

SUMMARY PLAN DESCRIPTION

OF THE

PORT OF HOUSTON AUTHORITY GROUP

INSURANCE PLAN

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

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**SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY
GROUP INSURANCE 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 Group Insurance Plan (the “**Plan**”) for the benefit of the eligible Employees (and their eligible Dependents) of the Plan Sponsor and the other adopting Employers, if any. The Plan Sponsor has amended and restated the Plan effective as of January 1, 2019.

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

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

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

FOREWORD

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

ARTICLE I DEFINITIONS

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

- 1.1 **Affiliate** means an affiliate of the Employer, including: (a) any corporation which is a member of a controlled group of corporations (as defined in Code Section 414(b)) which includes the Employer, (b) any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer, (c) any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer and (d) any other entity required to be aggregated with the Employer pursuant to Regulations under Code Section 414(o).
- 1.2 **Affordable Care Act** means the federal Patient Protection and Affordable Care Act of 2010, as amended by the federal Health Care and Education Reconciliation Act of 2010 and subsequent amendments, and the authoritative guidance issued thereunder by the appropriate governmental entities.
- 1.3 **Beneficiary** means a Beneficiary under the Plan as defined under the terms of the respective Welfare Program.
- 1.4 **Claims Administrator** means the third party administrator, insurance company or other entity, as set forth in Appendix C, designated by the Plan Administrator to determine eligibility for benefits, process claims and perform other administrative duties under the Plan or a Welfare Program.
- 1.5 **Claims Fiduciary** means the person or entity that serves as the named claims fiduciary with respect to reviewing and making final decisions regarding claims under a particular Welfare Program. The “Claims Fiduciary” shall be the Plan Administrator unless otherwise set forth in Appendix C.
- 1.6 **COBRA Administrator** means the Plan Administrator, or the third party designated by the Plan Administrator to perform COBRA administration under the Plan on behalf of the Plan Administrator, as set forth in Appendix C.
- 1.7 **Code** means the Internal Revenue Code of 1986, as amended, and the implementing regulations and other authority issued thereunder by the appropriate governmental authority. References herein to any section of the Code will also refer to any successor provision thereof.
- 1.8 **Dependent** means:
 - (a) An eligible Employee’s Spouse;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- 1.11 Employer** means the Plan Sponsor, or any of its Affiliates which have adopted the Plan with the consent of the Plan Sponsor. As of the Effective Date, the Plan Sponsor is the only Employer which has adopted and is participating in the Plan.
- 1.12 Fully-Insured Program** means each Welfare Program that is fully-insured with an insurance carrier. The Fully-Insured Programs of the Plan are listed in Appendix A to this SPD.
- 1.13 HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.
- 1.14 Participant** means an Employee of the Employer who (a) meets the requirements for eligibility as set forth in Article III and (b) properly enrolls for coverage under the Plan. The term "Participant" also includes any Dependent of a person specified in the immediately preceding sentence who is properly enrolled for coverage under the Plan. A person will cease to be a Participant when he no longer meets the requirements for eligibility as set forth in applicable provisions of the Plan.
- 1.15 Participant Contribution** means the pre-tax or after-tax contribution required to be paid by a Participant, if any, as determined under each Welfare Program. The term "Participant Contribution" thus includes, but is not limited to, contributions used for the provision of benefits under a self-funded arrangement of the Plan Sponsor or an Employer as well as contributions used to purchase coverage under the Policies.
- 1.16 PHSA** means the Public Health Service Act of 1944, as amended.
- 1.17 Plan** means the Port of Houston Authority Group Insurance Plan, which consists of (a) the Plan Document, (b) the insurance policies set forth in the Policy Appendix to the Plan Document and incorporated therein by reference, (c) this SPD (including all appendices attached hereto), and (d) each Welfare Program Document incorporated herein by reference, as all such documents may be modified, amended, supplemented, or superseded from time to time. The Plan Document, Policies, SPD and Welfare Program Documents are incorporated by reference and collectively contain all the terms and provisions of the Plan and together constitute the entire Plan.
- 1.18 Plan Document** means the wrap-around Plan document (including all appendices attached thereto), as may be amended from time to time, into which the Policies, this SPD document, and the Welfare Program Documents are incorporated by reference to together form the Plan.
- 1.19 Plan Administrator** means the person or entity which has the authority and responsibility, as exercised in its discretion, to manage and direct the operation of the Plan. The Plan Administrator may assign or delegate duties to third parties, such as the Claims Administrator or

