ATLANTIS CASINO RESORT SPA

EMPLOYEE HEALTH BENEFIT PLAN

PLAN DOCUMENT / SUMMARY PLAN DESCRIPTION

EFFECTIVE: JANUARY 1, 2019

CONTRACT ADMINISTRATOR:

Hometown Health Administrators
10315 Professional Circle
Reno, Nevada 89521

PLAN SPONSOR ACCEPTANCE OF RESPONSIBILITY

PLEASE SIGN BELOW TO ACKNOWLEDGE YOUR ACCEPTANCE OF RESPONSIBILITY FOR THE CONTENTS OF THIS DOCUMENT AND RETURN THIS SIGNED FORM TO:

Hometown Health
10315 Professional Circle
Reno, Nevada 89521

We, the Plan Sponsor, recognize that we have full responsibility for the contents of the Plan Document and that, while the Contract Administrator, its employees and/or subcontractors, may have assisted in the preparation of the document, we are responsible for the final text and meaning. We further certify that the document has been fully read, understood, and describes our intent with regard to our employee welfare plan.

Plan Sponsor/Plan Administrator: Atlantis Casino Resort Spa

Lori Dorn 2/20/19

Signed (authorized representative of Plan Sponsor) Date

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YOU SHOULD ALSO BE AWARE OF THE FOLLOWING REQUIREMENTS WHICH MAY APPLY TO YOUR PLAN...

- It is important that your Plan Document be reviewed and signed in a timely manner to assure that booklets can be prepared, printed and distributed to employees to assure compliance with ERISA requirements.

  Within 30 days of a request, the administrator of any employee benefit plan must furnish to the Secretary of the Dept. of Labor, any documents relating to the Plan, including but not limited to, the latest Summary Plan Description (the booklet) and any summaries of Plan changes not contained in the Summary Plan Description, the bargaining agreement, trust agreement, contract or other instrument(s) under which the Plan is established or operated.

- In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries must be furnished a summary of the change not later than 60 days after the adoption of the change. This does not apply if you provide summaries of modifications or changes at regular intervals of not more than 90 days. "Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

- Employee welfare benefit plans must file annual reports with the IRS on IRS/DOL/PBGC Form 5500.

  The 5500 form must be filed by the last day of the seventh month following the end of the Plan Year. An extension of up to 2.5 months may be granted for the filing of such forms.

  NOTE: The Secretary of Labor may assess a civil penalty against a Plan Administrator for failure or refusal to file an annual report.

- A Summary Annual Report (generally prepared in conjunction with the 5500 filing) must be given to Plan participants two months after the deadline (including extensions granted by the IRS) for filing the Form 5500.

  If you have any questions or concerns about these accounting requirements, talk to your broker/consultant, claims (contract) administrator, or accounting professional.

INTRODUCTION

This document is both the Summary Plan Description and the Plan Document for our benefit plan. We recommend that you take the time to review the contents of this document. In particular, we call the following to your attention:

- Most health claims of the Plan are handled by a Contract Administrator. The name, address and phone number of that company is:

  Hometown Health
  10315 Professional Circle
  Reno, Nevada 89521
  (775) 982-3232

  The Contract Administrator's office should also be contacted if you need additional information about Plan coverage for a specific drug, treatment, procedure, preventive service, etc. No charge will be made for the information.

- Some of the terms used in the document begin with a capital letter. These terms have a special meaning under the Plan and are included in the **Definitions** section. When reading the provisions of this Plan, it may be helpful to refer to this section. Becoming familiar with the terms defined there will give you a better understanding of the benefits and provisions.

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SOLICITUD DE INFORMACIONES EN ESPAÑOL

(Spanish Language Offer of Assistance)

Este documento está escrito en ingles y contiene un resumen de los derechos y beneficios de su plan de seguro. Si ud. tiene dificultad en comprender cualquier parte de este documento, comuniquese con los administradores de la:

Hometown Health
10315 Professional Circle
Reno, Nevada 89521

El horario de la oficina es: las ocho de la mañana hasta las cuatro de la tarde, lunes a viernes. Ud. tambien puede llamar a la oficina del administrador del plan de seguro a estos teléfonos: (775) 982-3232 / (800) 336-0123 para pedir ayuda.

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IMPORTANT INFORMATION

WHO TO CONTACT FOR ADDITIONAL INFORMATION

A Plan participant can obtain additional information about Plan coverage of a specific drug, treatment, procedure, preventive service, etc. from the office who handles claims on behalf of the Plan (the "Contract Administrator"). See the first page of the **General Plan Information** section for the name, address and phone number of the Contract Administrator.

SPECIAL NOTICES

The Newborns and Mothers Health Protection Act
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean delivery. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

The Women's Health and Cancer Rights Act
The health benefits of most plans must include coverage for the following post-mastectomy services and supplies when provided in a manner determined in consultation between the attending physician and the patient: (1) reconstruction of the breast on which a mastectomy has been performed, (2) surgery and reconstruction of the other breast to produce symmetrical appearance, (3) breast prostheses, and (4) physical complications of all stages of mastectomy, including lymphedemas.

Plan participants must be notified, upon enrollment and annually thereafter, of the availability of benefits required due to the WHCRA.

The Children's Health Insurance Program Reauthorization Act of 2009
Employees and Dependents who are eligible but not enrolled for the Employer's group health plan may enroll for coverage hereunder in the following instances:

- Loss of Medicaid or CHIP Eligibility: If the Employee's or Dependent's Medicaid or Children's Health Insurance Program (CHIP) coverage is terminated as a result of loss of eligibility, the Employee may request coverage under the Employer's group health plan coverage within sixty (60) days after Medicaid or CHIP coverage terminates.

- Eligibility for State Premium Assistance: Where a State has chosen to offer premium assistance subsidies for qualified employer-sponsored benefits (see NOTES) and if the Employee or Dependent becomes eligible for such subsidy under Medicaid or CHIP, then the Employee may request coverage under the Employer's group health plan within sixty (60) days after eligibility for the subsidy is determined.

NOTE: CHIPRA allows states to elect to offer premium assistance subsidies to qualified individuals. Such subsidies are not mandated.

Michelle's Law
Michelle's Law expands the eligibility period for a full-time student dependent attending an accredited academic or vocational school should the dependent suffer from a serious illness or injury resulting in a medical leave of absence or change in enrollment status if certain conditions are met for up to a special 12-month period.

Grandfathered Plan
This group health plan believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). Being a grandfathered health plan means that the Plan does not include certain consumer protections of the Affordable Care Act. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa.

Prohibition on Rescissions
The health care component plans in this Plan shall not rescind such plan or coverage with respect to a Covered Person once the Covered Person is covered under the Plan, except that this Section shall not apply to a Covered Person who has performed an act or practice that constitutes fraud or makes an intentional misrepresentation of material fact as prohibited by the terms of the Plan. Such coverage may not be cancelled except with prior notice to the Covered Person and only as permitted under Section 2701(c) or Section 2742(b) of the Patient Protection and Affordable Care Act.

UTILIZATION MANAGEMENT PROGRAM
HOSPITAL PREAUTHORIZATION

Inpatient Hospital admissions are subject to preauthorization. The purpose of preauthorization is to encourage Covered Persons to obtain quality medical care while utilizing the most cost efficient sources.

The Plan Sponsor has contracted with Hometown Health Care Program to manage this program. The name and phone number is:

Hometown Health
Medical Management Department
Phone: (775) 982-3034 or **(800) 336-0123**

Preauthorization Requirements - Prior to any non-emergency Hospital admission or outpatient surgery, except as noted, the Covered Person, or someone acting on his behalf, must contact Hometown Health Medical Management or authorization. For an emergency admission (i.e., an admission for a condition that occurs suddenly or unexpectedly and immediate treatment is required to avoid any threat to an individual's life, limb or organ function), Hometown Health Medical Management must be contacted within 48 hours after admission or no later than the first business day following a weekend or holiday admission.

A request for extended hospital days must be made by the Covered Person's attending Physician prior to the end of the previously-authorized stay. The request will be reviewed and the attending Physician will be notified of the number of additional Hospital days certified.

NOTE: In no instance will prior authorization be required for an Inpatient Pregnancy admission which does not exceed 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section delivery. However, if/when the Pregnancy confinement for the mother or newborn is expected to exceed these limits, prior authorization for such extended confinement is required.

Transplants (organ and tissue) – All pre-transplantation related expenses, including the admission for transplantation services must be pre-certified by the utilization management organization. See "Transplant-Related Expenses" in the Eligible Medical Expenses section of the Summary Plan Description. Also see, Choice of Network on Utah Travel Benefit.

Penalty for Non-Compliance - If the preauthorization requirements are not completed, a $500 penalty will be applied before Plan benefits are determined.

See the **Claims Procedures** section for information about a Claimant's right to appeal a reduced or denied claim.

Any financial penalties assessed due to failure to obtain a preauthorization will not apply toward any Deductibles, Coinsurance, Co-Pays or Out-of-Pocket Maximums of the Plan.

NOTE: The Plan will not reduce or deny a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required).

MORE INFORMATION ABOUT PREAUTHORIZATION

It is the **Employee's or Covered Person's responsibility** to make certain that the compliance procedures of this program are completed. To minimize the risk of reduced benefits, an Employee should contact the Utilization Management Organization to make certain that the facility or attending Physician has initiated the necessary processes.

Prior authorization is **not a guarantee of coverage**. The **Utilization Management Program** is designed ONLY to determine whether or not a proposed setting and course of treatment is Medically Necessary and appropriate. Benefits under the Plan will depend upon the person's eligibility for coverage and the Plan's limitations and exclusions. Nothing in the **Utilization Management Program** will increase benefits to cover any confinement or service which is not Medically Necessary or which is otherwise not covered under the Plan.

See "Pre-Service Claims" in the **Claims Procedures** section for more information, including information on appealing an adverse decision (i.e. a benefit reduction) under this program.

MEDICAL BENEFIT SUMMARY

CHOICE OF NETWORK OR NON-NETWORK PROVIDERS

The Plan Sponsor has contracted with an organization or "Network" of health care providers. When obtaining health care services, a Covered Person has a choice of using providers who are participating in that Network or any other Covered Providers of his choice (Non-Network providers).

Network providers have agreed to provide services to Covered Persons at negotiated rates. When a Covered Person uses a Network provider his out-of-pocket costs may be reduced because he will not be billed for expenses in excess of "Usual, Customary and Reasonable." The Plan may also include other benefit incentives to encourage Covered Persons to use Network providers whenever possible - see the Schedule of Medical Benefits, below.

The Plan Sponsor will automatically provide a Plan participant with information about how he can access a directory of Network Providers for his service area. This information will be provided without charge. The directory will be available either in hard copy as a separate document, or in electronic format. Since certain covered services and supplies may not be available through the Network, a Covered Person should refer to the Network list or directory to determine if any particular specialty is included.

Follow the link and select: Hometown Health Self-Funded
https://www.hometownhealth.com/provider-directory-filter/

Although there may be circumstances when a Network provider cannot be used, Non-Network providers will be paid at the Non-Network benefit levels EXCEPT as follows:

Emergency Care - If a Covered Person resides within the Network service area and requires care for a Medical Emergency and must use the services of a Non-Network provider, any such expenses will be paid at Network benefit levels.

No Choice of Provider - If, while receiving treatment in a covered Network facility on an Inpatient or Outpatient basis, a Covered Person receives ancillary services or supplies from a Non-Network provider in a situation in which he has no control over provider selection (such as in the selection of an emergency room Physician, an anesthesiologist or a provider for diagnostic services), such Non-Network services or supplies will be covered at the Network benefit levels. These services are subject to the Usual, Customary and Reasonable (UCR) rates.

Unavailable Services - If a Covered Person resides within the Network service area and, after thorough evaluation by the Plan, it is determined that there is no Network provider that can provide the required level of medical care, non-Network services will be covered at the Network benefit levels. These services are subject to the Usual, Customary and Reasonable (UCR) rates.

OTHER:

Travel Benefit (Utah) – Services not available within the local PPO network, which can be provided by University of Utah hospital, may be eligible for the Utah Travel Benefit.

Out-of-Area Dependents – if a Dependent (child) is residing outside of the Network service area, the dependent may gain access to a network upon notification to the Plan. If available, the out of area dependent may be assigned to the network and may use the providers in that network to obtain preferred benefits. The out of area covered dependent will be issued an ID card which provides the online link to find and use preferred providers in the network.

If the dependent is not setup to access the out of area network, non-Network services will be covered at the Network benefit levels and are subject to the Usual, Customary and Reasonable (UCR) rates.

UTAH TRAVEL BENEFIT

The Utah Travel Benefit is established to offset the cost of travel for patients and/or their support person or family members when Utilization Management provides the physician and/or the Covered Person, as an option for Tertiary Care (evaluation and/or treatment), authorization to receive treatment at the University of Utah Medical Center. If the Covered Person is approved for the Utah travel benefit, the Plan will waive deductible and coinsurance requirements for the approved treatment at a University of Utah facility.

Tertiary Care: Highly specialized medical care usually over an extended period of time that involves advanced and complex procedures and treatments performed by medical specialists in state-of-the-art facilities. Examples of tertiary care are specialist cancer care, neurosurgery (brain surgery), burn care and plastic surgery.

To qualify for the Utah Travel Benefit, the following must apply:

1. Covered Person and/or their treating physician has requested a referral to a specific facility/provider for Tertiary Care that is not in the primary PPO network and will require travel outside of Nevada.
2. Utilization Management has determined that the requested services are medically necessary and Tertiary Care cannot be provided in the primary PPO network.
3. Utilization Management has provided the physician and/or Covered Person, as an option, to receive Tertiary Care at the University of Utah Medical Center.
4. Covered Person has agreed to be in Case Management, and followed by a Case Manager while in Tertiary Care.
5. Prior to travel to Utah for Tertiary Care, the Covered Person must advise the RN Case Manager of travel to receive the benefit.

Single Episode of Care	
Travel expenses per day, per trip	$250 per patient, support person/caregiver or parent as defined below
Travel expenses maximum, per trip	$2,500 per single episode of care
Travel expenses calendar year maximum	$10,000

Covered Travel Expenses

1. For a covered child under the age of 19, travel expenses will be reimbursed at $250 per person for the patient and two parents or two legal guardians.
2. For a covered adult age 19 or older, travel expenses will be reimbursed for the person and one person/caregiver.
3. Coverage will include the day prior to a scheduled service and the day following the scheduled service not to exceed $2,500 per Episode of Care.

After approved travel to the University of Utah Medical Center for services, complete a Utah Travel Reimbursement Benefit Form, attach all receipts and submit to Medical Management at Hometown Health. For more information on University of Utah health care, visit www.healthcare.utah.edu.

SCHEDULE OF MEDICAL BENEFITS

Where rates have been negotiated with providers participating in the Network, such rates will apply to services of all providers (Network and Non-Network) and will be considered this Plan's Usual, Customary and Reasonable Allowance. This could result in substantial out of pocket expenses (patient liability) if a Non-Network Provider is used.

ANNUAL DEDUCTIBLES	Network	Non-Network
Individual Deductible	$350	$1,000
Family Maximum Deductible	$1,050	$3,000

Individual Deductible - The Individual Deductible is an amount which a Covered Person must contribute toward payment of Eligible Medical Expenses. In most instances, the Deductible applies before the Plan begins to provide benefits. The "Annual Deductible" applies each Calendar Year.

Family Maximum Deductible - If Eligible Medical Expenses equal to the Family Maximum Deductible are incurred collectively by family members during a Calendar Year and are applied toward Individual Deductibles, the Family Maximum Deductible is satisfied. A "family" includes a covered Employee and his covered Dependents.

INDIVIDUAL OUT-OF-POCKET

The Out-of-Pocket Calendar Year expense has three (3) Levels, as listed below.

Level I - A Covered Person will not be required to pay more than $25,000 for In-Network Eligible Medical Expenses during a Calendar Year for Level I. Once the $25,000 Out-of-Pocket Calendar Year Maximum has been reached, the Covered Person will move to Level II below. This does not apply to Non-Network Eligible Medical Expenses. See NOTE below for items that will not apply towards the $25,000 level.

Level II - Once a Covered Person satisfies Level I, the Plan will pay 100% of Network Eligible Medical Expenses until the Plan has paid a total of $250,000 in Network benefits for the same calendar year. When level II is satisfied, the Covered Person will move to Level III. This does not apply to Non-Network Eligible Medical Expenses. See NOTE below for items that will not apply towards the $25,000 level.

Level III - Once the Plan has paid $250,000 in the same calendar year, all remaining Network Eligible Medical Expenses will be reimbursed by the Plan at 10% for the balance of the Calendar Year. In addition, any non-Network Eligible Medical Expenses incurred after $250,000 has been paid by the Plan in a Calendar Year will also be paid by the Plan at 10%.

NOTE: The out-of-pocket expense in Levels I and II do not apply to or include:
- amounts applied or paid to satisfy any Deductible or Co-Pay requirements
- expenses incurred for services and supplies which are excluded by the Plan
- expenses incurred for services or supplies paid at a Network Benefit of less than 80%;
- expenses incurred for non-Network Eligible Medical Expenses; or
- any financial penalties assessed due to the Covered Person's failure to obtain a preauthorization as required under the Utilization Management Program.

