SUMMARY PLAN DESCRIPTION

OF THE

PORT OF HOUSTON AUTHORITY GROUP INSURANCE PLAN

(Amended and Restated Effective as of January 1, 2019)

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Port of Houston Authority of Harris County, Texas (the "**Plan Sponsor**") maintains the Port of Houston Authority Group Insurance Plan (the "**Plan**") for the benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers, if any. The Plan Sponsor has amended and restated the Plan effective as of January 1, 2019.

The Plan provides benefits to Participants, in accordance with the terms, conditions and limitations of the Plan. Terms of the Plan pertaining to eligibility, coverage, exclusions and limitations on coverage, and other rules pertaining to the benefits available under the Plan, are set forth herein and in the Welfare Program Documents (as defined herein) which are incorporated into this Summary Plan Description of the Plan (the "**SPD**") in their entirety by reference and attached hereto as Appendix B.

Please review this SPD carefully, including the Welfare Program Documents, before you assume that any expense you incur will be eligible for payment or reimbursement under the Plan. You should pay particular attention to the provisions in this SPD and the Welfare Program Documents concerning exclusions, limitations on coverage and precertification requirements.

The masculine gender of words used in this document includes the feminine gender, and words used in the singular include the plural, and vice-versa, when applicable. Terms with initial capital letters used in this SPD are defined in Article I.

FOREWORD

The benefits provided under the Plan are for the exclusive benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers of the Plan, if any. These benefits are intended to be continued indefinitely, however, the Plan Sponsor reserves the unilateral right and discretion to make any changes, without advance notice, to the Plan which it deems to be necessary or appropriate, in its discretion, to comply with applicable law, regulation or other authority issued by a governmental entity. The Plan Sponsor also reserves the unilateral right and discretion to amend, modify, or terminate, without advance notice, all or any part of the Plan and to make any other changes that it deems necessary or appropriate in its discretion. Changes in the Plan may occur in any or all parts of the Plan, including, but not limited to, benefit coverage, deductibles, maximums, copayments, exclusions, limitations, definitions, eligibility and the like, under any or all of the Welfare Programs identified in Appendix A. You should not, therefore, assume that the benefits which are provided under the Plan will continue to be available and remain unchanged, and you should disregard any information or communication (written or oral) that would seem to limit the Plan Sponsor's absolute right and discretion to terminate, suspend, discontinue or amend such benefits. Furthermore, the Plan Administrator and the Claims Fiduciary, as applicable, each reserve the absolute right, authority and discretion to interpret, construe, construct and administer the terms and provisions of the Plan, in their discretion, including correcting any error or defect, supplying any omission, reconciling any inconsistency, and making all findings of fact including, without limitation, any factual determination that may impact eligibility or a claim for benefits. Benefits under the Plan will be paid only if the Plan Administrator or Claims Fiduciary, as applicable, determines in its discretion that the Participant is entitled to them. All decisions, interpretations and other determinations of the Plan Administrator or Claims Fiduciary, as applicable, will be final, binding and conclusive on all persons and entities subject only to the claims appeal procedures of the Plan.

ARTICLE I
DEFINITIONS

The following terms, where capitalized, will have the meanings set forth below when used in this SPD and thus supersede any other meanings for the same terms set forth in the Welfare Programs, unless a different meaning is plainly required by the context:

1.1 **Affiliate** means an affiliate of the Employer, including: (a) any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer, (b) any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer, (c) any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer and (d) any other entity required to be aggregated with the Employer pursuant to Regulations under Code Section 414(o).

1.2 **Affordable Care Act** means the federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010 and subsequent amendments, and the authoritative guidance issued thereunder by the appropriate governmental entities.

1.3 **Beneficiary** means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

1.4 **Claims Administrator** means the third party administrator, insurance company or other entity, as set forth in Appendix C, designated by the Plan Administrator to determine eligibility for benefits, process claims and perform other administrative duties under the Plan or a Welfare Program.

1.5 **Claims Fiduciary** means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a particular Welfare Program. The "Claims Fiduciary" shall be the Plan Administrator unless otherwise set forth in Appendix C.

1.6 **COBRA Administrator** means the Plan Administrator, or the third party designated by the Plan Administrator to perform COBRA administration under the Plan on behalf of the Plan Administrator, as set forth in Appendix C.

1.7 **Code** means the Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code will also refer to any successor provision thereof.

1.8 **Dependent** means:

(a) An eligible Employee's Spouse;

(b) A Child (defined below) of an eligible Employee or an eligible Employee's Spouse, but only through the end of the month containing such Child's 26th birthday;

(c) A Child of an eligible Employee or an eligible Employee's Spouse, beginning with the month following the month containing such Child's 26th birthday, but only if such Child is dependent on the Employee or the Employee's Spouse because of a mental or physical handicap rendering the Child medically incapacitated and unable to be self-supportive ("**Disabled**"). The Child must satisfy either of the following requirements: (i) prior to the end of the month containing the Child's 26th birthday, the Child is Disabled and covered as a Dependent under the Plan or (ii) the Child is Disabled and over age 26 prior to the Child's parent first becoming eligible for coverage under the Plan, either as an Employee or as the Spouse of an Employee, and the Employee enrolls the Child in the Plan when the Employee first becomes eligible to enroll in such coverage (*i.e.*, such Disabled Child cannot later be added to coverage under the Plan). In addition, the Child must reside with the Employee in his household for more than one-half of the year, and the Child must not provide more than one-half of his own support for the year. Periodic proof of incapacity may be required by the Plan Administrator to continue coverage for the Child.

For purposes of determining eligibility for Dependent coverage, the term "Child" means a (i) biological child of an Employee, (ii) legally adopted child or a child placed for adoption with the Employee or Spouse, (iii) stepchild of an Employee, or (iv) child for whom the Employee or Spouse has a court appointed guardianship or conservatorship but only if such child primarily lives with the Employee and is a member of the Employee's household.

Any Child who does not meet one of the definitions in subsections (b) or (c) (above) will not be eligible for coverage under the Plan.

Notwithstanding the foregoing, if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of "Dependent" that is inconsistent with the definition in this Section 1.8, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

1.9 **Effective Date** means the effective date of the amendment and restatement of the Plan, *i.e.*, January 1, 2019.

1.10 **Employee** means any individual who is considered to be a common law employee of the Employer and on the payroll records of the Employer for purposes of federal income tax withholding under the Code, unless otherwise specifically provided in a Welfare Program. Except as otherwise specifically provided in a Welfare Program, the term "Employee" shall not include any person during any period that such person was classified on the Employer's records as other than an employee. In particular, it is expressly intended that out-sourced workers and individuals not treated as common law employees by the Employer on its payroll records are not Employees even if a court or administrative agency determines that such individuals are common law employees and not independent contractors. The term "Employee" shall not include anyone classified on the Employer's records as an independent contractor, agent, leased employee, contract employee, or similar classification, regardless of a determination by a governmental agency that any such person

is or was a common law employee of an Employer. For purposes of this definition, (a) a "leased employee" means any person, regardless of whether or not he is a "leased employee" as defined in Section 414(n)(2) of the Code, whose services are supplied by an employment, leasing, or temporary service agency and who is paid by or through an agency or third-party, and (b) an "independent contractor" means any person rendering service to the Employer and whom the Employer treats as an independent contractor by reporting payments for the person's services on IRS Form 1099 (or its successor), regardless of whether any agency (governmental or otherwise) or court concludes that the person is, or was, a common law employee of the Employer even if such determination has a retroactive effect.

Furthermore, notwithstanding anything to the contrary in a Welfare Program Document, the following categories of individuals shall not be considered "Employees" for any purposes of the Plan:

(a) *Union Employees*. Employees who are included in a unit of employees covered by a collective bargaining agreement between employee representatives and one or more Employers, if (A) there is evidence that the type of benefits provided under the Plan were the subject of good faith bargaining between the employee representatives and such Employer and (B) the collective bargaining agreement does not require the Employer to cover such employees under the Plan. For purposes of the preceding sentence, the term "employee representatives" shall not include any organization more than one-half of the members of which are employees who are owners, officers or executives of the Employer.

(b) *Part-time/Temporary/Seasonal/As-needed Employees*. As-needed employees, part-time employees, temporary employees, seasonal employees, or interns (which individually or collectively may be referred to by the Employer as "casual" employees), defined as follows:

(i) A "part-time employee" is an employee who is regularly scheduled to work for an Employer for less than 30 Hours of Service per week (or less than 130 Hours of Service per month).

(ii) A "seasonal employee" is an employee hired into a position with an Employer for which the customary annual employment is six months or less during the same part of the year, such as fall, spring, or summer. A seasonal employee's employment pertains to a certain season or period of the year which, by nature, may not be continuous or carried on throughout the year. Seasonal employees include, but are not limited to, summer interns.

(iii) A "temporary employee" is an employee who is hired to perform services for an Employer for a period which, as of the employee's start date, is not expected to exceed nine months, as determined by the Employer.

(iv) An "as-needed employee" is an employee who do not have regular or systematic hours of work or an expectation of continuing work. A typical as-needed employee is employed on a daily basis when the need arises.

(c) *Other*: Individuals paid for their work for the Employer through the payroll of the West Gulf Maritime Association, individuals who perform work for the Employer as members of Local 24, 28, or 1351 of the International Longshoreman's Association (ILA), and co-op workers.

1.11 Employer means the Plan Sponsor, or any of its Affiliates which have adopted the Plan with the consent of the Plan Sponsor. As of the Effective Date, the Plan Sponsor is the only Employer which has adopted and is participating in the Plan.

1.12 Fully-Insured Program means each Welfare Program that is fully-insured with an insurance carrier. The Fully-Insured Programs of the Plan are listed in Appendix A to this SPD.

1.13 HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended.

1.14 Participant means an Employee of the Employer who (a) meets the requirements for eligibility as set forth in Article III and (b) properly enrolls for coverage under the Plan. The term "Participant" also includes any Dependent of a person specified in the immediately preceding sentence who is properly enrolled for coverage under the Plan. A person will cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.

1.15 Participant Contribution means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" thus includes, but is not limited to, contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer as well as contributions used to purchase coverage under the Policies.

1.16 PHSA means the Public Health Service Act of 1944, as amended.

1.17 Plan means the Port of Houston Authority Group Insurance Plan, which consists of (a) the Plan Document, (b) the insurance policies set forth in the Policy Appendix to the Plan Document and incorporated therein by reference, (c) this SPD (including all appendices attached hereto), and (d) each Welfare Program Document incorporated herein by reference, as all such documents may be modified, amended, supplemented, or superseded from time to time. The Plan Document, Policies, SPD and Welfare Program Documents are incorporated by reference and collectively contain all the terms and provisions of the Plan and together constitute the entire Plan.

1.18 Plan Document means the wrap-around Plan document (including all appendices attached thereto), as may be amended from time to time, into which the Policies, this SPD document, and the Welfare Program Documents are incorporated by reference to together form the Plan.

1.19 Plan Administrator means the person or entity which has the authority and responsibility, as exercised in its discretion, to manage and direct the operation of the Plan. The Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator or

the Claims Fiduciary, under the terms of either the Plan or any Welfare Program, or by means of a separate written agreement. The Plan Sponsor shall be the "Plan Administrator" of the Plan.

1.20 **Plan Sponsor** means the Port of Houston Authority of Harris County, Texas, or its successor in interest.

1.21 **Plan Year** means each twelve (12) month calendar year commencing January 1st and ending on December 31st.

1.22 **Policy** means a group insurance policy or contract issued by an insurance carrier to the Plan Sponsor (or another Employer), pursuant to which employee welfare benefits under the Plan are provided to Participants, including any amendments, endorsements, or riders thereto and which is incorporated, in its entirety, into the Plan document by reference. The Policies are listed in the Policy Appendix attached to the Plan Document.

1.23 **SPD** means this Summary Plan Description document, including all appendices attached hereto, and each Welfare Program Document incorporated herein by reference, as all such documents may be modified, amended, supplemented, or superseded from time to time, and all of which are incorporated into the Plan by reference and together contain the entire terms and provisions of the Plan.

1.24 **Spouse** means a person to whom an Employee is lawfully married, which marriage was solemnized, authenticated and recorded as required by the state or foreign jurisdiction in which the marriage took place, to the extent such marriage is legally recognized as valid for purposes of applicable Federal law (including, but not limited to, the Code and the Affordable Care Act), and any regulations promulgated under such applicable Federal law, but will not include an individual divorced from the Employee under a court-approved divorce decree. The term "Spouse" will also include a common law spouse if the Employee and spouse became common law married in a state which recognizes common law marriages and meet all the requirements for common law marriage in that state. The Employee must provide proof of a ceremonial or common law marriage if requested by the Plan Administrator, such as, for example, an affidavit of marriage, or a marriage license or certificate of common law marriage issued by the applicable state. Notwithstanding the foregoing, if the applicable Welfare Program Document for a Fully-Insured Program provides a definition of "Spouse" that is inconsistent with the definition in this Section 1.24, the definition in such Welfare Program Document will control for purposes of that Fully-Insured Program.

1.25 **Welfare Program** means a program of benefits that is offered by an Employer under the Plan to provide group health or other welfare benefits coverage to eligible individuals. The Welfare Programs are incorporated into this SPD which, in turn, is incorporated into the Plan. Each Welfare Program under the Plan is identified in Appendix A of this SPD. The Plan Sponsor may add or delete a Welfare Program from the Plan by amending Appendix A without the need for a formal amendment to the Plan.

1.26 **Welfare Program Document** means a written arrangement, including (a) a benefits booklet, summary of coverage, plan document or summary plan description, including any

amendments, riders or attachments thereto, (b) an insurance contract between an Employer and an insurance company, health maintenance organization (HMO), administrative service organization (ASO) or other organization to provide certain group health benefits, including any amendments, endorsements or riders thereto, or (c) a certificate of coverage, schedule of benefits, notice or other instrument under which a Welfare Program is established, operated or maintained. Each of the documents referenced in items (a), (b) and (c) (above) is attached to this SPD as part of Appendix B and which is incorporated, in its entirety, herein by reference. A Welfare Program Document (or any portion thereof) will not, in and of itself, constitute either the written "Plan document" or the "Summary Plan Description" of the Plan, notwithstanding any references in any Welfare Program Document to the contrary; provided, however, each Welfare Program Document does contain certain of the terms and provisions of the Plan. Any reference to a Welfare Program Document also refers to any amendment, rider, exhibit or attachment thereto.

ARTICLE II
INTERPRETATION

Notwithstanding any reference in a Welfare Program Document that such Welfare Program Document, in and of itself (or any portion thereof), constitutes a "summary plan description" of the Plan, the official SPD consists of this document (including all appendices attached hereto) and the Welfare Program Documents incorporated herein by reference. If any term or provision of this SPD document conflicts with a term or provision of a Welfare Program Document, the term or provision of this SPD document will control unless specifically stated otherwise herein. Further, if a term or provision of this SPD document conflicts with any term or provision of the Plan Document, then the term or provision of the Plan Document will control and govern.

Notwithstanding the foregoing, if there is a conflict between a term or provision of the Plan Document, a Policy, a Welfare Program Document or this SPD, and such conflict involves a term or provision required by the Code or other controlling law, on the one hand, and a term or provision not so required on the other, the term or provision required by controlling law will control and govern. This determination will be made by the Plan Administrator in the exercise of its discretion. The terms and provisions of this SPD shall not enlarge the rights of a Participant, Dependent, or Beneficiary to any benefit available under a Welfare Program.

The terms and provisions of the Plan include the terms and provisions of the Plan Document, the Policies listed in the Policy Appendix to the Plan Document, the SPD, and the Welfare Program Documents.

ARTICLE III
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

(a) *General*. A full-time Employee who is regularly scheduled to work at least 30 hours per week is eligible to participate in the Plan. An eligible Employee may enroll an individual in the Plan in accordance with the Plan's enrollment procedures if such individual satisfies the definition of "Dependent" specified in Article I.

Subject to the foregoing provisions of this Section 3.1(a), an Employee or Dependent will be eligible to participate in the Plan only if and to the extent such person is eligible with respect to the particular benefit in question under a Welfare Program specified in Appendix A. A Welfare Program also (a) designates the Dependent or Beneficiary of an Employee who is eligible to receive benefits under the Plan, and (b) sets forth the criteria for coverage thereunder.

(b) *Leave of Absence*. An Employee who is not in active service due to a leave of absence as designated by the Employer (a "**LOA Employee**") may be eligible to continue participation in the Plan during such leave of absence for himself and for any of his Dependents who were Participants at the time the Employee ceased to be in active service, subject to the following:

(i) A LOA Employee's right to elect to continue participation in the Plan, the duration of any such continued participation, the Participant Contribution that may be charged during such leave of absence, and other terms and conditions of continued participation in the Plan during an approved leave of absence will be determined in accordance with the Employer's employee leave of absence policy as then in effect and which may be amended from time to time;

(ii) The provisions of this Section 3.1(b) shall be subject to, and construed in accordance with, the requirements of the FMLA and USERRA when applicable; and

(iii) If the continuation provisions specified in the Welfare Program Document for a Fully-Insured Program are inconsistent with the provisions of this Section 3.1(b), the continuation provisions in such Welfare Program Document will control for purposes of that Fully-Insured Program.

(c) *Substantiation*. At any time, the Plan Administrator may require acceptable proof that a Spouse or other claims Dependent qualifies, or continues to qualify, as a Dependent under the Plan. An Employee or Dependent may be required to reimburse the Plan for any benefits or reimbursements provided to an individual as a Dependent at a time when he did not satisfy the Plan's Dependent eligibility requirements. The Plan may require an Employee or Dependent to make such reimbursement according to the provisions of Section 9.7 of this SPD.

3.2 Enrollment.

An Employee who wishes to enroll himself and his eligible Dependents for coverage under the Plan when he first becomes eligible shall:

(a) Complete any benefits enrollment forms ("Forms"), written or electronic, as may be required by the Plan Administrator to name himself and each of his Dependents, if any, to be covered;

(b) Submit the completed Forms, in paper or online, as directed by the Plan Administrator;

(c) Agree to make any required contributions as indicated in the Plan enrollment documents.

For each person to be covered by the Plan, the required Forms must be completed by the Employee and received and accepted by the Plan Administrator no later than 30 consecutive days from the Employee's initial eligibility date. All required documentation, if any, must be included with the Forms and all eligibility requirements must have been met. If a Welfare Program does not require affirmative enrollment by an eligible Employee and automatically enrolls all eligible Employees and Dependents, then coverage under such Welfare Program will be effective as of the date of initial eligibility.

If the Forms are received and accepted within 30 days of the Employee's initial date of eligibility, coverage for the Employee and his Dependents will be effective on the Employee's initial date of eligibility. If an Employee does not enroll for coverage within 30 days of his initial eligibility date, the Employee may only enroll himself and his eligible Dependents during any "special enrollment" period under HIPAA (if the eligibility requirements for "special enrollment", as specified herein, are met) or any late or annual enrollment period, as provided in this document or a Welfare Program Document.

When requesting enrollment of a Dependent for coverage under the Plan, an Employee must submit documentation as requested by the Plan Administrator, and in accordance with the Plan Administrator's procedures and timeframes, to prove the status of such Dependent (*e.g.*, a marriage certificate for enrollment of a Spouse, or a birth certificate for enrollment of a Child). To the extent the Employee fails to submit the requested documentation as required, the Dependent will be deemed ineligible for coverage and his or her coverage may be denied or terminated.

3.3 Termination of Participation.

A Participant will cease being a Participant in the Plan and coverage under the Plan for the Participant and his or her Dependents and Beneficiaries shall terminate in accordance with the provisions of the specific Welfare Program. Notwithstanding the foregoing, a termination of coverage may only be effective retroactively if the Participant or Dependent (a) performs an act, practice or omission that constitutes fraud, (b) makes an intentional misrepresentation of material fact, or (c) fails to make a required Participant Contribution when due, or as otherwise permitted under the Affordable Care Act and the authoritative guidance issued thereunder.

Notwithstanding anything to the contrary contained herein or in a Welfare Program Document, the Plan Administrator reserves the right to terminate or deny coverage under the Plan to any individual who obtains or attempts to obtain benefits under the Plan or any other Employer benefit plan in a fraudulent manner, as determined by the Plan Administrator in its sole discretion and to its reasonable satisfaction. Examples of fraud that may result in termination or denial of an individual's coverage under the Plan include, but are not limited to, (a) the enrollment of an individual who does not meet the Plan's Dependent eligibility requirements, and (b) intentionally or negligently providing false or misleading information to the Plan Administrator or its delegate. The Plan Administrator further reserves the right to terminate or deny coverage under the Plan to any individual who is determined to have engaged in gross misconduct in regard to the individual's relationship with Employer, including, but not limited to, actions threatening the safety of others,

malicious use or theft of Employer property, falsification or forgery of documents, or unlawful harassment or discrimination, as determined by the Plan Administrator in its sole discretion and to its reasonable satisfaction.