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

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

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

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

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

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

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

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

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

ARTICLE II INTERPRETATION

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

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

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

ARTICLE III ELIGIBILITY AND PARTICIPATION

3.1 Eligibility.

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

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

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

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

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

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

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

3.2 Enrollment.

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

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

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

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

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

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

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

3.3 Termination of Participation.

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

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

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

ARTICLE IV FUNDING

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

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

ARTICLE V BENEFITS

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

ARTICLE VI CLAIMS PROCEDURES

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

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

ARTICLE VII AMENDMENT OR TERMINATION

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

7.1 Right to Amend.

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

7.2 Right to Terminate.

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

ARTICLE VIII RIGHT OF SUBROGATION AND REIMBURSEMENT

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

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

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

8.1 Benefits Subject to this Provision

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

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

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

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

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

8.2 When this Provision Applies

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

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

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

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

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

In addition to the foregoing, the Participant:

- (a) Authorizes the Plan to sue, compromise and settle in the Participant's name to the extent of the amount of medical or other benefits paid for the injury or illness under the Plan and the expenses incurred by the Plan in collecting this amount, and assigns to the Plan the Participant's rights to Recovery when the provisions of this Article VIII apply;
- (b) Must notify the Plan in writing of any proposed settlement and obtain the Plan's written consent before signing any release or agreeing to any settlement; and
- (c) Must cooperate fully with the Plan in its exercise of its rights under this Article VIII, do nothing that would interfere with or diminish those rights, and furnish any information as required by the Plan to exercise or enforce its rights hereunder.

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

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

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

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

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

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

8.3 Amount Subject to Subrogation or Reimbursement

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

8.4 When Recovery Includes the Cost of Past or Future Expenses

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

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

8.5 When a Participant Retains an Attorney

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

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

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

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

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

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

8.7 When a Participant Does Not Comply

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

ARTICLE IX ADMINISTRATION

9.1 Allocation of Authority.

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

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

9.2 Powers and Duties of Plan Administrator.

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

- (a) to have final discretionary authority to (1) administer, enforce, construe, and construct the Plan, including the Welfare Program Documents, (2) make decisions relating to all questions of eligibility to participate, and (3) make a determination of benefits including without limitation, reconciling any inconsistency, correcting any defect, supplying any omission, and making all findings of fact;
- (b) to prescribe procedures to be followed by Participants filing applications for benefits;
- (c) to prepare and distribute, in such manner as the Plan Administrator determines to be appropriate, any information that explains the Plan and benefits thereunder;
- (d) to receive from the Employer and from Participants such information as deemed to be necessary or appropriate for the proper administration of the Plan;
- (e) to furnish the Employer and the Participants such annual reports with respect to the administration of the Plan as deemed to be necessary or appropriate;
- (f) to receive, review and keep on file (as it deems necessary) reports of benefit payments by the Employer and reports of disbursements for expenses;
- (g) to exercise such authority and responsibility as it deems to be necessary or appropriate in order to comply with the terms of the Plan relating to the records of Participants, including, without limitation, an examination at the Employer's expense of the records of the Plan to be made by such attorneys, accountants, auditors, or other agents as it may select, in its discretion, for that purpose; and
- (h) to appoint persons or entities to assist in the administration as it deems to be advisable in its discretion; and the Plan Administrator may delegate thereto any power or duty imposed upon or granted to it under the Plan.

