurance. I. Psychotherapy used as professional training.

m. Conditions of an insured for which there is no reasonable hope of improvement as determined by the Plan's Mental Health Coordinator.

n. Chronic Schizophrenia

o. Aversion therapy

p. Tutoring and educational therapy for children performing poorly in school.

q. Emergency room medical charges for a suicide attempt or drug overdose are not a covered benefit.

3. CERTAIN TYPES OF CARE IN SPECIFIC SETTINGS:

a. Custodial, domiciliary, or convalescent care not requiring Skilled Nursing Care.

b. Alcohol and/or substance abuse rehabilitative services in a specialized inpatient or residential facility unless such services have been preauthorized by the Plan's Mental Health Coordinator.

4. TREATMENTS AND SERVICES SPECIFICALLY EXCLUDED

a. Any admission to an inpatient facility resulting in Members being discharged against medical advice. The Member will be responsible for all charges associated with the admission.

b. Organ donor treatment or services where a Member serves as the organ donor but recipient is not a Member of the Plan.

c. Dental examination, including the care, treatment, filling, or removal or replacement of teeth or structures or tissue directly supporting teeth; dental or oral surgery, except as specified in "Basic Covered Services." Any hospitalization related to any form of dentistry is excluded.

d. Orthodontic treatment.

e. Experimental medical, surgical or psychiatric procedures, and pharmaceutical regimes, elective abortion, holistic medicine, acupuncture, cytotoxin testing;

f. Special-duty nursing (except when Medically Necessary and authorized by the Members Primary Care Physician and the Plan's Medical Director);

g. Plastic or cosmetic surgery, except as provided in the section entitled "Limitations."

h. Therapy for learning disability and communication delay, perceptual disorders, mental retardation, behavioral disorders, marriage counseling and Attention Deficit Disorder.

i. All services or expenses of any kind, including complications, related to the pregnancy of any Dependent other than the Subscriber's spouse.

j. ALL infertility treatment, such as:

(1) Fertility drugs and substances, and supra-ovulatory cycling;

(2) Artificial insemination;

(3) Reversal of voluntary surgical sterilization procedures;

(4) Tuboplasty;

(5) In vitro fertilization; and

(6) Gamete Intrafallopian Transfer (GIFT) programs.

k. Mental health services required by a court order, and all other mental health services except as specifically set forth in "Basic Covered Services."

l. Surgery for weight control, weight control programs and weight control medications except for counseling by a Primary Care Physician.

m. Hypnotherapy.

n. Subcutaneous implants for contraception.

o. Sleep apnea studies except infant apnea and severe respiratory obstruction in adults which presents, in the opinion of the Primary Care Physician and the Plan's Medical Director, an urgent or life threatening situation.

p. Unless otherwise covered in the Plan Document, procedures involving the teeth or areas surrounding the teeth are not covered, including shortening of the mandible or maxillae, or correction of malocclusion;

q. Allergy treatment and allergy serum.

r. Experimental or investigational drugs (drugs which have not been approved as safe and effective for their intended use by the U.S. Food and Drug Administration). Immunization for travel abroad. The following rehabilitation programs, regardless of duration:

(1) Cardiac rehabilitation;

(2) Pulmonary rehabilitation;

(3) Mitral valve prolapse programs;

(4) Pain management programs;

(5) PMS programs;

(6) Work hardening programs; and

(7) Vocation rehabilitation.

s. Radial keratotomy and any other surgical procedure for the improvement of vision when vision care can be made adequate through the use of glasses or contact lens.

t. Oral medications dispensed in a Physician's office.

u. Outpatient prescriptions dispensed at a pharmacy (Pharmacy Benefits are available on a discounted fee basis through membership in Patient Physician Cooperatives or can be an added limited benefit as an addendum to this plan document.).

v. Services or expenses for routine foot care including but not limited to trimming of corns, calluses, and nails.

