AMENDMENT #1

TO
THE PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION
OF THE
EBTEC CORPORATION GROUP HEALTH PLAN

Effective November 1, 2010, the Summary Plan Description is hereby amended. A summary of changes follows:

- **Medical plan design changes**
  - Remove lifetime maximum.
  - Emergency room out-of-network cost-sharing is now waived in a true emergency.
  - Remove lifetime maximum on Jaw Joint/TMJ.
  - Remove copayments from all in-network preventive care.
  - Remove lifetime maximum for hearing aids.
  - Cover hearing exams at 100% in-network, 60% after deductible out-of-network.
  - Cover hearing aids at 80% after deductible in-network, 60% after deductible out-of-network, once every three years.
  - Cover routine newborn care out-of-network.

- **Dental and Vision plan changes**
  - Amended to cover basic pediatric services in accordance with PPACA.

- **Eligibility changes**
  - Children are eligible to age 26.

- **Pre-Existing Condition Limitations**
  - Amended to no longer apply to members under age 19.

- **Special Enrollment Rights**
  - Amended to allow one-time special enrollment opportunity to members who previously lost coverage due to the limiting dependent age and/or prior lifetime maximum.

- **Claims Procedures**
  - Expanded your rights during the Appeal of an Adverse Benefit Determination.
  - Shortened the time the Plan has to respond to an Urgent Pre-Service Claim Appeal from 72 hours to 24 hours.
## SCHEDULE OF MEDICAL BENEFITS

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MAXIMUM LIFETIME BENEFIT AMOUNT</strong></td>
<td>None</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** Any use of the term “Lifetime” refers to all periods an individual is covered under the Plan, it does not mean a Covered Person’s entire lifetime.

**NOTE:** The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar year maximum is 60 days total which may be split between Network and Non-Network providers.

### DEDUCTIBLE, PER CALENDAR YEAR

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Covered Person</td>
<td>$200</td>
<td>$600</td>
</tr>
<tr>
<td>Per Family Unit</td>
<td>$600</td>
<td>$1,800</td>
</tr>
</tbody>
</table>

### COPAYMENTS

<table>
<thead>
<tr>
<th>Service Description</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician visits</td>
<td>$15</td>
<td>N/A</td>
</tr>
<tr>
<td>Well child visit with immunization</td>
<td>$0</td>
<td>N/A</td>
</tr>
<tr>
<td>Well child visit without immunization</td>
<td>$0</td>
<td>N/A</td>
</tr>
<tr>
<td>Emergency Room</td>
<td>$100</td>
<td>$100</td>
</tr>
</tbody>
</table>

The Emergency room copayment is waived (1) for a life-threatening sickness, (2) for an Accidental Injury when treatment commences within 72 hours of the accident, or (3) if the patient is admitted to the Hospital on an emergency basis. The utilization review administrator, Hines and Associates, must be notified at (800) 670-7718 within 24 hours of the admission, even if the patient is discharged within 72 hours of the admission.

### MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Per Covered Person</td>
<td>$400</td>
<td>$1,200</td>
</tr>
<tr>
<td>Per Family Unit</td>
<td>$1,200</td>
<td>$3,600</td>
</tr>
</tbody>
</table>

The Plan will pay the designated percentage of Covered Charges until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise.

The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:
- Cost containment penalties
- Spinal manipulation/chiropractic charges
- Copayments
- Jaw joint/TMJ charges

<table>
<thead>
<tr>
<th></th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accident Related Expense up to $500</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