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

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

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

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

9.3 Delegation by the Plan Administrator.

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

9.4 Rules and Decisions.

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

9.5 Facility of Payment for Incapacitated Participant.

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

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

9.6 Assignment and Payment of Benefits.

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

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

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

9.7 Overpayments.

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

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

ARTICLE X COBRA CONTINUATION COVERAGE

10.1 Definitions.

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

- (a) *COBRA* means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
- (b) *Continuation Coverage* means the coverage elected by a Qualified Beneficiary as of the date of a Qualifying Event. This coverage will be the same as the health coverage provided to Similarly Situated Beneficiaries who have not experienced a Qualifying Event as of the date the Qualified Beneficiary experiences a Qualifying Event. If the provisions of the Plan are modified for Similarly Situated Beneficiaries, such coverage will also be modified in the same manner for all Qualified Beneficiaries as of the same date. Open enrollment rights extended to active Employees will also be extended to similarly situated Qualified Beneficiaries.
- (c) *Continuation Coverage Contribution* means the amount of premium contribution required to be paid by or on behalf of a Qualified Beneficiary for Continuation Coverage.
- (d) *Continuation Coverage Period* means the applicable time period for which Continuation Coverage may be elected.
- (e) *Covered Employee* means an individual who was covered under the Plan on the day prior to the Qualifying Event and who is or was provided such coverage by virtue of the individual's performance of services for one or more entities maintaining the Plan. If an individual who otherwise would be a Covered Employee is denied coverage under the Plan in violation of applicable law, including HIPAA, the individual is considered a Covered Employee.
- (f) *Open Enrollment Period* means a period during which an Employee covered under the Plan can choose to be covered under another plan or under another benefit option within the same plan, or add or eliminate coverage of family members.
- (g) *Qualified Beneficiary* means a Covered Employee or Qualifying Dependent.

(h) *Qualifying Dependent* means:

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

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

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

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

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

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

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

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

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

(vi) the death of a Covered Employee; or

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

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

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

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

10.2 Continuation of Benefits under COBRA.

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

10.3 Election of COBRA Coverage.

(a) COBRA Continuation Coverage for Terminated Employees.

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

(b) COBRA Continuation Coverage for Qualifying Dependent.

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

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

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

(c) Enrollment for COBRA Continuation Coverage.

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

(i) loss of coverage; or

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

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

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

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

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA Continuation Coverage. However, if a waiver is later revoked, coverage will not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan's "COBRA Administrator", at the address listed in Appendix C.

10.4 Period of COBRA Coverage.

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

Coverage under this Section 10.4 may not continue beyond:

- (a) the date on which the Employer ceases to maintain a group health plan within its controlled group;
- (b) the last day of the month for which premium payments have been made, if the individual fails to make premium payments on time, in accordance with Section 10.5;
- (c) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, first becomes enrolled in Medicare;
- (d) the date the Qualified Beneficiary, after the date he or she elects COBRA Continuation Coverage, (1) first becomes covered under another group health plan and (2) is no longer subjected, due to changes in the law or otherwise, to a pre-existing condition exclusion or limitation under the Qualified Beneficiary's other coverage or new employer plan; or

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

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

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

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

10.5 Contribution Requirements for COBRA Coverage.

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

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

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

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

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

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

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

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

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

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

10.7 Extension of COBRA Coverage Period.

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

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

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

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

- (a) the Social Security Administration ("SSA") determines that the Qualified Beneficiary was "disabled" on the date of the Qualifying Event or within the first sixty (60) days of COBRA Continuation Coverage following the Qualifying Event, and
- (b) the Qualified Beneficiary or the Covered Employee (or a representative of either) provides notice to the Plan Administrator, as described in Section 10.12, of such SSA determination:
 - (i) within sixty (60) days after the latest of (A) the date of the SSA determination, (B) the date on which the Qualifying Event occurred, (C) the date on which the Qualified Beneficiary loses coverage due to the Qualifying Event, or (D) the date on which the Qualified Beneficiary is informed, including through this SPD or a COBRA general notice, of the obligation to provide the disability notice and the Plan's procedures for providing such notice; but
 - (ii) not later than the last day of the initial eighteen (18) month period of COBRA Continuation Coverage.