ELIGIBLE MEDICAL EXPENSES	PPO IN-NETWORK	NON-PPO OUT-NETWORK
Physician Office Visits		
Primary Care Office Visit, per visit	$25 copay *	30% UCR
Primary Care Preventive Screening	$0 copay	30% UCR
Specialist Care	$25 copay *	30% UCR
Injections, per visit	$25 copay *	30% UCR
Other Services	80%	30% UCR
Hospital Facility Services		
Acute care hospital admission	$300 copay, then 80%	$1,000 copay, then 30% UCR
Outpatient observation	80%	30% UCR
Rehabilitation facility	80%	30% UCR
Skilled nursing facility	80%	30% UCR
Skilled nursing facility limited to 120 days per calendar year.		
Urgent Care and Emergency Services		
Urgent Care Services, per visit	$25 copay *	30% UCR
Emergency Room, per visit	$250 copay, then 80%	$1,000 copay, then 30% UCR
Ambulance, Admitted to Hospital (immediately following transport)	80%	80% UCR
Ambulance, not admitted	50%	50% UCR
Emergency copay is waived if admitted as inpatient to a PPO in-network hospital.		
Imaging, Laboratory Services and Diagnostic Testing		
All Imaging	80%	30% UCR
MRI, CT and PET	80%	30% UCR
Laboratory Services	80%	30% UCR
Diagnostic Testing/Services	80%	30% UCR
Outpatient Speech, Occupational and Physical Therapy		
Speech Therapy	80%	30% UCR
Occupational Therapy	80%	30% UCR
Physical Therapy, per visit	$20 copay, then 80%	30% UCR
Physical Therapy, limited to 30 visits per calender year.		
Other Outpatient Therpay and Rehabilitation Services		
Cardiac and pulmonary rehabilitation	80%	30% UCR
Wound therapy, outpatient	80%	30% UCR
Chemotherapy, specialist office or outpatient	80%	30% UCR
Radiation therapy	80%	30% UCR
Infusion therapy, specialist office or outpatient	80%	30% UCR
Surgical Services		
Surgery performed in Primary or Specialist office, per visit	$25 copay, then 80% *	30% UCR
Outpatient/Ambulatory Surgery Center, per use	$300 copay, then 80%	Not Covered
All surgical services require prior authorization.		

* Deductible does not apply.

Medical Supplies, Equipment and Prosthetics		
Durable Medical Equipment (DME)	80%	30% UCR
Prosthetics - see eligible medical expense	80%	30% UCR
Other Medical Services		
Chiropractice Care-spinal manipulation, per visit	$10 copay, then 80%	30% UCR
Hospice Services	100%	100% UCR
Transplant Related Service	80%	30% UCR
Virtual Visits (Renown Only Providers)	80%	Not Covered
Home Health Care	80%	30% UCR
Home Health is limited to 60 visitst per calendar year.		
Preventive Care		
Preventive and Wellness Care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. Preventive care services are not provided for specific health issues or conditions, on-going care, laboratory tests or health screenings necessary to manage or treat an already-identified medical issue or health condition. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. The list of covered services is lengthy and includes **well-child care, physical exams, pelvic exams & pap smears, preventive lab and testing, prostate cancer screenings, vaccines and immunizations and much more.**		
Preventive and Wellness Care	100%	Not Covered
Preventive screening services are subject to age and frequency guidelines recommended by the U.S. Preventive Services Task Force (USPSTF) A & B Recommendations and the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). **A full list of preventive care services is available at** http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/# **or by contacting the Administrator.**		
All Other Eligibile Medical Expenses	**80%**	**30% UCR**

IMPORTANT INFORMATION

The percentages shown in the summary reflect the amounts the Plan pays of Eligible Expenses after any required Deductible or Co-Pay has been deducted.

A "Co-Pay" is an amount the Covered Person must pay and the balance of the Eligible Expenses will be paid by the Plan unless a lesser percentage (%) is shown. Co-Pays are usually paid to the provider at the time of service.

Usual, Customary and Reasonable (UCR) - Where rates have been negotiated with providers participating in the Network, such rates will apply to services of all providers (Network and Non-Network) and will be considered this Plan's Usual, Customary and Reasonable Allowance. This could result in substantial out of pocket expenses (patient liability) if a Non-Network Provider is used.

THIS IS A SUMMARY ONLY. PLEASE REFER TO THE ELIGIBLE MEDICAL EXPENSES AND LIMITATIONS AND EXCLUSIONS SECTIONS FOR MORE INFORMATION.

ELIGIBLE MEDICAL EXPENSES

This section is a listing of those medical services, supplies and conditions which are covered by the Plan. This section must be read in conjunction with the Medical Benefit Summary to understand how Plan benefits are determined (application of Deductible requirements and Coinsurance percentages, etc.). All medical care must be received from or ordered by a Covered Provider.

Except as otherwise noted below or in the Medical Benefit Summary, eligible medical expenses are the Usual, Customary and Reasonable charges for the items listed below and which are incurred by a Covered Person - subject to the Definitions, Limitations and Exclusions and all other provisions of the Plan. In general, services and supplies must be approved by a Physician or other appropriate Covered Provider, must be Medically Necessary for the care and treatment of a covered Sickness, Accidental Injury, Pregnancy or other covered health care condition and must be preauthorized (if applicable).

For benefit purposes medical expenses will be deemed to be incurred on:

- the date a purchase is contracted;
- the date delivery is made; or
- the actual date a service is rendered.

Allergy Testing & Treatment - Allergy testing and treatment, including allergy injections.

Ambulance - Professional ground or air ambulance service when used to transport the Covered Person from the place where he is injured or stricken by a Sickness to the nearest Hospital or sanitarium where treatment can be given.

Ambulatory Surgical Center - Services and supplies provided by an Ambulatory Surgical Center (see **Definitions**) in connection with a covered Outpatient surgery.

Anesthesia - Anesthetics and services of a Physician or certified registered nurse anesthetist (C.R.N.A.) for the administration of anesthesia.

Blood - Blood and blood derivatives (if not replaced by or for the patient), including blood processing and administration services.

Cardiac Rehabilitation - Outpatient cardiac rehabilitation services prescribed by a Physician, rendered under a Physician's supervision and provided by a cardiac rehabilitation facility.

Chemotherapy - The use of chemical agents in the treatment or control of disease.

NOTE: High-dose chemotherapy in connection with a non-covered transplant procedure is <u>not</u> covered.

Chiropractic Care - Services of a licensed chiropractor (D.C.) for the treatment of a musculo-skeletal disorder (bone, muscle, tendon and joint) and for related diagnostic X-rays performed and billed by the chiropractor.

Diagnostic Lab & X-ray, Outpatient - Laboratory and X-ray services performed to diagnose medical disorders, including but not limited to electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally used by Physicians throughout the United States.

For benefit purposes, "Pre-Admission Testing" means diagnostic services provided prior to a scheduled Hospital admission when:

- the tests are ordered by the attending Physician;
- the tests are accepted by the Hospital in place of the same tests which would otherwise be done after admission;
- the tests are not repeated in the Hospital.

Dialysis Services - Dialysis services, including the training of a person to assist the patient with home dialysis, when provided by a Hospital, freestanding dialysis center or other appropriate Covered Provider.

Durable Medical Equipment - Rental of durable medical equipment (but not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury. The Plan will decide on purchase or rental.

Replacement of equipment will be covered when required because of pathological change or the natural growth process of a child under age 18.

"Durable medical equipment" includes such items as non-dental braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc., which: (1) can withstand repeated use, (2) are primarily and customarily used to serve a medical purpose, (3) generally are not useful to a person in the absence of Sickness or Accidental Injury, and (4) are appropriate for use in the home.

NOTE: Coverage for durable medical equipment coverage does not include expenses for repair or maintenance.

Home Health Care - Services and supplies which are furnished in accordance with a written home health care plan to a Covered Person who is disabled and essentially confined to the home. The home health care plan must be established in writing by the Covered Person's attending Physician and must be renewed every sixty (60) days during the period of home health care. Also, the attending Physician must examine the patient every sixty (60) days and must certify at least monthly that the patient would require Inpatient confinement in a Hospital or Skilled Nursing Facility in the absence of home health care.

Covered home health care services and supplies include, but are not limited to, the following. Such services and/or supplies must be provided through a Home Health Care Agency or by other Covered Providers as specified in the written home health care plan:

- part-time or intermittent services of a registered nurse (R.N.) or a licensed practical nurse (L.P.N.);
- services of physical and speech therapists;
- part-time or intermittent services of home health aides under the supervision of a registered nurse (R.N.) or a physical, occupational or speech therapist;
- medical supplies, drugs and medicines prescribed by a Physician and laboratory services, but only to the extent that such items would have been covered if the patient had been confined in a Hospital or Skilled Nursing Facility.

NOTE: Covered home health care expenses will not include:

- meals or nutritional services;
- housekeeper services;
- services or supplies not specified in the home health care plan;
- services of a relative of the Covered Person;
- services of any social worker;
- transportation services;
- care for tuberculosis or chemical dependency or alcoholism;
- care for the deaf or blind; or
- care for senility, mental handicap or mental/nervous conditions.

Hospice Care - Care of a Covered Person with a terminal prognosis (i.e., a life expectancy of six months or less) who has been admitted to a formal program of Hospice care. Eligible Medical Expenses include Hospice program charges for:

- Inpatient Hospice facility services and supplies;
- Outpatient services (i.e., services provided in the patient's home) including, but not limited to: (1) nursing care by a registered nurse, a licensed practical nurse, a vocational nurse or a public health nurse who is under the direct supervision of a registered nurse, (2) physical therapy and speech therapy when rendered by licensed therapists, (3) medical supplies, including drugs and biologicals and the use of medical appliances,

(4) Physician services, and (5) services, supplies and treatments deemed Medically Necessary and ordered by a Physician.

Hospital Services - Hospital services and supplies provided on an Outpatient basis, including emergency room use, and Inpatient care, including daily room and board and ancillary services and supplies. Coverage for room and board is limited to the Semi-Private Room Charge or the Usual, Customary and Reasonable charge for necessary confinement to an Intensive Care Unit.

Infertility Testing - An initial diagnostic exam and related tests to determine a diagnosis for infertility.

NOTE: Treatment of infertility is not covered.

Mammograms and Pap Smears - An annual cytologic screening test (pap smear) for women 18 years of age or older; a baseline mammogram for women between the ages of 35 and 40; and an annual mammogram for women 40 years of age or older.

Medical Supplies - Disposable medical supplies such as casts, splints, trusses, surgical dressings, catheters, colostomy bags and related supplies.

Midwife - Services of a certified or registered nurse midwife when provided in conjunction with a covered Pregnancy - see "Pregnancy" below.

Newborn Care - Hospital nursery services provided during the birth confinement to a covered well newborn child and routine pediatric care provided during such confinement. A circumcision will also be covered. If the newborn is not a Covered Person, then certain Hospital expenses will be covered as part of the mother's Pregnancy claim for delivery, if Plan benefits are payable for such Pregnancy delivery - see "Pregnancy" for more information.

In no instance will the Plan restrict benefits for a newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a Cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: A covered newborn who is sick or injured is eligible for benefits to the same extent as any other Covered Person.

Nursing Services, Private Duty - Services of a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing services when Medically Necessary and prescribed in writing by the attending Physician or surgeon specifically as to duration and type.

Nutritional Counseling - Diabetic Counseling

Occupational Therapy – Treatment by a licensed occupational therapist when specifically prescribed by a physician or surgeon as to type and duration, but only to the extent that the therapy will affect significant improvement in the condition being treated in a relatively short time.

Orthopedic Shoes - Orthopedic shoes or other supportive devices for the feet when needed for a congenital defect in a covered Dependent child.

Physical Rehabilitative Therapy (Inpatient) - Inpatient rehabilitative therapy rendered to a Covered Person in accordance with a written rehabilitative therapy treatment plan established and periodically reviewed by a Physician or D.O.) and submitted to the Plan prior to the commencement of any treatment.

Rehabilitative Therapy must be provided in a Hospital with a specialized rehabilitative department or in a Physical Rehabilitation Facility. Any such confinement must be Medically Necessary to restore and improve function that was lost following a Sickness or Accidental Injury. Also, confinement must begin within one (1) year of the date of the onset of the condition and continuing measurable progress must be demonstrated at regular intervals.

Eligible Medical Expenses are for those services and supplies which are part of a concentrated program that uses a

team of health care professionals to assist the patient in upgrading his or her ability to function independently. Such services and supplies include:

- Physician services, physical and occupational therapy, nursing care and audiological services and speech therapy provided by health care professionals who are licensed by the state to provide such services;
- social services by a social worker holding a master's degree from an accredited school of social work;
- respiratory therapy provided by a certified respiratory therapist;
- prescription drugs and medicines which cannot be self-administered;
- prosthetic and orthotic devices, including the testing, fitting or instruction in the use of such devices;
- other Medically necessary supplies or services prescribed by a Physician for the rehabilitation of a patient and ordinarily furnished by a Physical Rehabilitation Facility or a Hospital.

NOTE: Physical rehabilitation therapy coverage will not include:

- maintenance, non-medical self-help, recreational, educational or vocational therapy;
- custodial care;
- learning disabilities, speech delay or developmental delay;
- substance abuse (alcoholism or chemical dependency) rehabilitation;
- rehabilitative treatment for mental health conditions, other than basic psychiatric care.

Physical Therapy (Outpatient) - Professional services of a licensed physical therapist, when provided on an Outpatient basis and specifically prescribed by a Physician or surgeon as to type an duration, but only to the extent that the therapy is for improvement of bodily function.

Physician Services - Medical and surgical treatment by a Physician (M.D. or D.O.), including office, home or Hospital visits, clinic care and consultations. See "Second (& 3rd) Surgical Opinion" below for requirements applicable to surgery opinion consultations.

Pre-Admission Testing - see "Diagnostic Lab & X-ray, Outpatient"

Pregnancy - The following Pregnancy-related expenses of a covered Employee or covered Dependent spouse only. Pregnancy-related expenses include the following, but may include other services which are deemed to be Medically Necessary by the patient's attending Physician:

- pre-natal visits and routine pre-natal and post-partum care;
- expenses associated with a normal or Cesarean delivery.

In no instance will the Plan restrict benefits for a Pregnancy Hospital stay for a mother and her newborn to less than forty-eight (48) hours following a normal vaginal delivery or ninety-six (96) hours following a Cesarean section. Also, the **Utilization Management Program** requirements for Inpatient Hospital admissions will not apply for this minimum length of stay and early discharge is only permitted if the decision is made between the attending Physician and the mother.

NOTE: Pregnancy coverage will not include: (1) Lamaze and other charges for education related to pre-natal care and birthing procedures, (2) adoption expenses, or (3) expenses of a surrogate mother.

Preventive Care - Preventive and Wellness Care focuses on evaluating your current health status when you are symptom free and allows you to obtain early diagnosis and treatment to help avoid more serious health problems. Preventive care services are not provided for specific health issues or conditions, on-going care, laboratory tests or health screenings necessary to manage or treat an already-identified medical issue or health condition. During your preventive care visit, your doctor will determine what tests, health screenings and immunizations are right for you based on many factors such as your age, gender, overall health status, personal health history and your current health condition. Preventive screening services are subject to age and frequency guidelines recommended by the U.S. Preventive Services Task Force (USPSTF) A & B Recommendations and the Center for Disease Control (CDC) Advisory Committee on Immunization Practices (ACIP). A full list of preventive care services is available at http://www.hhs.gov/healthcare/facts-and-features/fact-sheets/preventive-services-covered-under-aca/# or by contacting the Administrator.

Prosthetics - Artificial limbs or eyes required to replace natural limbs or eyes which have been lost in an Accidental Injury and/or surgically removed, as well as post-mastectomy breast prosthetics and bra.

Expenses for repair and adjustment of a prosthetic. Replacement of a prosthetic will be covered only when required because of pathological change or the natural growth process of a child under age 18. No benefits are available for loss or damage.

Radiation Therapy - Radium and radioactive isotope therapy.

Respiratory Therapy - Professional services of a licensed respiratory or inhalation therapist, when specifically prescribed by a Physician or surgeon as to type and duration, but only to the extent that the therapy is for improvement of respiratory function.

Second (& 3rd) Surgical Opinion - A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation will also be covered if the second opinion does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who will be performing the actual surgery.

Skilled Nursing Facility - Inpatient care in Skilled Nursing Facility, but only when the admission to the facility or center is Medically Necessary and the patient is admitted by and remains under the active medical supervision of a Physician.

Eligible Medical Expenses for room and board in a Skilled Nursing Facility are limited to the facility's Semi-Private Room Charge.

Speech Therapy - Services by a qualified speech therapist, but only for the restoration of speech loss due to a Sickness or Accidental Injury or as a result of a congenital defect in a covered Dependent child.

> NOTE: Speech therapy will not be covered after the condition is stabilized medically, to a level where no further improvement can be anticipated. Also, speech therapy is not covered when it is educational in nature.

Sterilization Procedures - A surgical procedure for the purpose of sterilization (i.e., a vasectomy for a male or a tubal ligation for a female).

Transplant-Related Expenses (Human Tissue) - Eligible Medical Expenses incurred for any of the following Medically Necessary human-to-human organ or tissue transplants, when the transplant recipient is a Covered Person:

bone marrow, including autologous bone marrow
cornea
heart
heart/lung
lung
kidney
liver
pancreas

Coverage for a transplant also includes expenses incurred for organ and tissue procurement, consisting of removing, preserving and transporting the donated part, but only if benefits to the donor are not furnished under some other form of surgical-medical coverage. Coverage also includes any complications relating to the transplant.

