SUMMARY PLAN DESCRIPTION

OF THE

PORT OF HOUSTON AUTHORITY OPEB PLAN

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

Last update: January 1, 2019

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

Port of Houston Authority of Harris County, Texas (the "**Plan Sponsor**") maintains the Port of Houston Authority OPEB Plan (the "**Plan**") for the benefit of the eligible Retirees (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. The 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 Retirees (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 Beneficiary means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.

1.3 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.

1.4 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.

1.5 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.

1.6 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.

1.7 Defined Benefit Eligible Employee means an Employee who (a) is an "Eligible Employee" and (b) has completed at least one "Year of Service", as each of these terms is defined in the Defined Benefit Plan.

1.8 Defined Benefit Plan means the Port of Houston Authority Restated Retirement Plan, as it may be amended from time to time.

1.9 Defined Contribution Eligible Employee means an Employee who is an "Eligible Employee," as such term is defined in the Defined Contribution Plan.

1.10 Defined Contribution Plan means the Port of Houston Authority Defined Contribution Plan, as it may be amended from time to time.

1.11 Dependent means a dependent (including a Spouse) of a Retiree who is covered under the Plan, as such term is defined under the terms of the respective Welfare Program.

1.12 Disability Absence means the time period from a Participant's Disability Commencement Date until the earliest of (a) the Participant's Disability Recovery Date, (b) the date the Participant returns to active duty with the Employer, (c) the date the Participant attains age 65, or (d) the Participant's Disability Termination Date.

1.13 Disability Commencement Date means the effective date on which an Employee becomes Totally and Permanently Disabled.

1.14 Disability Recovery Date means the effective date that the Participant no longer qualifies to receive (a) payments under the LTD Plan or (b) disability benefits under the Social Security Act, as applicable.

1.15 Disability Retirement Eligibility Date means the earliest date on which an individual who becomes Totally and Permanently Disabled would meet the eligibility requirements set forth in Section 3.1(a), (b) or (c), as applicable, if the following is assumed: (a) such individual remains Totally and Permanently Disabled indefinitely and (b) any period of Total and Permanent Disability is credited as a Period of Service for purposes of determining such individual's eligibility under the Plan.

1.16 Disability Termination Date means the date a Totally and Permanently Disabled Employee terminates employment with the Employer.

1.17 Effective Date means January 1, 2019, which is the effective date of this amendment and restatement of the Plan.

1.18 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:

(1) 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).

(2) 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.

(3) 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.

(4) 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.

1.19 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.

1.20 Full Disability Period means the time period from a Participant's Disability Commencement Date until the earliest of (a) the Participant's Disability Recovery Date, (b) the date the Participant returns to active duty with the Employer, (c) the date the Participant attains age 65, or (d) the Participant's Disability Retirement Eligibility Date.

1.21 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.

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

1.23 Hour of Service means (a) each hour for which an Employee is directly or indirectly compensated or entitled to compensation by the Employer for the performance of duties (these hours will be credited to the Employee for the computation period in which the duties are performed); (b) each hour for which an Employee is directly or indirectly compensated or entitled to compensation by the Employer (irrespective of whether the employment relationship has terminated) for reasons other than performance of duties (such as vacation, holidays, sickness, jury duty, disability, lay-off, military duty or leave of absence) during the applicable computation period; (c) each hour for which back pay is awarded or agreed to by the Employer without regard to mitigation of damages (these hours will be credited to the Employee for the computation period or periods to which the award or agreement pertains rather than the computation period in which the award, agreement or payment is made). The same Hours of Service shall not be credited both under clause (a) or (b), as the case may be, and under clause (c).

Notwithstanding clause (b) in the immediately preceding paragraph, (1) no more than 501 Hours of Service are required to be credited to an Employee on account of any single continuous period during which the Employee performs no duties (whether or not such period occurs in a single computation period); (2) an hour for which an Employee is directly or indirectly paid, or entitled to payment, on account of a period during which no duties are performed is not required to be credited to the Employee if such payment is made or due under a plan maintained solely for the purpose of complying with applicable worker's compensation, or unemployment compensation or disability insurance laws; and (3) Hours of Service are not required to be credited for a payment which solely reimburses an Employee for medical or medically related expenses incurred by the Employee.

For purposes of clause (b) in the first paragraph of this Section 1.23, a payment shall be deemed to be made by or due from the Employer regardless of whether (a) such payment is made by or due from the Employer directly, or indirectly through, among others, a trust fund, or insurer, to which the Employer contributes or pays premiums, and (b) contributions made or due to the trust

fund, insurer, or other entity are for the benefit of particular Employees or are on behalf of a group of Employees.

1.24 LTD Plan means the long term disability insurance plan maintained by the Employer for its Employees, as it may be amended from time to time.

1.25 Medicare-Eligible Participant means a Participant who has met the requirements for eligibility for coverage under Parts A and B of Medicare on the basis of either (a) attainment of age sixty-five (65) or (b) such individual's disability, regardless of whether such individual is actually enrolled in Medicare Part A or B.

1.26 1-Year Break in Service means a Period of Severance of at least 365 consecutive days. Solely for the purpose of determining whether a Participant has incurred a 1-Year Break in Service, Hours of Service shall be recognized for "authorized leaves of absence" and "maternity and paternity leaves of absence," as such terms are defined in the following definitions:

(a) "An *authorized leave of absence*" means an unpaid, temporary cessation from active employment with the Employer by an Employee pursuant to an established nondiscriminatory policy, whether occasioned by illness, military service, or any other reason.

(b) A "*maternity or paternity leave of absence*" means an absence from work for any period by reason of the Employee's pregnancy, birth of the Employee's child, placement of a child with the Employee in connection with the adoption of such child, or any absence for the purpose of caring for such child for a period immediately following such birth or placement. For this purpose, Hours of Service shall be credited for the computation period in which the absence from work begins, only if credit therefore is necessary to prevent the Employee from incurring a 1-Year Break in Service or, in any other case, in the immediately following computation period. The Hours of Service credited for a "maternity or paternity leave of absence" shall be those that would normally have been credited but for such absence or, in any case in which the Administrator is unable to determine how such hours are normally credited, eight (8) Hours of Service per day. The total Hours of Service required to be credited for a "maternity or paternity leave of absence" shall not exceed the number of Hours of Service needed to prevent the Employee from incurring a 1-Year Break in Service.