5. DEVICES, EQUIPMENT AND SUPPLIES EXCLUDED

a. Wigs or prosthetic hair.

b. Corrective shoes and shoe inserts.

c. Equipment and appliances considered dispensable or convenient for use in the home, such as:

(1) dressings

(2) ostomy supplies

(3) disposable cervical collars

(4) urological supplies and

(5) supplies necessary to monitor glucose levels

d. All Durable Medical Equipment which is not listed as covered in “Basic Covered Services" hereof Partial listing of excluded items is as follows:

(1) corset/girdles

(2) support garments (such as Jobst stockings)

(3) restraints/safety equipment (i.e. belts, harnesses, etc.)

(4) overbed tables

(5) toilet rails & seats

(6) vibration/massage units or chairs

(7) seat lift chairs and similar apparatus

(8) whirlpool

(9) urinals/bed pans

(10) stools/chairs

(11) shower bench

(12) intercom systems

(13) oxygen cylinder racks

(14) pulmonaids

(15) air filtering units

(16) vacuum systems

(17) vacuum devices for impotence

(18) blood pressure cuffs stethoscopes

(19) TENs units

(20) exercise equipment

(21) motorized wheelchairs

(22) orthotics

(23) shoe inserts not a permanent part of shoes

(24) hearing aids

(25) pacemaker monitors

(26) contact lens or fitting of lens or eyeglasses except for first pair following cataract surgery

(27) aphakic lens

(28) bandage lens

(29) insulin pumps

SECTION 4 - CLAIMS PROCEDURES

A. NOTICE OF CLAIM

1. Written notice of a claim must be given to the Plan Supervisor within 90 days after the occurrence or commencement of any loss covered by this Plan, or as soon thereafter as is reasonably possible unless adequate reason can be shown for the delay.

2. Written notice of a claim must be given to the Plan Supervisor within 30 days after the date of termination with respect to claims incurred on the part of a covered individual whose coverage terminates for any reason.

3. A covered person eligible for receiving reimbursement from a loss covered as a benefit under this Plan must obtain a claim form from the Employer, complete the form, attach any required proofs of loss such as doctors' bills or hospital bills, and return it to the Plan Supervisor.

4. After verifying the covered person's eligibility, the Plan Supervisor will process the claim form and attachments thereto for payment.

5. Subsequent medical expenses relating to that sickness or injury may be submitted directly to the Plan Supervisor.

B. PAYMENT OF CLAIMS

1. Benefits which are eligible for payment under this Plan because of an injury or sickness of a covered person shall be paid to the employee.

2. Upon written direction, the employee may assign all or a portion of any benefit payments to be made directly to the provider of the services for which claims were made.

3. If the employee dies before all benefits have been paid, the remaining benefits may be paid to any relative of the employee or to any person or corporation appearing to the Plan Supervisor to be entitled to payment. Any payment made by the Plan Supervisor in good faith pursuant to this provision shall fully discharge the Plan, the Plan Administrator, and the Plan Supervisor from liability to the extent of such payment.

4. Benefits will be paid as they occur, upon receipt of due written proof of loss. If sufficient information has not been provided to process the claim, the covered person will be notified in writing of the additional information which is required and why it is needed before the claim can be processed and payment made.

C. CLAIM DENIAL

In the event a claim is denied, the covered person will be advised in writing of the following:

1. The reason for denial;

2. Special reference to Plan provisions on which the denial was based;

3. Any additional material or information necessary for further review of the claim;

4. An explanation of the Plan's review procedure.

D. REVIEW OF DENIED CLAIM

1. The claimant or an authorized representative may submit a written request for review of a denied claim to the Plan Administrator or Plan Supervisor within 60 days after receipt of the denial.

2. The claimant or an authorized representative may submit issues and comments in writing and review pertinent documents.

3. The Plan Administrator will review the evidence received, and if in its judgment there is just cause for a further review by the Plan Supervisor, the request will be forwarded to the Plan Supervisor.

4. The Plan Supervisor will then perform the review based upon the evidence submitted and render its written decision within 60 days, or within 120 days under special circumstances, after receipt of the request from the Plan Administrator. The written decision will include specific reasons for the decision and specific reference to the Plan provisions on which it is based.