The $500 benefit for accident related expenses is available only for certain expenses incurred within 90 days of the accident. Other expenses will be covered in the same manner as a Sickness and will be based on the types of expenses incurred. Expenses eligible for the $500 benefit include those for: (1) Physician services, (2) Hospital services, (3) diagnostic lab tests and X rays, (4) ambulance services (5) surgical dressings, splints, casts and devices used to reduce fractures and dislocations, (6) nursing services, (7) anesthesia, (8) prescription drugs, and (9) use of a Physician’s office or clinic operating room.
<table>
<thead>
<tr>
<th>COVERED CHARGES</th>
<th>NETWORK PROVIDERS</th>
<th>NON-NETWORK PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Room and Board</td>
<td>80% after deductible the semiprivate room rate</td>
<td>60% after deductible The semiprivate room rate</td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>80% after deductible Hospital’s ICU Charge</td>
<td>60% after deductible Hospital’s ICU Charge</td>
</tr>
<tr>
<td>Outpatient Services and Supplies</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Emergency Room Visit</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Emergency</td>
<td>100% after copayment (see Copayments on page 2)</td>
<td>100% after copayment (see Copayments on page 2)</td>
</tr>
<tr>
<td>Skilled Nursing Facility</td>
<td>80% after deductible the facility’s semiprivate room rate Limited to 60 days per confinement</td>
<td>60% after deductible the facility’s semiprivate room rate Limited to 60 days per confinement</td>
</tr>
<tr>
<td><strong>Physician Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient visits</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Office visits</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Specialist office visits</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Surgery</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Allergy testing</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Allergy serum and injections</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Diagnostic Testing (X-ray &amp; Lab)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Second (or third) Surgical Opinion</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Home Health Care</td>
<td>80% after deductible 120 visits Calendar Year maximum</td>
<td>60% after deductible 120 visits Calendar Year maximum</td>
</tr>
<tr>
<td>Inpatient Prescription Drugs</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Private Duty Nursing (Inpatient only)</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Bereavement Counseling</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Jaw Joint/TMJ</td>
<td>100% after copayment</td>
<td>50% after deductible</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Speech Therapy</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Prosthetics</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Orthotics</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Spinal Manipulation Chiropractic</td>
<td>100% after copayment Lesser of 52 visits or $2,000 Calendar year maximum</td>
<td>60% after deductible Lesser of 52 visits or $2,000 Calendar Year maximum</td>
</tr>
<tr>
<td></td>
<td>NETWORK PROVIDERS</td>
<td>NON-NETWORK PROVIDERS</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>--------------------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td><strong>Mental Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Well Adult Care</td>
<td>100% one per Calendar Year maximum</td>
<td>60% after deductible one per Calendar Year maximum</td>
</tr>
<tr>
<td>Includes:</td>
<td>office visits, pap smear, mammogram, prostate screening, gynecological exam, flu shots and HPV vaccine series.</td>
<td></td>
</tr>
<tr>
<td>Routine Well Adult Physical Exam</td>
<td>100% one per Calendar Year maximum</td>
<td>100% up to $75 (Employee and Spouse only)</td>
</tr>
<tr>
<td>Routine Well Newborn Care</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Routine Well Child Care</td>
<td>100%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Includes:</td>
<td>office visits, routine physical examination and immunizations, lab tests, patient history, development assessment, and anticipatory guidance.</td>
<td></td>
</tr>
<tr>
<td><strong>Hearing Exams, Aids and Fittings</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hearing Exams</td>
<td>100%</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hearing Aids</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Hearing aids are covered once every three years.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Transplant-Related Expenses</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benefits for transplant-related lodging and meal expense are limited to $10,000 per transplant benefit period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>If the organ donor is not a Covered Person, donor benefits are limited to $10,000 per transplant benefit period when the transplant services are received from Non-Network providers.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Re-transplantation is limited to two (2) re-transplants, for a total of three (3) transplants, per organ, per person, per Lifetime. Each transplant and re-transplant will have a new benefit period.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: A “transplant benefit period” is the period which begins on the date of the initial evaluation and ends on the date which is 12 consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Planning and Counseling</td>
<td>100% after copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Pregnancy</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Dependent daughters not covered.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Eligible Medical Expenses</td>
<td>80% after deductible</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>
## PRESCRIPTION DRUG BENEFIT