1.27 Participant means a Retiree 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.

1.28 Participant Contribution means the 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.

1.29 Period of Service means the elapsed time method service measurement period. A Period of Service is the aggregate of all periods commencing with the Employee's first day of employment or reemployment with the Employer and ending on the date that a 1-Year Break in Service begins. The first day of employment or reemployment is the first day that the Employee performs an Hour of Service. An Employee will also receive credit for any Period of Severance of less than twelve (12) consecutive months. The following periods shall be disregarded in determining a Participant's Period of Service for purposes of determining eligibility for benefits under this Plan:

(a) Service while the Employee did not satisfy the definition of "Employee";

(b) Except as provided in Section 3.1(d), service for which the Employee was not entitled to compensation; and

(c) Service prior to the date on which the Employee incurred five (5) consecutive 1-Year Breaks in Service, if the Employee's Period of Service on such date is less than five (5) years.

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

1.31 Plan means the Port of Houston Authority OPEB 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.

1.32 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.

1.33 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.

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

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

1.36 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.

1.37 Pre-10/24/17 LTD Employee means an Employee who became Totally and Permanently Disabled before October 24, 2017.

1.38 Post-10/23/17 LTD Employee means an Employee who became Totally and Permanently Disabled on or after October 24, 2017.

1.39 Retiree means an Employee who has retired in good standing from employment with the Employer. The term "Retiree" shall also include a Pre-10/24/17 LTD Employee who is receiving medical coverage under the Plan pursuant to Section 3.1(d)(1). However, until the Pre-10/24/17 LTD Employee actually retires (*i.e.*, first commences to receive a distribution of benefits under the Defined Benefit Plan or the Defined Contribution Plan), such designation as a "Retiree" shall be for purposes of the medical Welfare Programs under the Plan only.

1.40 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.

1.41 Spouse means a Retiree's spouse as defined under the terms of the respective Welfare Program.

1.42 Total and Permanent Disability or Totally and Permanently Disabled means a physical or mental condition for which (a) the Employee is eligible to receive benefits under the LTD Plan, or (b) if the Employee is not covered under the LTD Plan for any reason, if he is eligible to receive disability benefits under the Social Security Act.

1.43 Trust means all assets held by a Trustee pursuant to a Trust Agreement and the terms of the Plan.

1.44 Trust Agreement means a trust agreement with the Trustee which the Plan Sponsor may establish, be a party to, or amend from time to time, containing such provisions as it deems necessary or desirable in order to carry the provisions of the Plan into effect.

1.45 Trustee means the individuals or banking institution which shall accept the appointment to execute the duties of Trustee as set forth in the Plan and Trust Agreement. The Trustee is designated in Appendix C of this SPD.

1.46 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.

1.47 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) *Pre-1/1/2010 Hires Who Are Eligible for Defined Benefit Plan*. With respect to a Defined Benefit Eligible Employee who is hired by the Employer before January 1, 2010, a Retiree (and his eligible Dependents) will be eligible to participate in the Plan if, as of the day he ceased to be an Employee, the Retiree satisfied at least one of the following:

(1) the Retiree had attained age 62 and completed a Period of Service of at least one year;

(2) the Retiree had attained age 55 with at least 85 points (*i.e.*, the sum of the Retiree's age and Period of Service totaled at least 85); or

(3) the Retiree had completed a Period of Service of at least 30 years.

(b) *Post-12/31/2009 Hires Who Are Eligible for Defined Benefit Plan*. With respect to a Defined Benefit Eligible Employee who is hired by the Employer on or after January 1, 2010, a Retiree (and his eligible Dependents) will be eligible to participate in the Plan if, as of day he ceased to be an Employee, the Retiree satisfied at least one of the following:

(1) the Retiree had attained age 62 and completed a Period of Service of at least 12 years;

(2) the Retiree had attained age 55 with at least 85 points (*i.e.*, the sum of the Retiree's age and Period of Service totaled at least 85), provided that the Retiree had completed a Period of Service of at least 12 years; or

(3) the Retiree had completed a Period of Service of at least 30 years.

(c) *Hires Who Are Eligible for Defined Contribution Plan*. With respect to a Defined Contribution Eligible Employee who is hired by the Employer, a Retiree (and his eligible Dependents) will be eligible to participate in the Plan if, as of day he ceased to be an Employee, the Retiree satisfied at least one of the following:

(1) the Retiree had attained age 62 and completed a Period of Service of at least 12 years;

(2) the Retiree had attained age 55 with at least 85 points (*i.e.*, the sum of the Retiree's age and Period of Service totaled at least 85), provided that the Retiree had completed a Period of Service of at least 12 years; or

(3) the Retiree had completed a Period of Service of at least 30 years.

(d) *Disabled Employees*.

(1) *Disabled Prior to October 24, 2017.* A Pre-10/24/17 LTD Employee will be eligible for medical coverage under this Plan if he remains Totally and Permanently Disabled until such time as he has met the age and service requirements set forth in subsections (a), (b), or (c) of this Section 3.1, as applicable. In making such eligibility determination, the Pre-10/24/17 LTD Employee's Full Disability Period shall be credited as a Period of Service. If a Pre-10/24/17 LTD Employee returns to active service with the Employer after his Disability Recovery Date, then such person's Full Disability Period shall be credited as a Period of Service for purposes of determining his eligibility under the Plan (*i.e.*, following his later termination from employment).

A Pre-10/24/17 LTD Employee will become eligible for life insurance coverage under this Plan as of the date on which he first commences to receive a distribution of benefits under the Defined Benefit Plan or the Defined Contribution Plan, provided that he has met the age and service requirements set forth in subsections (a), (b), or (c) of this Section 3.1, as applicable, as of such date. In making such eligibility determination, the Pre-10/24/17 LTD Employee's Full Disability Period shall be credited as a Period of Service.