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

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

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

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

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

10.9 Coordination of Benefits - Medicare and COBRA.

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

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

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

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

10.10 Relocation and COBRA Coverage.

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

10.11 COBRA Coverage and HIPAA Special Enrollment Rules.

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

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

10.12 Qualified Beneficiary Notice Procedures.

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

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

(a) Qualifying Event Notice.

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

(b) Disability Determination Notice.

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

(c) Determination of End of Disability Notice.

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

(d) Birth, Adoption or Placement Notice.

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

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

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

10.14 Questions and Other Information Regarding COBRA Coverage.

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

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

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

ARTICLE XI HIPAA PRIVACY AND SECURITY

11.1 HIPAA Privacy and Security in General.

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

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

11.2 Designation of Health Care Components and Safeguards.

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

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

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

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

11.3 Use and Disclosure of Protected Health Information.

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

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

- (a) Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, Plan maximums and copayments as determined for an individual's claim);
- (b) Coordination of benefits or non-duplication of benefits;
- (c) Adjudication of health benefit claims (including appeals and other payment disputes);
- (d) Subrogation of health benefit claims;
- (e) Establishing employee contributions;
- (f) Risk adjusting amounts due based on enrollee health status and demographic characteristics;
- (g) Billing, collection activities and related health care data processing;
- (h) Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to Participant inquiries about payments;
- (i) Obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- (j) Medical necessity reviews or reviews of appropriateness of care or justification of

charges;

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

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

(m) Obtaining reimbursements due to the Plan.

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

(a) Quality assessment;

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

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

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

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

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

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

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

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

(iii) Resolution of internal grievances; and

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

11.4 Certification of Amendment of Plan Documents by Plan Sponsor.

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

11.5 Plan Sponsor Agrees to Certain Conditions for PHI.

The Plan Sponsor agrees to:

- (a) Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- (b) Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- (c) Not use or disclose PHI for employment-related actions and decisions unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- (d) Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless the use or disclosure is made pursuant to an authorization in compliance with HIPAA;
- (e) Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- (f) Make PHI available to an individual in accordance with HIPAA’s access requirements;
- (g) Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- (h) Make available the information required to provide an accounting of disclosures;
- (i) Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan’s compliance with HIPAA;
- (j) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible); and

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

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

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

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

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

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

11.6 Adequate Separation Between the Plan and the Plan Sponsor.

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

11.7 Limitations of PHI Access and Disclosure.

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

11.8 Noncompliance Issues.

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

11.9 Members of Organized Health Care Arrangement.

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

11.10 Additional Requirements Imposed by HITECH.

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

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

11.11 Limitation on the Use and Disclosure of Genetic Information.

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

11.12 Notification in Case of a Breach of Unsecured PHI.

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

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

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

11.13 Other Medical Privacy Laws.

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

ARTICLE XII MISCELLANEOUS LAW PROVISIONS

12.1 National Medical Support Notice.

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

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

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

(iii) the period to which the Notice applies.

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

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

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

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

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

(a) Compliance by Plans with Assignment of Rights.

A Welfare Program offered under the Plan that provides health benefits will comply with any assignment of rights made by or on behalf of such Participant or a Beneficiary of the Participant as required by a state plan for medical assistance approved under Title XIX of the Social Security Act pursuant to Section 1912(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993).

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

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

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

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

12.3 Health Program Coverage of Dependent Children in Adoption Cases.

(a) Coverage Effective Upon Placement For Adoption.

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

(b) Definitions.

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

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

adoption or Placement For Adoption.