<table>
<thead>
<tr>
<th></th>
<th>NETWORK</th>
<th>NON-NETWORK</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pharmacy Option (30 Day Supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$7 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Formulary Brand Name Drugs</td>
<td>$25 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Non-Formulary Brand Name Drugs</td>
<td>$40 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td><strong>Mail Order Option (90 Day Supply)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Generic Drugs</td>
<td>$14 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Formulary Brand Name Drugs</td>
<td>$50 copayment</td>
<td>60% after deductible</td>
</tr>
<tr>
<td>Non-Formulary Brand Name Drugs</td>
<td>$80 copayment</td>
<td>60% after deductible</td>
</tr>
</tbody>
</table>

Refer to the Prescription Drug Section for details on the Prescription Drug benefit.
The Dental Care Benefit Schedule of the Summary Plan Description is hereby amended to add the following change effective November 1, 2010:

Basic pediatric services, in accordance with the applicable provisions of the Patient Protection and Affordable Care Act, are not subject to the annual benefit maximum.
The Vision Benefit Summary of the Summary Plan Description is hereby amended to add the following change effective November 1, 2010:

Basic pediatric services, in accordance with the applicable provisions of the Patient Protection and Affordable Care Act, are not subject to the annual benefit maximum.
ELIGIBILITY, FUNDING, EFFECTIVE DATE
AND TERMINATION PROVISIONS

“Eligible Classes of Dependents” is hereby amended and replaced in its entirety with the below language effective November 1, 2010.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

(1) A covered Employee’s Spouse.
(2) Children from birth to the limiting age of 26 years. When the child reaches the limiting age, coverage will end on the child’s birthday.

The term “Spouse” shall mean the person recognized as the covered Employee’s husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

The term “children” shall include natural children, adopted children, Foster Children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee’s household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee’s household.

The phrase “child placed with a covered Employee in anticipation of adoption” refers to a child whom the Employee intends to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term “placed” means the assumption and retention by such 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 commenced.

Any child of a Plan Participant who is an alternate recipient under a qualified medical child support order shall be considered as having a right to Dependent coverage under this Plan.

A participant of this Plan may obtain, without charge, a copy of the procedures governing qualified medical child support order (QMCSO) determinations from the Plan Administrator.

(3) A covered child is one who reaches the limiting age and is Totally Disabled, incapable of self-sustaining employment by reason of mental or physical handicap, primarily dependent upon the covered Employee for support and maintenance and unmarried. The Plan Administrator may require, at reasonable intervals during the two years following the Dependent’s reaching the limiting age, subsequent proof of the child’s Total Disability and dependency.

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

These persons are excluded as Dependents: other individuals living in the covered Employee’s home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as an Employee.

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.
The Pre-Existing Conditions section is hereby amended to add the following language effective November 1, 2010.

PRE-EXISTING CONDITIONS

Members under the age of 19 will not be subject to any Pre-Existing Conditions Limitation.
The Special Enrollment Periods section is hereby amended to include the following Special Enrollment Periods:

The lifetime limit on the dollar value of benefits under this Plan no longer applies. Individuals whose coverage ended by reason of reaching a lifetime limit under the plan are eligible to enroll in the plan. Individuals have a one-time opportunity of 30 days from the date the Plan Administrator provides specific notice to request enrollment.

Individuals whose coverage ended, or who were denied coverage (or were not eligible for coverage), because the availability of dependent coverage of children ended before attainment of age 26 are eligible to enroll in this Plan. Individuals have a one-time opportunity of 30 days from the date the Plan Administrator provides notice to request enrollment.

Elections of coverage made in accordance with either of the two Special Enrollment Periods above will be effective retroactively to November 1, 2010.
The How to Submit A Claim section is hereby replaced in its entirety to reflect the following language effective November 1, 2010.

HOW TO SUBMIT A CLAIM

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

Claims are often submitted by the service provider. It is always your responsibility however, to ensure a claim is filed when Plan reimbursement is desired.