(2) *Disabled On or After October 24, 2017.* A Post-10/23/17 LTD Employee will be eligible to participate in the Plan if he has met the age and service requirements set forth in subsections (a), (b), or (c) of this Section 3.1, as applicable, on or before his Disability Termination Date. In making such eligibility determination, the Post-10/23/17 LTD Employee's Disability Absence shall be credited as a Period of Service. If a Post-10/23/17 LTD Employee returns to active service with the Employer after his Disability Recovery Date (regardless of whether such date is before or after his Disability Termination Date), then such person's Disability Absence shall be credited as a Period of Service for purposes of determining his eligibility under the Plan (*i.e.*, following his later termination from employment).

(3) *Exception for Fraud.* Notwithstanding the general rules set forth in paragraphs (1) and (2) above of this Section 3.1(d), the Plan Administrator reserves the right to disregard any portion of an individual's Total and Permanent Disability which would otherwise be credited as a Period of Service under such rules, in the event that the Plan Administrator determines, in its sole discretion and to its reasonable satisfaction, that the individual fraudulently obtained any disability benefits from the LTD Plan or the Social Security Administration. For example, the Plan Administrator may disregard credit for any time period during which the individual knew or should have known that the individual did not satisfy the definition of disability or the requirements for receiving disability benefits established by the LTD Plan or Social Security Administration.

(e) *Dependent Eligibility*.

(1) *General.* In order for a Retiree's Dependent to be eligible for coverage under the Plan, such Dependent must have been eligible to be covered as a spouse or other dependent under the Port of Houston Authority Group Insurance Plan or any successor group health plan thereto (the "**Active Plan**") on the Retiree's date of termination of employment. No individuals other than those described in the immediately preceding sentence may be covered under the Plan as Dependents. For example, if a Retiree gets divorced or his Spouse dies after the Retiree's retirement date, and then the Retiree remarries, his new spouse is not eligible for any coverage under the Plan. The same principle applies to non-Spouse Dependents that a Retiree may acquire for any reason after his date of retirement. In addition, if a Retiree's Dependent ceases to be such Retiree's Dependent at any time after the Retiree's date of termination of employment with the Employer, such individual will remain ineligible for any coverage under the Plan, even if the individual once again becomes the Retiree's Dependent. For example, if a Retiree gets divorced, and the Retiree later remarries the same individual, his Spouse is not eligible for any coverage under the Plan.

(2) *Survivor Eligibility*.

(A) If a Retiree who is eligible for coverage under the Plan dies, the deceased Retiree's surviving Spouse who is otherwise eligible for coverage under the Plan pursuant to subsection (e)(1) of this Section 3.1 shall continue to be eligible for coverage under the Plan. A surviving non-Spouse Dependent of a Retiree who is otherwise eligible for coverage under the Plan pursuant to subsection (e)(1) of this Section 3.1 shall continue to be eligible for coverage under the Plan until the later of (1) the date of the one-year anniversary of the Retiree's death (or at the end of the month containing the one-year anniversary of the Retiree's death, if so provided under the terms of the applicable Welfare Program Document), (2) the date such surviving non-Spouse Dependent attains age 18 (or at the end of the month containing the date the surviving non-Spouse Dependent attains age 18, if so provided under the terms of the applicable Welfare Program Document), or (3) the end of the day of June 30, 2019 (the "**Surviving Non-Spouse Dependent Ineligibility Date**").

(B) If a current Employee has met the age and service requirements to be eligible for coverage under the Plan pursuant to subsections (a), (b) or (c) of this Section 3.1 at the time of his death (*i.e.*, he would be eligible for coverage but for the fact that he has not terminated employment with the Employer), the deceased Employee's surviving Dependents who were *eligible* to be enrolled in the Active Plan as of the day preceding the Employee's death shall be eligible for coverage under the Plan (even if such surviving Dependents were not *actually* enrolled in the Active Plan on the day preceding the Employee's death); provided, however, that any non-Spouse Dependent shall become ineligible for coverage on the Surviving Non-Spouse Dependent Ineligibility Date.

(C) Except as specifically provided in this Section 3.1(e)(2), a surviving Dependent's eligibility for coverage shall be subject to the Plan's otherwise applicable provisions governing termination of coverage under the Plan.

(3) *Substantiation.* At any time, the Plan Administrator may require acceptable proof that a Spouse or other claimed Dependent qualifies, or continues to qualify, as a Dependent under the Plan. A Retiree 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 a Retiree or Dependent to make such reimbursement according to the provisions of Section 9.7 of this SPD.

Subject to the provisions of this Section 3.1, a Retiree or Dependent will be eligible to participate in the Plan only if, and to the extent, the Retiree is eligible with respect to the particular benefit in question under a Welfare Program, as determined by the Plan Administrator. The applicable Welfare Program shall (a) designate the Dependents and Beneficiaries of a Retiree who are eligible to receive benefits under the Plan and (b) set forth the criteria for coverage thereunder.

3.2 Enrollment.

A Retiree's or Dependent's enrollment in the Plan shall become effective as specified in the applicable Welfare Program. The Plan Administrator may establish policies and procedures in accordance with the Welfare Programs for the enrollment of Retirees (and/or their Dependents) under the Plan. The Plan Administrator shall provide enrollment forms, either paper or electronic, that must be completed by the prescribed deadline prior to commencement or reinstatement of coverage under the Plan.

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 Dependents and Beneficiaries shall terminate, in accordance with the provisions of the applicable Welfare Program.

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.

3.4 Medicare and Non-Medicare Welfare Programs.

As set forth in Appendix C, the Employer offers Medicare Welfare Programs and Non-Medicare Welfare Programs for medical and prescription drug coverage for Participants.