NOTE: When the recipient is not covered by this Plan and the donor is covered, expenses will not be covered for either the recipient or the donor.

Urgent Care Facilities - see **Definitions**

LIMITATIONS AND EXCLUSIONS

Except as specifically stated otherwise, no benefits will be payable for:

Abortion - An elective abortion procedure, unless the mother's life would be endangered if the Pregnancy were allowed to continue to term.

NOTE: Complications arising out of an abortion are covered as any other Sickness.

Acupuncture – see "Holistic or Homeopathic Treatment or Acupuncture"

Air Purification Units, Etc. - Air conditioners, air-purification units, humidifiers and electric heating units.

Autopsy - Expenses for an autopsy and any related expenses, except as required by the Plan Administrator or its designee.

Biofeedback, Behavior Modification, Etc. - Biofeedback, pain control programs, cognitive retraining or other types of services or training provided with the goal of patient self-help or self-care.

Certain Therapies - Vocational, educational, recreational, art, dance, or music therapy.

Chemical Dependency - Treatment of drug abuse, drug addiction, drug overdose, or any form of chemical dependency including any medical treatment for a child who is born with a diagnosed drug addiction problem.

Any losses sustained or contracted in consequence of the Covered Person being intoxicated or under the influence of any controlled substance, unless administered under the advice of a Physician. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Cosmetic & Reconstructive Surgery, Etc. - Any surgery, procedure, service, drug or supply done primarily to improve the appearance of any portion of the body. Cosmetic surgery exclusions include but are not limited to, surgery for sagging or extra skin, abdominoplasty, any augmentation or reduction procedures, rhinoplasty and associated surgery, epikeratophakia surgery, any augmentation or reduction procedures or correction of facial or breast asymmetry (except as defined below), treatment of male-pattern baldness or hair treatment, keloid scar or other scar revision therapy, any procedures utilizing an implant which cannot be expected to substantially alter physiologic functions, earring injuries and/or earlobe repair. Complications resulting from excluded cosmetic surgery or medical procedures are not covered. Psychological factors (for example, for self-image, difficult social or peer relations) do not constitute a physical bodily function or Medical Necessity.

The following are not subject to this exclusion:

- services necessitated by an Accidental Injury;
- coverage required by the Women's Health and Cancer Rights Act (i.e., reconstruction of the breast on which a mastectomy has been performed or surgery and reconstruction of the other breast to produce symmetrical appearance, and physical complications of all stages of a mastectomy, including lymphedemas). Coverage will be provided for such care as determined by the attending Physician in consultation with the patient;
- surgery which is necessary to correct a congenital abnormality in covered Dependent child.

NOTE: Expenses incurred for the removal of a mastectomy-related prosthesis will only be covered if Medically Necessary due to leakage.

Court-Ordered Care, Confinement or Treatment - Any care, confinement or treatment of a Covered Person as the result of a court order, unless the treatment or confinement would have been covered in the absence of the court order.

Criminal Activities - Any injury or illness resulting from or occurring during the Covered Person's commission or attempt to commit an aggravated assault or felony, taking part in a riot or civil disturbance, or taking part as a principal or as an accessory in illegal activities or an illegal occupation. This exclusion does not apply where such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Custodial Care - Care or confinement primarily for the purpose of meeting personal needs which could be rendered at home or by persons without professional skills or training. Any type of maintenance care which is not reasonably expected to improve the patient's condition, except as may be included as part of a formal Hospice care program.

Dental Care - Care or treatment on or to the teeth, alveolar processes, gingival tissue, or for malocclusion, except for the repair or prosthetic replacement of sound natural teeth and the setting of a jaw which are damaged in an Accidental Injury and provided such treatment is rendered within twelve (12) months after such accident.

Diagnostic Hospital Admissions - Confinement in a Hospital that is for diagnostic purposes only, when such diagnostic services could be performed in an Outpatient setting.

Drugs in Testing Phases - Medicines or drugs which are in the Food and Drug Administration Phases I, II, or III testing, drugs which are not commercially available for purchase or are not approved by the Food and Drug Administration for general use.

Ecological or Environmental Medicine - Chelation or chelation therapy, orthomolecular substances, or use of substances of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Hospitalization for environmental change.

Educational or Vocational Testing or Training - Special education or training for learning disorders, hyperkinetic syndromes, behavioral problems, mental handicap, or autistic disease of childhood.

Testing, evaluation, counseling or training for educational or vocational purposes or to assist an individual in pursuing a trade or occupation.

Educational services which are provided through or by a school district.

Excess Charges - Charges in excess of the Usual, Customary and Reasonable fees for services or supplies provided.

Exercise Equipment / Health Clubs - Exercising equipment, vibratory equipment, swimming or therapy pools. Enrollment in health, athletic or similar clubs.

Experimental / Investigational Treatment - Expenses for treatments, procedures, devices, or drugs which the Plan Sponsor determines, in the exercise of its discretion, are experimental, investigational, or done primarily for research. Treatments, procedures, devices, or drugs shall be excluded under this Plan unless:

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

"Reliable evidence" shall include anything determined to be such by the Plan Sponsor, within the exercise of its discretion, and may include published reports and articles in the medical and scientific literature generally considered to be authoritative by the medical professional community in the United States, including the *HCFA*

Medicare Coverage Issues Manual.

Foot Care, Routine - Non-surgical treatment of corns, calluses, toenails, or other routine foot conditions or care except for treatment which: (1) involves at least partial removal of a nail root, or (2) is necessitated by a metabolic or peripheral-vascular disease.

Orthopedic shoes, foot orthotics and other supportive appliances for the feet, except to the extent expressly covered - see "Orthopedic Shoes" in the list of Eligible Medical Expenses.

Forms Completion - Charges made for the completion of claim forms or for providing supplemental information.

Genetic Counseling or Testing - Counseling or testing concerning inherited (genetic) disorders. Except when covered under, see "Preventive Care", under Eligible Medical Expenses.

Government-Operated Facilities - Services furnished to the Covered Person in any veterans hospital, military hospital, institution or facility operated by the United States government or by any state government or any agency or instrumentality of such government, for which the Covered Person has no legal obligation to pay.

NOTE: This exclusion does not apply to treatment of non-service related disabilities or for Inpatient care provided in a military or other Federal government hospital to dependents of active duty armed service personnel or armed service retirees and their dependents. This exclusion does not apply where prohibited by law.

Hair Replacement - Replacement of nonproductive hair follicles with productive follicles from another area of the scalp or body for treatment of alopecia (baldness), or any other surgeries, treatments, drugs or supplies relating to baldness or hair loss. Expenses for or related to hair removal, hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa, or for hair replacement devices, including but not limited to wigs, toupees and/or hairpieces or hair analysis.

Hearing Aids, Exams, Etc. - Hearing exams, hearing aids, cochlear implants and all related services or supplies, or other internal or external devices for the purpose of improving, restoring or stimulating hearing.

Hazardous Pursuit, Hobby or Activity - Services, supplies, care and/or treatment of an injury or sickness that results from engaging in a hazardous pursuit, hobby or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, use of all terrain vehicles, mountain, ice or rock climbing, use of fireworks, handling explosives, skiing or snowboarding in closed areas, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicle or other machinery, and travel to countries with advisory warnings.

Injuries sustained in an automobile accident in which the Covered Person was not wearing a seat belt or other legally required restraint device.

Injuries suffered as a result of a motorcycle accident in which the Covered Person was not wearing a helmet approved for street use.

Injuries suffered as the result of an accident in which the Covered Person failed to use a crosswalk while crossing a street or where a Covered Person crossed against a light.

NOTE: This exclusion does not apply where any such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Holistic or Homeopathic Treatment or Acupuncture – Acupuncture or services, supplies, drugs or accommodations provided in connection with holistic or homeopathic treatment.

Hypnotherapy - Treatment by hypnotism.

Impregnation - see "Infertility Treatment / Impregnation"

Infertility Treatment / Impregnation - Procedures, drugs or supplies to correct infertility or to restore or enhance fertility, including embryonic transfer, GIFT (Gamete Intrafallopian Transfer), in-vitro fertilization, artificial insemination, services of any person acting as a surrogate mother or as being a recipient of a surrogate baby.

Late-Filed Claims - Claims which are not filed with the Contract Administrator for handling within the required time periods as included in the **Claims Procedures** section.

Maintenance Care - Services or supplies that cannot reasonably be expected to lessen the patient's disability or to enable him to live outside of an institution.

Marriage & Family Counseling - Counseling for the purpose of resolving family or marital difficulties.

Maternity / Family Planning Exclusions - Childbirth courses, expenses related to the maternity care and delivery expenses associated with a pregnant Dependent child, or expenses related to cryostorage of umbilical cord blood or other tissue or organs.

Medical Marijuana - Charges related to the acquisition or use of medical Marijuana.

Mental Health Care - Treatment of any type of mental or nervous disorder, including treatment of attention deficit disorders.

Missed Appointments - Expenses incurred for failure to keep a scheduled appointment.

Modifications of Homes or Vehicles - Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Covered Person, including without limitation, any construction or modification (e.g., ramps, elevators, chair lifts, scooter/wheelchair lifts, swimming pools, spas, air conditioning, asbestos removal, air filtration, hand rails, emergency alert system, overhead tracking systems, etc.)

No Charge / No Legal Requirement to Pay - Services for which no charge is made or for which a Covered Person is not required to pay, or is not billed or would not have been billed in the absence of coverage under this Plan. Where Medicare coverage is involved and this Plan is a "secondary" coverage, this exclusion will apply to those amounts which a Covered Person is not legally required to pay due to Medicare's "limiting charge" amounts.

> NOTE: This exclusion does not apply to any benefit or coverage which is available through the Medical Assistance Act (Medicaid).

Non-Prescription Drugs - Drugs for use outside of a hospital or other Inpatient facility which can be purchased over-the-counter and without a Physician's written prescription. Drugs for which there is a non-prescription equivalent available.

Not Listed Services or Supplies - Any services, care or supplies not specifically listed in the Plan Document as Eligible Medical Expenses are <u>not</u> covered under the Plan.

Not Medically Necessary / Not Physician Prescribed - Any services or supplies which are: (1) not Medically Necessary, or (2) not incurred on the advice of a Physician - unless expressly included herein.

Obesity - see "Weight Control"

Orthognathic Procedures - Jaw (mandibular) augmentation or reduction procedures.

Other Coverage - Services or supplies for which a Covered Person is entitled (or could have been entitled if proper

application had been made) to have reimbursed by or furnished by any plan, authority or law of any government, governmental agency (Federal or State, Dominion or Province or any political subdivision thereof). However, this provision does not apply to Medicare Secondary Payor or Medicaid Priority rules.

Services or supplies received from a health care department maintained by or on behalf of an employer, mutual benefit association, labor union, trustees or similar person(s) or group.

Outside United States - Charges incurred outside of the United States if the Covered Person traveled to such a location for the primary purpose of obtaining such services, drugs or supplies.

Personal Comfort or Convenience Items - Services or supplies provided for personal comfort and not necessary for treatment of covered Sickness, Accidental Injury, or Pregnancy including, but not limited to, the purchase or rental of telephones, televisions, orthopedic mattresses, allergy-free pillows, blankets and/or mattress covers, non-hospital adjustable beds, waterbeds, motorized transportation equipment, elevators, escalators, professional medical equipment (such as blood pressure kits) or supplies or attachments to such equipment.

Postage, Shipping, Handling Charges, Etc. - Any postage, shipping or handling charges which may occur in the transmittal of information to the Contract Administrator. Interest or financing charges.

Prior Coverages - Services or supplies for which the Covered Person is eligible for benefits under the plan which this Plan replaces.

Prior to Effective Date / After Termination Date - Charges incurred prior to an individual's effective date of coverage under the Plan or after coverage is terminated, except as may be expressly stated.

Prophylactic Surgery or Treatment - Expenses for all medical or surgical services or procedures, including prescription drugs and the use of prophylactic surgery when the services, procedures, prescription drugs, or prophylactic surgery is prescribed or performed for the purpose of:

- avoiding the possibility or risk of an illness, disease, physical or mental disorder or condition based on family history and/or genetic test results; or
- treating the consequences of chromosomal abnormalities or genetically transmitted characteristics, when there is an absence of objective medical evidence of the presence of disease or physical or mental disorder.

Psychological Services - Psychological services, counseling, or tutoring services for developmental delay, learning disability, or treatment of mental retardation, Down's syndrome, or autism.

NOTE: See "Mental Health Care" for exclusion of in the list of Eligible Medical Expenses for coverage of attention deficit disorders (ADD & ADHD).

Relative or Resident Care - Any service rendered to a Covered Person by a relative (i.e., a spouse, or a grandparent, parent, brother, sister, or child of the Employee or of the Employee's spouse) or anyone who customarily lives in the Covered Person's household.

Reversal Surgery - The reversal of a previous voluntary surgical procedure.

Self-Inflicted Injury - Any expenses resulting from voluntary self-inflicted injury or voluntary attempted self-destruction which occurred while sane or insane and regardless of whether the Covered Person was aware of or in control of his or her actions.

Expenses necessitated by: (1) the voluntary taking of drugs, except as prescribed by a Physician, (2) the voluntary taking of poison, or (3) the voluntary inhaling of gas.

NOTE: This exclusion does not apply where any such injury results from a medical condition (physical or mental), including a medical condition resulting from domestic violence (e.g. depression).

Self-Procured Services - Services rendered to a Covered Person who is not under the regular care of a Physician and for services, supplies or treatment, including any periods of hospital confinement, which are not recommended, approved and certified as necessary and reasonable by a Physician, except as may be specifically included in the list of **Eligible Medical Expenses**.

Sex-Related Disorders - Transsexualism, gender dysphoria, sexual reassignment or change, or other sexual dysfunctions or inadequacies which are not related to organic disease. Excluded services and supplies include, but are not limited to: therapy or counseling, medications, implants, hormone therapy, surgery, and other medical or psychiatric treatment.

Sleep Therapy - Sleep therapy, except for central or obstructive apnea when Medically Necessary.

Sterilization Reversal Surgery - Reconstruction (reversal) of prior elective sterilization procedures.

Telecommunications - Advice or consultation given by or through any form of telecommunication, except as may be specifically included in the **Medical Benefit Summary, see virtual visit.**

TMJ / Jaw Joint Treatment - Procedures, restorations or appliances for the treatment or for the prevention of temporomandibular joint dysfunction syndrome.

Travel - Travel or accommodation charges, whether or not recommended by a Physician, except for ambulance charges or as otherwise expressly included in the list of **Eligible Medical Expenses or under the Utilization Management program and Network Providers for the University of Utah services.**

Varicose Veins - Treatment for the removal of varicose veins, unless Medically Necessary.

Vision Care - Eye examinations for the purpose of prescribing corrective lenses, eye glasses or contact lenses or the fitting thereof, vision supplies or their fitting, replacement, repair or adjustment, orthoptics, vision therapy, or other special vision procedures, including procedures whose purpose is the correction of refractive error, such as radial keratotomy.

NOTE: This exclusion will not apply to the initial purchase of glasses or contact lenses following cataract surgery covered under this Plan.

Vitamins or Dietary Supplements - Cosmetics, dietary supplements, vitamins, diet pills, health or beauty aids, vitamin B-12 injections (except for pernicious anemia), acne preparations, and laxatives. Charges which result from appetite control, food addictions, eating disorders or any treatment of obesity. See also "Weight Control" below.

Vocational Testing or Training - Vocational testing, evaluation, counseling or training.

War or Active Duty - Health conditions resulting from insurrection, war (declared or undeclared) or any act of war and any complications therefrom, or service (past or present) in the armed forces of any country.

Weekend Admissions - Hospital room and board expenses incurred on a weekend which coincides with admission to a Hospital between 12:00 (noon) on Friday and 12:00 (noon) on Sunday unless: (1) the admission occurs one day prior to a scheduled surgery, (2) the Covered Person is admitted on an emergency basis, or (3) the admission is for Pregnancy delivery.

Weight Control – Any surgical or invasive treatment including gastric balloon, gastric bypass, gastric banding, gastric stapling for reduction of weight regardless of associated medical or psychological conditions, including surgical reversals and treatment of any complications resulting from surgical treatment of and/or for morbid obesity. Special diet or food supplement programs, products or medications for weight loss and weight loss programs. Residential treatment programs for obesity and/or morbid obesity and/or residential treatment for weight gain.

Wigs or Wig Maintenance - see "Hair Replacement"

Work-Related Conditions - Any condition which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain, including self-employment.

Any condition for which the Covered Person has or had a right to compensation under any Workers' Compensation or occupational disease law or any other legislation of similar purpose. However, if the Plan provides benefits for any such condition, the Plan Sponsor will be entitled to establish a lien upon such other benefits up to the amount paid.

PRESCRIPTION BENEFIT SUMMARY

Prescription drug coverage is provided through separate agreement(s) between the Plan Sponsor and a prescription drug vendor. The following is a summary of the program.

The prescription coverage includes a Retail Program with participating pharmacies and a Mail Service Program. A "participating pharmacy" has a contract with the prescription vendor to dispense drugs to Plan participants. The contract includes certain cost provisions. The Mail Service Program allows a Plan participant to receive a larger quantity of a prescription and is generally useful for long-term or maintenance-type drugs.

The Prescription Drug Program is administered and provided through WellDyneRx, a Pharmacy Benefit Manager (PBM). Access the WellDyneRxwebsite to obtain updated information regarding the Formulary list, covered and non-covered drugs, and a list of participating pharmacies along with helpful information on generic equivalent drugs.