1. For Plan reimbursements ALL BILLS MUST SHOW:
   - Name of Plan
   - Employee’s name
   - Name of Patient
   - Name, address, telephone number and tax identification number of the provider of care
   - Diagnosis
   - Type of services rendered, with diagnosis and/or procedure codes
   - Date of services
   - Charges

2. Send the above to the Claims Administrator at this address:
   Consolidated Health Plans, Inc.
   2077 Roosevelt Avenue
   Springfield, MA 01104
   (413) 733-4540 or (800) 633-7867
   Fax 413-733-4612
   www.consolidatedhealthplan.com

3. From time to time a claim form may be required. A claim form must be obtained from the Claims Administrator.

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 30 days of the date charges for the service were incurred. Benefits are based on the Plan’s provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) It’s not reasonably possible to submit the claim in that time; and

(b) the claim is submitted within 24 months from the date incurred. This 24 month period will not apply when the person is not legally capable of submitting the claim.

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

CLAIMS PROCEDURE

A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant that complies with the Plan’s reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days. If any provision of this Section conflicts with a contract of insurance, the provisions of such contract of insurance will apply.
Initial Claims
A Claim must be resolved, at the initial level, within 30 days of receipt. A Plan may, however, extend this decision making period for an additional 15 days for reasons beyond the control of the Plan.

If, after extending the time period for a first period of 15 days, the Plan Administrator determines that it will still be unable, for reasons beyond the control of the Plan, to make a decision within the extension period, the Plan may extend decision making for a second 15-day period.

Appropriate notice must be provided to the claimant before the end of the first 30 days and again before the end of each succeeding 15-day period. This notice will explain the circumstances requiring the extension and the date the Plan Administrator expects to render a decision to the claimant. It will explain the standards on which entitlement to the benefits is based, the unresolved issues that prevent a decision, the additional issues that prevent a decision, and the additional information needed to resolve the issues.

The claimant will have 45 days from the date of receipt of the written request to provide the required additional information.

Adverse Benefit Determinations

The Plan Administrator shall provide written or electronic notification of any Adverse Benefit Determination. The notice will state:

The specific reason or reasons for the adverse determination.

Reference to the specific Plan provisions on which the determination was based.

A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

A description of the Plan's review procedures and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

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.

If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge.

If the Adverse Benefit Determination is based on the Medical Necessity or Experimental and/or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Appeals

When a claimant receives an Adverse Benefit Determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The claimant will be notified of the determination on review of the Adverse Benefit Determination no later than 45 days after receipt of the request for review, unless special circumstances require an extension of time for processing. In such a case, the claimant will be notified, before the end of the initial review period, of the special circumstances requiring the extension and the date a decision is expected. If an extension is provided, the Plan Administrator must notify the claimant of the determination on review no later than 90 days after receipt of the request for review.
A document, record, or other information shall be considered relevant to a Claim if it:

- was relied upon in making the benefit determination;
- was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
- demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or
- constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be considered by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

**CLAIMS PROCEDURE**

Following is a description of how the Plan processes claims for benefits and reviews the appeal of any claim that is denied. The terms used in this section are defined below.

A "Claim" is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan's reasonable procedure for filing claims and making benefit claims determinations.

A "Claim" does not include a request for a determination of an individual's eligibility to participate in the Plan.

If a Claim is denied, in whole or in part, or if Plan coverage is rescinded retroactively for fraud or misrepresentation, the denial is known as an "Adverse Benefit Determination."

A claimant has the right to request a review of an Adverse Benefit Determination. This request is an "Appeal." If the Claim is denied at the end of the Appeal process, as described below, the Plan's final decision is known as a "Final Adverse Benefit Determination." If the claimant receives notice of a Final Adverse Benefit Determination, or if the Plan does not follow the Appeal procedures properly, the claimant then has the right to request an independent external review. The External Review procedures are described below.

Both the Claims and the Appeal procedures are intended to provide a full and fair review. This means, among other things, that Claims and Appeals will be decided in a manner designed to ensure the independence and impartiality of the persons involved in making these decisions.

A claimant must follow all Claims and Appeal procedures both internal and external, before he or she can file a lawsuit. If a lawsuit is brought, it must be filed within two years after the final determination of an Appeal.