Medicare-Eligible Participants seeking to obtain medical or prescription drug coverage through the Employer shall be required to enroll in a Medicare Welfare Program. Eligibility for each Medicare Welfare Program is subject to the condition precedent that such Medicare-Eligible Participant be enrolled in Medicare Parts A and B. Consequently, upon first becoming a Medicare-Eligible Participant, such Participant must enroll in Medicare Parts A and B and a Medicare Welfare Program within the enrollment period designated by the Centers for Medicare and Medicaid Services ("**CMS**") for such individual's initial enrollment in a Medicare Advantage Plan, as described at https://www.medicare.gov (the "**Medicare Enrollment Window**"). If, as of the date that an individual becomes a Medicare-Eligible Participant such Participant has not yet enrolled in Medicare Parts A and B, then, during such Medicare-Eligible Participant's Medicare Enrollment Window, such Participant may enroll or continue enrollment in a Non-Medicare Welfare Program, subject to any enrollment and participation requirements specified in such Non-Medicare Welfare Program. Upon expiration of the Medicare Enrollment Window, and for as long as an individual remains a Medicare-Eligible Participant, such Medicare-Eligible Participant shall be ineligible to enroll or continue enrollment in a Non-Medicare Welfare Program. If a Medicare-Eligible Participant fails to enroll in a Medicare Welfare Program during his Medicare Enrollment Window, then he may only join a Medicare Welfare Program during any annual or special enrollment period to the extent permitted under (and subject to any enrollment and participation requirements of) such Medicare Welfare Program.

The Employer shall have no liability to a Medicare-Eligible Participant under the Plan or otherwise for any penalties or coverage gaps that may result from such individual's failure to timely enroll or to remain continuously enrolled in Medicare Parts A and B and a Medicare Welfare Program after becoming a Medicare-Eligible Participant.

In accordance with procedures adopted by the Plan Administrator and communicated to eligible Participants, the Employer will reimburse a Medicare-Eligible Participant who has yet to reach age sixty-five (65) for such person's Medicare Part B premiums that are incurred from the date that such person enrolls in one of the Medicare Welfare Programs described in Appendix C until the earlier of (a) the date he attains age sixty-five (65) or (b) the date he is no longer a Medicare-Eligible Participant.

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 will 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, Retiree, 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.

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 Eligible Retiree 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 Eligible Retiree will be liable for any breach of this Article VIII by the Eligible Retiree 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 Retiree in any manner for any loss or damage that may result from the Retiree'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 Retiree 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, 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 Participants, if any, 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 Retiree* means a Retiree who is provided coverage under the Plan due to his performance of services for the Employer.

(f) *Qualified Beneficiary* means a Covered Retiree or Qualifying Dependent.

(g) Qualifying Dependent means:

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

(2) 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.

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

(1) a Covered Retiree's divorce or legal separation;

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

(3) a Covered Retiree's entitlement to benefits under Medicare;

(4) the death of a Covered Retiree; or

(5) a proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a Covered Retiree 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 Retiree (or Spouse or Dependent) for coverage under the Plan that results from the occurrence of one of the events listed above in Subsections (h)(i) – (i)(v). 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.

(i) *Similarly Situated Beneficiaries* means Retirees 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 Retiree is not eligible to elect COBRA Continuation Coverage upon termination of his coverage under this Plan.

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

Subject to Section 10.6, a Qualified Beneficiary who is a Qualifying Dependent of a Covered Retiree may elect COBRA Continuation Coverage, at his own expense, if his participation under the Plan would terminate as a result of a Qualifying Event.

(b) *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:

(1) loss of coverage; or

(2) 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 Retiree or his Spouse will be deemed to be an election for that Covered Retiree'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).

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 is a Covered Retiree 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 Retiree'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 (1) the date of the Qualified Beneficiary's death or (2) thirty-six (36) months from the date of the Covered Retiree'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 elects COBRA Continuation Coverage, first becomes enrolled in Medicare; or

(d) the date the Qualified Beneficiary, after the date he 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.

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 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.

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 representative) must notify the Plan Administrator, as described in Section 10.10, 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 notice provided upon enrollment, 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.

For all other Qualifying Events, 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 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.

10.8 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 (1) having applied for Medicare Part A, (2) having satisfied any waiting period requirement and (3) 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.

10.9 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.

10.10 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 Notices 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 10.10 will apply.

The Notice to inform the Plan Administrator of a Qualifying Event must contain: (a) the name of the Qualified Beneficiary; (b) the name of the Plan to which the Notice applies; (c) a description of the Qualifying Event; and (d) 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. The Qualified Beneficiary's signed certification shall be deemed "acceptable" evidence.

10.11 Questions and Other Information Regarding COBRA Coverage.

The Retiree Participant will be responsible for keeping the Plan Administrator informed of any Qualifying Events, changes in his address and the addresses of his Spouse and his 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 and prescription drug 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:

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

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

(3) Resolution of internal grievances; and

(4) 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:

(1) 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;

(2) 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;

(3) 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

(4) 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 the Health Information Technology for Economic and Clinical Health Act ("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) A brief description of what happened, including the date of the Breach and the date of its discovery, if known;

(b) 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;

(c) Any steps the individual should take to protect himself from potential harm resulting from the Breach;

(d) 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

(e) 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:

(1) 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);

(2) 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

(3) the period to which the Notice applies.

(b) If a Notice which satisfies Section 12.1(a) (above), 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:

(1) 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)(1) (above) to effectuate the coverage; and

(2) 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.

(3) 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 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.

12.4 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" or are otherwise 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.

12.5 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.

12.6 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**").

12.7 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 OPEB Plan

Plan Sponsor: Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326
(713) 670-2478

Plan Administrator: Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326
(713) 670-2478

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 and (2) life insurance benefits. A trust has been established from which certain Plan benefits and insurance premiums may be paid. As of the Effective Date, the trustee for the trust is as set forth in Appendix _C.

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) pay the costs for coverage. The Plan Sponsor has the right to require Participant Contributions and to change the amount of such contributions at any time and from time to time with respect to coverage under the Plan.