WellDyneRX

www.welldynerx.com

(844) 635-7351

RxBIN: 008878

SCHEDULE OF PRESCRIPTION BENEFITS

CALENDAR YEAR BENEFIT LIMITATION

ONCE PLAN PAYMENTS EQUAL $3,000 IN A CALENDAR YEAR FOR A COVERED PERSON, THE PLAN WILL PAY 50% OF THE COST OF THE PRESCRIPTION, AFTER THE CO-PAY.

PRESCRIPTION PROGRAM	**Benefits**
Calendar Year Deductible	$100 per person must be satisfied before Retail and Mail Service Program Co-Pays apply.
Retail Program (30 day supply) Generic Drug Formulary Brand Drug: when no generic is available when a generic is available Non-Formulary Brand Drug: when no generic is available when a generic is available	 $10 Co-Pay, then 100% $25 Co-Pay, then 100% $25 Co-Pay + difference in cost between generic and brand† $50 Co-Pay, then 100% $50 Co-Pay + difference in cost between generic and brand†
To use the Retail Program, a Covered Person takes his drug ID card to a participating pharmacy to fill his prescription order. See "Dispensing Limits" below.	

Mail Service Program (90 day supply) Generic Drug Formulary Brand Drug: when no generic is available when a generic is available Non-Formulary Brand Drug: when no generic is available when a generic is available	 $20 Co-Pay, then 100% $50 Co-Pay, then 100% $50 Co-Pay + difference in cost between generic and brand† $100, then 100% $100 Co-Pay + difference in cost between generic and brand†
The Mail Service Program is for maintenance (longer-term) drugs. See "Dispensing Limits" below.	
CALENDAR YEAR BENEFIT LIMITATION	ONCE PLAN PAYMENTS EQUAL $3,000 IN A CALENDAR YEAR FOR A COVERED PERSON, THE PLAN WILL PAY 50% OF THE COST OF THE PRESCRIPTION, AFTER THE CO-PAY.

† If a brand drug is purchased when a generic form of the drug is available, the Covered Person pays the brand Co-Pay plus the difference in cost between the brand drug and its generic equivalent. If this amount is larger than the total drug cost, then the Covered Person will pay the full cost of the drug.

FORMULARY DRUGS

The prescription program includes a list of formulary drugs. "Formulary drugs" are those on a preferred list where the prescription vendor has negotiated discounts with drug manufacturers. As a result, formulary drugs cost less to the Covered Person and to the Plan.

DISPENSING LIMITS

Covered prescription drugs are subject to the following dispensing limits. That is, the Co-Pay requirement or Covered Person's share of the drug cost (see the Schedule of Prescription Benefits above) applies to drugs/supplies obtained in the following quantities:

When Using the Retail Program:

- a 30-day supply of diabetic needles and syringes;
- a 30-day supply or one (1) 10 ml bottle of injectable insulin, whichever is greater;
- one (1) Imitrex Kit per month;
- a 30-day supply of any other drug.

When Using the Mail Service Program:

- a 90-day supply of diabetic needles and syringes;
- a 90-day supply or three (3) 10 ml bottles of injectable insulin, whichever is greater;
- three (3) Imitrex Kits per 90 days;
- a 90-day supply of any other drug.

COVERED PRESCRIPTION DRUGS

Covered prescription drugs include the following, whether obtained through the drug card program or mail-order option.

Legend Drugs - Drugs prescribed by a Physician that require a prescription either by federal or state law, except those which are listed in the "Expenses Not Covered" below. **Attention deficit disorder drugs are allowed for Covered Persons through age 18.**

Compounded Drugs - Compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity;

Insulin & Supplies - Insulin when prescribed by a Physician, including diabetic needles and syringes, and diabetic tests supplies (i.e., test strips and lancets).

EXPENSES NOT COVERED

The prescription drug coverage programs will not cover charges for any of the following:

Acne Drugs, Preparations, Washes and Lotions

Administration - Any charge for the administration of a covered drug.

Antihemophilic Factors, including Tissue Plasminogen Activator (TPA)

Anorexiants - Any charge for anorexiants (diet drugs).

Blood & Blood Plasma

Cosmetics

Experimental & Non-FDA Approved Drugs - Experimental drug and medicines, even though a charge is made to the Covered Person. Any drug not approved by the Food and Drug Administration (FDA) or any drug listed by the FDA as "less than effective."

Fertility Drugs or Agents

Fluoride Products

Immunizations Agents or Biological Sera

Impotence Drugs or Agents

Investigational Drugs - A drug or medicine labeled: "Caution – limited by federal law to investigational use."

Injectable Allergens, Serums, Toxoids and Vaccines

Laxatives

Lost or Stolen Drugs - Replacement of lost or stolen medications.

Medical Exclusions - A charge excluded under the **Limitations and Exclusions.**

Mental Health and Substance Abuse Drugs

No Charge - A charge for a prescribed drug which may be properly received without charge under a local, state or federal program, including Workers' Compensation or Occupational Disease Laws.

Non-Prescription Drugs - A drug or medicine that can legally be bought over-the-counter (i.e., without a written prescription). This does not apply to injectable insulin.

Non-Sedating Antihistamines – medications for allergies (e.g. Allegra, Zyrtec, Clarinex)

Proton Pump Inhibitor and H-2 Antagonist Agents – medications for heartburn, acid reflux, ulcers (e.g. Nexium, Protonix, Zantac, Pepcid). This does not apply to combination treatment for peptic ulcers caused by Helicobacter Pylori (e.g. Prevpac)

Vitamins & Dietary Supplements - Vitamins, except for prescribed prenatal vitamins and prescription vitamins with fluoride.
DISCLAIMER: THIS PRESCRIPTION INFORMATION IS ONLY A SUMMARY. IF THERE ARE ANY CONFLICTS BETWEEN THIS PRESCRIPTION INFORMATION AND THE TERMS OF AGREEMENT(S) BETWEEN THE PLAN SPONSOR AND THE PRESCRIPTION PROGRAM VENDOR, THE TERMS OF THE AGREEMENT(S) WILL GOVERN.

COORDINATION OF BENEFITS (COB)

All health care benefits provided under the Plan are subject to Coordination of Benefits as described below, unless specifically stated otherwise.

DEFINITIONS

As used in this COB section, the following terms will be capitalized and will have the meanings indicated:

Other Plan - Any of the following that provides benefits or services for health care services:

- group insurance, closed panel or other forms of group or group-type coverage (whether insured or uninsured). A "closed panel plan" is a plan that, except in an emergency, provides coverage only in the form of services obtained through a panel of providers that have contracted with or are employed by the plan;
- medical benefits under automobile contracts including no-fault auto insurance;
- homeowners insurance; and
- Medicare or other governmental benefits, as permitted by law.

An "Other Plan" does not include: (1) individual or family insurance, (2) closed panel or other individual coverage (except for group-type coverage), (3) school accident type coverage, (4) benefits for nonmedical components of group long-term care policies, (5) Medicare supplement policies, (6) Medicaid policies or coverage under other governmental plans, unless permitted by law.

NOTE: If an Other Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate plan.

This Plan - The coverages of this Plan.

Allowable Expense - A health care service or expense, including deductibles and copayments, that is covered at least in part by any of the plans (i.e., This Plan or Other Plan(s)) covering the Claimant. When a plan provides benefits in the form of services (an HMO, for example), the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid.

Claim Determination Period - A period which commences each January 1 and ends at 12 o'clock midnight on the next succeeding December 31, or that portion of such period during which the Claimant is covered under This Plan. The Claim Determination Period is the period during which This Plan's normal liability is determined (see "Effect on Benefits Under This Plan").

Custodial Parent - A parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the Calendar Year without regard to any temporary visitation.

EFFECT ON BENEFITS UNDER THIS PLAN

When Other Plan is Medicare - When, by law, This Plan is permitted to take a secondary position to Medicare, This Plan's liability will be reduced by the amount that could have been received under Medicare Parts A and B, regardless of whether: (1) the Covered Person has applied for Medicare, or (2) Medicare has paid for the expenses.

When Other Plan Does Not Contain a COB Provision - If an Other Plan does not contain a coordination of benefits provision that is consistent with the NAIC Model COB Contract Provisions, then such Other Plan will be "primary" and This Plan will pay its benefits AFTER such Other Plan(s). This Plan's liability will be the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

When Other Plan Contains a COB Provision - When an Other Plan also contains a coordination of benefits provision similar to this one, This Plan will determine its benefits using the "Order of Benefit Determination Rules" below. If, in accordance with those rules, This Plan is to pay benefits BEFORE an Other Plan, This Plan will pay its normal liability without regard to the benefits of the Other Plan. If This Plan, however, is to pay its benefits AFTER an Other Plan(s), it will pay the lesser of: (1) its normal liability or (2) total Allowable Expenses minus benefits paid by the Other Plan(s).

ORDER OF BENEFIT DETERMINATION RULES

Whether This Plan is the "primary" plan or a "secondary" plan is determined in accordance with the following rules. The first of the following rules that describes which pays its benefits first is the rule that will be used.

Non-Dependent vs. Dependent - The benefits of a plan which covers the Claimant other than as a dependent (i.e., as an employee, member, subscriber or retiree) will be determined before the benefits of a plan which covers such Claimant as a dependent. However, if the Claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber or retiree is secondary and the other plan is primary.

Child Covered Under More Than One Plan - When the Claimant is a dependent child, the primary plan is the plan of the parent whose birthday is earlier in the year if: (1) the child's parents are married or are not separated (whether or not they have ever been married), or (2) a court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage. If both parents have the same birthday, the plan that covered either of the parents longer is primary.

When the Claimant is a dependent child and the specific terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to Claim Determination Periods or plan years commencing after the plan is given notice of the court decree.

When the Claimant is a dependent child whose father and mother are not married, are separated (whether or not they even have been married) or are divorced, the order of benefits is:

- the plan of the Custodial Parent;
- the plan of the spouse of the Custodial Parent;
- the plan of the noncustodial parent; and then
- the plan of the spouse of the noncustodial parent.

Active vs. Inactive Employee - The plan that covers the Claimant as an employee who is neither laid off nor retired, is primary. The plan that covers a person as a dependent of an employee who is neither laid off nor retired, is primary. If the Other Plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Longer vs. Shorter Length of Coverage - The benefits of the plan which has covered the Claimant for the longer period of time are determined before those of the plan which has covered that person for the shorter period of time.

NOTE: If the preceding rules do not determine the primary plan, the Allowable Expenses shall be shared equally between This Plan and the Other Plan(s). However, This Plan will not pay more than it would have paid had it been primary.

OTHER INFORMATION ABOUT COORDINATION OF BENEFITS

Right to Receive and Release Necessary Information - For the purpose of enforcing or determining the applicability of the terms of this COB section or any similar provision of any Other Plan, the Contract Administrator may, without the consent of any person, release to or obtain from any insurance company, organization or person any information with respect to any person it deems to be necessary for such purposes. Any person claiming benefits under This Plan will furnish to the Contract Administrator such information as may be necessary to enforce this provision.

Facility of Payment - A payment made under an Other Plan may include an amount that should have been paid under This Plan. If it does, the Contract Administrator may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This Plan. The Plan will not have to pay that amount again.

Right of Recovery - If the amount of the payments made by the Plan is more than it should have paid under this COB section, the Plan may recover the excess from one or more of the persons it has paid or for whom it has paid - or any other person or organization that may be responsible for the benefits or services provided for the Claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

SUBROGATION

(Acts of Third Parties)

PAYMENT CONDITION

- The Plan, in its sole discretion, may elect to conditionally advance payment of medical 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 Covered Persons, Plan Beneficiaries, and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions(Collectively "Coverage").
- Covered Person(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 one hundred percent (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. By accepting benefits the Covered Person(s) agrees the Plan shall have an equitable lien on any funds received by the Covered Person(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 Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts.
- In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

SUBROGATION

- As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to subrogate the Plan to 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 Covered Person(s) is entitled, regardless of how classified or characterized.
- If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person(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 Plan may in its own name or in the name of the Covered Person(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.
- If the Covered Person(s) fails to file a claim or pursue damages against:

    - the responsible party, its insurer, or any other source on behalf of that party;
    - any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
    - any policy of insurance from any insurance company or guarantor of a third party;
    - worker's compensation or other liability insurance company; or,
    - any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;
    - the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(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

- 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 Covered Person(s) is fully compensated by his/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 subrogation lien. The obligation 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 Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
- 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, expressed written consent of the Plan.
- 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 Covered Person(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.
- 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 Covered Person(s).
- 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.

EXCESS INSURANCE

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 provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

- the responsible party, its insurer, or any other source on behalf of that party;
- any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- any policy of insurance from any insurance company or guarantor of a third party;
- worker's compensation or other liability insurance company or
- 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 Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person(s), or filing of bankruptcy by the Covered Person(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 Covered Person(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.

OBLIGATIONS

- It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:
  - 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;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;
  - to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
  - to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
  - to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
  - to not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan Beneficiary may have against any responsible party or Coverage.

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

OFFSET

Failure by the Covered Person(s) and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person(s) satisfies his or her obligation.

MINOR STATUS

- In the event the Covered Person(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.
- 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.

ELIGIBILITY AND EFFECTIVE DATES

Eligibility Requirements - Employees
To participate in the Plan coverages described herein, an Employee must be in full-time active employment for the Employer, performing all customary duties of his occupation at his usual place of employment (or at a location to which the business of the Employer requires him to travel) and work at least thirty (30) hours per week.

An Employee will be deemed in "active employment" on each day he is actually performing services for the Employer and on each day of a regular paid vacation or on a regular non-working day, provided he was actively at work on the last preceding regular working day. An Employee will also be deemed in "active employment" on any day on which he is absent from work during an approved FMLA leave or solely due to his own health status (see "Non-Discrimination Due to Health Status" in the **General Plan Information** section). An exception applies only to an Employee's first scheduled day of work. If an Employee does not report for employment on his first scheduled workday, he will not be considered as having commenced active employment.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Effective Date - Employees
An eligible Employee's coverage is effective after completion of ninety (90) days of full-time active employment.

An Employee has thirty-one (31) days, after completion of the waiting period, to enroll. Otherwise, his coverage can become effective only in accordance with the "Open Enrollment" or "Special Enrollment Rights" provisions below.

Eligibility Requirements - Dependents
An eligible Dependent of an Employee is:

a spouse. The marriage must meet all requirements of a valid marriage contract in the Employee's state of residence but will not include a common law spouse;

a child who is under age 26 (i.e. through age 25) unless the child age 19 through 25 has access to coverage under his own employer-sponsored health plan.

- a natural child;
- a stepchild;
- a child placed under the legal guardianship of the Employee;
- a child who is adopted by the Employee or placed with him for adoption prior to age 18. "Placed for adoption" means the assumption and retention by the Employee of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have begun;
- a child for whom the Employee or covered Dependent spouse is required to provide coverage due to a Medical Child Support Order (MCSO) which the Plan Sponsor determines to be a Qualified Medical Child Support Order in accordance with its written procedures (which are incorporated herein by reference and which can be obtained without charge). A QMCSO will also include a judgment, decree or order issued by a court of competent jurisdiction or through an administrative process established under state law and having the force and effect of law under state law and which satisfies the QMCSO requirements of ERISA (section 609(a));

An eligible Dependent does not include:

- a spouse following legal separation or a final decree of dissolution or divorce;
- a spouse of an Employee who is eligible for coverage through the spouse's employer;
- any person who has enrolled as an Employee under the Plan;
- any person who is covered as a Dependent of another Employee under the Plan.

See **Extension of Coverage** section(s) for instances when these eligibility requirements may be waived or modified.

Effective Date - Dependents
A Dependent who is eligible and enrolled when the Employee enrolls, will have coverage effective on the same date as the Employee. Dependents acquired later may be enrolled within thirty-one (31) days of their eligibility date (see the "Special Enrollment Rights" provision for details as well as instances when the loss of other coverage can allow a Dependent to be enrolled). Otherwise, a Dependent can be enrolled only in accordance with the "Open Enrollment" provision.

NOTE: In no instance will a Dependent's coverage become effective prior to the Employee's coverage effective date.

Special Enrollment Rights

Entitlement Due to Loss of Other Coverage - An individual who did not enroll in the Plan when first eligible, will be allowed to apply for coverage under the Plan at a later date if:

- he/she was covered under another group health plan or other health insurance coverage at the time coverage was initially offered. "Health insurance coverage" means benefits consisting of medical care under any hospital or medical service policy or certificate, hospital or medical service plan contract or health maintenance organization contract offered by a health insurance issuer;
- the Employee stated in writing at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan. However, this only applies if the Plan Sponsor required such a written statement and provided the person with notice of the requirement and the consequences of the requirement at such time;
- the individual lost the other coverage as a result of a certain event, such as loss of eligibility for coverage, exhaustion of the maximum COBRA continuation coverage period, termination of employment or reduction in the number of hours of employment, or employer contributions towards such coverage were terminated. Loss of other coverage for failure to pay premiums on a timely basis or for cause (e.g., making a fraudulent claim or making an intentional misrepresentation of a material fact with respect to the other coverage) will not be a valid loss of coverage for these purposes); and
- the Employee requested Plan enrollment within thirty (30) days of termination of the other coverage.

If the above conditions are met, Plan coverage will be effective on the first day of the first calendar month that begins after the date on which the Plan received the completed application.