Any of the authority and responsibilities of the Plan Administrator under the Claims and Appeal Procedures or the External Review Process, including the discretionary authority to interpret the terms of the Plan, may be delegated to a third party. If you have any questions regarding these procedures, please contact the Plan Administrator.

There are different kinds of Claims and each one has a specific timetable for each step in the review process. Upon receipt of the Claim, the Plan Administrator must decide whether to approve or deny the Claim. The Plan Administrator's notification to the claimant of its decision must be made as shown in the timetable. However, if the Claim has not been filed properly, or if it is incomplete, or if there are other matters beyond the control of the Plan Administrator, the claimant may be notified that the period for providing the notification will need to be extended. If the period is extended because the Plan Administrator needs more information from the claimant, the claimant must provide the requested information within the time shown on
the timetable. Once the Claim is complete, the Plan Administrator must make its decision as shown in the timetable. If the Claim is denied, in whole or in part, the claimant has the right to file an Appeal. Then the Plan Administrator must decide the Appeal and, if the Appeal is denied, provide notice to the claimant within the time periods shown on the timetable. The time periods shown in the timetable begin at the time the Claim or Appeal is filed in accordance with the Plan's procedures. Decisions will be made within a reasonable period of time appropriate to the circumstances, but within the maximum time periods listed in the timetables below. Unless otherwise noted, "days" means calendar days.

The definitions of the types of Claims are:

**Urgent Care Claim**
A Claim involving Urgent Care is any Claim for medical care or treatment where the Plan conditions receipt of benefits, in whole or in part, on approval in advance of obtaining the care or treatment, and using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the claimant; or the ability of the claimant to regain maximum function; or in the opinion of the attending or consulting physician, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

A Physician with knowledge of the claimant's medical condition may determine if a Claim is one involving Urgent Care. If there is no such Physician, an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine may make the determination.

In the case of a Claim involving Urgent Care, the following timetable applies:

- Notification to claimant of Claim determination: 24 hours
- Insufficient information on the Claim, or failure to follow the Plan's procedure for filing a Claim:
  - Notification to claimant, orally or in writing: 24 hours
  - Response by claimant, orally or in writing: 48 hours
  - Benefit determination, orally or in writing: 48 hours
  - Notification of Adverse Benefit Determination on Appeal: 72 hours

If there is an Adverse Benefit Determination on a Claim involving Urgent Care, a request for an expedited Appeal may be submitted orally or in writing by the claimant. All necessary information, including the Plan's benefit determination on review, may be transmitted between the Plan and the claimant by telephone, facsimile, or other similarly expeditious method. Alternatively, the claimant may request an expedited review under the External Review Process.

**Concurrent Care Claims**
A Concurrent Care Claim is a special type of Claim that arises if the Plan informs a claimant that benefits for a course of treatment that has been previously approved for a period of time or number of treatments is to be reduced or eliminated. In that case, the Plan must notify the claimant sufficiently in advance of the effective date of the reduction or elimination of treatment to allow the claimant to file an Appeal. This rule does not apply if benefits are reduced or eliminated due to Plan amendment or termination. A similar process applies for Claims based on a rescission of coverage for fraud or misrepresentation.

**Post-Service Claim**
A Post-Service Claim means any Claim for a Plan benefit that is not a Claim involving Urgent Care; in other words, a Claim that is a request for payment under the Plan for medical services already received by the claimant.
In the case of a Post-Service Claim, the following timetable applies:

- Notification to claimant of Adverse Benefit Determination: 30 days
- Extension due to matters beyond the control of the Plan: 15 days
- Extension due to insufficient information on the Claim: 15 days
- Response by claimant following notice of insufficient information: 45 days
- Notification of Adverse Benefit Determination on Appeal: 60 days

Notice to claimant of Adverse Benefit Determinations

If a Claim is denied in whole or in part, the denial is considered to be an Adverse Benefit Determination. Except with Urgent Care Claims, when the notification may be oral followed by written or electronic notification within three days of the oral notification, the Plan Administrator shall provide written or electronic notification of the Adverse Benefit Determination. The notice will state in a culturally and linguistically appropriate manner and in a manner calculated to be understood by the claimant:

1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

3) Reference to the specific Plan provisions on which the determination was based.