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY OPEB PLAN

APPENDIX A

The following Welfare Programs are incorporated, in their entirety, by reference into this SPD:

1. Aetna KelseyCare HMO for Non-Medicare Eligible Participants (Self-Insured Program);

2. Aetna Open Access for Non-Medicare Eligible Participants (Self-Insured Program);

3. Aetna Medicare Advantage PPO for Medicare Eligible Participants (Fully-Insured Program);

4. Aetna Medicare Advantage ESA PPO for Medicare Eligible Participants (Fully-Insured Program); and

5. Minnesota Life for Retiree Basic Life Insurance Program (Fully-Insured Program).

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY OPEB PLAN

APPENDIX B

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

Aetna Kelsey Care Medical Plan (Self-Insured Program)

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: In-Network Designated Provider (You will pay the least)	What You Will Pay: Non–Designated Provider (You will pay the most)	Limitations, Exceptions & Other Important Information
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.

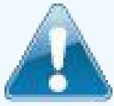
If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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.

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 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).

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.**

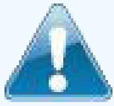
If you don't have **Minimum Essential Coverage** for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

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 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).

Aetna Medicare Advantage PPO

(Fully-Insured Program)

Aetna Medicare Plan (PPO)

The Plan Design and Benefits outlines expected costs for services and describes the benefits package. These details affect what you'll pay for care. So be sure to review all the pages in this section.

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PORT OF HOUSTON AUTHORITY
Aetna Medicare℠ Plan (PPO)

Medicare (S01) PPO
Rx 1209

Benefits and Premiums are effective January 01, 2019 through December 31, 2019

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network Providers	Out-of-Network Providers
Annual Deductible	$0	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.		
Annual Maximum Out-of-Pocket Amount	**Network services:**	**Network and out-of-network services:**
	$6,700	$10,000 for in and out-of-network services combined
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.		
Primary Care Physician Selection	Optional	Not Applicable
There is no requirement for member pre-certification. Your provider will do this on your behalf.		
Referral Requirement	There is no requirement for member pre-certification. Your provider will do this on your behalf.	
PREVENTIVE CARE	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Annual Wellness Exams One exam every 12 months.	$0	20%
Routine Physical Exams	$0	20%
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0	$0
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)** One routine GYN visit and pap smear every 24 months.	$0	20%

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Routine Mammograms (Breast Cancer Screening)	$0	20%
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.		
Routine Prostate Cancer Screening Exam	$0	20%
For covered males age 50 & over, every 12 months.		
Routine Colorectal Cancer Screening For all members age 50 & over.	$0	20%
Routine Bone Mass Measurement	$0	20%
Additional Medicare Preventive Services*	$0	20%
Medicare Diabetes Prevention Program (MDPP)	$0	20%
12 months of core session for program eligible members with an indication of pre-diabetes.		
Routine Eye Exams One annual exam every 12 months.	$0	20%
Routine Hearing Screening One exam every 12 months.	$0	20%
PHYSICIAN SERVICES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Primary Care Physician Visits	$20	20%
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.		
Physician Specialist Visits	$20	20%
DIAGNOSTIC PROCEDURES	**This is what you pay for Network Providers**	**This is what you pay for Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$20	20%
Outpatient Diagnostic X-ray	$20	20%
Outpatient Diagnostic Testing	$20	20%
Outpatient Complex Imaging	$20	20%

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Medicare (S01) PPO
Rx 1209

EMERGENCY MEDICAL CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Urgently Needed Care; Worldwide	$20	$20
Emergency Care; Worldwide (waived if admitted)	$90	$90
Ambulance Services	$20	20%
Observation Care Your cost share for Observation Care is based upon the services you receive.		

HOSPITAL CARE	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Hospital Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$250 per stay	20% per stay
Outpatient Surgery	$0	20%
Blood	All components of blood are covered beginning with the first pint.	

MENTAL HEALTH SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Mental Health Care The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$250 per stay	20% per stay
Outpatient Mental Health Care	$20	20%

ALCOHOL/DRUG ABUSE SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Inpatient Substance Abuse (Detox and Rehab) The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	$250 per stay	20% per stay
Outpatient Substance Abuse (Detox and Rehab)	$20	20%

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PORT OF HOUSTON AUTHORITY
Aetna Medicare℠ Plan (PPO)

Medicare (S01) PPO
Rx 1209

OTHER SERVICES	This is what you pay for Network Providers	This is what you pay for Out-of-Network Providers
Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-20; $75 copay per day, day(s) 21-100	20%
Limited to 100 days per Medicare Benefit Period**. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.		
Home Health Agency Care	$0	20%
Hospice Care	Covered by Original Medicare at a Medicare certified hospice.	
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$20	20%
Cardiac Rehabilitation Services	$20	20%
Pulmonary Rehabilitation Services	$20	20%
Radiation Therapy	$20	20%
Chiropractic Services	$15	20%
Limited to Original Medicare - covered services for manipulation of the spine.		
Durable Medical Equipment/ Prosthetic Devices	20%	20%
Podiatry Services	$20	20%
Limited to Original Medicare covered benefits only.		
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	$0	20%
Diabetic Eye Exams	$0	20%
Outpatient Dialysis Treatments	$20	$20
Medicare Part B Prescription Drugs	$0	20%
Medicare Covered Dental Non-routine care covered by Medicare.	$20	20%

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ADDITIONAL NON-MEDICARE COVERED SERVICES

Resources for Living Covered

For help locating resources for every day needs.

PHARMACY - PRESCRIPTION DRUG BENEFITS

Calendar-year deductible for prescription drugs $0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) $3,820

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

5 Tier Plan	Retail cost-sharing up to a 30-day supply	Retail cost-sharing up to a 90-day supply	Preferred mail order cost-sharing up to a 90-day supply
Tier 1 - Preferred Generic Generic Drugs	$5	$10	$10
Tier 2 - Generic Generic Drugs	$20	$40	$40

Tier 3 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$45	$90	$90
Tier 4 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$75	$150	$150
Tier 5 - Specialty Includes high-cost/unique generic and brand drugs	33%	Limited to one-month supply	Limited to one-month supply

Coverage Gap†

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here's your cost-sharing for covered Part D drugs between the Initial Coverage limit until you reach $5,100 in prescription drug expenses:

5 Tier Plan	**Retail cost-sharing up to a 30-day supply**	**Retail cost-sharing up to a 90-day supply**	**Preferred mail order cost-sharing up to a 90-day supply**
Tier 1 - Preferred Generic Generic Drugs	$5	$10	$10
Tier 2 - Generic Generic Drugs	$20	$40	$40
Tier 3 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$45	$90	$90

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		Medicare (S01) PPO Rx 1209	
Tier 4 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	37% Generic - 25% Brand	37% Generic - 25% Brand	37% Generic - 25% Brand
Tier 5 - Specialty Includes high-cost/unique generic and brand drugs	37% Generic - 25% Brand	Limited to one-month supply	Limited to one-month supply

Catastrophic Coverage	Greater of 5% of the cost of the drug - or - $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs.