ARTICLE IV
FUNDING

Notwithstanding anything contained herein or in a Welfare Program Document to the contrary, participation in the Plan by a Participant and the payment of Plan benefits will be conditioned on such Participant Contributions towards the cost of coverage under the Plan at such time and in such amounts as the Plan Administrator will establish from time to time. The Plan Administrator shall designate the applicable method by which the Participant must make any Participant Contributions, and the Participant must consent in writing (including electronically, as applicable) to such payment method to remain covered under the Plan. Nothing herein requires an Employer or the Plan Administrator to contribute to or under the Plan, or to maintain any fund or segregate any amount for the benefit of any Participant, Dependent, or Beneficiary, except to the extent specifically required under the terms of a Welfare Program. No Participant, Employee, Dependent, or Beneficiary will have any right to, or interest in, the assets of any Employer as the result of coverage under the Plan until actually paid.

Benefits or premiums for the Plan will be provided through a trust, insurance contracts, Policies, or through the general assets of the Employer in accordance with the terms of the relevant Welfare Program. An Employer will have no obligation, but will have the right, to insure or reinsure or to purchase stop loss coverage, where applicable, with respect to any Welfare Program under the Plan. To the extent that the Plan is provided through an Employer's purchase of insurance, payment of any benefits under such Welfare Program will be the sole responsibility of the insurer, and the Employer will have no responsibility for such payment.

ARTICLE V
BENEFITS

The actual terms and conditions of eligibility, coverage, exclusions, and limitations on coverage, and the additional rules pertaining to the benefits of Participants under the Plan, are set forth herein and in the Welfare Program Documents. Any maximum benefit amounts, deductibles, copayments, out-of-pocket maximum amounts, and the reimbursement percentages for eligible charges under the Plan are contained in the Welfare Program Documents, as they may be amended from time to time. The Welfare Program Documents, as then currently in effect, are incorporated in their entirety by reference into this SPD which, in turn, is incorporated by reference into the Plan.

ARTICLE VI
CLAIMS PROCEDURES

A claim for benefits under a Welfare Program, or an appeal of any adverse benefit determination under a Welfare Program, must be submitted in accordance with, and to the party designated under, the terms of such Welfare Program. To the extent that a Welfare Program is

subject to the Affordable Care Act, such Welfare Program will comply with the requirements of Section 2719 of the PHSA with respect to its appeals processes.

ARTICLE VII
AMENDMENT OR TERMINATION

The provisions of this Article VII will govern and control amendment and termination of the Plan, and will supersede any conflicting or inconsistent provisions set forth in a Welfare Program Document.

7.1 Right to Amend.

The Plan Sponsor, and any officer of the Plan Sponsor who is duly authorized by the Plan Sponsor for this purpose, will each have the right, authority, and power to make, at any time, and from time to time, any amendment to the Plan; provided, however, no amendment will prejudice any claim under the Plan that was incurred but not paid prior to the effective date of the amendment, unless the person or entity responsible for the amendment, as applicable, determines such amendment is necessary or desirable to comply with applicable law or is required under the particular Welfare Program. Moreover, if the Plan is amended, a Participant's right to receive coverage for expenses incurred for supplies or services that were actually received or actually rendered on his behalf before the effective date of such amendment will not be reduced or eliminated. However, an amendment may reduce or eliminate a Participant's right to receive coverage for expenses that are or will be incurred for supplies or services that are received or rendered on or after the effective date of the amendment, even if such supplies or services were approved or are part of a series of treatments or services that began prior to such effective date.

7.2 Right to Terminate.

The Plan Sponsor will have the right, authority, power, and discretion to terminate the Plan at any time, in whole or in part, without prior notice, to the extent deemed advisable in its discretion; provided, however, such termination will not prejudice any claim under the Plan that was incurred but not paid prior to the termination date unless the Plan Sponsor determines it is necessary or desirable to comply with applicable law.

ARTICLE VIII
RIGHT OF SUBROGATION AND REIMBURSEMENT

The provisions of this Article VIII will govern and control the Plan's rights to subrogation and reimbursement, and will supersede any subrogation and reimbursement provisions set forth in any Welfare Program Document (other than a Welfare Program Document for a Fully-Insured Program) to the extent that such other provisions are more restrictive or limited regarding the rights of the Plan than are these provisions. The Plan reserves all its subrogation and reimbursement rights, at law and in equity, to the full extent not contrary to applicable law as determined by the Plan Administrator.

The Plan Administrator may, in its discretion, designate a third party service provider or other person or entity to exercise the rights described in this Article VIII on behalf of the Plan. In addition, the Plan Administrator may, in its discretion and on a case-by-case basis, waive or limit

any of the subrogation and reimbursement rights set forth in this Article VIII on behalf of the Plan to the extent deemed appropriate. Any such waiver or limitation in a particular case will not limit or diminish in any way the Plan's rights in any other instance or at any other time.

8.1 Benefits Subject to this Provision

This Article VIII will apply to all benefits provided under the Plan, except for those provided under a Fully-Insured Program. For purposes of this Article VIII, certain terms are defined as follows:

(a) "**Recovery**" means any and all monies and property paid by a Third Party to (1) the Participant, (2) the Participant's attorney, assign, legal representative, or Beneficiary, (3) a trust of which the Participant is a beneficiary, or (4) any other person or entity on behalf of the Participant, by way of judgment, settlement, compromise or otherwise (no matter how those monies or property may be characterized, designated or allocated and irrespective of whether a finding of fault is made as to the Third Party) to compensate for any losses or damages caused by, resulting from, or in connection with, the injury or illness.

(b) "**Reimbursement**" means repayment to the Plan for medical or other benefits that it has paid to or on behalf of the Participant toward care and treatment of the injury or illness and for the expenses incurred by the Plan in collecting this amount, including the Plan's equitable rights to recovery.

(c) "**Subrogation**" means the Plan's right to pursue the Participant's claims against a Third Party for any or all medical or other benefits or charges paid by the Plan.

(d) "**Third Party**" means any individual or entity, other than the Plan, who is or may be liable, or legally or equitably responsible, to pay expenses, compensation or damages in connection with a Participant's injury or illness. The term "Third Party" may include the party or parties who caused the injury or illness; the insurer, guarantor or other indemnifier or indemnitor of the party or parties who caused the injury or illness; a Participant's own insurer, such as an uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or entity that is or may be liable or legally or equitably responsible for Reimbursement or payment in connection with the injury or illness.

8.2 When this Provision Applies

A Participant may incur medical or other charges related to any injury or illness caused by the act or omission of a Third Party. Consequently, such Third Party may be liable, or legally or equitably responsible, for payment of charges incurred in connection with the injury or illness. If so, the Participant may have a claim against that Third Party for payment of the medical or other charges. In that event, the Plan will be secondary payer, not primary, and the Plan will be Subrogated to all rights the Participant may have against that Third Party.

Furthermore, the Plan will have a right of first and primary Reimbursement enforceable by an equitable lien against any Recovery paid by the Third Party. The equitable lien will be equal to 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and

expenses incurred by the Plan in enforcing the provisions of this Article VIII (including, without limitation, attorneys' fees and costs of suit, and without regard to the outcome of such an action), regardless of whether or not the Participant has been made whole by the Third Party. This equitable lien will attach to the Recovery regardless of whether (a) the Participant receives the Recovery or (b) the Participant's attorney, a trust of which the Participant is a beneficiary, or other person or entity receives the Recovery on behalf of the Participant. This right of Reimbursement enforceable by an equitable lien is intended to entitle the Plan to equitable relief under applicable law, and will be construed accordingly.

As a condition to receiving benefits under the Plan, the Participant hereby agrees to immediately notify the Plan Administrator, in writing, of whatever benefits are payable under the Plan that arise out of any injury or illness that provides, or may provide, the Plan with Subrogation and/or Reimbursement rights under this Article VIII.

The Plan's equitable lien supersedes any right that the Participant may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Participant procures, or may be entitled to procure, regardless of whether the Participant has received compensation for any or all of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first and primary Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise. The Plan is not responsible for a Participant's legal fees and costs, is not required to share in any way for any payment of such fees and costs, and its equitable lien will not be reduced by any such fees and costs. As a condition to coverage and receiving benefits under the Plan, the Participant agrees that acceptance of benefits, as well as participation in the Plan, is constructive notice of the provisions of this Article VIII, and Participant hereby automatically grants an equitable lien to the Plan to be imposed upon and against all rights of Recovery with respect to Third Parties, as described above.

In addition to the foregoing, the Participant:

(a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VIII apply;

(b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and

(c) Must cooperate fully with the Plan in its exercise of its rights under this Article VIII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

Furthermore, the Plan Administrator reserves the absolute right and discretion to require a Participant who may have a claim against a Third Party for payment of medical or other charges that were paid, or are payable, by the Plan to execute and deliver a Subrogation and Reimbursement agreement acceptable to the Plan Administrator (including execution and delivery of a Subrogation and Reimbursement agreement by any

parent or guardian on behalf of a covered Dependent, even if such Dependent is of majority age) and, subject to Section 8.5, that acknowledges and affirms: (1) the conditional nature of medical or other benefits payments which are subject to Reimbursement and (2) the Plan's rights of full Subrogation and Reimbursement, as provided in this Article VIII ("**S&R Agreement**").

When a right of Recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for the same or other illnesses or injuries), the Participant will execute and deliver all required instruments and papers, including any S&R Agreement provided by the Plan, as well as doing and providing whatever else is needed, to secure the Plan's rights of Subrogation and Reimbursement, before any medical or other benefits will be paid by the Plan for the injury or illness. The Plan may file a copy of an S&R Agreement signed by the Participant and his attorney (and if applicable, signed by the parent or guardian on behalf of the covered Dependent) with such other entities, or the Plan may notify any other parties of the existence of Plan's equitable lien; provided, the Plan's rights will not be diminished if it fails to do so.

To the extent the Plan requires execution of an S&R Agreement by a Participant (and his attorney, as applicable), a Participant's claim for any medical or other benefits for any injury or illness will be incomplete until an executed S&R Agreement is submitted to the Plan Administrator. Such S&R Agreement must be submitted to the Plan Administrator within the timeframe applicable to the particular type of benefits claimed by the Participant, as specified in the Plan's claims procedures. Any failure to timely submit the required S&R Agreement in accordance with the Plan's claims procedures will constitute the basis for denial of the Participant's claim for benefits for the injury or illness, and will be subject to the Plan's claims appeal procedures.

The Plan Administrator may determine, in its sole discretion, that it is in the Plan's best interests to pay medical or other benefits for the injury or illness before an S&R Agreement and other papers are signed and actions taken (for example, to obtain a prompt payment discount); however, in that event, any payment by the Plan of such benefits prior to or without obtaining a signed S&R Agreement or other papers will not operate as a waiver of any of the Plan's Subrogation and Reimbursement rights and the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Participant will do nothing to prejudice the Plan's right to Subrogation and Reimbursement, and hereby acknowledges that participation in the Plan precludes operation of the "made-whole" and "common-fund" doctrines. A Participant who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount of benefits paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit, regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant who receives any such Recovery and does not immediately tender the Recovery to the Plan will be deemed to hold such Recovery in constructive trust for the Plan because the Participant is not the rightful owner of such Recovery to the extent the Plan has not been fully reimbursed. By participating in the Plan, or receiving benefits under the Plan, the Participant automatically agrees, without further notice, to all the terms and conditions of this Article VIII and any S&R Agreement.

The Plan Administrator has maximum discretion to interpret the terms of this Article VIII and to make changes in its interpretation as it deems necessary or appropriate.

8.3 Amount Subject to Subrogation or Reimbursement

Any amounts Recovered will be subject to Subrogation or Reimbursement, even if the payment the Participant receives is for, or is described as being for, damages other than medical expenses or other benefits paid, provided or covered by the Plan. This means that any Recovery will be automatically deemed to first cover the Reimbursement, and will not be allocated to or designated as reimbursement for any other costs or damages the Participant may have incurred, until the Plan is reimbursed in full and otherwise made whole. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount. The Plan has a right to recover in full, without reduction for attorneys' fees, costs, comparative negligence, limits of collectability or responsibility, or otherwise, even if the Participant does not receive full compensation for all of his charges and expenses.

8.4 When Recovery Includes the Cost of Past or Future Expenses

In certain circumstances, a Participant may receive a Recovery that includes amounts intended to be compensation for past and/or future expenses for treatment of the illness or injury that is the subject of the Recovery. The Plan will not cover any expenses for which compensation was provided through a previous Recovery. This exclusion will apply to the full extent of such Recovery or the amount of the expenses submitted to the Plan for payment, whichever is less. Participation in the Plan also precludes operation of the "made-whole" and "common-fund" doctrines in applying the provisions of this Article VIII.

It is the responsibility of the Participant to inform the Plan Administrator when expenses incurred are related to an illness or injury for which a Recovery has been made. Acceptance of benefits under the Plan for which the Participant has already received a Recovery will be considered fraud, and the Participant will be subject to any sanctions determined by the Plan Administrator, in its sole discretion, to be appropriate. The Participant is required to submit full and complete documentation of any such Recovery in order for the Plan to consider eligible expenses that exceed the Recovery.

8.5 When a Participant Retains an Attorney

If the Participant retains an attorney, the Plan will not pay any portion of the Participant's attorneys' fees and costs associated with the Recovery, nor will it reduce its Reimbursement pro-rata for the payment of the Participant's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

The Plan Administrator reserves the absolute right and discretion to require the Participant's attorney to sign an S&R Agreement as a condition to any payment of benefits under the Plan and as a condition to any payment of future benefits under the Plan for the same or other illnesses or injuries. Additionally, pursuant to such S&R Agreement, the Participant's attorney must acknowledge and consent to the fact that the "made-whole" and "common fund" doctrines

are inoperable under the Plan, and the attorney must agree not to assert either doctrine in his pursuit of Recovery.

Any Recovery paid to the Participant's attorney will be subject to the Plan's equitable lien, and thus an attorney who receives any Recovery has an absolute obligation to immediately tender the Recovery (to the extent of 100% of the amount paid by the Plan for the Participant's injury or illness and expenses incurred by the Plan in enforcing the provisions of this Article VIII, including attorneys' fees and costs of suit regardless of an action's outcome) to the Plan under the terms of this Article VIII. A Participant's attorney who receives any such Recovery and does not immediately tender the recovery to the Plan will be deemed to hold the Recovery in constructive trust for the Plan because neither the Participant nor his attorney is the rightful owner of the Recovery to the extent the Plan has not received full Reimbursement.

8.6 When the Participant is a Minor, is Deceased, is a COBRA Qualified Beneficiary or is a Dependent

The provisions of this Article VIII apply to the parents, trustee, guardian or other representatives of a minor Participant and to the heirs or personal representatives of the estate of a deceased Participant, regardless of applicable law and whether or not the representative has access to or control of the Recovery. For purposes of this Article VIII, the term "**Participant**" will also include a COBRA Qualified Beneficiary (as defined in Section 10.1) who has elected COBRA Continuation Coverage under the Plan. If a covered Dependent is the Participant whose benefits under the Plan are subject to the Plan's Subrogation and Reimbursement rights, the covered Employee who enrolled such Dependent under the Plan will also be required to execute the S&R Agreement, upon request, even if the Dependent is not a minor (*e.g.*, a full time post-secondary student) and, in such event, the Employee will be liable for any breach of this Article VIII by the Employee or by such Dependent.

8.7 When a Participant Does Not Comply

When a Participant does not comply with the provisions of this Article VIII, the Plan Administrator will have the power and authority, in its sole discretion, to (1) deny payment of any claims for benefits by or on behalf of the Participant and (2) deny or reduce future benefits payable (including payment of future benefits for the same or other injuries or illnesses) under the Plan by the amount due as Reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for the same or other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required Reimbursement. If the Plan must bring an action against a Participant to enforce the provisions of this Article VIII, the Participant will be obligated to pay the Plan's attorneys' fees and costs regardless of the action's outcome.

ARTICLE IX
ADMINISTRATION

9.1 Allocation of Authority.

The Plan Administrator will control and manage the operation and administration of the Plan, except to the extent such duties have been delegated to other persons or entities as provided

in the Plan or this SPD. Any decisions made by the Plan Administrator or Claims Fiduciary (or any other person or entity delegated authority by the Plan Administrator or Claims Fiduciary, as applicable, to determine benefits in accordance with the Plan) will be final and conclusive on all Participants, and all other persons and entities, subject only to the claims appeal provisions of the Plan. Neither the Plan Administrator nor any Employee will receive any compensation from the Plan with respect to services provided under the Plan, except an Employee may be entitled to benefits hereunder.

9.2 Powers and Duties of Plan Administrator.

The Plan Administrator (as well as the Claims Fiduciary, but only with respect to reviewing and making decisions regarding claims under a Welfare Program) will each have such powers as may be necessary to discharge its duties hereunder, including, but not by way of limitation, the following:

(a) to have final discretionary authority to (1) administer, enforce, construe, and construct the Plan, including the Welfare Program Documents, (2) make decisions relating to all questions of eligibility to participate, and (3) make a determination of benefits including without limitation, reconciling any inconsistency, correcting any defect, supplying any omission, and making all findings of fact;

(b) to prescribe procedures to be followed by Participants filing applications for benefits;

(c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;

(d) to receive from the Employer and from Participants such information as deemed to be necessary or appropriate for the proper administration of the Plan;

(e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as deemed to be necessary or appropriate;

(f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;

(g) to exercise such authority and responsibility as it deems to be necessary or appropriate in order to comply with the terms of the Plan relating to the records of Participants, including, without limitation, an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors, or other agents as it may select, in its discretion, for that purpose; and

(h) to appoint persons or entities to assist in the administration as it deems to be advisable in its discretion; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by prior interpretations or other evidence of intent, or as determined by

the Plan Administrator in its sole and exclusive judgment, the provision will be considered ambiguous and will be interpreted by the Plan Administrator (or the Claims Fiduciary if applicable) in a fashion consistent with its intent, as determined by the Plan Administrator (or the Claims Fiduciary if applicable). The Plan may be amended retroactively to cure any such ambiguity, notwithstanding anything in the Plan to the contrary.

The Plan Administrator (or Claims Fiduciary if applicable) may rely upon the direction or information from a Participant relating to such Participant's entitlement to benefits hereunder as being proper under the Plan, and will not be responsible for any act or failure to act. Neither the Plan Administrator nor the Employer makes any guarantee to any Employee in any manner for any loss or damage that may result from the Employee's participation in the Plan.

All decisions, interpretations, determinations, and actions in the exercise of the powers and duties described in this Section will be final and conclusive on all interested persons and entities subject only to the claims appeal provisions of the Plan. Benefits under the Plan will be paid only if the Plan Administrator (or Claims Fiduciary if applicable) determines in its discretion that the Participant is entitled to them.

9.3 Delegation by the Plan Administrator.

The Plan Administrator may delegate to other persons or entities any of the administrative functions relating to the Plan, together with all powers necessary to enable its designee(s) to properly carry out such duties hereunder, including, without limitation, delegation to the Claims Administrator, the Claims Fiduciary and the Disclosure Administrator. The Plan Administrator may employ such counsel, accountants, Claims Administrators, Claims Fiduciaries, consultants, actuaries, and such other persons or entities as it deems advisable in its discretion. The Plan Administrator, as well as any person to whom any duty or power in connection with the operation of the Plan is delegated, may rely upon all valuations, reports, and opinions furnished by any accountant, consultant, third-party administration service provider, legal counsel, or other specialist. Moreover, the Plan Administrator and any such delegate who is also an Employee will be fully protected in respect to any action taken or permitted in good faith in reliance on such information.

9.4 Rules and Decisions.

The Plan Administrator may adopt such rules and procedures, as it deems to be necessary or appropriate for the proper administration of the Plan. The Plan Administrator will be entitled to rely upon information furnished to it which appears proper without the necessity of any independent verification or investigation.

9.5 Facility of Payment for Incapacitated Participant.

Whenever, in the Claims Fiduciary's opinion, a Participant is entitled to receive any payment of a benefit hereunder and is under a legal disability or is incapacitated in any way so as to be unable to manage his own financial affairs (including physical and mental incompetence or status as a minor), the Claims Fiduciary may direct payments to such person or to the person's legal representative (such as a guardian or conservator, upon proper proof of appointment

furnished to the Claims Fiduciary), Dependent, or relative of such person for such person's benefit. Alternatively, the Claims Fiduciary may direct payment for the benefit of such person in such manner as the Claims Fiduciary deems to be advisable in its discretion. Any payment of a benefit, to the full extent thereof, that is made in accordance with the provisions of this Section 9.5 will be a complete discharge of any liability for the making of such payment under the Plan.

9.6 Assignment and Payment of Benefits.

The provisions of this Section 9.6 shall supersede any provisions of a Welfare Program Document (other than the Welfare Program Document(s) of a Fully-Insured Program) but only with respect to the subject matter hereof, and shall govern and control.

Except as otherwise expressly provided under the terms of a written agreement with a provider of healthcare services or supplies to which the Plan Administrator, the Claims Fiduciary, or other delegate of the Plan Administrator is a named party (a "**Plan Agreement**"), no rights and benefits under the Plan can be assigned or transferred to any person or entity, including, but not limited to, an out-of-network healthcare provider (or any representative or agent with respect to such provider), either before or after healthcare services or supplies are provided to or on behalf of a Participant. In the absence of a Plan Agreement which specifically provides for assignment of the Participant's benefits and/or rights under the Plan (*i.e.*, is not merely an agreement between the Participant and the provider or its representative or agent), the Plan Administrator and Claims Fiduciary, as applicable, each reserve the unilateral right and discretion to elect to make any benefit payment under the Plan directly to the provider, the Participant, or to another designated person or entity, with each such payment being made on behalf of the Participant, and not to such payment recipient in its or his own right. Moreover, if the Plan Administrator or Claims Fiduciary, as applicable, elects to make any such direct payment, it shall not constitute a waiver by the Plan Administrator or Claims Fiduciary of the anti-assignment provisions of this Section 9.6. In addition, any payment made under the Plan to any such person or entity discharges the Plan's responsibility to the Participant for benefits under the Plan to the full extent of such payment.