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

12.4 Continued Coverage of Pediatric Vaccine under Group Health Plans.

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

12.5 Family and Medical Leave Act.

(a) *Health Benefits.*

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

(i) General.

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

(ii) Re-enrollment.

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

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

(iii) COBRA.

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

(iv) Contributions.

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

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

(v) Termination of Benefits while on FMLA Leave.

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

(b) *Non-Health Benefits.*

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

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

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

12.6 Uniformed Services Employment and Reemployment Rights Act.

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

(a) Health Benefits.

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

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

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

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

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

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

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

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

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

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

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

(b) *Non-Health Benefits.*

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

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

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

12.7 Health Insurance Portability and Accountability Act.

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

(a) Eligibility.

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

(b) Enrollment.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) *HIPAA and COBRA Continuation Coverage.*

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

12.8 Mental Health Parity and Addiction Equity Act.

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

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

12.9 Newborns’ and Mothers’ Health Protection Act.

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

12.10 Women’s Health and Cancer Rights Act.

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

- (a) reconstruction of the breast on which the mastectomy has been performed;
- (b) surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- (c) prosthesis and treatment of physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

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

12.11 Genetic Information Nondiscrimination Act.

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

12.12 Affordable Care Act.

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

12.13 Other Laws.

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

12.14 Governing Law.

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

ARTICLE XIII IMPORTANT INFORMATION

Name of Plan: Port of Houston Authority Group Insurance Plan

Plan Sponsor: Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326
(713) 670-1005

Plan Administrator: Port of Houston Authority of Harris County, Texas
Attn: Human Resources Department
111 East Loop North
Houston, Texas 77029-4326
(713) 670-1005

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

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

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

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

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

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

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

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

APPENDIX A

As of January 1, 2026, the following Welfare Programs are incorporated, in their entirety, by reference into this SPD:

- Aetna Open Access Medical Plan (Self-Insured Program);
- Aetna Kelsey Care Medical Plan (Self-Insured Program);
- Aetna PPO Dental Plan (Fully-Insured Program);
- Aetna DMO Dental Plan (Fully-Insured Program);
- Aetna Vision Preferred Program (Fully-Insured Program);
- Securian Life Insurance Company Basic, Supplemental and Dependent Life & AD&D Insurance Program (Fully-Insured Program);
- Voya Short Term Disability Insurance Program (Fully-Insured Program);
- Voya Long Term Disability Insurance Program (Fully-Insured Program); and
- Employee Assistance Program (EAP) Resources for Living (Fully-Insured Program).

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

APPENDIX B

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

Aetna Open Access Medical Plan (Self-Insured Program)



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



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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	50% <u>coinsurance</u> , except no charge for immunizations up to age 6	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Imaging (CT/PET scans, MRIs)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
If you need drugs to treat your illness or condition More information about <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 for 30 day supply (retail), \$50 for 31-90 day supply (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$20 for 30 day supply (retail), \$50 for 31-90 day supply (retail)	Covers 30 day supply (retail), 31-90 day supply (retail & participating mail order). Includes contraceptive drugs & devices obtainable from a pharmacy. No charge for preferred generic FDA-approved women's contraceptives in- <u>network</u> . Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	<u>Copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$75 for 31-90 day supply (retail & mail order)	50% <u>coinsurance</u> after <u>copay</u> /prescription, <u>deductible</u> doesn't apply: \$30 for 30 day supply (retail), \$75 for 31-90 day supply (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)	
	Non-preferred brand drugs	<u>Copay/prescription, deductible</u> doesn't apply: \$60 for 30 day supply (retail), \$150 for 31-90 day supply (retail & mail order)	50% <u>coinsurance</u> after <u>copay/prescription, deductible</u> doesn't apply: \$60 for 30 day supply (retail), \$150 for 31-90 day supply (retail)	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage.
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	0% <u>coinsurance</u>	50% <u>coinsurance</u>	None
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	None
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay/visit, deductible</u> doesn't apply	\$250 <u>copay/visit, deductible</u> doesn't apply	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . 50% <u>coinsurance</u> after \$250 <u>copay/visit</u> for non-emergency use out-of-network.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of- <u>network</u> emergency use paid the same as in- <u>network</u> . Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$35 <u>copay/visit, deductible</u> doesn't apply	50% <u>coinsurance</u>	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay/stay</u>	50% <u>coinsurance</u>	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	Physician/surgeon fees	No charge	50% <u>coinsurance</u>	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office: \$20 <u>copay/visit, deductible</u> doesn't apply; other outpatient services: no charge	Office & other outpatient services: 50% <u>coinsurance</u>	None