5. No legal action against the Plan for the recovery of any claim shall be commenced within sixty (60) days or after three (3) years from the expiration of the time in which proof of claim is required.

E. ARBITRATION

Should an irreconcilable difference of opinion arise between the Plan Administrator and a claimant regarding any claim arising under the Plan, such difference shall be submitted to arbitration upon written request of either the Plan Administrator or the claimant. The procedure for such arbitration shall be in accordance with the Employee Benefit Plan Claims Arbitration Rules of the American Arbitration Association, incorporated by reference herein. The decision of the arbitrator shall be final and binding and judgment upon the award may be entered in any court having jurisdiction thereof. Completion of the arbitration is a condition precedent to any right of action by a claimant.

SECTION 5 - COORDINATION OF BENEFITS

If a covered person is entitled as a result of sickness or bodily injury to receive similar benefits simultaneously under this Plan and any other benefit plan (as defined below), benefits payable under this Plan will be coordinated with any benefits payable for the same disability under such other plan to the extent that the total amount paid will not exceed 100% of the incurred Eligible Charges. When a plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid.

A. BENEFITS SUBJECT TO THIS PROVISION:

All the benefits provided under this Plan are subject to this provision.

B. DEFINITIONS SUBJECT TO THIS PROVISION:

1. "Plan" shall mean any policy, contract or other arrangement for group, blanket, no-fault motor vehicle, or franchise insurance, including any arrangement for such insurance under any hospital, medical or dental service organization plan, any other service or prepayment plan, which is made through an employer, union, trustee, employee benefits professional, or U.S. Medicare. This includes automobile and homeowner medical liability coverage. Such term shall be construed separately with respect to each such policy, contract or other arrangement, and separately with respect to that portion of each such policy, contract or other arrangement which does reserve the right to take the benefits of other plans into consideration in the determination of benefits and that portion which does not.

2. "Allowable Expense" shall mean any necessary, reasonable, and customary item of expense actually charged to the covered person for whom claim is made under this Plan, at least a portion of which is a covered expense under at least one other Plan under which the covered person is entitled to receive benefits.

3. "Claim Determination Period" shall mean calendar year.

C. ORDER OF BENEFIT DETERMINATION:

If a covered person is entitled to receive benefits from this Plan as a result of sickness or injury, and is entitled simultaneously to receive benefits under any other plan which provides similar benefits, payment of benefits for such covered person shall be resolved in accordance with the following order of benefit determination:

1. Benefits of automobile and/or home-owners liability insurance shall be determined prior to determination of the benefits of this Plan.

2. Benefits of a plan, other than this Plan, which does not contain a provision for reducing its benefits by coordination with other plans shall be determined prior to determination of the benefits of this Plan.

3. Benefits of a plan, other than this Plan, which does contain a provision for reducing its benefits by coordination with other plans shall be coordinated with the benefits of this Plan with priority given, in the order listed, to the plan under which the covered person is entitled to receive benefits

a. other than as a dependent,

b. as a dependent of the parent whose birthday is the closest to the first of the calendar year if the eligible child is covered as a dependent on more than one Plan,

c. in the case of a person for whom claim is made as a dependent child,

(1) when the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody,

(2) when the parents are separated or divorced and the parent with custody of the child has remained, the benefits of the plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the stepparent, and the benefits of a plan which covers the

child as a dependent of the stepparent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody,

(3) if there is a court decree placing financial responsibility for health care, the benefits of the plan of the person named in the decree will be determined before benefits of any other plan covering the child, and if priority is not thereby readily established, benefits of such other plan shall be coordinated with the benefits of this Plan with priority given to the plan under which the covered person has been covered continuously for the longer period of time.

4. Benefits of a plan, other than this Plan, which cover the member for medical and/or hospital expenses which result from an accidental injury.