4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.

5) A description of the Plan's internal and external Appeal procedures, incorporating any voluntary appeal procedures offered by the Plan. This description will include information on how to initiate the Appeal and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following a Final Adverse Benefit Determination.

6) If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

7) If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

8) Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Appeals

When a claimant receives notification of an Adverse Benefit Determination, the claimant generally has 180 days following receipt of the notification in which to file a written request for an Appeal of the decision. However, for Concurrent Care Claims, the Claimant must file the Appeal prior to the scheduled reduction or termination of treatment. For a claim based on rescission of coverage, the claimant must file the Appeal within 30 days. A claimant may submit written comments, documents, records, and other information relating to the Claim.
If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim. The Plan Administrator shall provide the claimant, as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond, any new or additional evidence that is relied upon, considered or generated by or at the direction of the Plan. This evidence shall be provided free of charge.

A document, record, or other information shall be considered relevant to a Claim if it:

1) was relied upon in making the benefit determination;

2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3) demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4) constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The period of time within which a benefit determination on Appeal is required to be made shall begin at the time an Appeal is filed in writing in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

Before the Plan Administrator issues its Final Adverse Benefit Determination based on a new or additional rationale, the claimant must be provided, free of charge, with a copy of the rationale. The rationale must be provided as soon as possible and sufficiently in advance of the time within which a final determination on Appeal is required to allow the claimant time to respond.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial Adverse Benefit Determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

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

If the Appeal of a Claim is denied, in whole or in part, the Plan Administrator shall provide written notification of the Adverse Benefit Determination on Appeal. The notice will state, in a manner calculated to be understood by the claimant:

1) Information sufficient to allow the claimant to identify the Claim involved (including date of service, the healthcare provider, the claim amount, if applicable, the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning).

2) The specific reason or reasons for the adverse determination, including the denial code and its corresponding meaning, and a description of the Plan's standard, if any, that was used in denying the Claim.

3) Reference to the specific Plan provisions on which the determination was based.

4) A description of any additional material or information necessary for the claimant to perfect the Claim and an explanation of why such material or information is necessary.
A description of the Plan’s internal and external review procedures, incorporating any voluntary appeal procedures offered by the Plan and the time limits applicable to such procedures. This will include a statement of the claimant's right to bring a civil action under section 502 of ERISA following an Adverse Benefit Determination on review.

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. "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office."

If the Adverse Benefit Determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol, or criterion was relied upon in making the Adverse Benefit Determination and a copy will be provided free of charge to the claimant upon request.

If the Adverse Benefit Determination is based on the Medical Necessity or Experimental or Investigational treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided free of charge, upon request.

Information about the availability of and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under applicable federal law to assist individuals with the internal claims and appeals and external review process.

Voluntary appeals
In addition to the Claims and Appeals Procedures described above, the Plan permits voluntary dispute resolution procedures. If a claimant agrees in writing to use these procedures, any statute of limitations or other defense based on timeliness is tolled during the time any voluntary appeal is pending.

The Plan will not assert that a claimant has failed to exhaust administrative remedies merely because he or she did not elect to submit a benefit dispute to the voluntary appeal provided by the Plan. A claimant may elect a voluntary appeal after receipt of a Final Adverse Benefit Determination.

The Plan will provide to the claimant, at no cost and upon request, sufficient information about the voluntary appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. This information will include a statement that the decision will have no effect on the claimant's rights to any other benefits under the Plan; will list the rules of the appeal; state the claimant's right to representation; enumerate the process for selecting the decision maker; and give circumstances, if any, that may affect the impartiality of the decision maker.

No fees or costs will be imposed on the claimant as part of the voluntary level of appeal, and the claimant will be told this.

EXTERNAL REVIEWS

If a claimant receives a Final Adverse Benefit Determination under the Plan's internal Claims and Appeals Procedures, he or she may request that the Claim be reviewed under the Plan's External Review process.