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)	
	Inpatient services	\$250 <u>copay</u> /stay	50% <u>coinsurance</u>	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If you are pregnant	Office visits	No charge	50% <u>coinsurance</u>	<u>Cost sharing</u> does not apply for <u>preventive services</u> . Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound). Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care may apply.
	Childbirth/delivery professional services	No charge	50% <u>coinsurance</u>	
	Childbirth/delivery facility services	\$250 <u>copay</u> /stay	50% <u>coinsurance</u>	
If you need help recovering or have other special health needs	<u>Home health care</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	60 visits/calendar year. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit, <u>deductible</u> doesn't apply	50% <u>coinsurance</u>	35 visits/calendar year for Physical & Occupational Therapy, 60 visits/calendar year for Speech Therapy.
	<u>Habilitation services</u>	No charge	50% <u>coinsurance</u>	None
	<u>Skilled nursing care</u>	\$250 <u>copay</u> /stay	50% <u>coinsurance</u>	100 days/calendar year. Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
	<u>Durable medical equipment</u>	0% <u>coinsurance</u>	50% <u>coinsurance</u>	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	\$250 <u>copay</u> /stay for inpatient; 0% <u>coinsurance</u> for outpatient	50% <u>coinsurance</u>	Penalty of \$250 for failure to obtain <u>pre-authorization</u> for out-of-network care.
If your child needs dental or eye care	Children's eye exam	No charge	50% <u>coinsurance</u>	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 | • Dental care (Adult & Child) | • Non-emergency care when traveling outside the U.S. |
| • Bariatric surgery | • Glasses (Child) | • Routine foot care |
| • Cosmetic surgery | • Long-term care | • Weight loss programs |

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

- | | | |
|---|---|--|
| • Chiropractic care - 35 visits/calendar year. | • Infertility treatment - Limited to the diagnosis & treatment of underlying medical condition. | • Routine eye care (Adult) - 1 routine eye exam/24 months. |
| • Hearing aids - 1 hearing aid per ear/36 months. | • Private-duty nursing - 70- 8 hour shifts/calendar year. | |

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:

- 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 <http://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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://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 information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? 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 <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$250
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
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 condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$100
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,320

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$250
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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.

TTY: 711

English -	To access language services at no cost to you, call 1-800-370-4526.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-800-370-4526.
Cushitic-Oromo	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પછોરે માટે, કોલ કરો 1-800-370-4526.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