Disclosures of information about the Participant can only be made to a Participant or a Participant's authorized representative and in accordance with applicable law and the terms of the Plan.

9.7 Overpayments.

If, for any reason, any benefit, premium or fee under the Plan is erroneously paid to a Participant or to a healthcare or other services provider (including an assignee of the Participant as described in Section 9.6), insurance company, or other person or entity for the benefit of a Participant (collectively, a "**Third-Party Payee**"), such person or entity shall be responsible for refunding the overpayment to the Plan. If such overpayment is not refunded within a reasonable time period as determined by the Plan Administrator, the overpayment shall be (a) charged directly to the Participant (including, without limitation, a covered Employee on behalf of any of his Dependents or Beneficiaries) or Third-Party Payee as a reduction of the amount of future benefits otherwise payable on behalf of the Participant, or (b) recouped by any other method which the Plan Administrator or Claims Fiduciary deems appropriate in its discretion. For example, the selected repayment method may include, without limitation, (i) payroll deduction in the case of an

Employee or his Dependent or Beneficiary (in which case the Employee must execute such forms authorizing payroll deduction as the Plan Administrator shall require as a mandatory condition of his participation, or continued participation, in the Plan) or (ii) offsetting other payments made by the Plan to, or on behalf of, the Participant or to the same Third-Party Payee (in which case, such payment offset to a Third-Party Payee shall not constitute an adverse benefit determination that is subject to the claims and appeals procedures of the Plan). For purposes of clarity and not limitation, in the event of the application of any overpayment recoupment to a Third-Party Payee pursuant to the foregoing provisions of this Section 9.7, the offset of the overpayment hereunder is an adjustment to the amount owed to the Third-Party Payee to reflect the overpayment and shall not be considered to be the denial or partial denial of a benefit claim under the Plan.

ARTICLE X
COBRA CONTINUATION COVERAGE

10.1 Definitions.

For purposes of this Article X only, the following definitions will apply:

(a) *COBRA* means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

(b) *Continuation Coverage* means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage will be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of the Plan are modified for Similarly Situated Beneficiaries, such coverage will also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to similarly situated Qualified Beneficiaries.

(c) *Continuation Coverage Contribution* means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for Continuation Coverage.

(d) *Continuation Coverage Period* means the applicable time period for which Continuation Coverage may be elected.

(e) *Covered Employee* means an individual who was covered under the Plan on the day prior to the Qualifying Event and who is or was provided such coverage by virtue of the individual's performance of services for one or more entities maintaining the Plan. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.

(f) *Open Enrollment Period* means a period during which an Employee covered under the Plan can choose to be covered under another plan or under another benefit option within the same plan, or add or eliminate coverage of family members.

(g) *Qualified Beneficiary* means a Covered Employee or Qualifying Dependent.

(h) *Qualifying Dependent* means:

(i) a Dependent covered under the Plan on the day prior to the Qualifying Event; or

(ii) a Dependent child who is born to, adopted or placed for adoption with a Covered Employee during the Covered Employee's period of COBRA Continuation Coverage; or

(iii) a child who is covered under the Plan on the day prior to the Qualifying Event pursuant to the terms of a qualified medical child support order.

(i) *Qualifying Event* means any of the following events which would otherwise result in a Covered Employee's or a Qualifying Dependent's loss of health coverage under the Plan in the absence of this provision:

(i) a Covered Employee's termination of employment, for any reason other than gross misconduct;

(ii) a Covered Employee's reduction in work hours resulting in a change of status such that the Covered Employee is no longer eligible to be a Covered Employee;

(iii) a Covered Employee's divorce or legal separation;

(iv) a Qualified Dependent ceasing to qualify as a Dependent under the provisions of the Plan;

(v) a Covered Employee's entitlement to benefits under Medicare;

(vi) the death of a Covered Employee; or

(vii) the failure of a Covered Employee to return from FMLA leave (Note: the Covered Employee and family members will be entitled to COBRA Continuation Coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave); or

(viii) a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Employee retired at any time.

Note: A loss of health coverage under the Plan includes any increase in the premium or contribution that must be paid by the Covered Employee (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in Subsections (i)(i) – (i)(viii). The loss of coverage need not occur immediately after the event, so long as the loss of coverage occurs before the end of the maximum COBRA Continuation Coverage Period. If coverage is reduced or eliminated in anticipation of an event, such reduction or elimination is disregarded in determining whether the event causes a loss of coverage.

(j) *Similarly Situated Beneficiaries* means Employees or their Dependents, as applicable, who are Participants in the Plan.

10.2 Continuation of Benefits under COBRA.

Qualified Beneficiaries will have all continuation rights required by COBRA for group health plan benefits offered under the Welfare Programs within the Plan. To the extent a Welfare Program offering health benefits does not specify COBRA rights in accordance with Subchapter XX of Title 42 of the U.S. Code, the Plan will be administered in accordance with Subchapter XX of Title 42 of the U.S. Code and as set forth in this Article X. In addition, the Plan Administrator will adopt such policies and provide such forms, as it deems advisable to implement the rights contemplated by this Section 10.2.

10.3 Election of COBRA Coverage.

(a) *COBRA Continuation Coverage for Terminated Employees.*

A Qualified Beneficiary who is a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of either of the following Qualifying Events: termination of employment (other than for gross misconduct) or reduction of hours of employment with the Employer.

(b) *COBRA Continuation Coverage for Qualifying Dependent.*

Subject to Section 10.6, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Employee may elect COBRA Continuation Coverage, at his own expense, if:

(i) his participation under the Plan would terminate as a result of a Qualifying Event; or

(ii) the Qualifying Dependent is a child born to, adopted or placed for adoption with the Covered Employee during the Covered Employee's period of COBRA Continuation Coverage.

(c) *Enrollment for COBRA Continuation Coverage.*

A Qualified Beneficiary (or a third party on behalf of the Qualified Beneficiary) must complete and return the required enrollment materials within a maximum of sixty (60) days from the later of:

(i) loss of coverage; or

(ii) the date the Plan Administrator sends notice of eligibility for COBRA Continuation Coverage.

Failure to enroll for COBRA Continuation Coverage during this maximum sixty (60) day period will terminate all rights to COBRA Continuation Coverage under this Article X. A separate election as to what health coverage, if any, is desired may be made by or on behalf of each

Qualified Beneficiary. However, an affirmative election of COBRA Continuation Coverage by a Covered Employee or his Spouse will be deemed to be an election for that Covered Employee's Qualifying Dependents who would otherwise lose coverage under the Plan, unless the election specifically provides to the contrary. Elections for COBRA Continuation Coverage may be made by the Qualified Beneficiary or on his behalf by a third party (including a third party that is not a Qualified Beneficiary).

COBRA Continuation Coverage for a Qualified Beneficiary that is a child who is born to, adopted by or placed for adoption with a Covered Employee begins when the child is enrolled in the Plan, whether through special enrollment or open enrollment.

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA Continuation Coverage. However, if a waiver is later revoked, coverage will 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 made on the date they are sent to the Plan's "COBRA Administrator", at the address listed in Appendix C.

10.4 Period of COBRA Coverage.

A Qualified Beneficiary who qualifies for COBRA Continuation Coverage as a result of termination of employment (other than for gross misconduct) or reduction in hours of employment, may elect COBRA Continuation Coverage for up to eighteen (18) months measured from the date of the Qualifying Event. A Qualified Beneficiary who is a Covered Employee who is eligible for COBRA Continuation Coverage due to the bankruptcy of the Employer may continue COBRA Continuation Coverage until the date of the Covered Employee's death. A Qualified Beneficiary who is a Qualifying Dependent may continue COBRA Continuation Coverage (a) for up to thirty-six (36) months from the date of the Qualifying Event, or (b) if the Qualifying Event is the bankruptcy of the Employer, until the earlier of (i) the date of the Qualified Beneficiary's death or (ii) thirty-six (36) months from the date of the Covered Employee's death.

Coverage under this Section 10.4 may not continue beyond:

(a) the date on which the Employer ceases to maintain a group health plan within its controlled group;

(b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 10.5;

(c) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;

(d) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, (1) first becomes covered under another group health plan and (2) is no longer subjected, due to changes in the law or otherwise, to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or

(e) in the case of a disabled Qualified Beneficiary (and his disabled or non-disabled family members) receiving COBRA Continuation Coverage under the eleven (11) month extended coverage described in Section 10.7, and with respect to such extended coverage, the first day of the month that begins more than thirty (30) days after the date the Qualified Beneficiary is determined by the Social Security Administration to no longer be "disabled" within the meaning of the Social Security Act.

The Plan can terminate for cause the COBRA coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of Similarly Situated Beneficiaries, for example, for the submission of a fraudulent claim.

In the case of a Qualified Beneficiary who is a child born to, adopted by or placed for adoption with a Covered Employee during a period of COBRA Continuation Coverage, the maximum period of COBRA Continuation Coverage is the maximum period applicable to the Qualifying Event giving rise to the period of COBRA Continuation Coverage during which the child was born or placed for adoption.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA Continuation Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

10.5 Contribution Requirements for COBRA Coverage.

Qualified Beneficiaries who elect COBRA Continuation Coverage as a result of a Qualifying Event (or third parties on behalf of a Qualified Beneficiary) will be required to pay Continuation Coverage Contributions. Qualified Beneficiaries (or third parties on behalf of a Qualified Beneficiary) must make the Continuation Coverage Contributions monthly on or prior to the first day of the month of such coverage. However, a Qualified Beneficiary has forty-five (45) days from the date of an affirmative election to pay the Continuation Coverage Contributions for the first month plus the cost for the period between the date health coverage would otherwise have terminated due to the Qualifying Event and the date the Qualified Beneficiary actually elects COBRA Continuation Coverage. If the Qualified Beneficiary fails to make the Continuation Coverage Contribution for the first month's premium, coverage will either terminate or will be retroactively cancelled.

The Qualified Beneficiary will have a thirty (30) day grace period from the due date (the first of each month) to make the Continuation Coverage Contributions due for such month. Continuation Coverage Contributions must be postmarked on or before the end of the thirty (30) day grace period.

If Continuation Coverage Contributions are not made on a timely basis, COBRA Continuation Coverage will terminate as of the last day of the month for which such premiums were made on a timely basis. The thirty (30) day grace period will not apply to the forty-five (45) day period for payment of COBRA premiums as applicable to initial elections.

Except as provided in Section 10.7, the Continuation Coverage Contribution will be one

hundred percent (100%) of the cost of coverage plus a two percent (2%) administrative fee for a total contribution of one hundred two percent (102%) of the cost of coverage.

If timely payment of the Continuation Coverage Contribution is made to the Plan in an amount that is not significantly less than the amount due for a period of coverage, then the amount paid is deemed to satisfy the Plan's requirement for the amount that must be paid for Continuation Coverage Contribution, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time (thirty (30) days) for payment of the deficiency to be made. For purposes of this Section 10.5, an amount not significantly less than the amount the Plan requires to be paid will be defined as the lesser of fifty dollars ($50) or ten percent (10%) of the required payment amount.

10.6 Limitation on Qualified Beneficiary's Rights to COBRA Coverage.

If a Qualified Beneficiary loses, or will lose, health coverage under the Plan as a result of a Qualifying Event that is a divorce, legal separation or ceasing to be a Dependent, such Qualified Beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 10.12, within a maximum of sixty (60) days after the latest of (a) the Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of his responsibility to provide a Qualifying Event notice as described in this Section 10.6 and the Plan's procedures for providing such notice. Failure to make timely notification will result in a termination of the Qualified Beneficiary's rights to COBRA Continuation Coverage under this Article X.

A Qualified Beneficiary must notify the Plan Administrator, as described in Section 10.12, of the birth to, adoption by or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage.

For all other Qualifying Events (including when the Qualifying Event is the end of employment, the death of a Covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, a Covered Employee's entitlement to Medicare (Part A, Part B, or both)), the Employer must notify the Plan Administrator of the Qualifying Event. The notice must be provided within a maximum of thirty (30) days after the Qualifying Event.

10.7 Extension of COBRA Coverage Period.

A Qualified Beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 10.12, if a second Qualifying Event occurs while the Qualified Beneficiary is receiving COBRA Continuation Coverage. The Qualified Beneficiary must notify the Plan Administrator within a maximum of sixty (60) days after the latest of (a) the second Qualifying Event, (b) the date the Qualified Beneficiary would lose coverage on account of the second Qualifying Event, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of his responsibility to provide a notice of a second Qualifying Event and the Plan's procedures for providing such notice.

If a second Qualifying Event that is not a termination of employment or reduction in hours

occurs during an eighteen (18) month period of COBRA Continuation Coverage explained in Section 10.4 (or twenty-nine (29) month period, if extended due to disability), coverage may be extended to a maximum of thirty-six (36) months from the date of the first Qualifying Event for the affected Qualifying Dependent. Coverage will be extended, however, only if the second Qualifying Event would have caused the Qualifying Dependent to lose coverage under the Plan in the absence of the first Qualifying Event. Any such extension of COBRA Continuation Coverage applies only to Qualifying Dependents. Therefore, such extension would apply to a child adopted or placed for adoption with a Qualified Beneficiary, but would not apply to a spouse who was added to a Qualified Beneficiary's COBRA Continuation Coverage as a result of the Qualified Beneficiary's becoming married after commencement of the initial eighteen (18) month continuation period.

The maximum COBRA Continuation Coverage Period is extended up to eleven (11) months for Qualified Beneficiaries (and their disabled or non-disabled family members receiving COBRA Continuation Coverage due to the same Qualifying Event) for up to twenty-nine (29) months in total (measured from the date of the Qualifying Event), provided the following requirements are met:

(a) the Social Security Administration ("**SSA**") determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or within the first sixty (60) days of COBRA Continuation Coverage following the Qualifying Event, and

(b) the Qualified Beneficiary or the Covered Employee (or a representative of either) provides notice to the Plan Administrator, as described in Section 10.12, of such SSA determination:

(i) within sixty (60) days after the latest of (A) the date of the SSA determination, (B) the date on which the Qualifying Event occurred, (C) the date on which the Qualified Beneficiary loses coverage due to the Qualifying Event, or (D) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the obligation to provide the disability notice and the Plan's procedures for providing such notice; but

(ii) not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage.

In such event, the Continuation Coverage Contribution will be one hundred fifty percent (150%) of the cost of coverage for the nineteenth (19^{th}) through twenty-ninth (29^{th}) months of COBRA Continuation Coverage.

However, if a Qualified Beneficiary who meets the above requirements receives a final determination from the SSA that he is no longer disabled, said beneficiary or the Covered Employee (or a representative of either) must notify the Plan Administrator, as described in Section 10.12, within thirty (30) days after the later of (a) the date of that determination or (b) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the obligation to provide the end-of-disability notice and the Plan's procedures for providing such notice. Such a final determination by the SSA will end the disability extension of

COBRA Continuation Coverage for all Qualified Beneficiaries as of the later of either: (i) the first day of the month following thirty days (30) from the final determination date; or (ii) the end of the COBRA Continuation Coverage period without regard to the disability extension.

10.8 Responses to Inquiry Regarding Qualified Beneficiary's Right to Coverage.

If a provider of health care (such as a physician, hospital, or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary during the election period, the Plan will give a complete response to the health care provider about the Qualified Beneficiary's COBRA Continuation Coverage rights during the election period, and his right to retroactive coverage if COBRA is elected. If a provider of health care (such as a physician, a hospital or pharmacy) contacts the Plan to confirm coverage of a Qualified Beneficiary with respect to whom the required payment has not been made for the current period, but for whom any applicable grace period has not expired, the Plan will inform the health care provider of all of the details of the Qualified Beneficiary's right to pay for such coverage during the applicable grace period.

10.9 Coordination of Benefits - Medicare and COBRA.

For purposes of this Article X, "Medicare Entitlement" means being entitled to Medicare due to either (a) enrollment (automatically or otherwise) in Medicare Parts A or B, or (b) being medically determined to have end-stage renal disease ("**ESRD**") and (i) having applied for Medicare Part A, (ii) having satisfied any waiting period requirement and (iii) being either (A) insured under Social Security, (B) entitled to retirement benefits under Social Security or (C) a spouse or dependent of a person satisfying either (A) or (B). Such Medicare Entitlement is a COBRA terminating event.

If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours, and such Qualifying Event occurs less than eighteen (18) months after the date the Covered Employee became entitled to Medicare, the maximum period of COBRA Continuation Coverage for the Covered Employee's Qualifying Dependents will be extended to the last day of the thirty-six (36) month period measured from the date the Covered Employee became entitled to Medicare, while the maximum period of COBRA Continuation Coverage for the Covered Employee is eighteen (18) months from the Qualifying Event.

If a Covered Employee has a Qualifying Event due to his termination of employment or reduction in work hours and, after the Covered Employee has elected COBRA Continuation Coverage and during the first eighteen (18) months of COBRA Continuation Coverage (or twenty-nine (29) months if extended due to disability), the Covered Employee first becomes entitled to Medicare, the Covered Employee's COBRA Continuation Coverage will end, and the maximum period of COBRA Continuation Coverage for his Qualified Dependents who were Qualified Beneficiaries and elected COBRA Continuation Coverage will be extended to the last day of the thirty-six (36) month period measured from the date of the Qualifying Event. Coverage will be extended, however, only if the Covered Employee's Medicare entitlement would have caused such Qualifying Dependents to lose coverage under the Plan in the absence of the Qualifying Event. The Covered Employee or Qualifying Dependent (or a representative of either) must provide notice to the Plan Administrator, as described in Section 10.12, of the Covered Employee's Medicare entitlement within a maximum of sixty (60) days after the latest of (a) the date of

Medicare entitlement, (b) the date the Qualified Beneficiary would lose coverage on account of the Medicare Entitlement, or (c) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the responsibility to provide a notice of Medicare entitlement and the Plan's procedures for providing such notice.

10.10 Relocation and COBRA Coverage.

If a Qualified Beneficiary moves outside the service area of a region-specific benefit package, alternative COBRA coverage, if available to active employees, will be made available to the Qualified Beneficiary no sooner than the date of the Qualified Beneficiary's relocation, or if later, the first day of the month following the month in which the Qualified Beneficiary requests the alternative coverage. A Qualified Beneficiary has thirty (30) days from the date of the Qualified Beneficiary's relocation to request the alternative coverage.

10.11 COBRA Coverage and HIPAA Special Enrollment Rules.

Once a Qualified Beneficiary is receiving COBRA Continuation Coverage, the Qualified Beneficiary has the same right to enroll family members under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) rules as if the Qualified Beneficiary were an Employee or Participant in the Plan, provided that such family members do not become Qualified Beneficiaries, pursuant to Section 10.3, and are therefore not eligible to elect COBRA Continuation Coverage in their own right.

Election of COBRA Continuation Coverage by a Qualified Beneficiary may serve to bridge coverage between the Plan and any future coverage under another plan, may preserve the Qualified Beneficiary's Creditable Coverage period and reduce or avoid applicable preexisting condition exclusions under another plan.

10.12 Qualified Beneficiary Notice Procedures.

Any notice that a Qualified Beneficiary is required to provide under this Article X must be in writing. The Plan Administrator may contract with a third-party administrator to perform services as the Plan's COBRA Administrator. A Qualified Beneficiary must provide its applicable notice ("**Notice**") to the COBRA Administrator at the address set forth in Appendix C.

The required procedures for providing Notice under the Plan, including the form and content of Notices, are specified in the applicable Welfare Program Document(s). To the extent that a Welfare Program does not prescribe required procedures for providing Notices under the Plan, the procedures set out in this Section 10.12 will apply.

(a) Qualifying Event Notice.

The Notice to inform the Plan Administrator of a Qualifying Event (including a Covered Employee's entitlement to Medicare) must contain (1) the name of the Qualified Beneficiary; (2) the name of the Plan to which the Notice applies; (3) a description of the Qualifying Event; and (4) the date on which the Qualifying Event occurred. Evidence that the event has occurred, acceptable to the COBRA Administrator, must be provided with the Notice.

(b) Disability Determination Notice.

The Notice to inform the Plan Administrator of a Qualified Beneficiary's disability determination by the SSA must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's disability determination letter.

(c) Determination of End of Disability Notice.

The Notice to inform the Plan Administrator of the SSA's determination that a disabled Qualified Beneficiary is no longer disabled must contain (1) the name of the Qualified Beneficiary, (2) the name of the Plan to which the Notice applies, and (3) a copy of the SSA's determination letter that a disability no longer exists.

(d) Birth, Adoption or Placement Notice.

The Notice to inform the Plan Administrator of the birth, adoption or placement for adoption of a child with a Covered Employee receiving COBRA Continuation Coverage must contain (1) the name of the Covered Employee, (2) the name of the Plan to which the Notice applies, (3) the reason for the Notice (i.e., the birth, adoption or placement for adoption of a child, as applicable), and (4) the date of such child's birth, adoption or placement for adoption.