Insured Benefit Reviews
In general, an appeal where the benefits are provided under an insurance contract, are subject to binding State external review. Please contact the Plan Administrator for those that apply.

Self-funded and Self-insured Benefit Review
The External Review Process described below generally applies where the benefit under appeal is provided by a self-insured or self-funded plan. Such benefit appeals are not subject to a binding State external review process and the federal external review process applies. This type of review request must be filed in writing within 4 months after receipt of the Final Adverse Benefit Determination.
The Plan Administrator will determine whether the Claim is eligible for review under the External Review process. This determination is based on whether:

1) The claimant is or was covered under the Plan at the time the Claim was made or incurred;
2) The denial relates to the claimant's failure to meet the Plan's eligibility requirements;
3) The claimant has exhausted the Plan's internal Claims and Appeal Procedures; and
4) The claimant has provided all the information required to process an External Review.

Within one business day after completion of this preliminary review, the Plan Administrator will provide written notification to the claimant of whether the claim is eligible for External Review.

If the request for review is complete but not eligible for External Review, the Plan Administrator will notify the claimant of the reasons for its ineligibility. The notice will include contact information for the Employee Benefits Security Administration at its toll free number (866) 444-3272.

If the request is not complete, the notice will describe the information needed to complete it. The claimant will have 48 hours or until the last day of the 4 month filing period, whichever is later, to submit the additional information.

If the request is eligible for the External Review process, the Plan will assign it to a qualified independent review organization ("IRO"). The IRO is responsible for notifying the claimant, in writing, that the request for External Review has been accepted. The notice should include a statement that the claimant may submit in writing, within 10 business days, additional information the IRO must consider when conducting the review. The IRO will share this information with the Plan. The Plan may consider this information and decide to reverse its denial of the Claim. If the denial is reversed, the External Review process will end.

If the Plan does not reverse the denial, the IRO will make its decision on the basis of its review of all of the information in the record, as well as additional information where appropriate and available, such as:

1) The claimant's medical records;
2) The attending health care professional's recommendation;
3) Reports from appropriate health care professionals and other documents submitted by the plan or issuer, claimant, or the claimant's treating provider;
4) The terms of the Plan;
5) Appropriate practice guidelines;
6) Any applicable clinical review criteria developed and used by the plan; and
7) The opinion of the IRO's clinical reviewer.

The IRO must provide written notice to the Plan and the claimant of its final decision within 45 days after the IRO receives the request for the External Review. The IRO's decision notice must contain:

1) A general description of the reason for the External Review, including information sufficient to identify the claim;
2) The date the IRO received the assignment to conduct the review and the date of the IRO's decision;
3) References to the evidence or documentation the IRO considered in reaching its decision;
4) A discussion of the principal reason(s) for the IRO's decision;
5) A statement that the determination is binding and that judicial review may be available to the claimant; and

6) Contact information for any applicable office of health insurance consumer assistance or ombudsman established under the Patient Protection and Affordable Care Act (PPACA).

Generally, a claimant must exhaust the Plan's Claims and Procedures in order to be eligible for the External Review process. However, in some cases the Plan provides for an expedited External Review if:

1) The claimant receives an Adverse Benefit Determination that involves a medical condition for which the time for completion of the Plan's internal Claims and Appeal Procedures would seriously jeopardize the claimant's life or health or ability to regain maximum function and the claimant has filed a request for an expedited internal review; or

2) The claimant receives a Final Adverse Benefit Determination that involves a medical condition where the time for completion of a standard External Review process would seriously jeopardize the claimant's life or health or the claimant's ability to regain maximum function, or if the Final Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.

Immediately upon receipt of a request for expedited External Review, the Plan must determine and notify the claimant whether the request satisfies the requirements for expedited review, including the eligibility requirements for External Review listed above. If the request qualifies for expedited review, it will be assigned to an IRO. The IRO must make its determination and provide a notice of the decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited External Review. If the original notice of its decision is not in writing, the IRO must provide written confirmation of the decision within 48 hours to both the claimant and the plan.