Navajo -	T'áá ni nizaad k'éhjí bee níká a'doowoł doo búááh ílínígóó koji' hólne' 1-800-370-4526.
Pennsylvania Dutch -	Um Schprooch Services zu griege mitaus Koscht, ruff 1-800-370-4526.
Persian-Farsi -	برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-800-370-4526 تماس بگیرید.
Polish -	Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-800-370-4526.
Portuguese -	Para acessar os serviços de idiomas sem custo para você, ligue para 1-800-370-4526.
Punjabi -	ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਕੀਮਤ ਵਾਲੀਆਂ ਭਾਸ਼ਾ ਸੇਵਾਵਾਂ ਦੀ ਵਰਤੋਂ ਕਰਨ ਲਈ, 1-800-370-4526 'ਤੇ ਫ਼ੋਨ ਕਰੋ।
Russian -	Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-800-370-4526.
Samoan -	Mo le mauaina o auaunaga tau gagana e aunoa ma se totogi, vala'au le 1-800-370-4526.
Serbo-Croatian -	Za besplatne prevodilačke usluge pozovite 1-800-370-4526.
Spanish -	Para acceder a los servicios de idiomas sin costo, llame al 1-800-370-4526.
Syriac-Assyrian -	ܝܢ ܫܒܩܐ, ܝܢ ܝܠܚܝܬܐ ܕܐܬܝܬܐ ܕܠܝܥܬܐ ܕܝܠܕܐ, ܡܢ ܒܚܐ: 1-800-370-4526.
Tagalog -	Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-800-370-4526.
Thai -	หากท่านต้องการเข้าถึงการบริการทางด้านภาษาโดยไม่มีค่าใช้จ่าย โปรดโทร 1-800-370-4526.
Ukrainian -	Щоб отримати безкоштовний доступ до мовних послуг, задзвоніть за номером 1-800-370-4526.
Vietnamese -	Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-800-370-4526.

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, www.HealthReformPlanSBC.com 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 <u>deductible</u> ?	\$0.	See the Common Medical Events chart below for your costs for services this <u>plan</u> covers.
Are there services covered before you meet your <u>deductible</u> ?	No.	You will have to meet the <u>deductible</u> before the <u>plan</u> pays for any services
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services.
What is the <u>out-of-pocket limit</u> for this <u>plan</u> ?	KelseyCare In- <u>Network</u> : Individual \$1,500 / Family \$3,000.	The <u>out-of-pocket limit</u> is the most you could pay in a year for covered services. If you have other family members in this <u>plan</u> , they have to meet their own <u>out-of-pocket limits</u> until the overall family <u>out-of-pocket limit</u> has been met.
What is not included in the <u>out-of-pocket limit</u> ?	<u>Premiums</u> , <u>balance-billing</u> charges & health care this <u>plan</u> doesn't cover.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
Will you pay less if you use a <u>network provider</u> ?	Yes. See www.aetna.com/docfind or call 1-800-370-4526 for a list of in- <u>network providers</u> .	This <u>plan</u> uses a <u>provider network</u> . You will pay less if you use a <u>provider</u> in the <u>plan's network</u> . You will pay the most if you use an <u>out-of-network provider</u> , and you might receive a bill from a <u>provider</u> for the difference between the <u>provider's</u> charge and what your <u>plan</u> pays (<u>balance billing</u>). Be aware, your <u>network provider</u> might use an <u>out-of-network provider</u> for some services (such as lab work). Check with your <u>provider</u> before you get services.
Do you need a <u>referral</u> to see a <u>specialist</u> ?	Yes.	This <u>plan</u> will pay some or all of the costs to see a <u>specialist</u> for covered services but only if you have a <u>referral</u> before you see the <u>specialist</u> .