10.13 Special Second Election Period for Certain Eligible Individuals Who Did Not Elect COBRA Continuation Coverage.

Special COBRA rights may apply to certain Covered Employees who are eligible for trade adjustment assistance under the Trade Act of 2002 ("**TAA Employees**"). These TAA Employees may be entitled to a second opportunity to elect COBRA Continuation Coverage for themselves and certain family members (if they did not already elect COBRA Continuation Coverage) during a special second election period. This special second election period lasts for sixty (60) days or less. It is the 60-day period beginning on the first day of the month in which the TAA Employee becomes eligible for certain benefits under the Trade Act of 2002 and during the six (6) month period immediately after the TAA Employee's coverage under the Plan ends. A Covered Employee who qualifies or may qualify for this special election period should contact the Plan Administrator's Human Resources Department at the address and telephone number listed in Article XIII for additional information.

10.14 Questions and Other Information Regarding COBRA Coverage.

The Covered Employee will be responsible for keeping the Plan Administrator informed of any Qualifying Events and any changes in his address and the addresses of his Spouse and Dependents. Questions concerning a Participant's COBRA coverage rights should be directed to the COBRA Administrator at the address and/or telephone number listed in Appendix C.

In the event that the Plan Administrator changes COBRA Administrators or the Participant

is unable to reach the above-referenced COBRA Administrator, the Participant should direct questions to the Plan Administrator's Human Resources Department at the address and telephone number listed in Article XIII.

ARTICLE XI
HIPAA PRIVACY AND SECURITY

11.1 HIPAA Privacy and Security in General.

This Article XI is intended to comply with the requirements under the Health Insurance Portability and Accountability Act of 1996, as amended ("**HIPAA**"), the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E, as promulgated under HIPAA ("**Privacy Standards**"), the Security Standards for the Protection of Electronic Protected Health Information at 45 CFR part 160 and part 164, subpart C, as promulgated under HIPAA ("**Security Standards**"), the HIPAA Enforcement Rules at 45 CFR part 160, subparts C through E ("**Enforcement Rules**") and the "**Breach Notification Rules**" issued under the Health Information Technology for Economic and Clinical Health Act ("**HITECH**"), as each of the foregoing were amended, generally effective as of September 23, 2013, by the regulations issued on January 25, 2013 ("**HIPAA Omnibus Rules**"). References to any section of the Privacy Standards, the Security Standards, the Enforcement Rules or the Breach Notification Rules shall include any amendments or successor provisions thereto, including the HIPAA Omnibus Rules.

For purposes of this Article XI, "Protected Health Information" ("**PHI**") means information, including genetic information, that is created or received by the Plan which (1) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual, (2) identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual, and (3) is transmitted or maintained in any form or medium. "Electronic Protected Health Information" ("**ePHI**") means individually identifiable health information that is created or received by the Plan and transmitted by or maintained in electronic media.

11.2 Designation of Health Care Components and Safeguards.

To the extent the Plan is a hybrid entity (as defined by 45 CFR § 164.103 of the Privacy Standards), the provisions of this Article XI will only apply to the health care components of the Plan (collectively referred to as the "**Health Care Components**"). All references to Protected Health Information (PHI) or Electronic Protected Health Information (ePHI) in this Article XI refer to PHI or ePHI that is created or received by or on behalf of the Health Care Components. The Health Care Components will thus comply with the following requirements:

(a) The Health Care Components of the Plan will not disclose PHI to another component of the Plan in circumstances in which the Privacy Standards would prohibit such disclosure if the Health Care Components and the other component were separate and distinct legal entities; and

(b) If an employee of the Plan Sponsor performs duties for both the Health Care Components of the Plan and for another component of the Plan, such employee will not use or disclose PHI created or received in the course of, or incident to, the employee's work for the Health Care Component in a way prohibited by the Privacy Standards.

Note: For purposes of this Section 11.2, the portions of the Plan which provide medical benefits, prescription drug benefits, dental benefits, vision care benefits and employee assistance program benefits constitute the Health Care Components.

11.3 Use and Disclosure of Protected Health Information.

The Plan Sponsor may only use and disclose PHI that it receives from a Health Care Component of the Plan, which is considered a "group health plan" as defined by the Privacy Standards, as permitted and/or required by, and consistent with, the Privacy Standards. This includes, but is not limited to, the right to use and disclose a Participant's PHI in connection with payment, treatment, and health care operations, or as otherwise permitted or required by law. The Plan shall not use or disclose PHI that is genetic information for underwriting purposes.

The term "***payment***", for this purpose, includes activities undertaken by the Health Care Component of the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

(a) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);

(b) Coordination of benefits or non-duplication of benefits;

(c) Adjudication of health benefit claims (including appeals and other payment disputes);

(d) Subrogation of health benefit claims;

(e) Establishing employee contributions;

(f) Risk adjusting amounts due based on enrollee health status and demographic characteristics;

(g) Billing, collection activities and related health care data processing;

(h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;

(i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);

(j) Medical necessity reviews or reviews of appropriateness of care or justification of

charges;

(k) Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

(l) Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

(m) Obtaining reimbursements due to the Plan.

The term "***health care operations***", for this purpose, includes, but is not limited to, the following activities:

(a) Quality assessment;

(b) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

(c) Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;

(d) Enrollment, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);

(e) Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

(f) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies; and

(g) Business management and general administrative activities of the Plan, including, but not limited to:

(i) Management activities relating to the implementation of, and compliance with, HIPAA's administrative simplification requirements;

(ii) Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

(iii) Resolution of internal grievances; and

(iv) Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

11.4 Certification of Amendment of Plan Documents by Plan Sponsor.

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the provisions set forth in this Article XI.

11.5 Plan Sponsor Agrees to Certain Conditions for PHI.

The Plan Sponsor agrees to:

(a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;

(c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;

(e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;

(f) Make PHI available to an individual in accordance with HIPAA's access requirements;

(g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) Make available the information required to provide an accounting of disclosures;

(i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA;

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

(k) Establish separation between the Plan and the Plan Sponsor in accordance with 45 CFR § 164.504(f)(2)(iii).

With respect to ePHI, the Plan Sponsor agrees, on behalf of the Plan, to:

(i) Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Plan;

(ii) Ensure that adequate separation required by 45 C.F.R. §164.504(f)(2)(iii) under the Privacy Standards is supported by reasonable and appropriate security measures;

(iii) Ensure that any agent, including a subcontractor, to whom it provides this information or who receives this information on behalf of the Plan agrees to implement reasonable and appropriate security measures to protect the information; and

(iv) Report to the Plan any security incident of which it becomes aware, in accordance with the administrative procedures adopted by the Plan for compliance with the Security Standards.

11.6 Adequate Separation Between the Plan and the Plan Sponsor.

In accordance with the Privacy Standards, only the employees or classes of employees designated in Appendix D may be given access to PHI.

11.7 Limitations of PHI Access and Disclosure.

The persons described in Appendix D may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan.

11.8 Noncompliance Issues.

If the persons described in Appendix D do not comply with the Plan document, the Plan Sponsor will provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

11.9 Members of Organized Health Care Arrangement.

To the extent that any Health Care Component is fully-insured, the Plan and the health insurance issuer or HMO with respect to such Health Care Component are an organized health care arrangement (as defined in § 160.103 of the Privacy Standards), but only with respect to PHI created or received by the health insurance issuer or HMO that relates to the individuals who are Participants or Beneficiaries in such Health Care Component.

11.10 Additional Requirements Imposed by HITECH.

The provisions of this Section 11.10 will apply to the Plan to the extent the Plan is a "covered entity" as defined in 45 CFR § 160.103. In accordance with, and to the extent required

by, HITECH and the regulations and other authority promulgated thereunder by the appropriate governmental authority, the Plan will (a) comply with notification requirements when unsecured PHI has been accessed, acquired, or disclosed as a result of a breach, (b) comply with an individual's request to restrict disclosure of PHI, (c) limit disclosures of PHI to a limited data set or the minimum necessary, (d) provide an accounting of disclosures, and (e) provide access to PHI in electronic format.

11.11 Limitation on the Use and Disclosure of Genetic Information.

Notwithstanding anything herein to the contrary, no "genetic information" (as defined by Section 105 of the Genetic Information Nondiscrimination Act of 2008) shall be used or disclosed for underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, or ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance).

11.12 Notification in Case of a Breach of Unsecured PHI.

In the event of the acquisition, access, use, or disclosure of PHI in a manner not permitted by the Privacy Standards that constitutes a "Breach," as such term is defined in 45 CFR 164.402, the Plan, or its designee, shall notify each individual whose PHI has been, or is reasonably believed to have been, accessed, acquired, used or disclosed as a result of the Breach no later than sixty (60) days after the Plan, or its designee, discovers the Breach, unless notification may be delayed as permitted by 45 CFR 164.412 because such notice would impede a criminal investigation or damage national security. The Plan, or its designee, will mail individual notifications by first-class mail to the individual's last known address or by electronic mail, provided that electronic disclosure is permitted by the applicable regulations. The individual notification will include the following information:

- A brief description of what happened, including the date of the Breach and the date of its discovery, if known;
- A description of the type of PHI involved, such as name, social security number, date of birth, address, account number, diagnosis, disability code, or other type of information involved;
- Any steps the individual should take to protect himself from potential harm resulting from the Breach;
- A brief description of what the Plan or its business associate is doing to investigate the Breach, mitigate harm to individuals, and to protect against further Breaches; and
- Contact procedures for individuals to ask questions or learn additional information, including a toll-free telephone number, e-mail address, web site, or postal address.

If the Breach involves more than 500 residents of a state or jurisdiction, the Plan, or its designee, will also notify prominent media outlets that service the state or jurisdiction of the Breach. Additionally, the Plan will notify the Secretary of the Department of Health and Human Services of the Breach as required by 45 CFR 164.408.

11.13 Other Medical Privacy Laws.

The Plan will comply with the Privacy Standards and the Security Standards as well as with any applicable federal, state and local laws governing confidentiality of health care information, to the extent such laws are not preempted by HIPAA.

ARTICLE XII
MISCELLANEOUS LAW PROVISIONS

12.1 National Medical Support Notice.

(a) The Plan will comply with an appropriately completed National Medical Support Notice ("**Notice**") promulgated pursuant to Section 401(b) of the Child Support Performance and Incentive Act of 1998 if the Notice does not require the Plan to provide any type of form of benefit, or any option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 13822 of the Omnibus Budget Reconciliation Act of 1993), and the Notice clearly specifies the following:

(i) the name and the last known mailing address (if any) of the Participant and the name and mailing address of each Alternate Recipient (an official of a state or political subdivision may be substituted for the mailing address of any Alternate Recipient, if provided for in the Notice);

(ii) a reasonable description of the type of coverage to be provided to each Alternate Recipient, or the manner in which such type of coverage is to be determined; and

(iii) the period to which the Notice applies.

(b) If a Notice which satisfies Section 12.1(a), is issued for a child of a Participant under the Plan who is a noncustodial parent of the child, the Plan Administrator, within forty (40) business days after the date of the Notice, will:

(i) notify the state agency issuing the Notice with respect to such child whether coverage of the child is available under the terms of the Plan and, if so, whether such child is covered under the Plan and either the effective date of the coverage or, if necessary, any steps to be taken by the custodial parent (or by the official of a state or political subdivision thereof substituted for the name of such child pursuant to Section 12.1(a)(i) to effectuate the coverage; and

(ii) provide to the custodial parent (or such substituted official) a description of the coverage available and any forms or documents necessary to effectuate such coverage.

(c) Nothing in this Section 12.1 will be construed as requiring the Plan, upon receipt of Notice, to provide benefits under the Plan (or eligibility for such benefits) in addition to benefits (or eligibility for benefits) provided under the terms of the Plan as of immediately before the receipt of such Notice.

12.2 Rights of States for Group Health Plans where Participants are Eligible for Medical Benefits.

(a) *Compliance by Plans with Assignment of Rights.*

A Welfare Program offered under the Plan that provides health benefits will comply with any assignment of rights made by or on behalf of such Participant or a Beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(l)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

(b) *Enrollment and Provision of Benefits Without Regard to Medicaid Eligibility.*

In determining or making any payments for benefits of an individual as a Participant or Beneficiary, the fact that the individual is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

(c) *Acquisition by States of Rights of Third Parties.*

If payment has been made under a state plan for medical assistance approved under Title XIX of the Social Security Act offered under the Plan in any case in which a group health plan has a legal liability to make payment for items or services constituting such assistance, payment for benefits under the Plan will be made in accordance with any state law which provides that the state has acquired the rights with respect to a Participant to such payment for such items or services; provided, however that in no event will such a state law be applied to the extent it attempts to create rights for the state plan which are greater than those of the Participant under the Plan, specifically including any state law which provides that a state plan can make a claim for benefits or recover benefits beyond the period permitted under the Plan.

12.3 Health Program Coverage of Dependent Children in Adoption Cases.

(a) *Coverage Effective Upon Placement For Adoption.*

Notwithstanding anything in the Welfare Program Documents to the contrary, if a Welfare Program offered under the Plan provides health coverage for Dependent children of Participants or Beneficiaries, such Welfare Program will provide benefits to Dependent children Placed For Adoption with Participants or Beneficiaries under the same terms and conditions as apply in case of Dependent children who are natural children of Participants or Beneficiaries under the Plan, irrespective of whether the adoption has become final.

(b) *Definitions.*

For purposes of this Section 12.3, the following definitions apply:

(i) Child means, in connection with any adoption or Placement For Adoption of the Child, an individual who has not attained age eighteen (18) as of the date of such

adoption or Placement For Adoption.

(ii) Placement, Placement For Adoption, or being Placed For Adoption, in connection with any Placement For Adoption of a Child with any person, means the assumption and retention by such person of a legal obligation for total or partial support of such Child in anticipation of adoption of such Child. The Child's Placement with such person terminates upon the termination of such legal obligation.

12.4 Continued Coverage of Pediatric Vaccine under Group Health Plans.

A Welfare Program offered under the Plan that is a health plan may not reduce its coverage of the costs of pediatric vaccines (as defined under Section 1928(h)(6) of the Social Security Act as amended by Section 13830 of the Omnibus Budget Reconciliation Act of 1993) below the coverage it provided as of May 1, 1993.

12.5 Family and Medical Leave Act.

(a) *Health Benefits*.

This subsection (a) shall apply to a Welfare Program to the extent it provides health benefits.

(i) General.

If an Employee Participant takes a leave pursuant to the federal Family and Medical Leave Act ("**FMLA**"), health benefits coverage for such Participant may continue, subject to the Participant's continued participation in the Plan, on the same basis as for active Participants for the first day on which such approved leave began until the end of the FMLA leave, pursuant to the requirements of the FMLA. The Employee may continue his coverage for the period of the leave of absence, but not to exceed the period prescribed by the FMLA, provided that he pays any required Participant Contributions under the Plan. If the Employee fails to return to work on expiration of the leave period or notifies the Employer during the leave that he will not be returning to work due to reasons within his control, his coverage under the Plan will be terminated on the date he fails to return to work or the date following the date he gives such notice to the Employer.

(ii) Re-enrollment.

An Employee Participant who elects to revoke coverage under the Section 125 cafeteria plan sponsored by the Plan Sponsor ("**Flex Plan**") or whose coverage terminates during a leave granted pursuant to FMLA for failure to make any required Participant Contribution, will be eligible to re-enroll in the Plan immediately upon returning from the FMLA leave subject to payment of applicable Participant Contributions. Coverage will commence on the day of his return to employment to active service subject to administrative policies for election of coverage established by the Plan Administrator and payment of any required Participant Contributions. However, coverage will be reinstated only if the

person(s) had coverage under the Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated, subject to any changes that affect the work force as a whole.

(iii) COBRA.

An approved leave of absence, which may include a leave pursuant to FMLA, does not constitute a Qualifying Event under COBRA within the meaning of Section 10.11. The failure of the Employee Participant to return to work following the FMLA leave is a COBRA Qualifying Event. Notification by the Participant of the Participant's intent not to return from FMLA leave is a COBRA Qualifying Event if such failure to return results in a termination of employment. The last day of such leave will be deemed the date the Qualifying Event occurred.

(iv) Contributions.

An Employee Participant in the Plan who takes an FMLA leave is entitled to continue to participate in the Welfare Programs provided under the Plan during such leave. However, if the Participant is also a participant in the Flex Plan, the Participant may revoke his election to participate in the Flex Plan. If the Participant does not revoke his Flex Plan election, or if he does not participate in the Flex Plan, he must continue to make Participant Contributions to the Plan on a pay-as-you-go basis, unless the Participant makes advance payments or, if permitted under administrative policies adopted by the Plan Administrator, subsequent payments following the Participant's return from leave, provided that such administration has been previously approved by the Plan Administrator. Deductions for coverage or participation while on a *paid* leave will be withheld from the Participant's paychecks during the leave.

If the Participant revokes his election to participate in the Flex Plan, then the Participant may, upon timely return from FMLA leave, elect to reinstate his election to participate in the Flex Plan. Such benefits provided under the Flex Plan will be reinstated upon the Participant's re-election.

(v) Termination of Benefits while on FMLA Leave.

If a Participant's coverage under the Plan has been terminated while on FMLA leave, such coverage will be reinstated upon timely return from FMLA leave. A Participant who elected to cease participation in the Flex Plan while on FMLA leave may elect to commence participation upon timely return from FMLA leave.

(b) *Non-Health Benefits*.

This subsection (b) shall apply to a Welfare Program to the extent it provides non-health benefits.

An Employee Participant shall be entitled to benefits under the Plan during a period of leave pursuant to the FMLA, at a minimum, to the same extent that similarly-

situated Employees on other forms of leave (paid or unpaid, as appropriate) are entitled to benefits under the Plan during such other forms of leave, as determined by the Employer's established leave of absence policy. Upon timely return to active employment at the end of an Employee's FMLA leave, benefits under the Plan shall be resumed in the same manner and at the same levels as provided to the Employee when the leave began (and subject to any changes in benefit levels that may have taken place during the period of FMLA leave affecting all Participants), unless otherwise elected by the Employee. Upon return from FMLA leave, an Employee shall not be required to re-qualify for any Plan benefits the Employee was entitled to receive as a Participant before his FMLA leave began.

12.6 Uniformed Services Employment and Reemployment Rights Act.

The Plan will comply with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("**USERRA**") with regard to continuation rights during an approved military leave of absence and reenrollment rights on return from such military leave of absence.

(a) *Health Benefits*.

This subsection (a) shall apply to a Welfare Program to the extent it provides health benefits.

(i) An Employee who is not at work because of a period of duty in the Uniformed Services (as defined in USERRA), may, at the Employee's election, continue coverage in any or all Welfare Programs under the Plan during the period of absence, so long as the Employee satisfies the necessary provisions and makes any required Participant Contribution as provided under USERRA.

(ii) The maximum period of coverage for an Employee, an Employee's Spouse and/or Dependents, if any, under a Welfare Program during a period of duty in the Uniformed Services will be governed by the applicable limitations and provisions contained in USERRA unless more generous limitations are provided under the Employer's leave of absence policy.

(iii) An Employee who elects to continue coverage in one or more Welfare Programs under the Plan will pay:

(A) the Employee's share, if any, for coverage under the Plan if the Employee performs service in the Uniformed Services for up to thirty-one (31) days; or

(B) one hundred two percent (102%) of the full premium or cost under the Plan (determined in the same manner as the applicable COBRA Continuation Coverage premium under Section 4980B(f)(4) of the Code) if the Employee performs service in the Uniformed Services for thirty-one (31) days or more.

(iv) During the period of service in the Uniformed Services, the Employee may pay the necessary costs associated with coverage under the Plan, if any, by:

(A) remitting payment to the Employer on or before each pay period for which the Participant Contributions would have been deducted from the Employee's paycheck had the Employee not been absent serving in the Uniformed Services, provided that any delinquent payments must be made within thirty (30) days after their due date;

(B) at the Employee's request, prepaying the amounts that will become due during the period of service in the Uniformed Services out of one or more of the Employee's paychecks preceding such period of service in the Uniformed Services; or

(C) pre-approved arrangement with the Plan Administrator and in accordance with administrative policies adopted by the Plan Administrator wherein the Employer pays the Employee's Participant Contributions during the Employee's period of service in the Uniformed Services. Upon return from such service, the Employee will reimburse the Employer for such previous payments.

Any Employee who is a Participant, who is not at work because of service in the Uniformed Services and who returns to active employment within the relevant time period determined under USERRA, will be eligible to return to work and immediately participate in the same Welfare Programs which the Participant had elected to participate in prior to serving in the Uniformed Services, subject to any changes in the Welfare Programs that affect the workforce as a whole, provided that the Participant returns to employment with the same benefit eligibility status that he held prior to serving in the Uniformed Services, and provided further, that the Participant makes all required elections to participate in the Plan on a timely basis. Except to the extent provided in administrative policies adopted by the Plan Administrator (or the Employer, if applicable), the maximum period of health care coverage available to a Participant (and his Dependents) while on a USERRA leave of absence will end on the earlier of (i) the last day of the maximum coverage period prescribed under USERRA (or if required by USERRA's discrimination rules, the last day of the longest period that the Employer's Leave of Absence policy permits Welfare Program coverage to continue) or (ii) the day after the date upon which the person fails to apply for a return to a position of employment within the time required under Section 4312(a) of USERRA. For purposes of determining eligibility for health benefits (and only if the Participant pays the full amount which the Employer is permitted to charge the Participant for health coverage under USERRA), a Participant who experiences a reduction in hours or termination of employment solely due to a USERRA leave will continue to be considered qualified as a Participant under the Plan until the earliest date that the termination of his health benefits is permitted under USERRA.