NOTE: For a Dependent to enroll under the terms of this provision, the Employee must be enrolled or must enroll concurrently.

Entitlement Due to Acquiring New Dependent(s) - If an Employee acquires one (1) or more new eligible Dependents through marriage, birth, adoption, or placement for adoption (as defined by Federal law), application for their coverage may be made within thirty-one (31) days of the date the new Dependent or Dependents are acquired (the "triggering event") and Plan coverage will be effective as follows - see NOTE:

- where Employee's marriage is the "triggering event" - the spouse's coverage (and the coverage of any eligible Dependent children the Employee acquires in the marriage) will be effective on the date of marriage;
- where birth, adoption or placement for adoption is the "triggering event" - the child's coverage will be effective on the date of the event (i.e., concurrent with the child's date of birth, date of placement or date of adoption). The "triggering event" date for a newborn adoptive child is the child's date of birth if the child is placed with the Employee within thirty-one (31) days of birth.

NOTES: For a newly-acquired Dependent to be enrolled under the terms of this provision, the Employee must be enrolled or must enroll concurrently. If the newly-acquired Dependent is a child, the spouse is also eligible to enroll. However, other Dependent children who were not enrolled when first eligible are not considered to be newly acquired and can only be enrolled in accordance with the late enrollment provisions of the Plan.

A child named in a Qualified Medical Child Support Order (QMCSO) by a court of competent jurisdiction may be added and will not be subject to the late enrollment requirements. A copy of the QMCSO along with a completed,

signed enrollment card must be submitted within thirty-one (31) days of finalization of the court order by an individual identified by the court as authorized to request such enrollment.

Entitlement due to The Children's Health Insurance Program Reauthorization Act of 2009 ("CHIPRA"), effective April 1, 2009

- Loss of Eligibility for Medicaid or CHIP - employees and dependents who are eligible but not enrolled for coverage under the plan may enroll when the employee's or dependent's Medicaid or CHIP coverage terminates as a result of loss of eligibility and the employee requests coverage under the group health plan not later than 60 days after the date of termination.

- Premium Assistance Eligibility - employees and dependents who are eligible but not enrolled for coverage under the plan may enroll when the employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP and the employee requests coverage under the plan within 60 days after the date the employee or dependent is determined eligible for the premium assistance.

Open Enrollment

If an individual does not enroll when he is first eligible to do so or if coverage terminates, he may later enroll, if then eligible, during an Open Enrollment period which will be held in the month of December of each year. Plan coverage will be effective as of the next following January.

NOTE: See "Special Enrollment Rights" for exceptions to this provision.

Reinstatement

If an Employee returns to active employment and eligible status following an approved leave of absence in accordance with the Employer's guidelines and the Family and Medical Leave Act (FMLA), and during the leave the Employee discontinued paying his share of the cost of coverage causing coverage to terminate, such Employee may have coverage reinstated (for himself and any Dependents who were covered at the point contributions ceased). No waiting period requirement will be applied.

In accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), certain Employees who return to active employment following active duty service as a member of the United States armed forces, will be reinstated to coverage under the Plan immediately upon returning from military service. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

If an individual's coverage is terminated by Employer solely due to number of hours worked, that individual must complete another six (6) month measurement period of continuous employment to be eligible for reinstatement.

If an Employee or Dependent returns to an eligible status after having experienced a "Qualifying Event" and having continued Plan coverage, without interruption, as a "Qualified Beneficiary" under the terms of the **COBRA Continuation Coverage**, such person will be reinstated to active status and will have uninterrupted coverage under the Plan.

Transfer of Coverage

If a husband and wife are both Employees and are covered as Employees under this Plan and one of them terminates, the terminating spouse and any of his eligible and enrolled Dependents will be permitted to enroll under the remaining Employee's coverage, as long as enrollment occurs within thirty-one (31) days from the termination date. Such new coverage will be deemed a continuation of prior coverage and will not operate to reduce or increase any coverage to which the person was entitled while enrolled as the Employee or the Dependent of the terminated Employee.
If a Dependent transfers to Employee status, no waiting period will be required and coverage will continue from the prior status under the Plan without additional requirements.

TERMINATION OF COVERAGE

Employee Coverage Termination
An Employee's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan;
- termination of participation in the Plan by the Employee;
- the end of the period for which Employee last made the required contribution, if the coverage is provided on a contributory basis (i.e. Employee shares in the cost);

at midnight on the date on which the covered Employee leaves or is dismissed from the employment of the Employer or ceases to be eligible or engaged in active employment for the required number of hours as specified in **Eligibility and Effective Dates** section - except when coverage is extended under the terms of any **Extension of Coverage** provision; or

the date the Employee becomes covered another group medical plan offered by the Employer.

NOTE: Unused vacation days or severance pay following cessation of active work will NOT count as extending the period of time coverage will remain in effect.

Dependent Coverage Termination
A Dependent's coverage under the Plan will terminate upon the earliest of the following:

- termination of the Plan or discontinuance of Dependent coverage under the Plan;
- termination of the coverage of the Employee;
- at midnight of the last day the Dependent meets the eligibility requirements of the Plan, except when coverage is extended under the terms of any **Extension of Coverage** provision. An Employee's adoptive child ceases to be eligible on the date on which the petition for adoption is dismissed or denied or the date on which the placement is disrupted prior to legal adoption and the child is removed from placement with the Employee; or
- the end of the period for which the Employee last made the required contribution for such coverage, if Dependent's coverage is provided on a contributory basis (i.e., Employee shares in the cost). However, in the case of a child covered due to a Qualified Medical Child Support Order (QMCSO), the Employee must provide proof that the child support order is no longer in effect or that the Dependent has replacement coverage which will take effect immediately upon termination.

Michelle's Law
Full-time student dependents that are currently eligible, enrolled and attending an accredited academic or vocational school who may suffer from a serious illness or injury may continue with the same eligibility for coverage under the Plan for up to a special 12-month period, if specific requirements are met, as follows:

- The Dependent must be covered as a full-time student, as defined by the Plan, at an accredited academic or vocational school immediately before the first day of the medically necessary leave of absence or change in enrollment involved;
- The enrolled student Dependent must experience a serious illness or injury to be considered for this special medical leave of absence or change in enrollment status;
- The Plan must be provided a written certification by a treating physician of the student Dependent stating that this student Dependent is suffering from a serious illness or injury and that the leave of absence or change in enrollment status (including change in the Dependent's enrollment from part-time student status from full-

time student status) is medically necessary;

- The student Dependent must provide the physician certification to the health plan immediately following the serious illness or injury to provide for this special medical leave of absence or change in enrollment status;
- The student Dependent under the certified special medical leave of absence or change in enrollment status will continue until the earlier of:
  - 12 months after the first day of the medically necessary leave of absence or change of enrollment status; or
  - the date such coverage would otherwise terminate under the terms of the Plan, including failure to pay premium, or the student Dependent has aged out of the Plan, or the special medical leave or absence or change of enrollment status is no longer needed.

*- (See **COBRA Continuation Coverage**) -*

EXTENSION OF COVERAGE PROVISIONS

After the termination of coverage date (as determined by the **Termination of Coverage** section), coverage may be continued in the circumstances identified below. Unless expressly stated otherwise, however, coverage for a Dependent will not extend beyond the date the Employee's coverage ceases.

Extension of Coverage for Handicapped Dependent Children
If an already covered Dependent child attains the age which would otherwise terminate his status as a "Dependent" and:

- if on the day immediately prior to the attainment of such age the child was a covered Dependent under the Plan; and
- at the time of attainment of such age the child is incapable of self-sustaining employment by reason of mental retardation or physical handicap or disability which commenced prior to the attainment of such age; and
- such child is primarily dependent upon the Employee for support and maintenance;

then such child's status as a "Dependent" will not terminate solely by reason of his having attained the specified age and he will continue to be considered a covered Dependent under the Plan so long as he remains in such condition, and otherwise conforms to the definition of "Dependent."

The Employee must submit to the Contract Administrator proof of the child's incapacity within thirty-one (31) days of the child's attainment of such age, and thereafter as may be required, but not more frequently than once a year after the two-year period following the child's attainment of such age. If proof of incapacity is not submitted within thirty one (31) days of the date a request for such proof is made, coverage will terminate at the end of the 31-day period.

Extensions of Coverage During Absence From Work
If an Employee fails to continue in active employment but is not terminated from employment (e.g., he is absent due to an approved leave, a temporary layoff, etc.), he may be permitted to continue health care coverages for himself and his Dependents though he could be required to pay the full cost of coverage during such absence. Any such extended coverage allowances will be provided on a non-discriminatory basis and are as outlined in the Employer's personnel policies or other Employee communications. Such documents are incorporated by reference.

Except as noted, any coverage which is extended under the terms of this provision will automatically and immediately cease on the earliest of the following dates:

- the date specified in the Employer's written personnel policies or Employee communications;
- the end of the period for which the last contribution was paid, if such contribution is required;
- the date of termination of this Plan.

NOTE: The Plan Sponsor intends to comply with the Family and Medical Leave Act of 1993 (FMLA). To the extent that the FMLA applies to the Employer, Plan benefits may be maintained during certain leaves of absence at the levels and under the conditions that would have been present if employment was continuous. Employee eligibility requirements, the obligations of the Employer and Employee concerning conditions of leave, and notification and reporting requirements are specified in the FMLA. Any Plan provisions which are found to conflict with the FMLA are modified to comply with at least the minimum requirements of the Act.

Extension of Coverage During Military Service
Regardless of an Employer's established termination or leave of absence policies, the Plan will at all times comply with the regulations of the Uniformed Services Employment and Reemployment Rights Act (USERRA) for an Employee or Dependent entering military service. These rights include up to 18 months of extended health care coverage upon payment of the entire cost of coverage plus a reasonable administration fee. Additional information concerning the USERRA can be obtained from the Plan Sponsor.

- *(See **COBRA Continuation Coverage**)* -

CLAIMS PROCEDURES

It is the intent of the Plan Administrator that the following claims procedures comply with the United States Department of Labor ("DOL") regulation, 29 CFR § 2560.503-1, and the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). Where any provision is in conflict with the DOL's claims procedure regulations, ERISA, or any other applicable law, such law shall control.

SUBMITTING A CLAIM

A claim is a request for a benefit determination which is made, in accordance with the Plan's procedures, by a Claimant or his authorized representative. A claim must be received by the person or organizational unit customarily responsible for handling benefit matters on behalf of the Plan so that the claim review and benefit determination process can begin. A claim must name the Plan, a specific Claimant, a specific health condition or symptom or diagnostic code, and a specific treatment, service or supply (or procedure/revenue codes) for which a benefit or benefit determination is requested, the date of service, the amount of charges, the address (location) where services are received, and provider name, address, phone number and tax identification number.

There are two types of claims: (1) Pre-Service Claims, and (2) Post-Service Claims:

1) A Pre-Service Claim is a written or oral request for benefit determination where the terms of the Plan condition benefits, in whole or in part, on prior approval of the proposed care (e.g., a utilization review requirement). See the **Utilization Management Program** section and "Transplant-Related Services" in the **Medical Benefit Summary** for that information.

   A Pre-Service Claim should be submitted to:

   Medical Management Department
   Phone: (775) 982-3034 or **(800) 336-0123**

   Important: A benefit determination for a Pre-Service Claim shall only be for the purposes of assessing the Medical Necessity and appropriateness of care and delivery setting. A benefit determination for a Pre-Service Claim is not a guarantee of benefits from the Plan. Plan benefit payments are subject to review upon submission of a claim to the Plan after medical services have been received, and are subject to all related Plan provisions, including exclusions and limitations.

2) A Post-Service Claim is a written request for benefit determination after a service has been rendered and expense has been incurred. A Post-Service Claim must be submitted to the claims office within one hundred eighty (180) days of the date charges are incurred to be considered for benefits under the Plan. Failure to furnish such proof within the time required will not invalidate or reduce any claim, if it was not reasonably possible to furnish the information within the time frame specified.

   A Post-Service Claim should be submitted to:

   EDI Payor ID #88023
   Hometown Health
   P.O. Box 981703
   El Paso, TX 79998-1703

   NOTE: In accordance with federal law, the Centers for Medicare and Medicaid Services (CMS) have three (3) years to submit claims when CMS has paid as the primary plan and the Plan should have been primary.

ASSIGNMENTS TO PROVIDERS

All Eligible Medical Expenses reimbursable under the Plan will be paid to the covered Employee except that: (1) assignments of benefits to Hospitals, Physicians or other providers of service will be honored, (2) the Plan may pay benefits directly to providers of service unless the Covered Person requests otherwise, in writing, within the time limits for filing proof of loss, and (3) the Plan may make benefit payments for a child covered by a Qualified

Medical Child Support Order (a QMCSO) directly to the custodial parent or legal guardian of such child.

Benefits due to any Network provider will be considered "assigned" to such provider and will be paid directly to such provider, whether or not a written assignment of benefits was executed. Notwithstanding any assignment or non-assignment of benefits to the contrary, upon payment of the benefits due under the Plan, the Plan is deemed to have fulfilled its obligations with respect to such benefits, whether or not payment is made in accordance with any assignment or request.

No covered Employee or Dependent may, at any time, either while covered under the Plan or following termination of coverage, assign his right to sue to recover benefits under the Plan, or enforce rights due under the Plan or any other causes of action which he may have against the Plan or its fiduciaries.

NOTE: Benefit payments on behalf of a Covered Person who is also covered by a state's Medicaid program will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as created by an assignment of rights made by the Covered Person or his beneficiary as may be required by the state Medicaid plan. Furthermore, the Plan will honor any subrogation rights that a state may have gained from a Medicaid-eligible beneficiary due to the state's having paid Medicaid benefits that were payable under the Plan.

CLAIMS TIME LIMITS AND ALLOWANCES

The chart below sets forth the time limits and allowances which apply to the Plan and a Claimant with respect to claims filings, administration and benefit determinations (i.e., how quickly the Plan must respond to claims notices, filings and claims appeals and how much time is allowed for Claimants to respond, etc.). If there is any variance between the following information and the intended requirements of the law, the law will prevail.

Important: These claims procedures address the periods within which claims determinations must be decided, not paid. Benefit payments must be made within reasonable periods of time following Plan approval as governed by ERISA.

"PRE-SERVICE" CLAIM ACTIVITY	TIME LIMIT OR ALLOWANCE
Urgent Claim - defined below	
Claimant Makes Initial Incomplete Claim Request	Within not more than 24 hours (and as soon as possible taking into account the medical exigencies), Plan notifies Claimant of material needed to complete the claim request. Notification may be oral unless Claimant requests a written notice. Claimant will have a reasonable period of time, but not less than 48 hours, to provide the required information to complete the claim.
Plan Receives Completing Information	Plan notifies Claimant, in writing or electronically, of its benefit determination as soon as possible and not later than 48 hours after the earlier of: (1) receipt of the completing information, or (2) the period of time Claimant was allowed to provide the completing information. Oral notice can be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to the Claimant not later than 3 days after an oral notification.
Claimant Makes Initial Complete Claim Request	Within not more than 72 hours (and as soon as possible taking into account the medical exigencies), Plan responds with written or electronic benefit determination. Oral notice can be given in addition to written or electronic notice. Written or electronic notice of a benefit denial or reduction (an "adverse benefit determination") must be provided to the Claimant not later than 3 days after an oral notification.

Claimant Appeals	See "Appeal Procedures" subsection. An appeal for an urgent claim may be made orally or in writing.
Plan Responds to Appeal	Within not more than 72 hours (and as soon as possible taking into account the medical exigencies), after receipt of Claimant's appeal.

An "urgent claim" is an oral or written request for benefit determination where the decision would result in either of the following if decided within the time frames for non-urgent claims: (1) serious jeopardy to the Claimant's life or health, or the ability to regain maximum function, or (2) in the judgment of a Physician knowledgeable about the Claimant's condition, severe pain that could not be adequately managed without the care or treatment being claimed. All necessary information, including the Plan's handling of an appeal, shall be transmitted between the Plan and the Claimant by telephone, facsimile or other available and similarly expeditious methods.

Whether a claim is urgent will generally be decided by an individual acting on behalf of the Plan and applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. However, if a Physician familiar with the Claimant's condition decides that the claim involves urgent care, the Plan must defer to the Physician's judgment.

Where the "Time Limit or Allowance" stated above reflects "or sooner if possible", this phrase means that an earlier response may be required, taking into account the medical exigencies.

NOTE: THE BENEFIT DETERMINATION TIME FRAMES STATED ABOVE SHALL BEGIN AT THE TIME A CLAIM IS FILED IN ACCORDANCE WITH THE PROCEDURES OF THE PLAN, WITHOUT REGARD TO WHETHER ALL THE INFORMATION NECESSARY TO MAKE A BENEFIT DETERMINATION ACCOMPANIES THE FILING.

"PRE-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Concurrent Care Claim - defined below	
Plan Makes an Adverse Claim Decision	Plan notifies Claimant of intent to reduce or deny benefits before any reduction or termination of benefits is made and provides enough time to allow the Claimant to appeal and obtain a determination on review before the benefit is reduced or terminated. Any decision with the potential of causing disruption to ongoing care which is Medically Necessary, is subject to the urgent claim rules.
Claimant Requests Extension for Urgent Care	Plan notifies Claimant of its benefit determination within not more than 24 hours after receipt of the request (and as soon as possible taking into account the medical exigencies), provided such request is made at least 24 hours prior to the expiration of the previously-approved period of time or treatment. Otherwise, the Plan's notification must be made in accordance with the time allowances for appeal of an urgent, pre-service or post-service claim, as appropriate.