D. COORDINATION OF BENEFITS WITH MEDICARE

1. A covered individual who has attained the age at which U.S. Medicare Benefits are available shall be deemed to be enrolled under Parts A and B, whether or not actually so enrolled for such benefits.

2. For types of benefits covered by both this Plan and Medicare, benefits shall be administered in accordance with Federal Government regulations, but in no event shall benefits paid exceed 100% of eligible expenses.

E. AMOUNT OF BENEFITS

The amount of benefits payable under this Plan by the terms of this provision for allowable expenses incurred by the covered person during any claim determination period:

1. shall not exceed the amount which would be payable under this Plan in the absence of this provision, and

2. shall be reduced to the extent that the sum of such reduced benefits and benefits payable under all other plans shall not exceed the total of such allowable expenses.

BENEFITS PAYABLE UNDER ANY OTHER PLAN SHALL INCLUDE BENEFITS WHICH WOULD BE PAYABLE IF CLAIM WERE DULY MADE.

F. FACILITY OF ADMINISTRATION

For the purposes of determining the applicability and implementing the terms of this provision or of any other provision of similar purpose contained in any other plan,

1. the Plan Supervisor, without the consent of any person, may release to or obtain from any other source any information required for such purposes, and any covered person claiming benefits under this Plan shall supply to the Plan Supervisor any information required for such purposes;

2. the Plan Supervisor shall have the right to pay to any other plan making payments which should have been made under this Plan by the terms of this provision such amounts as the Plan Supervisor shall determine to be warranted to satisfy the intent of this provision, and any amounts so paid shall be considered to be benefits paid under the Plan and shall discharge the Plan from all liability to the extent of such payments; and

3. the Plan Supervisor shall have the right to recover payments made for allowable expenses under this Plan in excess of the maximum amount of payment necessary to satisfy the intent of this provision to the extent of such excess from one or more of any individuals to, or for, or with respect to, whom such payments were made, any other plans, or any other organizations.

SECTION I - CONTINUATION OF BENEFITS UNDER THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985 (COBRA)

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA, Public Law 99-272, Title X) applies to employers with twenty or more employees covered under an employer-sponsored medical benefit Plan. COBRA provides temporary extension of health coverage, the same benefits provided under the existing Policy, (called "Continuation Coverage") where coverage would otherwise end, subject to the following called "qualifying events":

A. COVERED EMPLOYEE - has the option of continuing coverage for themselves and their Covered Dependents for eighteen (18) months if he/she is no longer an Eligible Employee due to the reduction of working hours or terminated from employment for other than gross misconduct on the Employee's part.

B. COVERED DEPENDENT - have the option to continue coverage for themselves for thirty-six (36) months if benefits under this Plan would otherwise terminate for the following reasons:

1. Death of the Employee; or

2. Divorce or legal separation of the Employee and Spouse; or

3. Employee becomes eligible for Medicare; or

4. A Dependent Child reaches the maximum age for benefits under this Plan.

5. COBRA covers only those Dependents who were covered on the Plan on the day before the qualifying event.

C. ELECTION OF CONTINUATION COVERAGE

1. The Covered Person has the responsibility of informing the Employer within sixty (60) of the qualifying event.

2. The Employer must notify the Plan Supervisor immediately of the Covered Person's intent to continue coverage on a form provided for such purpose.

3. Contribution must be paid by the Covered Person at 102% of the Contribution effective for the Actively at Work Eligible Employee and their Covered Dependents no later than 30 days following the election and every month thereafter for the period of continued coverage.

4. If Employee or Dependent does not elect continuation coverage, his/her health coverage will terminate according to terms of Section 2 of this Plan Document.

D. TERMINATION OF CONTINUATION COVERAGE

Continuation coverage may be cut short for any of the following reasons:

1. The Employer no longer provides group health coverage for any employees; or

2. RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of this Plan, or to determine acceptability of any applicant for participation in this Plan, the Plan Supervisor may release or obtain any necessary information. In so acting, the Plan Supervisor shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Supervisor such information as may be necessary to implement this provision.