(b) *Non-Health Benefits*.

This subsection (b) shall apply to a Welfare Program to the extent it provides non-health benefits.

During a period of duty in the "Uniformed Services" (as defined in USERRA), the Employee shall be deemed to be "on furlough" or "leave of absence" from the Employer. The Employee shall be entitled to benefits under the Plan in accordance with the Employer's administrative policies and procedures regarding leaves of absence for military

service under USERRA, but at a minimum, to the same extent as similarly-situated Employees who are on non-USERRA leave of absence from the Employer. If Plan benefits to which Employees on non-USERRA leave of absence are entitled vary according to the type of leave, the Employee on leave under USERRA must be given at least the most favorable benefits under the Plan accorded to any comparable form of leave.

12.7 Health Insurance Portability and Accountability Act.

The Plan will comply with HIPAA with respect to a Welfare Program offered under the Plan that provides health benefits, except to the extent that such health benefits are "excepted benefits" which are not subject to HIPAA's portability provisions.

(a) *Eligibility.*

The Plan will not base eligibility rules or Waiting Periods on any of the following: health status, mental or physical medical condition, genetic information or evidence of insurability or disability. However, the Plan may continue to provide for the exclusion of specified health conditions or lifetime maximums on certain specific benefits provided under the Plan. These restrictions do not preclude the Plan from applying differing benefit levels, benefit schedules or premium rates in certain situations as provided under HIPAA.

(b) *Enrollment.*

(i) Loss of coverage. Special enrollment periods will generally be provided for eligible Employees and their eligible Dependents (including their eligible Spouses and eligible Domestic Partners) whose other health coverage terminates due to (A) exhaustion of COBRA continuation coverage, or (B) if the other coverage is not COBRA continuation coverage, "loss of eligibility" for the other health coverage (for reasons other than the individual's failure to pay premiums or for cause) or termination of employer contributions toward the cost of the other coverage, if the Employee had previously declined coverage under the Plan or a particular Welfare Program for himself and/or his Dependents because he or they had other coverage under a group health plan or health insurance. For this purpose, "loss of eligibility" includes, but is not limited to:

(A) A loss of eligibility for the other coverage resulting from legal separation, divorce, cessation of dependent status (such as attaining the maximum age for eligibility as a dependent child under the other coverage), death of the Employee, termination of employment, a reduction in the number of hours of employment, or any loss of eligibility for coverage after a period that is measured based on any of those events;

(B) In the case of other coverage offered through an HMO, or other arrangement, in the individual market that does not provide benefits to individuals who no longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

(C) In the case of other coverage offered through an HMO, or other arrangement, in the group market that does not provide benefits to individuals who no

longer reside, live, or work in a service area, loss of coverage because an individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual), and no other benefit package is available to the individual;

(D) A situation in which an individual incurs a claim under the other coverage that would meet or exceed a lifetime maximum benefit limit on all benefits; and

(E) A situation in which the other coverage no longer offers any benefits to the class of similarly situated individuals that includes the individual.

If the other coverage is COBRA Continuation Coverage, the coverage must be exhausted. A loss of COBRA Coverage resulting from the individual's failure to pay premiums is not considered exhaustion of COBRA Coverage for purposes of permitting special enrollment.

To be eligible for special enrollment, the Employee must request enrollment no more than thirty-one (31) days after the termination of the other coverage (or after the employer stops contributing toward the other coverage), or for purposes of subsection (D) above, after a claim is denied under the other coverage due to the operation of the lifetime maximum benefit limit on all benefits. The Employee must also have met any requirements under the Plan for stating in writing that coverage was previously declined due to other health coverage.

(ii) Acquisition of New Dependent. Special enrollment periods will be available for the following individuals, in the event the eligible Employee acquires a new Spouse, Domestic Partner or Dependent as a result of marriage or establishment of a domestic partnership, birth, adoption or placement for adoption, if enrollment is requested no more than thirty-one (31) days following the applicable event:

(A) The eligible Employee, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above;

(B) The eligible Spouse or eligible Domestic Partner of the Participant, if either (1) the Spouse or Domestic Partner becomes the Participant's newly-acquired Dependent through marriage or establishment of a domestic partnership, or (2) the Participant acquires a new Dependent child as described in this subsection (b)(ii) above;

(C) The eligible Employee and his eligible Spouse or eligible Domestic Partner, if either (1) the Spouse or Domestic Partner becomes the Employee's newly-acquired Dependent through marriage or establishment of a Domestic Partnership, or (2) the Employee acquires a new Dependent child as described in this subsection (b)(ii);

(D) The eligible Dependents of the Participant, if the Participant acquires a new Dependent as described in this subsection (b)(ii) above;

(E) The eligible Employee and his eligible Dependents, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above; and

(F) The eligible Employee, his eligible Spouse or eligible Domestic Partner and his eligible Dependents, if the Employee acquires a new Dependent as described in this subsection (b)(ii) above.

In the event of an acquisition of a new Dependent due to birth, adoption or placement for adoption, coverage may be effective retroactively to the date of such birth, adoption or placement for adoption. All other enrollments pursuant to a HIPAA special enrollment right will be effective no sooner than the date the Plan Administrator receives the completed enrollment form and no later than the first day of the month following the date the Plan Administrator receives the completed enrollment form.

(iii) Medicaid/CHIP Special Enrollment Period. Notwithstanding any provisions of the Plan to the contrary, the Plan shall permit an eligible Employee or an eligible Employee's Dependent who is eligible for, but not enrolled in, coverage under the Plan to elect to enroll in the Plan if either of the following conditions is met:

(A) *Termination of Medicaid or CHIP coverage*. The eligible Employee or the eligible Employee's Dependent is (i) covered under a Medicaid plan under Title XIX of the Social Security Act ("**Medicaid**") or under a State child health plan under Title XXI of such Act ("**CHIP**"), and (ii) coverage of the eligible Employee or the eligible Employee's Dependent under such a plan is terminated as a result of loss of eligibility for such coverage; or

(B) *Eligibility for Employment Assistance under Medicaid or CHIP*. The eligible Employee or the eligible Employee's Dependent becomes eligible for assistance under Medicaid or CHIP.

In order to enroll in the Plan due to an event described in clause (A) or (B) above, the eligible Employee must request coverage under the Plan not later than sixty (60) days after the date: (a) of termination of coverage under Medicaid or CHIP or (b) the eligible Employee or his eligible Dependent is determined to be eligible for assistance under Medicaid or CHIP. The request for coverage must be made in writing to the Plan Administrator.

With respect to an eligible Employee or eligible Employee's Dependent who elects coverage in accordance with this Section 12.7(b)(iii), coverage under the Plan shall be effective as of the first day of the month following the date the completed request for enrollment is received and accepted by the Plan Administrator.

(c) *HIPAA and COBRA Continuation Coverage.*

COBRA Continuation Coverage, as amended by HIPAA, will be provided in accordance with Article X herein.

12.8 Mental Health Parity and Addiction Equity Act.

The Plan will comply with the Mental Health Parity and Addiction Equity Act of 2008 ("**MHPAEA**") with respect to health benefits provided under a Welfare Program, except to the

extent that such health benefits are "excepted benefits" that are not subject to the MHPAEA provisions in Section 2726 of the PHSA. If a Welfare Program offered under the Plan provides medical and surgical benefits and mental health benefits or substance use disorder benefits, then the Welfare Program shall be construed and administered in accordance with Section 2726 of the PHSA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

12.9 Newborns' and Mothers' Health Protection Act.

The Plan will comply with the Newborns' and Mothers' Health Protection Act ("**NMHPA**") with respect to health benefits provided under a Welfare Program, except to the extent that such health benefits are "excepted benefits" which are not subject to the NMHPA provisions in Section 2725 of the PHSA. Under NMHPA, the Plan and health insurance issuers offering group health insurance generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than forty-eight (48) hours following a vaginal delivery or ninety-six (96) hours following a cesarean section delivery. However, the Plan or the issuer may pay for a shorter stay if the attending provider, after consultation with the mother, discharges the mother or newborn earlier. The Plan and the insurers may not set the level of benefits or out-of-pocket costs so that any later portion of the forty-eight (48) hour (or ninety-six (96) hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay. The Plan or insurers may not require that a physician or other health care provider obtain authorization for prescribing a length of stay of up to forty-eight (48) hours or ninety-six (96) hours, as applicable.

12.10 Women's Health and Cancer Rights Act.

The Plan will comply with the Women's Health and Cancer Rights Act ("**WHCRA**") with respect to health benefits provided under a Welfare Program, except to the extent that such health benefits are "excepted benefits" which are not subject to the WHCRA provisions in Section 2727 of the PHSA. A Welfare Program offered under the Plan that provides health coverage will provide coverage for the following medical and surgical benefits for an individual who is receiving health plan benefits in connection with a mastectomy and who has elected breast reconstruction:

(a) reconstruction of the breast on which the mastectomy has been performed;

(b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

The manner of coverage will be determined in consultation with the attending health care provider and patient. Coverage for breast reconstruction and related services associated with a mastectomy will be subject to deductibles, co-payments, coinsurance amounts, pre-certification and utilization review requirements that are consistent with those that apply to other benefits under the Welfare Program.

12.11 Genetic Information Nondiscrimination Act.

The Plan will comply with the Genetic Information Nondiscrimination Act of 2008 as provided in Section 2753 of the PHSA and the regulations and other authority promulgated thereunder by the appropriate governmental authority.

12.12 Affordable Care Act.

The Plan will comply with the Affordable Care Act, and the regulations and other authority promulgated thereunder by the appropriate governmental authority, with respect to health benefits provided under a Welfare Program, except to the extent that such health benefits are not subject to the Affordable Care Act.

12.13 Other Laws.

The Plan shall comply with all other laws applicable to a Welfare Program to the extent not preempted by controlling federal law. Notwithstanding any reference to the contrary in a Welfare Program Document, the Plan is a governmental plan that is not subject to the Employee Retirement Income Security Act of 1974, as amended ("**ERISA**").

12.14 Governing Law.

The Plan shall be construed, regulated and administered under the laws of the State of Texas without regard to its conflicts of law principles, except as preempted by other controlling federal law, or as otherwise expressly provided in the applicable Welfare Program.

ARTICLE XIII
IMPORTANT INFORMATION

Name of Plan: Port of Houston Authority Group Insurance Plan

Plan Sponsor: Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326
(713) 670-2400

Plan Administrator: Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326
(713) 670-2400

Plan Sponsor's Employer Identification Number: 74-6001217.

Type of Plan: The Plan is a group health plan maintained by a state governmental entity which provides (1) medical and prescription drug benefits, (2) dental benefits, (3) vision benefits, (4) basic, supplemental and dependent life insurance benefits, (5) accident insurance benefits, (6)

long-term disability insurance benefits and (7) employee assistance program benefits. No trust is maintained in connection with the Plan.

Type of Administration: The Plan is administered by the Plan Administrator, with benefits being provided in accordance with the terms, limits and conditions of the Plan. The Plan Administrator has engaged the Claims Fiduciaries and Claims Administrators, as set forth in Appendix C, to process claims and perform other administrative duties under the Plan.

Agent for Service of Legal Process: The Plan Administrator at the address listed above, c/o Chief Legal Officer.

Plan Year: The Plan and its records are kept on a Plan Year basis. The Plan Year is the 12-month period beginning each January 1st and ending on December 31st.

Sources of Contributions: The adopting Employer(s) and Participants pay the costs for coverage. The Plan Sponsor determines the portion of costs to be paid by the adopting Employers and the Participants.

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY
GROUP INSURANCE PLAN
(Amended and Restated Effective as of January 1, 2019)

APPENDIX A

As of January 1, 2019, the following Welfare Programs are incorporated, in their entirety, by reference into this SPD:

- Aetna Open Access Medical Plan (Self-Insured Program);
- Aetna Kelsey Care Medical Plan (Self-Insured Program);
- Aetna PPO Dental Plan (Fully-Insured Program);
- Aetna DMO Dental Plan (Fully-Insured Program);
- Ameritas Vision Program (Fully-Insured Program);
- Minnesota Life Insurance Company Basic, Supplemental and Dependent Life & AD&D Insurance Program (Fully-Insured Program);
- Aetna Long Term Disability Insurance Program (Fully-Insured Program); and
- Interface Employee Assistance Program (EAP) (Fully-Insured Program).

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY
GROUP INSURANCE PLAN
(Amended and Restated Effective as of January 1, 2019)

APPENDIX B

The Welfare Program Documents are attached hereto and incorporated, in their entirety, into this SPD by reference.

Aetna Open Access Medical Plan (Self-Insured Program)

aetna : PORT OF HOUSTON AUTHORITY : Aetna Open Access® Managed Choice®- $250 Deductible Plan

Coverage for: Individual + Family | **Plan Type:** POS

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=071800-120020-031765 or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: Individual $250 / Family $500. Out–of–Network: Individual $5,000 / Family $10,000.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Emergency care & prescription drugs; plus in-network office visits & preventive care are covered before you meet your deductible.	This plan covers some items and services even if you haven't yet met the deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network: Individual $1,500 / Family $3,000. Out–of–Network: Individual $10,000 / Family $20,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges, health care this plan doesn't cover & penalties for failure to obtain pre-authorization for services.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit, deductible doesn't apply	50% coinsurance	None
	Specialist visit	$40 copay/visit, deductible doesn't apply	50% coinsurance	None
	Preventive care / screening / immunization	No charge	50% coinsurance, except deductible doesn't apply to child immunizations up to age 6	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	0% coinsurance	50% coinsurance	None
	Imaging (CT/PET scans, MRIs)	0% coinsurance	50% coinsurance	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/valueplus Value Plus Formulary	Preferred generic drugs	Copay/prescription, deductible doesn't apply: $20 for 30 day supply (retail), $50 for 31-90 day supply (retail & mail order)	50% coinsurance after copay/prescription, deductible doesn't apply: $20 (retail)	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Copay/prescription, deductible doesn't apply: $30 for 30 day supply (retail), $75 for 31-90 day supply (retail & mail order)	50% coinsurance after copay/prescription, deductible doesn't apply: $30 (retail)	
	Non-preferred generic/brand drugs	Copay/prescription, deductible doesn't apply: $60 for 30 day supply (retail), $150 for 31-90 day supply (retail & mail order)	50% coinsurance after copay/prescription, deductible doesn't apply: $60 (retail)	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Applicable cost as noted above for generic or brand drugs	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% coinsurance	50% coinsurance	None
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need immediate medical attention	Emergency room care	$125 copay/visit, deductible doesn't apply	$125 copay/visit, deductible doesn't apply	50% coinsurance after $125 copay/visit for non-emergency use out-of-network.
	Emergency medical transportation	0% coinsurance	0% coinsurance	No coverage for non-emergency transport.
	Urgent care	$35 copay/visit, deductible doesn't apply	50% coinsurance	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/stay	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Physician/surgeon fees	0% coinsurance	50% coinsurance	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay/visit, deductible doesn't apply; other outpatient services: 0% coinsurance	Office & other outpatient services: 50% coinsurance	None
	Inpatient services	$250 copay/stay	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If you are pregnant	Office visits	No charge	50% coinsurance	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.) Penalty of $400 for failure to obtain pre-authorization for out-of-network care may apply.
	Childbirth/delivery professional services	0% coinsurance	50% coinsurance	
	Childbirth/delivery facility services	$250 copay/stay	50% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Provider (You will pay the least)	Out–of–Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	0% coinsurance	50% coinsurance	60 visits/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Rehabilitation services	$20 copay/visit, deductible doesn't apply	50% coinsurance	None
	Habilitation services	$20 copay/visit, deductible doesn't apply	50% coinsurance	Limited to treatment of Autism.
	Skilled nursing care	0% coinsurance	50% coinsurance	100 days/calendar year. Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
	Durable medical equipment	0% coinsurance	50% coinsurance	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	0% coinsurance	50% coinsurance	Penalty of $400 for failure to obtain pre-authorization for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	50% coinsurance	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Acupuncture
- Bariatric surgery
- Cosmetic surgery
- Dental care (Adult & Child)
- Glasses (Child)
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Routine foot care
- Weight loss programs - Except for required preventive services.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Chiropractic care
- Hearing aids
- Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.
- Private-duty nursing - 70 - 8 hour shifts/calendar year.
- Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Texas Department of Insurance, (800) 578-4677, http://www.tdi.texas.gov/index.html

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- Texas Department of Insurance, (800) 578-4677, http://www.tdi.texas.gov/index.html.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, (800) 578-4677, http://www.tdi.texas.gov/index.html.

Does this plan provide Minimum Essential Coverage? Yes.

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? **Yes.**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$250**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$610**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled

The plan's overall deductible	**$250**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$100
Copayments	$1,400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$250**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other coinsurance	**0%**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$250
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$550**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

Smartphone or Tablet

To view documents from your smartphone or tablet, the free WinZip app is required. It may be available from your App Store.

Non-Discrimination

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call the number on your ID card.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator

P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030, Fresno, CA 93779)

1-800-648-7817, TTY: 711, Fax: 859-425-3379 (CA HMO customers: 1-860-262-7705)

Email: CRCoordinator@aetna.com

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna Kelsey Care Medical Plan (Self-Insured Program)

aetna : PORT OF HOUSTON AUTHORITY : HMO - Kelseycare

Coverage for: Individual + Family | **Plan Type:** HMO

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, https://www.aetna.com/sbcsearch/getpolicydocs?u=071800-120020-031745 or by calling 1-800-370-4526. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at https://www.healthcare.gov/sbc-glossary/ or call 1-800-370-4526 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0.	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible?	No.	You will have to meet the deductible before the plan pays for any services.
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	In-Network Designated: Individual $1,500 / Family $3,000.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit?	Premiums, balance-billing charges & health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in-network designated providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	No.	You can see the specialist you choose without a referral.

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Designated Provider (You will pay the least)	Non–Designated Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay/visit	Not covered	None
	Specialist visit	$40 copay/visit	Not covered	None
	Preventive care / screening / immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	None
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.aetnapharmacy.com/valueplus Value Plus Formulary	Preferred generic drugs	Copay/prescription: $20 for 30 day supply (retail), $50 for 31-90 day supply (retail & mail order)	Not covered	Covers 30 day supply (retail), 31-90 day supply (retail & mail order). Includes contraceptive drugs & devices obtainable from a pharmacy, oral fertility drugs. No charge for preferred generic FDA-approved women's contraceptives in-network. Review your formulary for prescriptions requiring precertification or step therapy for coverage. Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	Copay/prescription: $30 for 30 day supply (retail), $75 for 31-90 day supply (retail & mail order)	Not covered	
	Non-preferred generic/brand drugs	Copay/prescription: $60 for 30 day supply (retail), $150 for 31-90 day supply (retail & mail order)	Not covered	
	Specialty drugs	Applicable cost as noted above for generic or brand drugs	Not covered	None
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions & Other Important Information
		In-Network Designated Provider (You will pay the least)	Non–Designated Provider (You will pay the most)	
If you need immediate medical attention	Emergency room care	$125 copay/visit	$125 copay/visit	No coverage for non-emergency use.
	Emergency medical transportation	No charge	No charge	No coverage for non-emergency transport.
	Urgent care	$35 copay/visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	$250 copay/stay	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: $20 copay/visit; other outpatient services: no charge	Not covered	None
	Inpatient services	$250 copay/stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	Cost sharing does not apply for preventive services. Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound.)
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	$250 copay/stay	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	3 visits/day & 60 visits/calendar year.
	Rehabilitation services	$20 copay/visit	Not covered	None
	Habilitation services	$20 copay/visit	Not covered	Limited to treatment of Autism.
	Skilled nursing care	No charge	Not covered	100 days/calendar year.
	Durable medical equipment	No charge	Not covered	Limited to 1 durable medical equipment for same/similar purpose. Excludes repairs for misuse/abuse.
	Hospice services	$250 copay/stay for inpatient; no charge for outpatient	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	1 routine eye exam/24 months.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)		
• Acupuncture • Bariatric surgery • Cosmetic surgery • Dental care (Adult & Child)	• Glasses (Child) • Hearing aids • Long-term care • Non-emergency care when traveling outside the U.S.	• Private-duty nursing • Routine foot care • Weight loss programs - Except for required preventive services.
Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Chiropractic care	• Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition.	• Routine eye care (Adult) - 1 routine eye exam/24 months.

Your Rights to Continue Coverage:

There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: Texas Department of Insurance, (800) 578-4677, http://www.tdi.texas.gov/index.html

- For more information on your rights to continue coverage, contact the plan at 1-800-370-4526.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- If your coverage is a church plan, church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact their State insurance regulator regarding their possible rights to continuation coverage under State law.

Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights:

There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, contact:

- Aetna directly by calling the toll free number on your Medical ID Card, or by calling our general toll free number at 1-800-370-4526.
- Texas Department of Insurance, (800) 578-4677, http://www.tdi.texas.gov/index.html.
- If your group health coverage is subject to ERISA, you may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, you may also contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.

- Additionally, a consumer assistance program can help you file your appeal. Contact Texas Department of Insurance, 333 Guadalupe, Austin, TX 78701, (800) 578-4677, http://www.tdi.texas.gov/index.html.