A "concurrent care claim" is a Claimant's request to extend a previously-approved ongoing course of treatment (e.g., kidney dialysis) beyond the approved period of time or number of treatments. An adverse claim decision for concurrent care does not include a benefit reduction or denial due to Plan amendment or termination.

Non-Urgent Claim	
Claimant Makes Initial Incomplete Claim Request	Within 5 days of receipt of the incomplete claim request, Plan notifies Claimant, orally or in writing, of material needed to complete the claim request. Claimant may request a written notification. Claimant has at least 45 days from receipt of such notice to provide required information.
Plan Receives Completing Information	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 15 days, Plan responds with written or electronic benefit determination. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.

Claimant Appeals	See "Appeal Procedures" subsection.
Plan Responds to Appeal	Within 30 days after receipt of appeal (or where Plan provides for 2 levels of appeal, within 15 days for each appeal).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 15-day period.

In the case of any extension as outlined above, the notice of extension which is provided to the Employee or Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to respond to those issues. Where the Contract Administrator requires additional information of the Employee or Claimant, the Contract Administrator must afford the Employee or Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Employee or Claimant until the date on which the response to the request for additional information is made.

"POST-SERVICE" CLAIM ACTIVITY	**TIME LIMIT OR ALLOWANCE**
Claimant Makes Initial Incomplete Claim Request	Within 30 days (and sooner if reasonably possible), Plan advises Claimant of material needed to complete the claim request. The Plan may extend this period for up to 15 days with full notice to the Claimant - see definition of "full notice" below. Claimant has at least 45 days to provide required information.
Plan Receives Completing Information	Within 30 days, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Makes Initial Complete Claim Request	Within 30 days of receiving the claim, Plan approves or denies claim. 15 additional days may be allowed with full notice to Claimant - see definition of "full notice" below.
Claimant Appeals	See "Appeals Procedures" subsection.
Plan Responds to Appeal	Within 60 days after receipt of appeal (or within 30 days for each appeal if Plan provides for two appeal levels).

"Full notice" means that notice is provided to the Claimant describing the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. Such extension must be necessary due to matters beyond the control of the Plan and notification to Claimant must occur prior to the expiration of the initial 30-day or 60-day period.

In the case of any extension as outlined above, the notice of extension which is provided to the Employee or Claimant shall specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to respond to those issues. Where the Contract Administrator requires additional information of the Employee or Claimant, the Contract Administrator must afford the Employee or Claimant at least 45 days to provide the specific information. In such case, the benefit determination period will be tolled (suspended) from the date on which notification of the extension is sent to the Employee or Claimant until the date on which the response to the request for additional information is made.

Authorized Representative May Act for Claimant

Any of the above actions which can be done by the Claimant can also be done by an authorized representative acting on the Claimant's behalf. The Claimant may be required to provide reasonable proof of such authorization. For an urgent claim, a health care professional, with knowledge of a Claimant's medical condition, will be permitted to act as the authorized representative of the Claimant. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Benefit Determinations

Upon the Contract Administrator's receipt of a written claim for benefits and pursuant to the procedures described herein, the Contract Administrator will review the claim submission, proof of claim, and all associated and/or applicable information provided by the Claimant and gathered independently by the Contract Administrator in light of the Plan Document through which benefits of the Plan are paid. Further, the Contract Administrator will assure that all benefit determinations are applied consistently to similarly-situated Plan participants by maintaining

appropriate claim and benefit records which shall be reviewed periodically and on a case-by-case basis to determine past practices in similar claim situations. Documentation of such reviews shall be made available to the Employee or Claimant upon request. Should the Contract Administrator at any time during it's review period determine that additional information is required from the Employee or Claimant, the Contract Administrator will request such necessary information from the Employee. The Contract Administrator will make every effort to make its benefit determination in as reasonable a time frame as possible.

Calculating Time Periods
For benefit determination, the period of time within which such determination is required begins at the time a claim is filed in accordance with the Plan's reasonable procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that an extended period of time is permitted due to a Claimant's failure to submit necessary information, the period for making the determination will be tolled (suspended) from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

Written or Electronic Notices
The Plan shall provide a Claimant with written or electronic notification of any benefit reduction or denial. Written or electronic notice of an approved benefit must be provided only for Pre-Service benefit determinations.

"Notice" or "notification" means the delivery or furnishing of information in a manner that satisfies the standards of 29 CFR 2520.104b-1(b) as appropriate with respect to material required to be furnished or made available to an individual. Any electronic notification shall comply with the standards of 29 CFR 2520.104b-1(c)(1)(i), (ii) (iii), and (iv) and 2520.104b-1(c)(2)(i) and (ii).

CLAIMS DENIALS

If a claim is wholly or partially denied (see NOTE), the Claimant will be given written or electronic notification of such denial within the time frames required by law - see "Claims Time Limits and Allowances". The notice will include the following and will be provided in a manner intended to be understood by the Claimant:

- the specific reason(s) for the decision to reduce or deny benefits:
- specific reference to the Plan provision(s) on which the denial is based as well as identification of and access to any guidelines, rules, and protocols which were relied upon in making the decision. Where a Plan utilizes a specific internal rule or protocol, the notice may either set forth the protocol or include a statement that a copy of such protocol will be furnished to the Claimant or his authorized representative free of charge and upon request. A notification of denial or benefit reduction based on Medical Necessity or experimental treatment or other similar exclusion or limit must explain the scientific or clinical judgment of the Plan in applying the terms of the Plan to the Claimant's medical circumstances, or must include a statement that such explanation will be provided to the Claimant free of charge upon request;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records or other information relevant to the Claimant's claim for benefits;
- the identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice, or a statement that the identity of the expert(s) will be provided upon request;
- a description of any additional information needed to change the decision and an explanation of why it is needed;
- a description of the Plan's procedures and time limits for appealed claims, including a statement of the Claimant's right to bring a civil action under section 502(a) of ERISA. A denial of an urgent claim must describe the expedited appeal process for urgent health claims. An urgent claim denial may be made orally to the Claimant if a written or electronic notification is furnished to the Claimant within 3 days after the oral notification.

NOTE: A claim denial, or an "adverse benefit determination", means any of the following: a denial, reduction (which includes any instance where the Plan pays less than the total amount of expenses submitted with regard to a claim), termination of a benefit, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including a denial, reduction, or termination of a benefit, or a failure to provide or make payment, in whole or in part for a benefit resulting from the application of

any utilization review, as well as a 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 or appropriate.

Denial of a claim for failure to obtain a prior approval under circumstances that would make obtaining such prior approval impossible or where application of the prior approval process could seriously jeopardize the life or health of the patient (e.g., the patient is unconscious and is in need of immediate care at the time medical treatment is required) is prohibited.

APPEAL PROCEDURES

Filing an Appeal and Appeal Review
Within 180 days of receiving notice of a claim reduction or denial, a Claimant may appeal his claim, in writing, to a new decision-maker (an appropriate Named Fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor a subordinate of the initial decision-maker) and he may submit new information (comments, documents, records, etc.) in support of his appeal.

In response to his appeal,.the Claimant is entitled to a full and fair review of the claim and a new decision and not simply a review of whether the initial decision was reasonable. A "full and fair review" takes into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether the information was submitted or considered in the initial benefit determination.

At such time as the Claimant appeals a denied claim, he will be provided, upon request and free of charge, with access to and copies of all documents, records and other information relevant to his claim for benefits, without regard to whether the Plan relied on the material. The Plan will also disclose the names of any medical or health professionals consulted as part of the claim process, whether or not such information was submitted or considered in the initial benefit determination.

For appeal of a denial based in whole or in part 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 new decision-maker shall consult with an independent health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. Such professional must be independent of any health care professional involved in the initial decision to reduce or deny benefits. "Health care professional" means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Decision on Appeal
A decision with regard to the claim appeal will be made within the allowed time frame - see "Claims Time Limits and Allowances". If special circumstances which are out of the Plan's control, require an extension of time, written notice of the extension will be furnished to the Claimant prior to the termination of the initially-allowed time. The extension notice will explain the special circumstances requiring an extension and the date the Plan expects to render the final decision. No extension is permitted for urgent claims.

The decision on appeal will be in writing or by electronic notification. With respect to an urgent care claim, the decision may be provided by phone, facsimile or other available and similarly expeditious method. If the decision is to continue to reduce or deny benefits, the notification will be provided in a manner calculated to be understood by the Claimant and will include:

- the specific reason(s) for the decision;
- reference to the pertinent Plan provisions on which the decision is based;
- a statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to the claim. "Relevant" information includes a document, record or other information which: (1) was relied upon in making the benefit determination, (2) was submitted, considered or generated in the course of making the benefit determination, whether or not it was relied upon, (3) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination, or (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied benefit for the Claimant's diagnosis, whether or not it was relied upon. The Plan will also disclose any documents that were created or received by the Plan during the

appeal process;
- identification of any medical or vocational experts whose advice was obtained in connection with the claim denial, whether or not the advice was relied upon in making the decision;
- identification of and access to any guidelines, rules, protocols which were relied upon in making the decision. Where a Plan utilizes a specific internal rule or protocol, the notice may either set forth the protocol or include a statement that a copy of such protocol will be furnished to the Claimant or his authorized representative free of charge and upon request. A notification of denial or benefit reduction based on Medical Necessity or experimental treatment or other similar exclusion or limit must explain the scientific or clinical judgment of the Plan in applying the terms of the Plan to the Claimant's medical circumstances, or must include a statement that such explanation will be provided to the Claimant free of charge upon request;
- a statement describing any voluntary appeal procedures offered by the Plan, the Claimant's right to obtain the information about such procedures, and a statement of the Claimant's right to bring an action under ERISA section 502(a).

In accordance with Federal law, the Plan cannot require more than two (2) levels of mandatory appeal. If more than one (1) level of mandatory appeal is required, both must be completed within the time frame applicable to one (1) level.

Voluntary Additional Levels of Appeal
Subject to the Plan Administrator's established procedures, up to two (2) voluntary additional levels of appeal (including arbitration or any other form of dispute resolution) are permitted, but only after exhaustion of the Plan's mandatory appeal procedure.

A Claimant cannot be required to pursue any voluntary level of appeal and a voluntary level of appeal cannot stop the Claimant from filing suit. The Plan waives any right to assert that a Claimant has failed to exhaust administrative remedies because the Claimant did not elect to pursue a voluntary level of appeal. Any statute of limitations or other defense based on timeliness is tolled (suspended) while a voluntary appeal is in process or pending.

A Claimant may contact the Plan Administrator to determine if a voluntary appeal level is part of the Plan's written procedures and, upon request, the Claimant will be provided with: (1) sufficient information relating to the voluntary level of appeal to enable him to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that his decision as to whether or not to use a voluntary level of appeal will have no effect on his rights to any other benefits under the Plan, (2) information about the applicable rules, (3) notice of his right to representation, (4) the process for selecting the decision-maker, and (5) the circumstances, if any, that may affect the impartiality of the decision-maker, such as any financial or personal interests in the result or any past or present relationship with any party to the review process. No fees or costs may be imposed on the Claimant as part of the voluntary level of appeal.

NOTE: Arbitration is permitted as a level of appeal, but only if the Claimant is provided with full disclosure regarding the process, arbitrator, relationships, right to representation, and only if Claimant agrees to such arbitration after completing the internal appeal process. Mandatory arbitration is permitted only as a mandatory appeal level. However, a Claimant is not precluded from challenging the decision under Section 502(c) of ERISA (Employee Retirement Income Security Act) or other applicable law.

DEFINITIONS

When capitalized herein, the following items will have the meanings shown below.

Accidental Injury - Any accidental bodily injury which is caused by external forces under unexpected circumstances and which is not excluded due to being employment-related (see **Limitations and Exclusions** section). Sprains and strains resulting from over-exertion, excessive use or over-stretching will not be considered Accidental Injury for purposes of benefit determination.

Ambulatory Surgical Center - Any public or private establishment which:

- complies with all licensing and other legal requirements and is operating lawfully in the jurisdiction where it is located;
- has an organized medical staff of Physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
- does not provide services or other accommodations for patients to stay overnight.

Calendar Year - The period of time commencing at 12:01 A.M. on January 1 of each year and ending at 12:01 A.M. on the next succeeding January 1. Each succeeding like period will be considered a new Calendar Year.

Claimant - Any Covered Person on whose behalf a claim is submitted for benefits under the Plan.

Coinsurance - The pre-determined percentage of allowable charges that a Covered Person pays.

Contract Administrator - A company which performs all functions reasonably related to the general management, supervision and administration of the Plan in accordance with the terms and conditions of an administration agreement between the Contract Administrator and the Plan Sponsor.

Convalescent Hospital - see "Skilled Nursing Facility"

Co-Pay - An amount a Covered Person must pay. The balance of the Eligible Medical Expense will be paid by the Plan unless a lesser percentage (%) is shown in the **Medical Benefit Summary**. Co-Pays are usually paid to the provider at the time of service.

Covered Person - A covered Employee, a covered Dependent, and a Qualified Beneficiary (COBRA). See **Eligibility and Effective Dates** and **COBRA Continuation Coverage** sections for further information.

NOTE: In enrolling an individual as a Covered Person or in determining or making benefit payments to or on behalf of a Covered Person, the eligibility of the individual for state Medicaid benefits will not be taken into account.

Covered Provider - An individual who is:

- licensed to perform certain health care services which are covered under the Plan and who is acting within the scope of his license; or
- in the absence of licensing requirements, is certified by the appropriate regulatory agency or professional association;
- and who is a:

  Certified or Registered Nurse Midwife
  Certified Registered Nurse Anesthetist (C.R.N.A.)
  Chiropractor (D.C.) - see definition of "Physician"
  Dentist (D.D.S or D.M.D.) - see definition of "Physician"
  Licensed Practical Nurse (L.P.N.)
  Licensed Psychiatric Nurse
  Licensed Vocational Nurse (L.V.N.)

Nurse Practitioner
Occupational Therapist (O.T.R.)
Physical Therapist (P.T. or R.P.T.)
Physician - see definition of "Physician"
Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.) - see definition of "Physician"
Prosthetist or Prosthetist-orthotist
Registered Nurse (R.N.)
Respiratory Therapist
Speech Therapist or Pathologist

A "Covered Provider" will also include the following when appropriately-licensed and providing services which are covered by the Plan:

- facilities as are defined herein including, but not limited to, Hospitals, Ambulatory Surgical Facilities, etc.;
- hemodialysis and Outpatient clinics under the direction of a Physician (M.D.);
- speech centers;
- portable X-ray companies;
- independent laboratories and lab technicians;
- blood banks;
- ambulance companies.

NOTE: A Covered Provider does not include a Covered Person treating himself or any relative or person who resides in the Covered Person's household - see "Relative or Resident Care" in the list of **Limitations and Exclusions**.

Deductible - A Deductible is an amount a Covered Person must pay. Deductibles usually must be paid before the Plan will begin to provide benefits.

Dependent - see **Eligibility and Effective Dates** section

Eligible Medical Expense(s) - Expense which is: (1) covered by a specific benefit provision of the Plan Document and (2) incurred while a person is a Covered Person.

Emergency - see "Medical Emergency"

Employee - see **Eligibility and Effective Dates** section

Employer(s) - The Employer or Employers participating in the Plan as stated in the **General Plan Information** section.

Fiduciary - A Fiduciary of the Plan has binding power to make decisions regarding Plan policies, interpretations, practices or procedures. A Fiduciary will thus include, but not be limited to, the Plan Administrator, officers and directors of the Plan Sponsor.

Free-Standing Chemical Dependency Treatment Center - A place which meets all of the following requirements:

- it is accredited as a hospital under the Hospital Accreditation Program of the Joint Commission on the Accreditation of Hospitals;
- it is operated chiefly for the treatment of chemical dependency;
- it provides only treatment that is directly under the supervision of a Physician; and

it provides 24-hour nursing service by registered graduate nurses (R.N.s).

Home Health Care Agency - An agency or organization which:

- is primarily engaged in and duly licensed, if such licensing is required by the appropriate licensing authority, to provide skilled nursing services and other therapeutic services;
- has policies established by a professional group associated with the agency or organization which includes at least one registered nurse (R.N.) to govern the services provided;

- provides for full-time supervision of such services by a Physician or by a registered nurse;
- maintains a complete medical record on each patient;
- has a full-time administrator.

In rural areas where there are no agencies which meet the above requirements or areas in which the available agencies do not meet the needs of the community, the services of visiting nurses may be substituted for the services of an agency.

Hospice - An entity providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for Covered Persons suffering from a condition that has a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one registered nurse, and must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital - An institution which:

- is operated pursuant to law for the care and treatment of sick and injured persons under the supervision of one or more licensed Physicians and which: (1) provides 24-hour nursing care on a resident Inpatient basis; (2) has organized facilities both for diagnosis and for surgery; and (3) is licensed under the federal Medicare program; or

NOTE: A "Hospital" does not include a rest home, nursing home, place for custodial care, home for the aged, or an institution operated by a state, county or city for the care of the mentally ill, or any governmental agency of the United States or Canada.

Inpatient - A person physically occupying a room and being charged for room and board in a facility (Hospital, Skilled Nursing Facility, etc.) which is covered by the Plan and to which the person has been assigned on a 24-hour-a-day basis without being issued passes to leave the premises.