Catastrophic Coverage benefits start once $5,100 in true out-of-pocket costs is incurred.

Requirements:	
Precertification	Applies
Step-Therapy	Applies

Non-Part D Drug Rider

- Not Covered

* Additional Medicare preventive services include:

- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

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**A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Not all PPO Plans are available in all areas

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com). Quantity limits and restrictions may apply.

The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31 day supply.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." So, most specialty drugs are not available at the mail-order cost share.

You must continue to pay your Part B premium.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

Aetna Medicare Advantage ESA PPO

(Fully-Insured Program)

Aetna Medicare Plan (PPO)

The Plan Design and Benefits outlines expected costs for services and describes the benefits package. These details affect what you'll pay for care. So be sure to review all the pages in this section.

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PORT OF HOUSTON AUTHORITY
Aetna Medicare℠ Plan (PPO)

Medicare (S01) ESA PPO
Rx 1209

Benefits and Premiums are effective January 01, 2019 through December 31, 2019

PLAN DESIGN AND BENEFITS
PROVIDED BY AETNA LIFE INSURANCE COMPANY

PLAN FEATURES	Network & Out-of-Network Providers
Annual Deductible	$0
This is the amount you have to pay out of pocket before the plan will pay its share for your covered Medicare Part A and B services.	
Annual Maximum Out-of-Pocket Amount	$6,700
Annual maximum out-of-pocket limit amount includes any deductible, copayment or coinsurance that you pay. It will apply to all medical expenses except Hearing Aid Reimbursement, Vision Reimbursement and Medicare prescription drug coverage that may be available on your plan.	
Primary Care Physician Selection	Optional
There is no requirement for member pre-certification. Your provider will do this on your behalf.	
Referral Requirement	None
PREVENTIVE CARE	**This is what you pay for Network & Out-of-Network Providers**
Annual Wellness Exams One exam every 12 months.	$0
Routine Physical Exams	$0
Medicare Covered Immunizations Pneumococcal, Flu, Hepatitis B	$0
Routine GYN Care **(Cervical and Vaginal Cancer Screenings)**	$0
One routine GYN visit and pap smear every 24 months.	
Routine Mammograms **(Breast Cancer Screening)**	$0
One baseline mammogram for members age 35-39; and one annual mammogram for members age 40 & over.	

Routine Prostate Cancer Screening Exam	$0
For covered males age 50 & over, every 12 months.	
Routine Colorectal Cancer Screening For all members age 50 & over.	$0
Routine Bone Mass Measurement	$0
Additional Medicare Preventive Services*	$0
Medicare Diabetes Prevention Program (MDPP)	$0
12 months of core session for program eligible members with an indication of pre-diabetes.	
Routine Eye Exams One annual exam every 12 months.	$0
Routine Hearing Screening One exam every 12 months.	$0
PHYSICIAN SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Primary Care Physician Visits	$20
Includes services of an internist, general physician, family practitioner for routine care as well as diagnosis and treatment of an illness or injury and in-office surgery.	
Physician Specialist Visits	$20
DIAGNOSTIC PROCEDURES	**This is what you pay for Network & Out-of-Network Providers**
Outpatient Diagnostic Laboratory	$20
Outpatient Diagnostic X-ray	$20
Outpatient Diagnostic Testing	$20
Outpatient Complex Imaging	$20
EMERGENCY MEDICAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Urgently Needed Care; Worldwide	$20
Emergency Care; Worldwide (waived if admitted)	$90

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Ambulance Services	$20
Observation Care Your cost share for Observation Care is based upon the services you receive.	
HOSPITAL CARE	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Hospital Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Surgery	$0
Blood	All components of blood are covered beginning with the first pint.
MENTAL HEALTH SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Mental Health Care	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Mental Health Care	$20
ALCOHOL/DRUG ABUSE SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Inpatient Substance Abuse (Detox and Rehab)	$250 per stay
The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Outpatient Substance Abuse (Detox and Rehab)	$20
OTHER SERVICES	**This is what you pay for Network & Out-of-Network Providers**
Skilled Nursing Facility (SNF) Care	$0 copay per day, day(s) 1-20; $75 copay per day, day(s) 21-100
Limited to 100 days per Medicare Benefit Period**. The member cost sharing applies to covered benefits incurred during a member's inpatient stay.	
Home Health Agency Care	$0

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Hospice Care	Covered by Original Medicare at a Medicare certified hospice.
Outpatient Rehabilitation Services (Speech, Physical, and Occupational therapy)	$20
Cardiac Rehabilitation Services	$20
Pulmonary Rehabilitation Services	$20
Radiation Therapy	$20
Chiropractic Services Limited to Original Medicare - covered services for manipulation of the spine.	$15
Durable Medical Equipment/ Prosthetic Devices	20%
Podiatry Services Limited to Original Medicare covered benefits only.	$20
Diabetic Supplies Includes supplies to monitor your blood glucose from LifeScan.	$0
Diabetic Eye Exams	$0
Outpatient Dialysis Treatments	$20
Medicare Part B Prescription Drugs	$0
Medicare Covered Dental Non-routine care covered by Medicare.	$20
ADDITIONAL NON-MEDICARE COVERED SERVICES	
Resources for Living For help locating resources for every day needs.	Covered
PHARMACY - PRESCRIPTION DRUG BENEFITS	
Calendar-year deductible for prescription drugs	$0

Prescription drug calendar year deductible must be satisfied before any Medicare Prescription Drug benefits are paid. Covered Medicare Prescription Drug expenses will accumulate toward the pharmacy deductible.