Does this plan provide Minimum Essential Coverage? **Yes.**

If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan Meet Minimum Value Standard? **Yes.**

If your **plan** doesn't meet the **Minimum Value Standards**, you may be eligible for a **premium tax credit** to help you pay for a **plan** through the **Marketplace.**

----------To see examples of how this plan might cover costs for a sample medical situation, see the next section.----------

About these Coverage Examples:

This is not a cost estimator. Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

Peg is Having a baby

(9 months of in-network pre-natal care and a hospital delivery)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$0**

This EXAMPLE event includes services like:
Specialist office visits (*prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests (*ultrasounds and blood work)*
Specialist visit *(anesthesia)*

Total Example Cost	**$12,800**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$360**

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$0**

This EXAMPLE event includes services like:
Primary care physician office visits (*including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

Total Example Cost	**$7,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$0
Copayments	$1,500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1,520**

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

The plan's overall deductible	**$0**
Specialist copayment	**$40**
Hospital (facility) copayment	**$250**
Other copayment	**$0**

This EXAMPLE event includes services like:
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

Total Example Cost	**$1,900**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$0
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$300**

Note: These numbers assume the patient does not participate in the plan's wellness program. If you participate in the plan's wellness program, you may be able to reduce your costs. For more information about the wellness program, please contact: 1-800-370-4526.

The plan would be responsible for the other costs of these EXAMPLE covered services.

Assistive Technology

Persons using assistive technology may not be able to fully access the following information. For assistance, please call 1-800-370-4526.

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna PPO Dental Plan (Fully-Insured Program)

Dental Benefits Summary

	Passive PDN With PDNII Network
Annual Deductible*	
Individual	**$50**
Family	**$150**
Preventive Services	**100%**
Basic Services	**80%**
Major Services	**50%**
Annual Benefit Maximum	**$1,000**
Office Visit Copay	**N/A**
Orthodontic Services**	**50%**
Orthodontic Deductible	**None**
Orthodontic Lifetime Maximum	**$1,000**

***The deductible applies to: Basic & Major services only**
****Orthodontia is covered only for children (appliance must be placed prior to age 20).**

Partial List of Services	Passive PDN With PDNII Network
Preventive	
Oral examinations (a)	100%
Cleanings (a) Adult/Child	100%
Fluoride (a)	100%
Sealants (permanent molars only) (a)	100%
Bitewing Images (a)	100%
Full mouth series Images (a)	100%
Space Maintainers	100%
Basic	
Root canal therapy	
Anterior teeth / Bicuspid teeth	80%
Scaling and root planing (a)	80%
Gingivectomy*	80%
Amalgam (silver) fillings	80%
Composite fillings (anterior teeth only)	80%
Stainless steel crowns	80%
Incision and drainage of abscess*	80%
Uncomplicated extractions	80%
Surgical removal of erupted tooth*	80%
Surgical removal of impacted tooth (soft tissue)*	80%
Major	
Inlays	50%
Onlays	50%
Crowns	50%
Crown lengthening	50%
Full & partial dentures	50%
Pontics	50%
Root canal therapy, molar teeth	50%
Osseous surgery (a)*	50%
Surgical removal of impacted tooth (partial bony/ full bony)*	50%
General anesthesia/intravenous sedation*	50%
Denture repairs	50%
Crown Build-Ups	50%

***Certain services may be covered under the Medical Plan. Contact Member Services for more details.**
(a) Frequency and/or age limitations may apply to these services. These limits are described in the booklet/certificate.

Other Important Information

This Aetna Dental® Participating Dental Network (PDN) benefits summary is provided by Aetna Life Insurance Company for some of the more frequently performed dental procedures. Under the Dental Participating Dental Network (PDN) plan, you may choose at the time of service either a PDN participating dentist or any nonparticipating dentist. With the PDN plan, savings are possible because the participating dentists have agreed to provide care for covered services at negotiated rates. Non-participating benefits are subject to recognized charge limits.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week.

When emergency services are provided by a participating PDN dentist, your co-payment/coinsurance amount will be based on a negotiated fee schedule. When emergency services are provided by a non-participating dentist, you will be responsible for the difference between the plan payment and the dentist's usual charge. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Partial List of Exclusions and Limitations* - Coverage is not provided for the following:

1. Services or supplies that are covered in whole or in part:
   (a) under any other part of this Dental Care Plan; or
   (b) under any other plan of group benefits provided by or through your employer.
2. Services and supplies to diagnose or treat a disease or injury that is not:
   (a) a non-occupational disease; or
   (b) a non-occupational injury.
3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.
4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.
5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.
6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals. (Does not apply to TX plans)
7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion.
8. Those for any of the following services (Does not apply to the DMO plan in TX):
   (a) an appliance or modification of one if an impression for it was made before the person became a covered person;
   (b) a crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person; or
   (c) root canal therapy if the pulp chamber for it was opened before the person became a covered person.
9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.
10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.

11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.
13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.
14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Those in connection with a service given to a person age 5 or older if that person becomes a covered person other than:

   (a) during the first 31 days the person is eligible for this coverage, or
   (b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
      (i) after the end of the 12-month period starting on the date the person became a covered person; or
      (ii) as a result of accidental injuries sustained while the person was a covered person; or
      (iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.
16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

17. Those for a crown, cast or processed restoration unless:
    (a) it is treatment for decay or traumatic injury, and teeth cannot be restored with a filling material; or
    (b) the tooth is an abutment to a covered partial denture or fixed bridge.
18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.
19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.
20. Services needed solely in connection with non-covered services.
21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services.

Any exclusion above will not apply to the extent that coverage of the charges is required under any law that applies to the coverage.
*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Replacement Rule
The replacement of; addition to; or modification of: existing dentures; crowns; casts or processed restorations; removable denture; fixed bridgework; or other prosthetic services is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 8 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 8 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:
    (a) the service must be listed on the Dental Care Schedule;
    (b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
    (c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:
    (a) the copayment for the approved less costly service; plus
    (b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dentals online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern.

In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate.
All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.

In Texas, the Dental Participating Dental Network (PDN) is known as the Participating Dental Network (PDN), and is administered by Aetna Life Insurance Company.

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability.

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

For language assistance in your language call 877-238-6200 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-238-6200. (Spanish)

欲取得繁體中文語言協助，請撥打877-238-6200，無需付費。(Chinese)

Pour une assistance linguistique en français appeler le 877-238-6200 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-238-6200 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-238-6200 an. (German)

للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني 877-238-6200. (Arabic)

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 877-238-6200 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-238-6200. (Italian)

日本語で援助をご希望の方は、877-238-6200 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-238-6200 번으로 전화해 주십시오. (Korean)

برای راهنمایی به زبان فارسی با شماره 877-238-6200. بدون هیچ هزینه ای تماس بگیرید. انگلیسی (Persian)

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-238-6200. (Polish)

Para obter assistência linguística em português ligue para o 877-238-6200 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-238-6200. (Russian)

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-238-6200. (Vietnamese)

Aetna DMO Dental Plan (Fully-Insured Program)

aetna®

Port of Houston Authority
Plan 65
Effective Date: 01-01-2019

Dental Benefits Summary

CODE	PROCEDURE	PATIENT PAYS	CODE	PROCEDURE	PATIENT PAYS
Office Visit Copay		$5			
DIAGNOSTIC					
D0120-D0180	Oral Evaluations	No Charge	D0277	Vertical Bitewings - 7 to 8 Films	No Charge
D0210	Full mouth series Images	No Charge	D0330	Panoramic Image	No Charge
D0220-D0230	Periapicals	No Charge	D0391	Interpretation of Diagnostic Image	No Charge
D0240	Intraoral, Occlusal Image	No Charge	D0460	Pulp Vitality Test	No Charge
D0250-D0251	Extraoral Images	No Charge	D0470	Diagnostic Casts	No Charge
D0270-D0274	Bitewings	No Charge	D0472-D0474	Accession of Tissue	No Charge
PREVENTIVE					
D1110	Prophy - Adult	No Charge	D1510	Space Maintainer - Fixed Unilateral	No Charge
D1120	Prophy - Child	No Charge	D1515	Space Maintainer - Fixed Bilateral	No Charge
D4346	Scaling in presence of generalized moderate/severe gingival inflammation – full mouth, after oral evaluation	$30	D1520	Space Maintainer - Removable Unilateral	No Charge
D1208	Fluoride - Child	No Charge	D1525	Space Maintainer - Removable Bilateral	No Charge
D1206	Application of Topical Fluoride Varnish	No Charge	D1550	Recement Space Maintainer	$12
D1330	Oral Hygiene Instruction	No Charge	D1555	Removal of Space Maintainer	$12
D1351, D1354	Sealant	No Charge	D1575	Distal shoe space maintainer - fixed - unilateral	No Charge
D1352	Preventive Resin Restoration	No Charge	D2990	Resin Infiltration of Lesion	No Charge
D1353	Sealant Repair - Per Tooth	No Charge			
Diagnostic and Preventive services may be subject to age and frequency limitations. See your booklet for details.					
RESTORATIVE					
PRIMARY OR PERMANENT TEETH					
D2140	Amalgam - 1 Surf Primary or Permanent	No Charge	D2391	Resin-Based Composite 1 Surf, Posterior	$35
D2150	Amalgam - 2 Surf Primary or Permanent	No Charge	D2392	Resin-Based Composite 2 Surf, Posterior	$45
D2160	Amalgam - 3 Surf Primary or Permanent	No Charge	D2393	Resin-Based Composite 3 Surf, Posterior	$55
D2161	Amalgam - 4+ Surf Primary or Permanent	No Charge	D2394	Resin-Based Composite 4+ Surf, Posterior	$75
D2330	Resin-Based Composite 1 Surf, Anterior	No Charge	D2921	Reattachment of tooth fragment, incisal edge or dusp	$4
D2331	Resin-Based Composite 2 Surf, Anterior	No Charge	D2940	Protective Restoration	No Charge
D2332	Resin-Based Composite 3 Surf, Anterior	No Charge	D2941	Interim therapeutic restoration - primary dentition	No Charge
D2335	Resin-Based Composite 4+ Surf; Anterior (or involving Incisal angle)	$40	D2951	Pin Retention - In Addition to Restoration	$10
D2390	Resin-Based Composite Crown, Anterior	$40			
CROWNS/BRIDGES					
D2510	Inlay - Metallic 1 Surf	$190	D6076	Implant Supported Retainer for Porcelain Fused to Metal FPD (Titanium, Titanium Alloy or High Noble Metal)	$225
D2520	Inlay - Metallic 2 Surf	$190	D6077	Implant Supported Retainer for Cast Metal FPD (Titanium, Titanium Alloy or High Noble Metal)	$225
D2530	Inlay - Metallic 3 Surf	$190	D6094	Abutment Supported Crown - (Titanium)	$225
D2542	Onlay - Metallic 2 Surf	$200	D6110	Implant Abut Sup Removable Dent-MaxCom	$275
D2543	Onlay - Metallic 3 Surf	$200	D6111	Implant Abut Sup Removable Dent-Mand Com	$275
D2544	Onlay, Metallic - 4 or More Surf	$200	D6112	Implant Abut Sup Removable Dent-Max Par	$275
D2610	Inlay, Porcelain/Ceramic - 1 Surf	$190	D6113	Implant Abut Sup Removable Dent-Mand Par	$275
D2620	Inlay, Porcelain/Ceramic - 2 Surf	$190	D6114	Implant Abut Sup Fixed Dent-Max Com	$275
D2630	Inlay, Porcelain/Ceramic - 3 or More Surf	$190	D6115	Implant Abut Sup Fixed Dent-Mand Com	$275
D2642	Onlay, Porcelain/Ceramic - 2 Surf	$200	D6116	Implant Abut Sup Fixed Dent-Max Par	$275
D2643	Onlay, Porcelain/Ceramic - 3 Surf	$200	D6117	Implant Abut Sup Fixed Dent-Mand Par	$275
D2644	Onlay, Porcelain/Ceramic - 4 or More Surf	$200	D6205	Pontic - Indirect Resin Based Composite	$225
D2650	Inlay, Composite/Resin - 1 Surf	$190	D6210	Pontic - Cast High Noble Metal	$225
D2651	Inlay, Composite/Resin - 2 Surf	$190	D6211	Pontic - Cast Predominantly Base Metal	$225
D2652	Inlay, Composite/Resin - 3 Surf	$190	D6212	Pontic - Cast Noble Metal	$225
D2662	Onlay, Composite/Resin - 2 Surf	$200	D6214	Pontic - Titanium	$225
D2663	Onlay, Composite/Resin - 3 Surf	$200	D6240	Pontic - Porcelain Fused to High Noble Metal	$225
D2664	Onlay, Composite/Resin - 4 or More Surf	$200	D6241	Pontic - Porcelain Fused to Predominantly Base	$225
D2710	Crown - Resin-Based Composite, Indirect	$225	D6242	Pontic - Porcelain Fused to Noble Metal	$225

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Dental Benefits Summary

D2712	Crown - 3/4 Resin-Based Composite, Indirect	$180	D6245	Pontic - Porcelain/Ceramic	$225
D2720	Crown - Resin With High Noble Metal	$225	D6250	Pontic - Resin With High Noble Metal	$225
D2721	Crown - Resin With Predominantly Base Metal	$225	D6251	Pontic - Resin With Predominantly Base Metal	$225
D2722	Crown - Resin With Noble Metal	$225	D6252	Pontic - Resin With Noble Metal	$225
D2740	Crown - Porcelain/Ceramic Substrate	$225	D6545	Retainer - Cast Metal for Resin-Bonded Fixed	$190
D2750	Crown - Porcelain Fused to High Noble Metal	$225	D6548	Retainer - Porcelain/Ceramic for Resin-Bonded Fixed Prosthesis	$190
D2751	Crown - Porcelain Fused to Predominantly Base Metal	$225	D6549	Resin Retainer - Resin Bonded Prosthesis	$113
D2752	Crown - Porcelain Fused to Noble Metal	$225	D6600	Inlay - Porcelain/Ceramic, 2 Surf	$190
D2780	Crown - 3/4 Cast High Noble Metal	$225	D6601	Inlay - Porcelain/Ceramic, 3+ Surf	$190
D2781	Crown - 3/4 Cast Predominantly Based Metal	$225	D6602	Inlay - Cast High Noble Metal, 2 Surf	$220
D2782	Crown - 3/4 Cast Noble Metal	$225	D6603	Inlay - Cast High Noble Metal, 3+ Surf	$220
D2783	Crown - 3/4 Porcelain/Ceramic	$225	D6604	Inlay - Cast Predominantly Base Metal, 2 Surf	$190
D2790	Crown - Full Cast High Noble Metal	$225	D6605	Inlay - Cast Predominantly Base Metal, 3+ Surf	$190
D2791	Crown - Full Cast Predominantly Base Metal	$225	D6606	Inlay - Cast Noble Metal, 2 Surf	$210
D2792	Crown - Full Cast Noble Metal	$225	D6607	Inlay - Cast Noble Metal, 3+ Surf	$210
D2794	Crown - Titanium	$225	D6608	Onlay - Porcelain/Ceramic, 2 Surf	$200
D2910	Recement Inlay, Onlay or Partial Coverage Restoration	$5	D6609	Onlay - Porcelain/Ceramic, 3+ Surf	$200
D2915	Recement Cast or Prefab Post and Core	$3	D6610	Onlay - Cast High Noble Metal, 2 Surf	$230
D2920	Recement Crown	$5	D6611	Onlay - Cast High Noble Metal, 3+ Surf	$230
D2929	Prefab Porcelain/Ceramic Crown - Primary Tooth	No Charge	D6612	Onlay - Cast Predominantly Base Metal, 2 Surf	$200
D2930	Prefab, Stainless Steel Crown - Primary Tooth	No Charge	D6613	Onlay - Cast Predominantly Base Metal, 3+ Surf	$200
D2931	Prefab, Stainless Steel Crown - Permanent Tooth	$40	D6614	Onlay - Cast Noble Metal, 2 Surf	$220
D2934	Prefabricated Esthetic Coated Stainless Steel Crown - Primary Tooth	No Charge	D6615	Onlay - Cast Noble Metal, 3+ Surf	$220
D2950	Core Buildup, Including Any Pins	$60	D6624	Inlay - Titanium	$220
D2952	Post & Core in Addition to Crown	$80	D6634	Onlay - Titanium	$230
D6058	Abutment Supported Porcelain/Ceramic Crown	$225	D6710	Crown - Indirect Resin Based Composite	$225
D6059	Abutment Supported Porcelain Fused to Metal Crown (High Noble Metal)	$225	D6720	Crown - Resin With High Noble Metal	$225
D6060	Abutment Supported Porcelain Fused to Metal Crown (Predominantly Base Metal)	$225	D6721	Crown - Resin With Predominantly Base Metal	$225
D6061	Abutment Supported Porcelain Fused to Metal Crown (Noble Metal)	$225	D6722	Crown - Resin With Noble Metal	$225
D6062	Abutment Supported Cast Metal Crown (High Noble Metal)	$225	D6740	Crown - Porcelain/Ceramic	$225
D6063	Abutment Supported Cast Metal Crown (Predominantly Base Metal)	$225	D6750	Crown - Porcelain Fused to High Noble Metal	$225
D6064	Abutment Supported Cast Metal Crown (Noble Metal)	$225	D6751	Crown - Porcelain Fused to Predominantly Base Metal	$225
D6065	Implant Supported Porcelain/Ceramic Crown	$225	D6752	Crown - Porcelain Fused to Noble Metal	$225
D6066	Implant Supported Porcelain Fused to Metal Crown (Titanium, Titanium Alloy or High Noble	$225	D6780	Crown - 3/4 Cast High Noble Metal	$225
D6067	Implant Supported Metal Crown (Titanium, Titanium Alloy or High Noble Metal)	$225	D6781	Crown - 3/4 Cast Predominantly Base Metal	$225
D6068	Abutment Supported Retainer for Porcelain/Ceramic FPD	$225	D6782	Crown - 3/4 Cast Noble Metal	$225
D6069	Abutment Supported Retainer for Porcelain Fused to Metal FPD (High Noble Metal)	$225	D6783	Crown - 3/4 Porcelain/Ceramic	$225
D6070	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Predominantly Base Metal)	$225	D6790	Crown - Full Cast High Noble Metal	$225
D6071	Abutment Supported Retainer for Porcelain Fused to Metal FPD (Noble Metal)	$225	D6791	Crown - Full Cast Predominantly Base Metal	$225
D6072	Abutment Supported Retainer for Cast Metal FPD (High Noble Metal)	$225	D6792	Crown - Full Cast Noble Metal	$225
D6073	Abutment Supported Retainer for Cast Metal FPD (Predominantly Base Metal)	$225	D6794	Crown - Titanium	$225

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Dental Benefits Summary

D6074	Abutment Supported Retainer for Cast Metal FPD (Noble Metal)	$225	D6930	Recement Fixed Partial Denture	$15
D6075	Implant Supported Retainer for Ceramic FPD	$225	Additional Charge per Unit for Full Mouth Rehabilitation.		$125
Full mouth rehabilitation is defined as 6 or more units of covered crowns and/or pontics under one treatment plan.					
Charges for crowns and bridgework are per unit. There will be additional charges for the actual cost for gold/high noble metal.					
ENDODONTICS					
D3110	Pulp Cap - Direct (excluding final restoration)	No Charge	D3333	Internal Root Repair of Perforation Defects	$40
D3120	Pulp Cap - Indirect (excluding final restoration)	No Charge	D3346	Retreatment of Previous Root Canal Therapy - Anterior	$150
D3220	Therapeutic Pulpotomy (excluding final restoration)	No Charge	D3347	Retreatment of Previous Root Canal Therapy - Bicuspid	$170
D3221	Pulpal Debridement, Primary and Permanent Teeth	$10	D3348	Retreatment of Previous Root Canal Therapy - Molar	$275
D3222	Partial Pulpotomy	No Charge	D3410 (1)	Apicoectomy/Periradicular Surgery - Anterior	$65
D3230	Pulpal Therapy (Resorbable Filling) - Anterior, Primary Tooth	No Charge	D3421 (1)	Apicoectomy/Periradicular Surgery - Bicuspid (First Root)	$65
D3240	Pulpal Therapy (Resorbable Filling) - Posterior, Primary Tooth	No Charge	D3425 (1)	Apicoectomy/Periradicular Surgery - Molar (First Root)	$80
D3310	Root Canal Therapy - Anterior (excluding final restoration)	$50	D3426 (1)	Apicoectomy/Periradicular Surgery- Each Additional Root	$40
D3320	Root Canal Therapy - Bicuspid (excluding final restoration)	$70	D3427 (1)	Periradicular surgery without apicoectomy	$49
D3330	Root Canal Therapy - Molar (excluding final restoration)	$175	D3430 (1)	Retrograde Filling - Per Root	$20
D3331	Treatment of Root Canal Obstruction, Nonsurgical Access	$50	D3450 (1)	Root Amputation - Per Root	$60
D3332	Incomplete Endodontic Therapy; Inoperable, Unrestorable or Fractured Tooth	$35			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
PERIODONTICS					
D4210 (1)	Gingivectomy or Gingivoplasty - 4 or More Teeth - Per Quadrant	$100	D4275 (1)	Soft Tissue Allograft	$230
D4211 (1)	Gingivectomy or Gingivoplasty - 1-3 Teeth - Per Quadrant	$30	D4276 (1)	Connective Tissue/Pedicle Graft, Per Tooth	$190
D4212 (1)	Gingivectomy to allow access, per tooth	$12	D4277 (1)	Free soft tissue graft - first tooth	$82
D4240 (1)	Gingival Flap Procedure, Including Root Planing - 4 or More Teeth - Per Quadrant	$110	D4278 (1)	Free soft tissue graft - each additional tooth	$41
D4241 (1)	Gingival Flap Procedure, Including Root Planing - 1-3 Teeth - Per Quadrant	$66	D4283 (1)	Autogenous connective tissue graft	$63
D4245 (1)	Apically Positioned Flap	$90	D4285 (1)	Non-autogenous connective tissue graft	$127
D4249	Clinical Crown Lengthening, Hard Tissue	$150	D4341	Periodontal Scaling and Root Planing - 4 or More Teeth - Per Quadrant	$50
D4260 (1)	Osseous Surgery (Including Flap Entry and Closure) - 4 or More Teeth - Per Quadrant	$250	D4342	Periodontal Scaling and Root Planing - 1-3 Teeth - Per Quadrant	$30
D4261 (1)	Osseous Surgery (Including Flap Entry and Closure) - 1-3 Teeth - Per Quadrant	$150	D4355	Debridement	$60
D4268 (1)	Surgical Revision Procedure, Per Tooth	$100	D4910	Periodontal Maintenance	$30
D4270 (1)	Pedicle Soft Tissue Graft Procedure	$190	D4920	Unscheduled Dressing Change (By Someone Other Than Treating Dentist)	$10
D4273 (1)	Subepithelial Connective Tissue Graft, Per Tooth	$115			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
PROSTHODONTICS-REMOVABLE (2)					
D5110	Complete Denture - Maxillary	$275	D5223-D5224	Immediate max/mand partial denture - cast base framework w/resin denture base (including any conventional clasps, rests and teeth)	$374