Intensive Care Unit - Intensive Care Unit (ICU), Newborn Intensive Care Unit (NICU), Coronary Care Unit (CCU), Burn Unit, or Intermediate Care Unit - A Hospital area or accommodation exclusively reserved for critically and seriously ill patients requiring constant observation as prescribed by the attending Physician, which provides room and board, specialized registered professional nursing and other nursing care and special equipment and supplies on a stand-by basis and which is separated from the rest of the Hospital's facilities.

Lifetime - All periods an individual is covered under the Plan, including any prior periods covered under the Plan.

Medical Emergency - An Accidental Injury or the sudden onset of a medical condition with severe symptoms requiring immediate medical care. Examples include: heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions, or other such acute medical conditions.

Medically Necessary - Any health care treatment, service or supply determined by the Plan Administrator to meet each of the following requirements:

- it is ordered by a Physician for the diagnosis or treatment of a Sickness or Accidental Injury;
- the prevailing opinion within the appropriate specialty of the United States medical profession is that it is safe and effective for its intended use and that omission would adversely affect the person's medical condition;
- it is furnished by a provider with appropriate training and experience, acting within the scope of his or her license, and
- it is provided at the most appropriate level of care needed to treat the particular condition.

With respect to Inpatient services and supplies, "Medically Necessary" further means that the health condition requires a degree and frequency of services and treatment which can be provided ONLY on an Inpatient basis.

The Plan Administrator will determine whether the above requirements have been met based on: (1) published reports in authoritative medical and scientific literature, (2) regulations, reports, publications or evaluations issued by government agencies such as the National Institute of Health, the Food and Drug Administration (FDA), and the Centers for Medicare and Medicaid Services (CMS), (3) listing in the following compendia: *The American Hospital*

Formulary Service Drug Information and *The United States Pharmacopoeia Dispensing Information*; and (4) other authoritative medical resources to the extent the Plan Administrator determines them to be necessary.

Medicare - Health Insurance for the Aged and Disabled as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, and as amended from time to time.

Network Provider - Any medical provider who is contracted with the Network, a preferred provider organization contracted with Atlantis Casino Resort Spa to provide medical care to Covered Persons at negotiated rates.

Non-Network Provider - Any medical provider that is not contracted with the Network, a preferred provider organization contracted with Atlantis Casino Resort Spa to provide health care services to Covered Persons.

Out-of-Pocket Maximum - The maximum amount of Eligible Medical Expenses that a Covered Person is required to pay in any Calendar Year due to the Plan's cost-sharing (%-sharing) provisions.

Outpatient - Services rendered on other than an Inpatient basis at a Hospital or at a covered non-Hospital facility.

Physical Rehabilitation Facility - A facility which is:

- primarily engaged in providing diagnostic, therapeutic and restorative services through licensed health care professionals to injured, ill or disabled individuals; and
- accredited by the Commission on Accreditation for Rehabilitation Facilities or the Professional Services Board of the American Speech-Language-Hearing Association.

Physician - A legally qualified physician or surgeon licensed by the recognized licensing authority of the state in which he practices and who is acting within the scope of his license. A "Physician" also includes a licensed dentist, podiatrist, chiropractor, psychiatrist, psychologist and Christian Science practitioners practicing within their respective fields.

NOTE: The term "Physician" will not include the Covered Person himself, his relatives (see **Limitations and Exclusions**) or interns, residents, fellows or others enrolled in a graduate medical education program.

Plan - The benefits described by the Plan Document or incorporated by reference and including any prior statement of the Plan. The name of the Plan is shown in the **General Plan Information** section.

Plan Administrator - see "Plan Sponsor"

Plan Document - A formal written document which describes the plan of benefits and the provisions under which such benefits will be paid to Covered Persons, including any amendments.

Plan Sponsor - The entity sponsoring this Plan. The Plan Sponsor may also be referred to as the Plan Administrator. See **General Plan Information** section for further information.

Pregnancy - Pre-natal and post-natal care during pregnancy, childbirth, miscarriage or complications arising therefrom. See "Pregnancy" in the list of **Eligible Medical Expenses** for further information.

Primary Care Physician - A family practice, internal medicine or pediatric physician who has contracted with the Plan through the Network to provide coordinated care to Covered Persons.

Semi-Private Room Charge - The standard charge by a facility for semi-private room and board accommodations, or the average of such charges where the facility has more than one established level of such charges, or 90% of the lowest charge by the facility for single bed room and board accommodations where the facility does not provide any semi-private accommodations.

Sickness - Sickness will mean bodily illness or disease (other than mental health conditions), and congenital abnormalities of a covered newborn child. Also, a condition must be diagnosed by a Physician in order to be considered a Sickness by this Plan.

Skilled Nursing Facility - An institution which:

- is duly licensed as an extended care facility, skilled nursing facility, or intermediate care facility and is operated in accordance with the governing laws and regulations;
- is primarily engaged in providing accommodations and skilled nursing care 24-hours-a-day;
- is under the full-time supervision of a Physician or a registered nurse;
- admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician;
- has established methods and procedures for the dispensing and administering of drugs;
- has an effective utilization review plan;
- is approved and licensed by Medicare;
- has a written transfer agreement in effect with one or more Hospitals; and
- is not, other than incidentally, a nursing home, a hotel, a school or a similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Urgent Care Facility - A facility which is engaged primarily in providing minor emergency and episodic medical care and which has:

- a board-certified Physician, a registered nurse (R.N.) and a registered X-ray technician in attendance at all times;
- X-ray and laboratory equipment and a life support system.

An Urgent Care Facility may include a clinic located at, operated in conjunction with, or which is part of a regular Hospital.

Usual, Customary and Reasonable (UCR) – Where rates have been negotiated with providers participating in the Network, such rates will apply to services of all providers (network and non-network) and will be considered this Plan's Usual, Customary and Reasonable Allowance.

GENERAL PLAN INFORMATION

Name of Plan:	**Atlantis Casino Resort Spa Employee Health Benefit Plan**
Plan Sponsor / Plan Administrator: Address: Business Phone Number:	**Atlantis Casino Resort Spa** 3800 S. Virginia Street Reno, NV 89502 (775) 825-4700
Participating Employer:	**Atlantis Casino Resort Spa**
Plan Sponsor ID Number (EIN):	**88-0117859**
Plan Number:	**501**
Plan Year:	**January 1 through December 31**
Plan Benefits:	**Medical Benefits**
Named Fiduciary: Address:	**Atlantis Casino Resort Spa** 3800 S. Virginia Street Reno, NV 89502
(See also definition of "Fiduciary")	
Designated Legal Agent: Address:	**Atlantis Casino Resort Spa** 3800 S. Virginia Street Reno, NV 89502
(Legal process may be served upon the Plan Sponsor or a Fiduciary)	
Applicable Collective Bargaining Agreement(s):	**None**
Contract Administrator: Street Address: Mailing Address: Phone:	**Hometown Health** 10315 Professional Circle Reno, Nevada 89521 10315 Professional Circle Reno, Nevada 89521 (775) 982-3232

FUNDING - SOURCES AND USES

Contribution Determinations
The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by the Employer(s) and the amount to be contributed (if any) by each Employee.

Employee Obligations
The coverage(s) afforded to an Employee by this Plan may require Employee contribution but will be at least partially funded by the Employer. If an Employee elects to enroll Dependent(s) under the Plan, the Employee may be responsible for payment of all or a portion of the Dependent contributions suitable to cover such enrollment. For active Employees, the Employer will deduct such costs on a regular basis from the Employee's wages or salary.

Employer Obligations
The Employer will make contributions to the Plan for the health care coverage(s) of Employees and may contribute to the cost of Dependent coverage.

Employer contributions and those paid by Employee, if any, will be placed in a special account or accounts administered by the Contract Administrator to provide the non-insured benefits under the Plan. Contributions for insured coverages or ancillary coverages (see **Additional Plan Coverages** section, if any) will be paid directly to the provider of such coverage.

Plan Funded Benefits
The contributions will be applied to provide the benefits under the Plan.

Insurance Policy(ies)
Contributions may be used to purchase insurance coverage(s) to ensure that the Plan will meet its self-funded obligations. The policy(ies) may be reviewed upon request submitted to the Plan Sponsor. The Plan Sponsor is also available to answer any questions about the coverages. The provisions of the Plan Document in no way modify those of any insurance policy.

Administration Expenses
Contributions may also be used to pay: (1) administrative expenses of the Plan in accordance with the terms and conditions of any administration agreement between the Plan Sponsor and Contract Administrator(s) and (2) other reasonable operating expenses of the Plan.

Taxes
Any premium or other taxes which may be imposed by any state or other taxing authority and which are applicable to the coverages of the Plan will be paid by the Plan Sponsor.

NOTE: To provide benefits, purchase insurance protection, pay administrative expenses and any necessary taxes, the contributions which are paid by Employees will be used first and any remaining Plan obligations will be paid by Employer contributions. Should total Plan liabilities in a Plan Year be less than total Employee contributions, any excess will be applied to reduce total Employee contribution requirements in the subsequent Plan Year or, at Plan Sponsor's discretion, may be used in any other manner which is consistent with ERISA guidelines.

ADMINISTRATIVE PROVISIONS

Administration (type of)
Certain benefits of the Plan are administered by a Contract Administrator under the terms and conditions of administration agreement(s) between the Plan Sponsor and Contract Administrator. The Contract Administrator is not an insurance company.

Alternative Care
In addition to the benefits specified herein, the Plan may elect to offer benefits for services furnished by any provider pursuant to an approved alternative treatment plan for a Covered Person.

The Plan will provide such alternative benefits at the Plan Sponsor's sole discretion and only when and for so long as it determines that alternative services are Medically Necessary and cost-effective, and that the total benefits paid for such services do not exceed the total benefits to which the Claimant would otherwise be entitled under this Plan in the absence of alternative benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it will not be obligated to provide the same or similar benefits for that person or other Covered Persons in any other instance, nor will such election be construed as a waiver of the Plan Sponsor's right to administer the Plan thereafter in strict accordance with the provisions of the Plan Document.

Amendment or Termination of the Plan
The Plan Sponsor expects the Plan to be permanent, but since future conditions affecting the Plan Sponsor or Employer(s) cannot be anticipated or foreseen, the Plan Sponsor must necessarily and does hereby reserve the right to, without the consent of any participant or beneficiary:

- determine eligibility for benefits or to construe the terms of the Plan;

- alter or postpone the method of payment of any benefit;
- amend any provision of these administrative provisions;
- make any modifications or amendments to the Plan as are necessary or appropriate to qualify or maintain the Plan as a plan meeting the requirements of the applicable sections of the Internal Revenue Code or ERISA; and
- terminate, suspend, withdraw, amend or modify the Plan in whole or in part at any time and on a retroactive basis, if necessary, provided, however, that no modification or amendment shall divest an Employee of a right to those benefits to which he has become entitled under the Plan.

NOTE: Any modification, amendment or termination action will be done in writing, and by resolution of a majority of the Plan Sponsor's board of directors, or by written amendment which is signed by at least one Fiduciary of the Plan. Employees will be provided with notice of the change within the time allowed by federal law.

Anticipation, Alienation, Sale or Transfer
Except for assignments to providers of service (see **Claims Procedures** section), no benefit payable under the provisions of the Plan will be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge will be void; nor will such benefit be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, covered Dependent or beneficiary, including claims of creditors, claims for alimony or support, and any like or unlike claims.

Clerical Error
Clerical error by the Employer or Plan Sponsor will not invalidate coverage otherwise validly in force nor continue coverage otherwise validly terminated.

Discrepancies
In the event that there may be a discrepancy between the booklet(s) provided to Employees (the "Summary Plan Description") and the Plan Document, the Plan Document will prevail.

Entire Contract
The Plan Document, any amendments, and the individual applications, if any, of Covered Persons will constitute the entire contract between the parties. The Plan does not constitute a contract of employment or in any way affect the rights of an Employer to discharge any Employee.

Facility of Payment
Every person receiving or claiming benefits under the Plan will be presumed to be mentally and physically competent and of age. However, in the event the Plan determines that the Employee is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Employee has not provided the Plan with an address at which he can be located for payment, the Plan may, during the lifetime of the Employee, pay any amount otherwise payable to the Employee, to the husband or wife or relative by blood of the Employee, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Employee before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Employee: lawful spouse, child or children, mother, father, brothers, or sisters, or the Employee's estate, as the Plan Sponsor in its sole discretion may designate. Any payment in accordance with this provision will discharge the obligation of the Plan.

If a guardian, conservator or other person legally vested with the care of the estate of any person receiving or claiming benefits under the Plan is appointed by a court of competent jurisdiction, payments will be made to such guardian or conservator or other person, provided that proper proof of appointment is furnished in a form and manner suitable to the Fiduciaries. To the extent permitted by law, any such payment so made will be a complete discharge of any liability therefore under the Plan.

Fiduciaries
Fiduciaries will serve at the discretion of the Plan Sponsor and will serve without compensation, but they will be entitled to reimbursement of their expenses properly and actually incurred in an official capacity. The Plan Sponsor may at any time and from time to time remove any Fiduciary or appoint new Fiduciaries. Any Fiduciary may resign at any time upon 30 days' notice in writing delivered to the Plan Sponsor. Fiduciaries may act at a meeting or without a meeting, by a majority of the Fiduciaries at the time in office. The Fiduciaries may appoint a member as

its secretary who will have such powers and responsibilities relating to the administration of benefits under the Plan as the Fiduciaries may delegate.

Fiduciary Responsibility, Authority and Discretion
Fiduciaries will discharge their duties under the Plan solely in the interest of the Employees and their beneficiaries and for the exclusive purpose of providing benefits to Employees and their beneficiaries and defraying the reasonable expenses of administering the Plan.

The Fiduciaries will administer the Plan and will have the authority to exercise the powers and discretion conferred on them by the Plan and will have such other powers and authorities necessary or proper for the administration of the Plan as may be determined from time to time by the Plan Sponsor.

In carrying out their responsibilities under the Plan, Fiduciaries will have discretionary authority to interpret the terms of the Plan and Plan Document, even if the terms are found to be ambiguous, and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

The Fiduciaries may employ such agents, attorneys, accountants, investment advisors or other persons (who also may be employed by the Employer) or third parties (such as, but not limited to provider networks or utilization management organizations) as in their opinion may be desirable for the administration of the Plan, and may pay any such person or third party reasonable compensation. The Fiduciaries may delegate to any agent, attorney, accountant or other person or third party selected by them, any power or duty vested in, imposed upon, or granted to them by the Plan. However, the Fiduciaries will not be liable for acts or omissions of any agent, attorney, accountant or other person or third party except to the extent that the appointing Fiduciaries violated their own general fiduciary duties in: (1)establishing or implementing the Plan procedures for allocation or delegation, (2) allocating or delegating the responsibility, or (3) continuing the allocation or delegation.

Force Majeure
Should the performance of any act required by the Plan be prevented or delayed by reason of any act of nature, strike, lock-out, labor troubles, restrictive governmental laws or regulations, or any other cause beyond a party's control, the time for the performance of the act will be extended for a period equivalent to the period of delay, and non-performance of the act during the period of delay will be excused. In such an event, however, all parties will use reasonable efforts to perform their respective obligations under the Plan.

Gender and Number
Except as indicated by the context, any masculine terminology will also include the feminine (and vice-versa) and any term in the singular will also include the plural (and vice-versa).

Illegality of Particular Provision
The illegality of any particular provision of the Plan Document will not affect the other provisions, but the Plan Document will be construed in all respects as if such invalid provision were omitted.

Indemnification
To the extent permitted by law, Employees of the Employer, the Fiduciaries, and all agents and representatives of the Fiduciaries will be indemnified by the Plan Sponsor and saved harmless against any claims and conduct relating to the administration of the Plan except claims arising from gross negligence, willful neglect, or willful misconduct. The Plan Sponsor reserves the right to select and approve counsel and also the right to take the lead in any action in which it may be liable as an indemnitor.

Legal Actions
No Employee, Dependent or other beneficiary will have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to benefits under this Plan will be resolved by the Plan Sponsor under and pursuant to the Plan Document.

No legal action may be brought to recover on the Plan within sixty (60) days after written proof of loss has been given as required by the Plan. No such action may be brought after three (3) years from the time written proof of loss is required to be given.

Loss of Benefits
To the extent permitted by law, the following circumstances may result in disqualification, ineligibility or denial, loss, forfeiture, suspension, offset, reduction or recovery of any benefit that a Plan participant or beneficiary might otherwise reasonably expect the Plan to provide based on the description of benefits:

- an employee's cessation of active service for the employer;
- a Plan participant's failure to pay his share of the cost of coverage, if any, in a timely manner;
- a dependent ceases to meet the Plan's eligibility requirements (e.g., a child reaches a maximum age limit or a spouse divorces);
- a Plan participant is injured and expenses for treatment may be paid by or recovered from a third party;
- a claim for benefits is not filed within the time limits of the Plan.

Material Modification
In the case of any modification or change to the Plan that is a "material reduction in covered services or benefits," Plan participants and beneficiaries are to be furnished a summary of the change not later than sixty (60) days after the adoption of the change. This does not apply if the Plan Sponsor provides summaries of modifications or changes at regular intervals of not more than ninety (90) days. "Material modifications" are those which would be construed by the average Plan participant as being "important" reductions in coverage. Such reductions are outlined by the Department of Labor in Section 2520.104b-3(d)(3) of the regulations.