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PORT OF HOUSTON AUTHORITY
Aetna Medicare℠ Plan (PPO)

Medicare (S01) ESA PPO
Rx 1209

Pharmacy Network S2

Your Medicare Part D plan is associated with pharmacies in the above network. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com).

Formulary (Drug List) GRP B2

Your cost for generic drugs is usually lower than your cost for brand drugs. However, Aetna in some instances combines higher cost generic drugs on brand tiers.

Initial Coverage Limit (ICL) $3,820

The Initial Coverage Limit includes the plan deductible, if applicable. This is your cost sharing until covered Medicare prescription drug expenses reach the Initial Coverage Limit (and after the deductible is satisfied, if your plan has a deductible):

5 Tier Plan	**Retail cost-sharing up to a 30-day supply**	**Retail cost-sharing up to a 90-day supply**	**Preferred mail order cost-sharing up to a 90-day supply**
Tier 1 - Preferred Generic Generic Drugs	$5	$10	$10
Tier 2 - Generic Generic Drugs	$20	$40	$40
Tier 3 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$45	$90	$90
Tier 4 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	$75	$150	$150

Tier 5 - Specialty Includes high-cost/unique generic and brand drugs	33%	Limited to one-month supply	Limited to one-month supply

Coverage Gap†

The Coverage Gap starts once covered Medicare prescription drug expenses have reached the Initial Coverage limit. Here's your cost-sharing for covered Part D drugs between the Initial Coverage limit until you reach $5,100 in prescription drug expenses:

5 Tier Plan	**Retail cost-sharing up to a 30-day supply**	**Retail cost-sharing up to a 90-day supply**	**Preferred mail order cost-sharing up to a 90-day supply**
Tier 1 - Preferred Generic Generic Drugs	$5	$10	$10
Tier 2 - Generic Generic Drugs	$20	$40	$40
Tier 3 - Preferred Brand Includes some high-cost generic and preferred brand drugs	$45	$90	$90
Tier 4 - Non-Preferred Drug Includes some high-cost generic and non-preferred brand drugs	37% Generic - 25% Brand	37% Generic - 25% Brand	37% Generic - 25% Brand

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Tier 5 - Specialty Includes high-cost/unique generic and brand drugs	37% Generic - 25% Brand	Limited to one-month supply	Limited to one-month supply

Catastrophic Coverage	Greater of 5% of the cost of the drug - or - $3.40 for a generic drug or a drug that is treated like a generic and $8.50 for all other drugs.
Catastrophic Coverage benefits start once $5,100 in true out-of-pocket costs is incurred.	
Requirements:	
Precertification	Applies
Step-Therapy	Applies
Non-Part D Drug Rider	• Not Covered

* Additional Medicare preventive services include:
- Ultrasound screening for abdominal aortic aneurysm (AAA)
- Cardiovascular disease screening
- Diabetes screening tests and diabetes self-management training (DSMT)
- Medical nutrition therapy
- Glaucoma screening
- Screening and behavioral counseling to quit smoking and tobacco use
- Screening and behavioral counseling for alcohol misuse
- Adult depression screening
- Behavioral counseling for and screening to prevent sexually transmitted infections
- Behavioral therapy for obesity
- Behavioral therapy for cardiovascular disease
- Behavioral therapy for HIV screening
- Hepatitis C screening
- Lung cancer screening

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**A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Not all PPO Plans are available in all areas

You must use network pharmacies to receive plan benefits except in limited, non-routine circumstances as defined in the EOC. In these situations, you are limited to a 30 day supply. To find a network pharmacy, you can visit our website (http://www.aetnaretireeplans.com). Quantity limits and restrictions may apply.

The formulary, pharmacy network and/or provider network may change at any time. You will receive notice when necessary.

Your coverage is provided through a contract with your former employer/union/trust. The plan benefits administrator will provide you with information about your plan premium (if applicable).

If you reside in a long-term care facility, your cost share is the same as at a retail pharmacy and you may receive up to a 31 day supply.

Members who get "extra help" don't need to fill prescriptions at preferred network pharmacies to get Low Income Subsidy (LIS) copays.

Specialty pharmacies fill high-cost specialty drugs that require special handling. Although specialty pharmacies may deliver covered medicines through the mail, they are not considered "mail-order pharmacies." So, most specialty drugs are not available at the mail-order cost share.

You must continue to pay your Part B premium.

See Evidence of Coverage for a complete description of plan benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by service area.

For mail-order, you can get prescription drugs shipped to your home through the network mail-order delivery program. Typically, mail-order drugs arrive within 7-10 days. You can call 1-888-792-3862, (TTY users should call 711) 24 hours a day, seven days a week, if you do not receive your mail-order drugs within this timeframe. Members may have the option to sign-up for automated mail-order delivery.

Aetna receives rebates from drug manufacturers that may be taken into account in determining Aetna's preferred drug list. Rebates do not reduce the amount a member pays the pharmacy for covered prescriptions. Pharmacy participation is subject to change.

Participating physicians, hospitals and other health care providers are independent contractors and are neither agents nor employees of Aetna. The availability of any particular provider cannot be guaranteed, and provider network composition is subject to change.

In case of emergency, you should call 911 or the local emergency hotline. Or you should go directly to an emergency care facility.

The following is a partial list of what isn't covered or limits to coverage under this plan:

- Services that are not medically necessary unless the service is covered by Original Medicare or otherwise noted in your Evidence of Coverage
- Plastic or cosmetic surgery unless it is covered by Original Medicare
- Custodial care
- Experimental procedures or treatments that Original Medicare doesn't cover
- Outpatient prescription drugs unless covered under Original Medicare Part B

†Your former employer/union/trust provides some additional coverage during the Coverage Gap stage for covered drugs. Your cost share appears in the chart above.

For brand drugs not included in the additional coverage provided by your former employer/union/trust, the Medicare Coverage Gap Discount Program applies. The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand name drugs. You pay 25% of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You also receive some coverage for generic drugs. You pay no more than 37% of the cost for generic drugs and the plan pays the rest. For generic drugs, the amount paid by the plan (63%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap.