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Dental Benefits Summary

D5120	Complete Denture - Mandibular	$275	D5225	Maxillary Partial Denture - Flexible Base (including any clasps, rests and teeth)	$330
D5130	Immediate Denture - Maxillary	$325	D5226	Mandibular Partial Denture - Flexible Base (including any clasps, rests and teeth)	$330
D5140	Immediate Denture - Mandibular	$325	D5281	Removable Unilateral Partial Denture - One Piece Cast Metal (including clasps and teeth)	$275
D5211	Maxillary Partial Denture - Resin Base (including any conventional clasps, rests and	$275	D5410	Adjust Complete Denture - Maxillary	$10
D5212	Mandibular Partial Denture - Resin Base (including any conventional clasps, rests and teeth)	$275	D5411	Adjust Complete Denture - Mandibular	$10
D5213	Maxillary Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$325	D5421	Adjust Partial Denture - Maxillary	$10
D5214	Mandibular Partial Denture - Cast Metal Framework with Resin Denture Bases (including any conventional clasps, rests and teeth)	$325	D5422	Adjust Partial Denture - Mandibular	$10
D5221-D5222	Immediate max/mand partial dental - resin base (including any conventional clasps, rests and teeth)	$316			
(2) Includes relines, adjustments, rebases within the 1st six months. Adjustments to dentures that are done within six months of placement of the denture, are limited to no more than four adjustments.					
REPAIRS TO PROSTHETICS					
D5510	Repair Broken Complete Denture Base	$30	D5730	Reline Complete Maxillary Denture (Chairside)	$40
D5520	Replace Missing or Broken Teeth - Complete Denture (each tooth)	$35	D5731	Reline Complete Mandibular Denture (Chairside)	$40
D5610	Repair Resin Denture Base	$35	D5740	Reline Maxillary Partial Denture (Chairside)	$40
D5620	Repair Cast Framework	$35	D5741	Reline Mandibular Partial Denture (Chairside)	$40
D5630	Repair or Replace Broken Clasp	$35	D5750	Reline Complete Maxillary Denture (Lab)	$90
D5640	Replace Broken Teeth - Per Tooth	$35	D5751	Reline Complete Mandibular Denture (Lab)	$90
D5650	Add Tooth to Existing Partial Denture	$35	D5760	Reline Maxillary Partial Denture (Lab)	$90
D5660	Add Clasp to Existing Partial Denture	$40	D5761	Reline Mandibular Partial Denture (Lab)	$90
D5670	Replace All Teeth and Acrylic on Cast Metal Framework (Maxillary)	$100	D5820	Interim Partial Denture (Maxillary) (3)	$90
D5671	Replace All Teeth and Acrylic on Cast Metal Framework (Mandibular)	$100	D5821	Interim Partial Denture (Mandibular) (3)	$90
D5710	Rebase Complete Maxillary Denture	$100	D5850	Tissue Conditioning, Maxillary	$40
D5711	Rebase Complete Mandibular Denture	$100	D5851	Tissue Conditioning, Mandibular	$40
D5720	Rebase Maxillary Partial Denture	$100	D5860	Overdenture - Complete, by Report	$275
D5721	Rebase Mandibular Partial Denture	$100			
(3) Eligible on Anterior Teeth only.					
ORAL SURGERY					
D7111	Extraction, Coronal Remnants - Deciduous Tooth	No Charge	D7285 (1)	Biopsy of Oral Tissue - Hard (Bone, Tooth)	$50
D7140	Extraction, Erupted Tooth or Exposed Root (Elevation and/or Forceps Removal)	No Charge	D7286 (1)	Biopsy of Oral Tissue - Soft	$50
D7210 (1)	Surgical Removal of Erupted Tooth	No Charge	D7287 (1)	Cytological Sample Collection	$25
D7220 (1)	Removal of Impacted Tooth - Soft Tissue	No Charge	D7310 (1)	Alveoloplasty in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$18
D7230 (1)	Removal of Impacted Tooth - Partially Bony	$45	D7311 (1)	Alveoloplasty in Conjunction With Extractions - 1 to 3 Teeth or Tooth Spaces - Per Quadrant	$9
D7240 (1)	Removal of Impacted Tooth - Completely Bony	$70	D7320 (1)	Alveoloplasty Not in Conjunction With Extractions - 4 or More Teeth or Tooth Spaces - Per Quadrant	$25
D7241 (1)	Removal of Impacted Tooth - Completely Bony, With Unusual Surgical Complications	$70	D7321 (1)	Alveoloplasty Not in Conjunction With Extractions - 1-3 Teeth or Tooth Spaces - Per Quadrant	$13
D7250 (1)	Surgical Removal of Residual Tooth Roots	$15	D7510 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue	$10

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Dental Benefits Summary

D7251	Coronectomy - intentional partial tooth removal	$35	D7511 (1)	Incision and Drainage of Abcess - Intraoral Soft Tissue - Complicated	$11
D7280 (1)	Surgical Access of Unerupted Tooth	$26	D7960 (1)	Frenulectomy (Frenectomy, Frenotomy) Separate Procedure	$24
D7282 (1)	Mobilization of Erupted or Malpositioned Tooth to Aid Eruption	$30	D7963 (1)	Frenuloplasty	$25
D7283	Placement of Device to Facilitate Eruption of Impacted Tooth	$6			
(1) Certain services may be covered under the Medical Plan. Contact Member Services for more details.					
OTHER (ADJUNCTIVE) SERVICES					
D9110	Palliative (Emergency) Treatment of Dental Pain - minor procedure	$10	D9940	Occlusal Guard, by Report	$100
D9223	Deep sedation/general anesthesia - each 15 minute increment	$83	D9943	Occlusal guard adjustment	$13
D9243	Intravenous conscious sedation/analgesia - each 15 minute increment	$83	D9942	Repair and/or Reline of Occlusal Guard	$18
D9310	Consultation - Diagnostic Service Provided by Dentist or Physician Other Than Requesting Dentist or Physician	No Charge	D9951	Occlusal Adjustment - limited	$20
D9311	Consultation with a medical health care professional	No Charge	D9952	Occlusal Adjustment - complete	$80
D9932-D9935	Denture cleaning and inspection	$25			
ORTHODONTICS					
	Orthodontic Screening Exam	$30			
	Diagnostic Records	$150			
	Comprehensive Orthodontic Treatment				
	Adolescent	$1,945			
	Adult	$1,945			
	Orthodontic Retention	$275			

PLAN EXCLUSIONS AND LIMITATIONS*

Some Services Not Covered Under the Plan Are:

1. Services or supplies that are covered in whole or in part:
(a) under any other part of this Dental Care Plan; or
(b) under any other plan of group benefits provided by or through your employer.

2. Services and supplies to diagnose or treat a disease or injury that is not:
(a) a non-occupational disease; or
(b) a non-occupational injury.

3. Services not listed in the Dental Care Schedule that applies, unless otherwise specified in the Booklet-Certificate.

4. Those for replacement of a lost, missing or stolen appliance, and those for replacement of appliances that have been damaged due to abuse, misuse or neglect.

5. Those for plastic, reconstructive or cosmetic surgery, or other dental services or supplies, that are primarily intended to improve, alter or enhance appearance. This applies whether or not the services and supplies are for psychological or emotional reasons. Facings on molar crowns and pontics will always be considered cosmetic.

6. Those for or in connection with services, procedures, drugs or other supplies that are determined by Aetna to be experimental or still under clinical investigation by health professionals. (Does not apply to TX plans)

7. Those for dentures, crowns, inlays, onlays, bridgework, or other appliances or services used for the purpose of splinting, to alter vertical dimension, to restore occlusion, or to correct attrition, abrasion or erosion. Does not apply to CA contracts.

8. Those for any of the following services (Does not apply to TX contracts):
(a) An appliance or modification of one if an impression for it was made before the person became a covered person;
(b) A crown, bridge, or cast or processed restoration if a tooth was prepared for it before the person became a covered person;
(c) Root canal therapy if the pulp chamber for it was opened before the person became a covered person.

9. Services that Aetna defines as not necessary for the diagnosis, care or treatment of the condition involved. This applies even if they are prescribed, recommended or approved by the attending physician or dentist.

10. Those for services intended for treatment of any jaw joint disorder, unless otherwise specified in the Booklet-Certificate.

11. Those for space maintainers, except when needed to preserve space resulting from the premature loss of deciduous teeth.

12. Those for orthodontic treatment, unless otherwise specified in the Booklet-Certificate.

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Dental Benefits Summary

13. Those for general anesthesia and intravenous sedation, unless specifically covered. For plans that cover these services, they will not be eligible for benefits unless done in conjunction with another necessary covered service.

14. Those for treatment by other than a dentist, except that scaling or cleaning of teeth and topical application of fluoride may be done by a licensed dental hygienist. In this case, the treatment must be given under the supervision and guidance of a dentist.

15. Those in connection with a service given to a dependent age 5 or older if that dependent becomes a covered dependent other than:
(a) during the first 31 days the dependent is eligible for this coverage, or
(b) as prescribed for any period of open enrollment agreed to by the employer and Aetna. This does not apply to charges incurred:
(i) after the end of the 12-month period starting on the date the dependent became a covered dependent; or
(ii) as a result of accidental injuries sustained while the dependent was a covered dependent; or
(iii) for a primary care service in the Dental Care Schedule that applies as shown under the headings Visits and Exams, and X-rays and Pathology.

16. Services given by a nonparticipating dental provider to the extent that the charges exceed the amount payable for the services shown in the Dental Care Schedule that applies.

17. Those for a crown, cast or processed restoration unless:
(a) It is treatment for decay or traumatic injury and teeth cannot be restored with a filling material; or
(b) The tooth is an abutment to a covered partial denture or fixed bridge.

18. Those for pontics, crowns, cast or processed restorations made with high-noble metals, unless otherwise specified in the Booklet-Certificate.

19. Those for surgical removal of impacted wisdom teeth only for orthodontic reasons, unless otherwise specified in the Booklet-Certificate.

20. Services needed solely in connection with non-covered services.

21. Services done where there is no evidence of pathology, dysfunction or disease other than covered preventive services. Does not apply to CA contracts.

Any exclusion above will not apply to the extent that coverage of the charge is required under any law that applies to the coverage.

*This is a partial list of exclusions and limitations, others may apply. Please check your plan booklet for details.

Other Important Information

This Benefit summary of the Aetna Dental Maintenance Organization (DMO®) provides information on benefits provided when services are rendered by a participating dentist. In order for a covered person to be eligible for benefits, dental services must be provided by a primary care dentist selected from the network of participating DMO dentists. Out of network benefits may apply. Please refer to your Schedule of Benefits.

Due to state law, limited (varying by state) DMO® benefits for non-emergency services rendered by non-participating providers are available for plan contracts written in: CT, IL, KY and OH and for members residing in MA and OK (regardless of contract situs state).

Specialty Referrals

1. Under the DMO dental plan, services performed by specialists are eligible for coverage only when prescribed by the primary care dentist and authorized by Aetna Dental. If Aetna's payment to the specialty dentist is based on a negotiated fee, then the member's copayment for the service will be based on the same negotiated fee. If Aetna's payment is on another basis, then the copayment will be based on the dentist's usual fee for the service, reviewed by Aetna for reasonableness.

2. DMO members may visit an orthodontist without first obtaining a referral from their primary care dentist. In an effort to ease the administrative burden on both participating Aetna dentists and members, Dental has opened direct access for DMO members to orthodontic services.

Emergency Dental Care

If you need emergency dental care for the palliative treatment (pain relieving, stabilizing) of a dental emergency, you are covered 24 hours a day, 7 days a week. You should contact your Primary Care Dentist to receive treatment. If you are unable to contact your PCD, contact Member Services for assistance in locating a dentist. Refer to your plan documents for details. Subject to state requirements. Out-of-area emergency dental care may be reviewed by our dental consultants to verify appropriateness of treatment.

Your Dental Care Plan Coverage Is Subject to the Following Rules:

Dental Benefits Summary

Replacement Rule
The replacement of; addition to; or modification of:
existing dentures;
crowns;
casts or processed restorations;
removable denture;
fixed bridgework; or
other prosthetic services
is covered only if one of the following terms is met:

The replacement or addition of teeth is required to replace one or more teeth extracted after the existing denture or bridgework was installed. This coverage must have been in force for the covered person when the extraction took place.

The existing denture, crown; cast or processed restoration, removable denture, bridgework, or other prosthetic service cannot be made serviceable, and was installed at least 5 years before its replacement.

The existing denture is an immediate temporary one to replace one or more natural teeth extracted while the person is covered, and cannot be made permanent, and replacement by a permanent denture is required. The replacement must take place within 12 months from the date of initial installation of the immediate temporary denture.

The extraction of a third molar does not qualify. Any such appliance or fixed bridge must include the replacement of an extracted tooth or teeth.

Tooth Missing But Not Replaced Rule (Does not apply to TX and CA contracts.)
Coverage for the first installation of removable dentures; fixed bridgework and other prosthetic services is subject to the requirements that such removable dentures; fixed bridgework and other prosthetic services are (i) needed to replace one or more natural teeth that were removed while this policy was in force for the covered person; and (ii) are not abutments to a partial denture; removable bridge; or fixed bridge installed during the prior 5 years.

Alternate Treatment Rule: If more than one service can be used to treat a covered person's dental condition, Aetna may decide to authorize coverage only for a less costly covered service provided that all of the following terms are met:

(a) the service must be listed on the Dental Care Schedule;
(b) the service selected must be deemed by the dental profession to be an appropriate method of treatment; and
(c) the service selected must meet broadly accepted national standards of dental practice.

If treatment is being given by a participating dental provider and the covered person asks for a more costly covered service than that for which coverage is approved, the specific copayment for such service will consist of:

(a) the copayment for the approved less costly service; plus
(b) the difference in cost between the approved less costly service and the more costly covered service.

Finding Participating Providers

Consult Aetna Dental's online provider directory, DocFind®, for the most current provider listings. Participating providers are independent contractors in private practice and are neither employees nor agents of Aetna Dental or its affiliates. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change without notice. Not every provider listed in the directory will be accepting new patients. Although Aetna Dental has identified providers who were not accepting patients in our DMO plan as known to Aetna Dental at the time the provider directory was created, the status of a provider's practice may have changed. For the most current information, please contact the selected provider or Aetna Member Services at the toll-free number on your online ID card, or use our Internet-based provider directory (DocFind) available at www.aetna.com.

Specific products may not be available on both a self-funded and insured basis. The information in this document is subject to change without notice. In case of a conflict between your plan documents and this information, the plan documents will govern. In the event of a problem with coverage, members should contact Member Services at the toll-free number on their online ID cards for information on how to utilize the grievance procedure when appropriate. All member care and related decisions are the sole responsibility of participating providers. Aetna Dental does not provide health care services and, therefore, cannot guarantee any results or outcomes.

Dental plans are provided or administered by Aetna Life Insurance Company, Aetna Dental Inc., Aetna Dental of California Inc. and/or Aetna Health Inc.
In Arizona, DMO Dental Plans are provided or administered by Aetna Health Inc.

Port of Houston Authority
Plan 65
Effective Date: 01-01-2019

Dental Benefits Summary

This material is for informational purposes only and is neither an offer of coverage nor dental advice. It contains only a partial, general description of plan or program benefits and does not constitute a contract. Aetna does not provide dental services and, therefore, cannot guarantee any results or outcomes. The availability of a plan or program may vary by geographic service area. Certain dental plans are available only for groups of a certain size in accordance with underwriting guidelines. Some benefits are subject to limitations or exclusions. Consult the plan documents (Schedule of Benefits, Certificate/Evidence of Coverage, Booklet, Booklet-Certificate, Group Agreement, Group Policy) to determine governing contractual provisions, including procedures, exclusions and limitations relating to your plan.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color,

Aetna provides free aids/services to people with disabilities and to people who need language assistance.

If you need a qualified interpreter, written information in other formats, translation or other services, call 877-238-6200.

If you believe we have failed to provide these services or otherwise discriminated based on a protected class noted above, you can also file a grievance with the Civil Rights Coordinator by contacting:

Civil Rights Coordinator,
P.O. Box 14462, Lexington, KY 40512 (CA HMO customers: PO Box 24030 Fresno, CA 93779),
1-800-648-7817, TTY: 711,
Fax: 859-425-3379 (CA HMO customers: 860-262-7705),
CRCoordinator@aetna.com.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, or at 1-800-368-1019, 800-537-7697 (TDD).

Aetna is the brand name used for products and services provided by one or more of the Aetna group of subsidiary companies, including Aetna Life Insurance Company, Coventry Health Care plans and their affiliates (Aetna).
TTY: 711

For language assistance in your language call 877-238-6200 at no cost. (English)

Para obtener asistencia lingüística en español, llame sin cargo al 877-238-6200. (Spanish)

欲取得繁體中文語言協助，請撥打877-238-6200，**無需付費。**(Chinese)

Pour une assistance linguistique en français appeler le 877-238-6200 sans frais. (French)

Para sa tulong sa wika na nasa Tagalog, tawagan ang 877-238-6200 nang walang bayad. (Tagalog)

Benötigen Sie Hilfe oder Informationen in deutscher Sprache? Rufen Sie uns kostenlos unter der Nummer 877-238-6200 an. (German)

(Arabic) .6200-238-877 للمساعدة في (اللغة العربية)، الرجاء الاتصال على الرقم المجاني

Pou jwenn asistans nan lang Kreyòl Ayisyen, rele nimewo 877-238-6200 gratis. (French Creole)

Per ricevere assistenza linguistica in italiano, può chiamare gratuitamente 877-238-6200. (Italian)

日本語で援助をご希望の方は、877-238-6200 まで無料でお電話ください。(Japanese)

한국어로 언어 지원을 받고 싶으시면 무료 통화번호인 877-238-6200 번으로 전화해 주십시오. (Korean)

(Persian) برای راهنمایی به زبان فارسی با شماره 877-238-6200. بدون هیچ هزینه ای تماس بگیرید. انگلیسی

Aby uzyskać pomoc w języku polskim, zadzwoń bezpłatnie pod numer 877-238-6200. (Polish)

Para obter assistência linguística em português ligue para o 877-238-6200 gratuitamente. (Portuguese)

Чтобы получить помощь русскоязычного переводчика, позвоните по бесплатному номеру 877-238-6200. (Russian)

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Dental Benefits Summary

Để được hỗ trợ ngôn ngữ bằng (ngôn ngữ), hãy gọi miễn phí đến số 877-238-6200. (Vietnamese)

"Patient Pays" applies to procedures provided by the member's Primary Care Dentist or approved specialty dentist.

Ameritas Basic Vision Plan (Fully-Insured Program)

PORT OF HOUSTON AUTHORITY

Eye Care Highlight Sheet

Ameritas

Standard Plan Summary Policy# 010-40106

Effective Date: 1/1/2019

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	15% discount See Additional Focus Features.	No benefit
Elective	Up to $130	Up to $105
Medically Necessary	Covered in full	Up to $210
Frames	$130**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*

***The Costco allowance will be the wholesale equivalent.*

Lens Options (member cost)*

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses		
(Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Laser Vision Correction

Each Eye	Year One	Year Two	Year Three
	$175	$175	$350

Monthly Rates

Employee Only (EE)	$7.68
EE + Spouse	$15.16
EE + Children	$13.28
EE + Spouse & Children	$20.76

PORT OF HOUSTON AUTHORITY

Eye Care Highlight Sheet

Ameritas

Additional Focus® Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance.*
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

Rx Savings

Our valued plan members and their covered dependents can save on prescription medications at over 60,000 pharmacies across the nation including CVS, Walgreens, Rite Aid and Walmart. This Rx discount is offered at no additional cost, and it is not insurance.
To receive this Rx discount, Ameritas plan members just need to visit us at ameritas.com and sign into (or create) a secure member account where they can access and print an online-only Rx discount savings ID card.