Misstatement / Misrepresentation
If the marital status, Dependent status or age of a Covered Person has been misstated or misrepresented in an enrollment form and if the amount of the contribution required with respect to such Covered Person is based on such criteria, an adjustment of the required contribution will be made based on the Covered Person's true status.

If marital status, Dependent status or age is a factor in determining eligibility or the amount of a benefit and there has been a misstatement of such status with regard to an individual in an enrollment form or claims filing, his eligibility, benefits or both, will be adjusted to reflect his true status.

A misstatement of marital status, Dependent status or age will void coverage not validly in force and will neither continue coverage otherwise validly terminated nor terminate coverage otherwise validly in force. The Plan will make any necessary adjustments in contributions, benefits or eligibility as soon as possible after discovery of the misstatement or misrepresentation. The Plan will also be entitled to recover any excess benefits paid or receive any shortage in contributions required due to such misstatement or misrepresentation.

Misuse of Identification Card
If an Employee or covered Dependent permits any person who is not a covered member of the family unit to use any identification card issued, the Plan Sponsor may give Employee written notice that his (and his family's) coverage will be terminated at the end of thirty-one (31) days from the date written notice is given.

Non-Discrimination Due to Health Status
An individual will not be prevented from becoming covered under the Plan due to a health status-related factor. A "health status-related factor" means any of the following:

- a medical condition (whether physical or mental and including conditions arising out of acts of domestic violence)
- claims experience
- receipt of health care
- medical history
- evidence of insurability
- disability
- genetic information

Physical Examination
The Plan Sponsor, at Plan expense, will have the right and opportunity to have a Physician of its choice examine the Covered Person when and as often as it may reasonably require during the pendency of any claim.

Plan Administrator Discretion & Authority
The Plan Administrator has the exclusive authority, it its sole and absolute discretion, to take any and all actions necessary to or appropriate to interpret the terms of the Plan in order to make all determinations thereunder. Benefits under this plan will be paid only if the Plan Administrator decides, in his discretion, that the eligible Employee or eligible Dependent is entitled to them. The Plan Sponsor shall make determinations regarding coverage and eligibility. The Plan Administrator or the delegated Contract Administrator shall make determinations regarding Plan Benefits.

Privacy Rules & Intent to Comply
On and after April 14, 2003, (or effective April 14, 2004 if the Plan's premium equivalent is less than $5 million annually), the Plan Sponsor certifies that the Plan is amended (by separate addendum) to comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rules") of the Health Insurance Portability and Accountability Act (HIPAA). See the section entitled **Privacy Rules** for more information.

Purpose of the Plan
The purpose of the Plan is to provide certain health care benefits for eligible Employees of the Employer(s) and their eligible Dependents.

Reimbursements
Plan's Right to Reimburse Another Party - Whenever any benefit payments which should have been made under the Plan have been made by another party, the Plan Sponsor and the Contract Administrator will be authorized to pay such benefits to the other party; provided, however, that the amounts so paid will be deemed to be benefit payments under the Plan, and the Plan will be fully discharged from liability for such payments to the full extent thereof.

Plan's Right to be Reimbursed for Clerical Error - When, as a result of clerical error, benefit payments have been made by the Plan in excess of the benefits to which a Claimant is entitled, the Plan will have the right to recover all such excess amounts from the Employee, or any other persons, insurance companies or other payees, and the Employee or Claimant will make a good faith attempt to assist in such repayment. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from the Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Plan's Right to Recover for Claims Paid Prior to Final Determination of Liability - The Plan Sponsor may, in its sole discretion, pay benefits for care or services pending a determination of whether or not such care or services are covered hereunder. Such payment will not affect or waive any exclusion, and to the extent benefits for such care or services have been provided, the Plan will be entitled to recoup and recover the amount paid therefore from the Covered Person or the provider of service in the event it is determined that such care or services are not covered. The Covered Person (parent, if a minor) will execute and deliver to the Plan Sponsor or the Contract Administrator all assignments and other documents necessary or useful for the purpose of enforcing the Plan's rights under this provision. If the Plan is not reimbursed in a timely manner after notice and proof of such overpayment has been provided to the Employee, then the Contract Administrator, upon authorization from Plan Sponsor, may deduct the amount of the overpayment from any future claims payable to the Employee or any of his Dependents.

Rights Against the Plan Sponsor or Employer
Neither the establishment of the Plan, nor any modification thereof, nor any distributions hereunder, will be construed as giving to any Employee or any person any legal or equitable rights against the Plan Sponsor, its shareholders, directors, or officers, or as giving any person the right to be retained in the employ of the Employer.

Titles or Headings
Where titles or headings precede explanatory text throughout the Plan Document, such titles or headings are intended for reference only. They are not intended and will not be construed to be a substantive part of the Plan Document and will not affect the validity, construction or effect of the Plan Document provisions.

Termination for Fraud
An individual's Plan coverage or eligibility for coverage may be terminated if:

the individual submits any claim that contains false or fraudulent elements under state or federal law;

- a civil or criminal case finds that the individual has submitted claims that contain false or fraudulent elements under state or federal law;
- an individual has submitted a claim which, in good faith judgment and investigation, he knew or should have known, contained false or fraudulent elements under state or federal law.

Termination for fraud will be made in writing and with 31-day notice to the individual.

Type of Plan
The Plan is a group health plan which is governed by the Employee Retirement Income Security Act (ERISA) and subject to the Health Insurance Portability and Accountability Act (HIPAA). The Employer-funded ("self-funded") benefits of the Plan are not guaranteed under a contract or policy of insurance.

Workers' Compensation
The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation.

STATEMENT OF RIGHTS

As a participant in this Plan, an individual is entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

- examine, without charge, at the Plan Administrator's office and at other specified locations such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor;
- obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The 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 health care coverage for himself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. The Employee or his Dependents may have to pay for such coverage. See the **COBRA Continuation Coverage** section for additional details about these rights;

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan (the Fiduciaries). Fiduciaries have a duty to operate the Plan prudently and in the interest of Plan participants and beneficiaries. No one, including the Employer, may fire a Plan participant or discriminate against him to prevent him from obtaining a welfare benefit or exercising rights under ERISA.

If an individual's claim for a welfare benefit is denied in whole or in part, he must receive a written explanation of the reason for the denial. He has the right to have the Plan review and reconsider his claim.

Under ERISA, there are steps he can take to enforce the above rights. For instance, if he requests materials from the Plan and does not receive them within 30 days, he may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay him up to $110 a day until he receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If he has a claim for benefits which is denied or ignored, in whole or in part, he may, file suit in a state or Federal court but not before he exhausts the Plan's mandatory appeals, where applicable (see the **Claims Procedures** section). In addition, if he disagrees with the Plan Sponsor's decision or lack thereof, concerning the qualified status of a medical child support order (QMCSO), he may file suit in Federal court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if he is discriminated against for asserting his rights, he may seek assistance from the U.S. Department of Labor, or he may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If he is successful, the court may order the person he has sued to pay these costs and fees. If he loses, the court may order him to pay these costs and fees, for example, if it finds his claim is frivolous.

If an Employee or Plan participant has any questions about the Plan, he should contact the Plan Administrator. If he has any questions about this statement or about his rights under ERISA, he should contact:

- the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his telephone directory; or
- the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

COBRA CONTINUATION COVERAGE

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail.

Definitions - When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - An individual who, on the day before a Qualifying Event, is covered under the Plan by virtue of being either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

- Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and resultant continuation coverage period also apply to the child.
- An individual who is not covered under the Plan on the day before a Qualifying Event because he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law. The individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.
- Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events which would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;
- reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
- for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;
- for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
- for an Employee's spouse or child, the death of the covered Employee;
- for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit).

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

Notification - The Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 14 days of receipt of notice of a Qualifying Event. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event has occurred which permits him to exercise coverage continuation rights under COBRA. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Employer or Plan Administrator within 60 days of a Qualifying Event that is: (1) a Dependent child's ceasing to be eligible under the requirements of the Plan, or (2) the divorce or legal separation of the Employee from his/her spouse.

Election and Election Period - COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open enrollment rights which allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

Effective Date of Coverage - COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

Level of Benefits - COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a Deductible requirement, a Qualified Beneficiary's Deductible amount at the beginning of the COBRA continuation period must be equal to his Deductible amount immediately before that date. If the Deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family Deductibles are computed separately based on the members in each unit. Other Plan limits are treated in the same manner as Deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

Cost of Continuation Coverage - The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for NonCOBRA Beneficiaries. Qualified Beneficiaries can be charged up to 150% of the full cost for the 11-month disability extension period if the disabled person is among those extending coverage.

The initial "premium" (cost of coverage) payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or the date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- the cost previously charged was less than the maximum permitted by law;
- the increase is due to a rate increase at Plan renewal;
- the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's full cost of coverage if the disabled person is among those extending coverage; or
- the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments which are not significantly less than the required amount are deemed to satisfy the Plan's payment requirement, unless the Plan notifies the Qualified Beneficiary of the deficiency and grants a reasonable period of time (at least 30 days) to make full payment.

If premiums are not paid by the first day of the period of coverage, the Plan has the option to cancel coverage until payment is received and then reinstate the coverage retroactively to the beginning of the period of coverage.

NOTE: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage for a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

Maximum Coverage Periods - The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary and are as follows:

- if the Qualifying Event is a termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see "Disability Extension" information below), the 18 months is extended to 29 months;
- if the Qualifying Event occurs to a Dependent due to Employee's enrollment in the Medicare program before

the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;
- for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs which provides an 18-month or 29-month maximum coverage period and is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the original period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period more than 36 months after the date of the first Qualifying Event.

Also, COBRA coverage will run concurrently with medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). That is, if an Employee on military leave continues coverage for 18 months under USERRA, 18 months of COBRA entitlement will be exhausted, unless there was another Qualifying Event.

Disability Extension - An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social Security Administration's disability determination date which falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Plan must also be notified if the Qualified Beneficiary is later determined by Social Security to be no longer disabled.

If an individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period. This applies even if the disabled person does not elect the extension him/herself.

Termination of Continuation Coverage - Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- the last day of the applicable maximum coverage period - see "Maximum Coverage Periods" above;
- the date on which the Employer ceases to provide any group health plan to any Employee;
- the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan;
- the date, after the date of the COBRA election, that the Qualified Beneficiary becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;
- in the case of a Qualified Beneficiary entitled to a disability extension, the later of:

    - 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
    - the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;

- the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not

received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

Effect of the Trade Act - In response to Public Law 107-210, referred to as the Trade Act of 2002 ("TAA"), the Plan is deemed to be "Qualified Health Insurance" pursuant to TAA, the Plan provides COBRA continuation of coverage in the manner required of the Plan by TAA for individuals who suffer loss of their medical benefits under the Plan due to foreign trade competition or shifts of production to other countries, as determined by the U.S. International Trade Commission and the Department of Labor pursuant to the Trade Act of 1974, as amended.

Eligible Individuals - The Plan Administrator shall recognize those individuals who are deemed eligible for federal income tax credit of their health insurance cost or who receive a benefit from the Pension Benefit Guaranty Corporation ("PBGC"), pursuant to TAA as of or after November 4, 2002. The Plan Administrator shall require documentation evidencing eligibility of TAA benefits, including but not limited to, a government certificate of TAA eligibility, a PBGC benefit statement, federal income tax filings, etc. The Plan need not require every available document to establish evidence of TAA eligibility. The burden for evidencing TAA eligibility is that of the individual applying for coverage under the Plan. The Plan shall not be required to assist such individual in gathering such evidence.

Temporary Extension of COBRA Election Period

Definitions:

- Nonelecting TAA-Eligible Individual – A TAA-Eligible Individual who has a TAA related loss of coverage and did not elect COBRA continuation coverage during the TAA-Related Election Period.
- TAA-Eligible Individual – An eligible TAA recipient and an eligible alternative TAA recipient.
- TAA-Related Election Period – with respect to a TAA-related loss of coverage, the 60-day period that begins on the first day of the month in which the individual becomes a TAA-Eligible Individual.
- TAA-Related Loss of Coverage – means, with respect to an individual whose separation from employment gives rise to being a TAA-Eligible Individual, the loss of health benefits coverage associated with such separation.

In the case of an otherwise COBRA Qualified Beneficiary who is a Nonelecting TAA-Eligible Individual, such individual may elect COBRA continuation of coverage during the TAA-Related Election Period, but only if such election is made not later than 6 months after the date of the TAA-Related Loss of Coverage.

Any continuation of coverage elected by a TAA-Eligible Individual shall commence at the beginning of the TAA-Related Election Period, and shall not include any period prior to the such individual's TAA-Related Election Period.

PRIVACY RULES

On and after April 14, 2003 (or effective April 14, 2004 if the Plan's premium equivalent is less than $5 million annually), the Plan will comply with the Standards for Privacy of Individually Identifiable Health Information (i.e., the "Privacy Rule") of the Health Insurance Portability and Accountability Act (HIPAA). Such standards control the dissemination of "protected health information" (herein also "PHI") of Plan participants.

PHI is individually identifiable health information created or received by the Plan that relates to a person's physical or mental health, to the health care of that person, or to the payment for that health care, whether that information is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium. Privacy standards will be implemented and enforced in the offices of the Employer and Plan Sponsor and any other entities that may assist in the operation of the Plan.

In general, the Privacy Rules permit the Plan to use and disclose an individual's PHI, without obtaining his authorization, only if the use or disclosure is to carry out payment of benefits or for health care operations or if the use or disclosure falls within one of the limited circumstances described in the rules (e.g., the disclosure is required by law or for public health activities). For these purposes: "payment" means activities associated with eligibility and coverage determinations, coordination of benefits, claims management, utilization review and other related health plan administrative activities; "health care operations" means other health plan administrative tasks such as quality improvement activities, activities related to obtaining health insurance policies or stop loss insurance, and legal and auditing functions.

In order to comply with the Privacy Rules, the Plan Sponsor agrees to:

- receive PHI from the Plan only when the entity providing PHI has received written certification that the Plan Document has been amended;
- adopt privacy policies. Such policies will include the uses and disclosures the Plan will make with regard to protected health information of Plan participants and when and to whom such information (PHI) will or will not be disclosed. Those policies are incorporated into the Plan Document by reference;
- establish safeguards for information, including security systems for data processing and storage;
- maintain the confidentially of all PHI, unless an individual gives specific consent or authorization to disclose such data or unless the data is used for health care payment or Plan operations;
- receive PHI, in the absence of an individual's express authorization, only to carry out Plan administration functions such as quality assurance, claims processing, auditing, monitoring and management of carve-out plans (such as vision or dental);
- even when health information is used for payment and Plan operations, only the minimum necessary information will be requested and obtained;
- not use or disclose PHI for employment-related purposes or in connection with any other benefit or employee benefit plan of the Plan Sponsor;
- not use or further disclose protected health information (PHI) other than as permitted or required by the Plan Document and by law;
- report to the Plan any inconsistent uses or disclosures of PHI of which the Plan Sponsor becomes aware;
- make Plan participants' PHI available to them upon request in accordance with the Privacy Rules;
- make Plan Participants' PHI available to them for amendment and correction in accordance with the Privacy Rules;
- make PHI available as required to provide an accounting of non-routine disclosures;
- make the Plan Sponsor's internal practices, books, and records related to uses and disclosure of PHI available to the Health and Human Services department for purposes of compliance enforcement;
- when feasible, return or destroy all PHI received from the Plan once it is no longer needed;
- provide for adequate separation of the Plan and the Plan Sponsor (i.e., create "firewalls"), by:
    - identifying which specific employees, classes of employees or others under the control of the Plan Sponsor will have access to PHI and restrict that access to Plan administration purposes, and
    - establishing a mechanism for resolving issues of noncompliance by the individuals who have access.
- ensure that any agents or subcontractors of the Plan who receive PHI will abide by the same restrictions and conditions that apply to the Plan Sponsor;

- train employees in privacy protection requirements and appoint a privacy official responsible for such protections;
- provide sanctions for those employees who violate the policies;
- establish grievance procedures for individuals who believe their privacy rights have been violated;
- adopt (or assure that the component operating the Plan adopts) the data transmission standards and code sets as prescribed by the Health and Human Services (HHS) to promote administrative simplification and reduce administrative costs.

NOTE: The Privacy Rules requirements do not apply if the Employer is provided only with "summary health information" and the information is provided only for the purpose of obtaining premium bids or for modifying or terminating the Plan. "Summary health information" is claims-related information that is in a form that excludes individual identifiers such as names, addresses, social security numbers or other unique patient identifying numbers or characteristics.

ADOPTION OF THE PLAN DOCUMENT

Adoption
The Plan Sponsor hereby adopts this Plan Document on the date shown below. This Plan Document replaces any and all prior statements of the Plan benefits which are described herein.

Purpose of the Plan
The purpose of the Plan is to provide certain benefits for eligible Employees of the Employer(s) and their eligible Dependents. The benefits provided by the Plan are as listed in the **General Plan Information** section.

Conformity with Law
If any provision of this Plan is contrary to any law to which it is subject, such provision is hereby amended to conform to such law.

Employers
Employers participating in this Plan are as stated in the section entitled **General Plan Information**.

The Plan Sponsor may act for and on behalf of any and all of the participating Employers in all matters pertaining to the Plan, and every act, agreement, or notice by the Plan Sponsor will be binding on all such Employers.

Acceptance of the Plan Document
IN WITNESS WHEREOF, the Plan Sponsor has caused this instrument to be executed, effective as of January 1, 2019.

Atlantis Casino Resort Spa

By: _____

Title: _____