You continue paying the discounted price for brand name drugs and no more than 37% of the costs of generic drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2019, that amount is $5,100. Coinsurance-based cost-sharing is applied against the overall cost of the drug, prior to the application of any discounts or benefits.

Coinsurance is applied against the overall cost of the drug, before any discounts or benefits are applied.

Aetna's retiree pharmacy coverage is an enhanced Part D Employer Group Waiver Plan that is offered as a single integrated product. The enhanced Part D plan consists of two components: basic Medicare Part D benefits and supplemental benefits. Basic Medicare Part D benefits are offered by Aetna based on our contract with CMS. We receive monthly payments from CMS to pay for basic Part D benefits. Supplemental benefits are non-Medicare benefits that provide enhanced coverage beyond basic Part D. Supplemental benefits are paid for by plan sponsors or members and may include benefits for non-Part D drugs. Aetna reports claim information to CMS according to the source of applicable payment (Medicare Part D, plan sponsor or member).

There are three general rules about drugs that Medicare drug plans will not cover under Part D. This plan cannot:

- Cover a drug that would be covered under Medicare Part A or Part B.
- Cover a drug purchased outside the United States and its territories.
- Generally cover drugs prescribed for "off label" use, (any use of the drug other than indicated on a drug's label as approved by the Food and Drug Administration) unless supported by criteria included in certain reference books like the American Hospital Formulary Service Drug Information, the DRUGDEX Information System and the USPDI or its successor.

Additionally, by law, the following categories of drugs are not normally covered by a Medicare prescription drug plan unless we offer enhanced drug coverage for which additional premium may be charged. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs". These drugs include:

- Drugs used for the treatment of weight loss, weight gain or anorexia
- Drugs used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Outpatient drugs that the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs used to promote fertility
- Drugs used to relieve the symptoms of cough and colds
- Non-prescription drugs, also called over-the-counter (OTC) drugs
- Drugs when used for the treatment of sexual or erectile dysfunction

Aetna Medicare is a PDP, HMO, PPO plan with a Medicare contract. Our SNPs also have contracts with State Medicaid programs. Enrollment in our plans depends on contract renewal.

You can read the *Medicare & You 2019* Handbook. Every year in the fall, this booklet is mailed to people with Medicare. It has a summary of Medicare benefits, rights and protections, and answers to the most frequently asked questions about Medicare. If you don't have a copy of this booklet, you can get it at the Medicare website (http://www.medicare.gov) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

ATTENTION: If you speak another language, language assistance services, free of charge, are available to you. Call 1-888-267-2637 (TTY: 711). Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-888-267-2637 (TTY: 711). Traditional Chinese: 注意：如果您使用中文，您可以免費獲得語言援助服務。請致電 1-888-267-2637 (TTY: 711).

You can also visit our website at www.aetnaretireeplans.com. As a reminder, our website has the most up-to-date information about our provider network (Provider Directory) and our list of covered drugs (Formulary/Drug List).

This information is not a complete description of benefits. Contact the plan for more information. Limitations, copayments, and restrictions may apply. Benefits, premium and/or co-payments/co-insurance may change on January 1 of each year.

Plans are offered by Aetna Health Inc., Aetna Health of California Inc., and/or Aetna Life Insurance Company (Aetna). Not all health services are covered. See Evidence of Coverage for a complete description of benefits, exclusions, limitations and conditions of coverage. Plan features and availability may vary by location.

If there is a difference between this document and the Evidence of Coverage (EOC), the EOC is considered correct.

Information is believed to be accurate as of the production date; however, it is subject to change. For more information about Aetna plans, go to www.aetna.com.

Please contact Customer Service toll-free at 1-888-267-2637 (TTY: 711) for additional information. Hours are 8 a.m. to 6 p.m. local time, Monday through Friday.

This is the end of this plan benefit summary

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GRP_0009_659

Minnesota Life Insurance Company Basic Life Insurance Program (Fully-Insured Program)

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY OPEB PLAN

APPENDIX C

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
Non-Medicare Program: Aetna KelseyCare HMO for Non-Medicare Eligible Participants (Self-Insured Program)	**Medical Claims:** Aetna PO Box 981106 El Paso, TX 79998-1106 **Prescription Drug Claims:** Aetna RX Home Delivery PO Box 219484 Kansas City, MO 64121-9484
Non-Medicare Program: Aetna Open Access for Non-Medicare Eligible Participants (Self-Insured Program)	**Medical Claims:** Aetna PO Box 981106 El Paso, TX 79998-1106 **Prescription Drug Claims:** Aetna RX Home Delivery PO Box 219484 Kansas City, MO 64121-9484
Medicare Program: Aetna Medicare Advantage PPO for Medicare Eligible Participants (Fully-Insured Program)	**Medical Claims:** Aetna PO Box 981106 El Paso, TX 79998-1106 **Prescription Drug Claims:** Aetna RX Home Delivery PO Box 52446 Phoenix, AZ 85072-2446 **Medicare Part B Reimbursements (Self-Funded):** Port of Houston Authority of Harris County, Texas Attn: Human Resources Department 111 East Loop North Houston, Texas 77029-4326

<table>
<tr><th>Welfare Program</th><th>Claims Administrator / Claims Fiduciary</th></tr>
<tr><td>Medicare Program: Aetna Medicare Advantage ESA PPO for Medicare Eligible Participants (Fully-Insured Program)</td><td>Medical Claims:
Aetna
PO Box 981106
El Paso, TX 79998-1106

Prescription Drug Claims:
Aetna RX Home Delivery
PO Box 52446
Phoenix, AZ 85072-2446

Medicare Part B Reimbursements (Self-Funded):
Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326</td></tr>
<tr><td>Minnesota Life Retiree Life Insurance Program</td><td>Minnesota Life Insurance Company
400 Robert Street North
St Paul, MN 55101-2098</td></tr>
</table>

The COBRA Administrator for the Plan is:

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

The Trustee for the Plan's trust is:

Compass Bank
2200 Post Oak Boulevard, 18th Floor
Houston, TX 77056

BBVA Compass
P. O. Box 4886
Houston, TX 77210-4886

SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY OPEB PLAN

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.