Retail Chain Affiliate Providers Available with Focus Plans

Effective January 1, 2012, retail chain affiliate providers, which include Costco® Optical and Visionworks, give members added convenience and additional retail choices. Costco Optical has 400 locations across the country, while Visionworks manages nearly 400 optical stores in 37 states and DC, including well-known stores such as EyeMasters, Visionworks, Dr. Bizer's VisionWorld, Eye DRx, and Hour Eyes, to name a few. Members enjoy a covered-in-full benefit experience with equivalent frame benefit at any of these retail chain locations.

Eye Care Plan Member Service

Focus eye care from Ameritas Group features the money-saving eye care network of VSP. Customer service is available to plan members through VSP's well-trained and helpful service representatives. Call or go online to locate the nearest VSP network provider, view plan benefit information and more. Locate a VSP provider at: ameritas.com or View plan benefit information at: vsp.com

VSP Call Center: 1-800-877-7195

- Service representative hours: 5 a.m. to 7 p.m. PST Monday through Friday, 6 a.m. to 2:30 p.m. PST Saturday
- Interactive Voice Response available 24/7

Section 125

This plan is provided as part of the Policyholder's Section 125 Plan. Each employee has the option under the Section 125 Plan of participating or not participating in this plan. If an employee does not elect to participate when initially eligible, he/she may elect to participate at the Policyholder's next Annual Election Period.

Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S. Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

Ameritas Enhanced Vision Plan (Fully-Insured Program)

PORT OF HOUSTON AUTHORITY

Eye Care Highlight Sheet

Ameritas

Enhanced Plan Summary Policy# 010-40106 Effective Date: 1/1/2019

	VSP Choice Network + Affiliates	Out of Network
Deductibles		
	$10 Exam	$10 Exam
	$25 Eye Glass Lenses or Frames*	$25 Eye Glass Lenses or Frames
Annual Eye Exam	Covered in full	Up to $45
Lenses (per pair)		
Single Vision	Covered in full	Up to $30
Bifocal	Covered in full	Up to $50
Trifocal	Covered in full	Up to $65
Lenticular	Covered in full	Up to $100
Progressive	See lens options	NA
Contacts		
Fit & Follow Up Exams	15% discount See Additional Focus Features.	No benefit
Elective	Up to $150	Up to $105
Medically Necessary	Covered in full	Up to $210
Frames	$150**	Up to $70
Frequencies (months)		
Exam/Lens/Frame	12/12/12 Based on date of service	12/12/12 Based on date of service

**Deductible applies to a complete pair of glasses or to frames, whichever is selected.*
***The Costco allowance will be the wholesale equivalent.*

Lens Options (member cost) *

	VSP Choice Network + Affiliates (Other than Costco)	Out of Network
Progressive Lenses	Up to provider's contracted fee for Lined Bifocal Lenses. The patient is responsible for the difference between the base lens and the Progressive Lens charge.	Up to Lined Bifocal allowance.
Std. Polycarbonate	Covered in full for dependent children $33 adults	No benefit
Solid Plastic Dye	$15 (except Pink I & II)	No benefit
Plastic Gradient Dye	$17	No benefit
Photochromatic Lenses (Glass & Plastic)	$31-$82	No benefit
Scratch Resistant Coating	$17-$33	No benefit
Anti-Reflective Coating	$43-$85	No benefit
Ultraviolet Coating	$16	No benefit

**Lens Option member costs vary by prescription, option chosen and retail locations.*

Laser Vision Correction

Each Eye	Year One	Year Two	Year Three
	$175	$175	$350

Monthly Rates

Employee Only (EE)	$8.68
EE + Spouse	$17.16
EE + Children	$14.78
EE + Spouse & Children	$23.26

PORT OF HOUSTON AUTHORITY

Eye Care Highlight Sheet

Ameritas

Additional Focus® Choice Network Features

Contact Lenses Elective	Allowance can be applied to disposables, but the dollar amount must be used all at once (provider will order 3 or 6 month supply). Applies when contacts are chosen in lieu of glasses. For plans without a separate contact fitting & evaluation (which includes follow up contact lens exams), the cost of the fitting and evaluation is deducted from the allowance.
Additional Glasses	20% off additional complete pairs of prescription glasses and/or prescription sunglasses.*
Frame Discount	VSP offers 20% off any amount above the retail allowance. *
Laser VisionCare	VSP offers an average discount of 15% off or 5% off a promotional offer for LASIK Custom LASIK and PRK. The maximum out-of-pocket per eye for members is $1,800 for LASIK and $2,300 for custom LASIK using Wavefront technology, and $1,500 for PRK. In order to receive the benefit, a VSP provider must coordinate the procedure.
Low Vision	With prior authorization, 75% of approved amount (up to $1,000 is covered every two years).

Based on applicable laws, reduced costs may vary by doctor location.

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Eye Care Plan Member Service

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- Interactive Voice Response available 24/7

Section 125

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Worldwide Support

When our members travel abroad, they'll have peace of mind knowing that should a dental or vision need arise, help is just a phone call away. Through AXA Assistance, Ameritas offers its dental and vision plan members 24-hour access to dental or vision provider referrals when traveling outside the U.S. Immediately after a call is made to AXA, an assistance coordinator assesses the situation, provides credible provider referrals and can even assist with making the appointment. Within 48 hours following the appointment, the coordinator calls the member to find out if additional assistance is needed. If all is well, the case is closed. Then, the plan member may submit a claim to Ameritas for reimbursement consideration based on applicable plan benefits. Contact AXA Assistance USA toll free by calling 866-662-2731, or call collect from anywhere in the world by dialing 1-312-935-3727.

Language Services

We recognize the importance of communicating with our growing number of multilingual customers. That is why we offer a language assistance program that gives you access to: Spanish-speaking claims contact center representatives, telephone interpretation services in a wide range of languages, online dental network provider search in Spanish and a variety of Spanish documents such as enrollment forms, claim forms and certificates of insurance.

Minnesota Life Insurance Company Basic, Supplemental and Dependent Life & AD&D Insurance Plan (Fully-Insured Program)

The Municipal POOL®
Administered by Ochs, Inc.

Port of Houston Authority

Your Group Life Insurance Benefits

Your employer offers Term Life insurance to benefit eligible employees. Coverage is underwritten by Minnesota Life Insurance Company and administered by Ochs, Inc.

BASIC TERM LIFE (employer paid)

Amount

- 1.5x annual salary, rounded to the next higher $1,000
- Maximum: $500,000

Additional Information

- **Guaranteed** - no election required

SUPPLEMENTAL LIFE PROGRAM (employee paid)

Build a stronger financial package to protect your family against the unexpected loss of life and income during your working years.

Through a **Supplemental Term Life Program,** employees can elect additional insurance for themselves, their spouse and their children. Enrolling for employee or spouse supplemental term life will require Evidence of Insurability (EOI) and underwriting approval - except as a new employee or if a qualified family status change occurs, at which time guaranteed issue (GI) coverage is available.

GUARANTEED ISSUE

New Employees

can elect coverage during their 31 day initial enrollment period - without health questions. Evidence of Insurability will be required outside of this opportunity (except for a qualified family status change) and also for elections greater than the **guaranteed amounts** below.

Guaranteed Amounts[1]

- **Employees** - the lesser of 2x salary or $350,000
- **Your spouse** - up to $25,000
- **Your children** - $10,000

Coverage	Amount	Additional Information
Employee Supplemental Term Life	• Elect 1, 2, 3, 4, or 5x annual salary, rounded to the next higher $1,000 • Maximum: $650,000	• Evidence of Insurability is required[1] • Coverage increased due to salary changed guaranteed to plan maximum • New employees - see Guaranteed Issue opportunity
Spouse Term Life	• $5,000 increments • Maximum: $150,000	• A spouse is not eligible if also eligible as an employee • An employee must be insured for supplemental coverage in order to be insured for dependent coverage • Evidence of Insurability is required[1] • New employees - see Guaranteed Issue opportunity
Child Term Life	• $10,000 • $500 benefit for children age live birth to 6 months	• Elections are Guaranteed each annual enrollment • Children are eligible from live birth to age 19, or 25 if full-time student • An employee must be insured for supplemental coverage in order to be insured for dependent coverage • A child may only be covered by one parent if both are employees • New employees - see Guaranteed Issue opportunity

[1]GI amounts are available for new employees and for qualified family status changes (i.e. marriage or birth/adoption of a child). Amounts are subject to plan maximums.

more >>>

Monthly cost per $1,000
Employee and Spouse Term Life

Age	Employee Rate	Spouse Rate
<25	$0.05	$0.03
25-29	$0.06	$0.04
30-34	$0.08	$0.06
35-39	$0.10	$0.07
40-44	$0.12	$0.08
45-49	$0.18	$0.12
50-54	$0.29	$0.19
55-59	$0.51	$0.31
60-64	$0.73	$0.52
65-69	$1.24	$0.91
70-74	$2.10	$1.53
75*	$2.10	$1.53

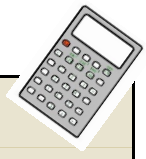
Rates increase with age and are subject to change.
*Rates beyond age 75 are available upon request.

Child Term Life monthly cost

$0.83 for $10,000 of insurance on each eligible child, regardless of the number of children.

How much life insurance do you need?

Visit LifeBenefits.com/insuranceneeds to use an interactive resource to help estimate the amount of insurance your family would need to meet financial obligations in the event of death.



Calculate your cost:
(or see the attached rate chart)

Total coverage you need divided by 1,000	$_____
x your rate (from the table above)	$_____
= your monthly premium	$_____

Beneficiary Designations

Naming a beneficiary is an important right of life insurance ownership; this determines who receives the death benefit. It is recommended you review and update your elections periodically.

Your life insurance plan includes features and services at no additional cost, beyond the premiums you pay.

Plan Features

- **Waiver of Premium** - If you become totally and permanently disabled, life insurance premiums may be waived.
- **Accelerated Benefit** - If an insured person becomes terminally ill with a life expectancy of 12 months or less, he/she may request early payment of up to 100% of the life insurance amount in force.
- **Portability -** If you are no longer eligible for group coverage, you have 31 days to port your group life insurance. Portable coverage ends at age 70. Premiums may be higher than those paid by active employees.
- **Conversion -** If you are no longer eligible for group coverage or your portability period is ending, you have 31 days to convert this coverage to an individual life insurance policy. Premiums may be higher than those paid by active employees.

LifeSuite Services

- **Travel Assistance** - Access to 24/7/365 emergency travel assistance services provided by RedpointWTP LLC. More information is available at lifebenefits.com/travel, or by calling 1-855-516-5433.
- **Legal, Financial and Grief Counseling** - Services such as drafting legal documents and consultations are provided by Ceridian HCM, Inc. Additional information is available at lifeworks.com: Username: **lfg**, Password: **resources,** or by calling 1-877-849-6034.
- **Legacy Planning** - Active and retired employees and their families can access resources to help work through end-of-life issues or plan a funeral. Visit: LegacyPlanningResources.com.
- **Beneficiary Financial Counseling** - Beneficiaries who receive at least $25,000 in policy benefits may choose to use independent beneficiary counseling services from PricewaterhouseCoopers LLP.

For more information about LifeSuite Services visit:
brainshark.com/securian/LifeSuiteServices

Convenient Payroll Deductions

- Premiums are automatically deducted from your paycheck.

Questions

Contact your benefits office or Ochs, Inc. M-F 8:00 a.m. to 4:30 p.m. CT (**Phone:** 651-665-3789 / 1-800-392-7295 or **Email:** ochs@ochsinc.com). A representative is available to help you.

Take Action - Enroll Now

Don't miss this enrollment opportunity!

Turn forms in to your Benefits Office.

Rev. 10-2015

OCHS INC. | SECURIAN®

400 Robert Street North | Suite 1880 | St. Paul, MN 55101
www.ochsinc.com

Aetna Long Term Disability Insurance Program (Fully-Insured Program)

Port of Houston Authority -Full Time

Your Summary of Long Term Disability (LTD) Benefits

Coverage Effective Date: **01/01/2015**

Your Long Term Disability Benefits

Financial protection during illness or injury

Coverage Basics

When am I eligible for coverage?	You qualify if you are an active full time employee working **at least 30** hours a week. You must be working in an eligible group as defined by your employer.
When does coverage becomes effective?	Your coverage will begin on **01/01/2015** if you are actively at work. If you are a new hire or have not been previously covered by your employer's plan, you may need to complete a probationary or waiting period before your coverage begins.
How much Long Term Disability is offered by my employer?	**60%** of your Pre-disability Earnings* up to **$8,000** a month is paid for by your employer . *Generally, Pre-disability Earnings include your total income before taxes and any deductions for pre-tax contributions. For definition of your Pre-disability earnings please consult your Booklet-Certificate for additional information.
Are all types of illnesses and injuries covered?	Long Term Disability covers injuries and illnesses that are both work-related and non-work-related.
When does my benefit begin and end?	You are eligible for Long Term Disability (LTD) benefits if you have a significant change in your physical or mental condition(s) and cannot perform the material duties of your occupation because of that illness, injury or disabling pregnancy-related condition. As a result, your work earnings are **80%** or less than your predisability earnings. Your benefit will extend beyond **24** months only if you cannot perform the material duties of any reasonable occupation and your work earnings are **60%** or less of your predisability earnings. If your occupation requires a professional license or certification, you will not be considered disabled solely because you lose your license or certification. Once your claim is approved, you will be eligible to receive LTD benefits starting on the **90th** day after the date your disability began. Generally your benefit payment will continue for as long as you remain disabled and meet the requirements of the LTD policy, or until you reach age 65, whichever is sooner. If your disability occurs at age 62 or above, your benefit may be reduced based on pre-determined schedule. Please refer to your Booklet-Certificate.

LTD Rate/$100 cov monthly payroll: $.450

Interface Employee Assistance Program (EAP)

(Fully-Insured Program)

Interface EAP

Interface Employee Assistance Program - EAP Executive Summary Available to the Port of Houston Authority Employees, Spouse, and Dependents				Face-to-face EAP 6-Session
Member Services	Emotional Health	Individualized Counseling	Over 7,000 licensed providers nationally available for confidential counseling issues such as stress, depression, work/life issues, marital/family, legal, financial, alcohol/substance abuse, grief, parent/child issues. Includes Department of Transportation (DOT) Substance Abuse Professional (SAP) referrals	Sessions are per person, per issue, per year
			24 hour toll free telephonic access to crisis counselors	Unlimited
		Website	Includes online access to supplemental EAP information, frequently asked questions, articles, ability to request services online	☑
	Work/Life Services	Legal Services	Up to 3 no cost legal consultations, face-to-face or telephonic for any legal issue (excluding employement law, sideline business, tax law, immigration). Up to 25% discount off attorney's fees after. Available free simple will kit and identify theft resources.	☑
		Financial Services	Up to 3 no cost financial consultations, telephonically, for issues with debt mangement or future financial planning. Services include, but are not limited to, retirement, college funds, investment planning, budgeting, debt consolidation	☑
		Website	Includes online legal library, financial resources, and database resources for school, college, adoption, elder care, and child care	☑
	Wellness	Website	Includes health and wellness resources, personal health profiles, gym discounts, health tutorials, and modules for walking, weight loss, and smoking cessation	☑
Client Services	Organizational Guidance & Workplace Support	Mangement Consultations	Telephonic management consultations regarding work performance issues and referrals to EAP	Unlimited
		Job Performance Referrals	Face-to-face EAP referrals to counselors for job performance issues with reported attendance and compliance (signed Release of Information required)	Unlimited
		Substance Abuse Referrals	Face-to-face EAP referrals to counselors for substance abuse/addiction issues with available reported attendance and compliance (signed Release of Information required)	Unlimited
		Critical Incident Stress Debreifings	Critical Incident Stress Debriefings and Grief Debriefings available includes on-site counseling, assessment, normalization and referral for incidents such as robbery, employee death, traumatic accident, etc.	4 combined CISD/GD & Wellness training hours Included*
	Training & Orientations	Wellness Seminars	Interface EAP will coordinate and provide Wellness Seminars. Topics include, but are not limited to, stress management, change mastery, holiday stress, active listening, and various legal and financial topics	
		Supervisor Training	Supervisory/Management training for supervisors on recognizing, documenting, and referring an employee with job performance issues to the EAP, as well as providing information on all services of the EAP. Includes DOT Reasonable Suspicion Training. Webinars available.	6 combined Supervisory Training & Orientation hours included*
Account Support	Program Management	Employee Orientations	Employee orientation to familiarize employees with the services provided and the process for utilizing the program. Webinars available.	
		Promotional Materials	No cost promotional materials are available physically and electronically and include brochures, flyers, and wallet cards, orientation CD/DVD, posters, and a monthly electronic newsletter	☑
		Health Fair Support	Promotional materials available, and give-a-way items for health fairs. Includes available full day of staffing.	2 Health Fair Days included*
		Account Management	Designated account executive with support of client services team	☑
	Reporting	Utilization Reports	Quarterly utilization reports that include nature of the contact, referral source, and demographics of employees (providing that certain information will not jeopardize confidentiality). Ad Hoc reporting is available upon request.	☑

*Hours and days beyond those included in the contract are subject to In-Service Fee Schedule

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY
GROUP INSURANCE PLAN
(Amended and Restated Effective as of January 1, 2019)

APPENDIX C

As of January 1, 2019, the following third party entities serve as Claims Administrators and Claims Fiduciaries under the Plan with respect to the following Welfare Programs:

Welfare Program	Claims Administrator / Claims Fiduciary
• Aetna Open Access Medical Plan (Self-Insured Program)	***Medical Claims*** Aetna PO Box 981106 El Paso, TX 79998-1106 ***Prescription Drug Mail Order Program*** Aetna Rx Home Delivery Kansas City P.O. Box 219484 Kansas City, MO 64121-9484
• Aetna Kelsey Care Medical Plan (Self-Insured Program)	***Medical Claims*** Aetna PO Box 981106 El Paso, TX 79998-1106 ***Prescription Drug Mail Order Program*** Aetna Rx Home Delivery Kansas City P.O. Box 219484 Kansas City, MO 64121-9484
• Aetna PPO Dental Plan (Fully-Insured Program)	Aetna Dental Plan P.O. Box 14462 Lexington, KY 40512
• Aetna DMO Dental Plan (Fully-Insured Program)	Aetna Dental Plan P.O. Box 14462 Lexington, KY 40512
• Ameritas Vision Program (Fully-Insured Program)	Ameritas Life Insurance Corp. P.O. Box 82657 Lincoln, Nebraska 68501-2657

Welfare Program	Claims Administrator / Claims Fiduciary
• Minnesota Life Insurance Basic Employee Life/AD&D, Supplemental and Dependent Life Insurance Program (Fully-Insured Program)	Minnesota Life Insurance Company 400 Robert Street North St. Paul, Minnesota 55101-2098
• Aetna Long Term Disability Insurance Program (Fully-Insured Program)	Aetna Life Insurance Company 151 Farmington Avenue Hartford, Connecticut 06156
• Interface Employee Assistance Program (EAP) (Fully-Insured Program)	Interface Behavioral Health P.O. Box 421879 Houston, TX 77242-1879

The COBRA Administrator for the Plan is:

Discovery Benefits, Inc.
4321 20th Avenue S
Fargo, ND 58103

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY
GROUP INSURANCE PLAN
(Amended and Restated Effective as of January 1, 2019)

APPENDIX D

The following job classifications of employees (or classes of employees) are hereby designated as being entitled to receive Protected Health Information subject to HIPAA from the Plan:

- All employees who work in the Employer's Human Resources Department, to the extent necessary to perform plan operation and administration job duties on behalf of the Plan;

- Employer's Chief People Officer (*i.e.*, the HR Director's supervisor) and his or her administrative staff of employees, to the extent necessary to perform oversight and decision-making duties related to the operation and administration of the Plan;

- Employer's Chief Legal Officer, to the extent necessary to perform oversight and decision-making duties related to legal matters under the Plan;

- Employer's primary in-house attorney as assigned to the Human Resources Department or any in-house attorney who was previously assigned to the Human Resources Department, to the extent necessary to address legal matters under the Plan;

- The Plan's Privacy Official, to the extent necessary to perform the requisite duties under the Plan;

- The Plan's Complaint Official, to the extent necessary to perform the requisite duties under the Plan;

- Employees of Employer's Technology Division; provided, however, that such employees shall only be entitled to access Protected Health Information stored on the Employer's technology systems to the extent necessary to perform information technology functions on behalf of the Plan;

- Employees of Employer's Internal Audit Department; provided, however, that such employees shall only be entitled to access Protected Health Information to the extent necessary to handle any audit of the Plan; and

- Employees of Employer's Payroll, Accounts Payable, and Financial Accounting Departments; provided, however, that such employees shall only be entitled to access Protected Health Information to the extent necessary to perform payroll, accounting, and payable functions on behalf of the Plan.