E. SUBROGATION

In the event benefits are paid under this Plan for charges incurred by a covered person as a result of accidental bodily injury or sickness, and if the covered person makes a recovery (whether by settlement, judgment, or otherwise) from any person or organization responsible for causing such injury or sickness, or under any no-fault automobile insurance statute, then the Plan shall have a lien upon any recovery. The covered person shall reimburse the Plan to the extent of such benefit paid, but in no event shall the covered person be required to make reimbursement in an amount exceeding the recovery made by the covered person.

F. TERMINATION OF PLAN

This Plan shall continue in effect until terminated by the Plan Sponsor. The Plan Sponsor may terminate the Plan at any time by giving written notice to all participating members at least 30 days prior to the date of termination.

G. WORKER'S COMPENSATION

This Plan is not in lieu of and does not affect any requirements or elections for coverage by Worker's Compensation Insurance either on a mandatory or a voluntary basis. Additionally, any care or treatment which would have been covered under a policy of Worker's Compensation Insurance on a mandatory or a voluntary basis will not be covered under this Plan. Even if the Employer has taken the option not to carry Worker's Compensation Insurance on a voluntary basis, as is allowed in some states, such Employer will be deemed self-insured or alternatively insured for those risks and not covered under this Plan.

H. MISCELLANEOUS

1. Except for assignments of reimbursements payable for coverage for hospital, surgical or medical charges, no assignment of any rights or benefits hereunder shall be effective.

2. To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any member or employee of any member.

3. Section titles are for reference only and are not to be considered in the interpretation of this Plan.

4. Any provision of the Plan which is in conflict with the law of the state or other jurisdiction which governs this Plan shall be deemed amended to conform with the minimum requirements of the law. No provision herein is intended, however, to alter the preemption of state law relating to this Plan by ERISA.

5. A failure to enforce any provisions of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

6. The covered person shall have the sole right to select a physician, surgeon, or hospital from whom or which to obtain the benefits available hereunder, and to maintain a physician/patient relationship.

7. Employer Sponsor shall have the right and the Plan Document shall incorporate other health and life insurance benefits which the trust may purchase from insurers and reinsurers, which benefits are defined in the policies issued to the members by those insurers and reinsurers, including reinsuring 100% of the risks represented by the benefits described in this Plan Document.

SECTION 7 - GENERAL PROVISIONS

A. CHANGE IN BENEFITS

The Plan Administrator may from time to time alter, amend, or modify the provisions of this Plan Document and the benefits available hereunder in any manner, by written notice to the employees. Any change in benefits subject to the terms of this Plan occasioned by a change in a covered employee's classification shall become effective automatically on the first of the month following the effective date of such change, except:

1. If on the day an employee's benefits were scheduled to be changed the employee were by reason of injury or sickness unable to perform active work on a full-time basis, no change in benefits would be effective until such time as the employee returns to active work on a full-time basis.

2. Any change in benefits with respect to a Covered Dependent who is totally disabled on the day such change would otherwise become effective shall not become effective until the day such dependent resumes the normal activities of a person of like age and sex.

B. No PRE-EXISTING CONDITION LIMITATION

C. RIGHT OF RECOVERY

If, for any reason, amounts excess of those due for any benefits under this Plan have been paid, the Plan Supervisor shall have the right to recover such amounts from any person, plan or organization.

Attachment A
MEDICAL AND HOSPITAL FEE SCHEDULES
PER DEFINITION IN THIS PLAN OF USUAL AND CUSTOMARY

Current Medicare RBRVS Fee Schedule and DRG Schedule for Medicare
in Harris County Texas

Prescription Drug Benefit Addendum

Prescription Drugs are covered by this plan based on the formulary and price limitations of the Plan Sponsor.

The formulary is in Attachment F.

The patient responsibility is a $5 copayment for generic drugs, and a $50 copayment for brand name drug.

Drugs not listed in the formulary are not covered and are the patient’s responsibility.

Experimental drugs are not covered.