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
		KelseyCare In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 <u>copay</u> /visit	Not covered	None
	<u>Specialist</u> visit	\$40 <u>copay</u> /visit	Not covered	None
	<u>Preventive care</u> / <u>screening</u> /immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your <u>provider</u> if the services needed are preventive. Then check what your <u>plan</u> will pay for.
If you have a test	<u>Diagnostic test</u> (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 <u>prescription drug coverage</u> is available at www.aetnapharmacy.com/advancedcontrol	Generic drugs	<u>Copay</u> /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. No charge for preferred generic FDA-approved women's contraceptives <u>in-network</u> . Your cost will be higher for choosing Brand over Generics.
	Preferred brand drugs	<u>Copay</u> /prescription: \$30 for 30 day supply (retail), \$75 for 31-90 day supply (retail & mail order)	Not covered	
	Non-preferred brand drugs	<u>Copay</u> /prescription: \$60 for 30 day supply (retail), \$150 for 31-90 day supply (retail & mail order)	Not covered	
	<u>Specialty drugs</u>	Applicable cost as noted above for generic or brand drugs	Not covered	All prescriptions must be filled through the Aetna Specialty Performance Pharmacy <u>Network</u> . Precertification required for coverage.
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
		KelseyCare In-Network (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you need immediate medical attention	<u>Emergency room care</u>	\$250 <u>copay</u> /visit	\$250 <u>copay</u> /visit	Out-of-network emergency use paid the same as in-network. No coverage for non-emergency use.
	<u>Emergency medical transportation</u>	No charge	No charge	Out-of-network emergency use paid the same as in-network. Non-emergency transport: not covered, except if pre-authorized.
	<u>Urgent care</u>	\$35 <u>copay</u> /visit	Not covered	No coverage for non-urgent use.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$250 <u>copay</u> /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 <u>copay</u> /visit; other outpatient services: no charge	Not covered	None
	Inpatient services	\$250 <u>copay</u> /stay	Not covered	None
If you are pregnant	Office visits	No charge	Not covered	<u>Cost sharing</u> does not apply for <u>preventive services</u> . 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 <u>copay</u> /stay	Not covered	
If you need help recovering or have other special health needs	<u>Home health care</u>	No charge	Not covered	None
	<u>Rehabilitation services</u>	\$20 <u>copay</u> /visit	Not covered	None
	<u>Habilitation services</u>	No charge	Not covered	None
	<u>Skilled nursing care</u>	No charge	Not covered	100 days/calendar year.
	<u>Durable medical equipment</u>	No charge	Not covered	Limited to 1 <u>durable medical equipment</u> for same/similar purpose. Excludes repairs for misuse/abuse.
	<u>Hospice services</u>	\$250 <u>copay</u> /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 | • Glasses (Child) | • Private-duty nursing |
| • Bariatric surgery | • Long-term care | • Routine foot care |
| • Cosmetic surgery | • Non-emergency care when traveling outside the U.S. | • Weight loss programs |
| • Dental care (Adult & Child) | | |

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

- | | | |
|---|--|--|
| • Chiropractic care | • Infertility treatment - For more information & exceptions, see policy document provided by your employer or call the number on your ID card. | • Routine eye care (Adult) - 1 routine eye exam/24 months. |
| • Hearing aids - 1 hearing aid per ear/36 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:

- 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 <http://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 on how 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:

- If your group health coverage is subject to ERISA, you may contact Aetna directly by calling the toll-free number on your Medical ID Card, or by calling our general number at 1-800-370-4526. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://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 information is at: <http://www.aetna.com/individuals-families-health-insurance/rights-resources/complaints-grievances-appeals/index.html>.

Does this plan provide Minimum Essential Coverage? Yes.

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

Does this plan meet Minimum Value Standards? 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 <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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	\$12,700
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In this example, Peg would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$300
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
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 condition)

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$0

This EXAMPLE event includes services like:

Primary care provider office visits (*including disease education*)
Diagnostic tests (*blood work*)
Prescription drugs
Diabetic supplies (*glucose meter*)

Total Example Cost	\$5,600
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In this example, Joe would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$1,200
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$20
The total Joe would pay is	\$1,220

Mia's Simple Fracture

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

■ The <u>plan's</u> overall <u>deductible</u>	\$0
■ <u>Specialist</u> <u>copayment</u>	\$40
■ Hospital (facility) <u>copayment</u>	\$250
■ Other <u>copayment</u>	\$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	\$2,800
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In this example, Mia would pay:

<u>Cost Sharing</u>	
<u>Deductibles</u>	\$0
<u>Copayments</u>	\$400
<u>Coinsurance</u>	\$0
<u>What isn't covered</u>	
Limits or exclusions	\$0
The total Mia would pay is	\$400

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.

TTY: 711

English -	To access language services at no cost to you, call 1-800-370-4526.
Amharic -	የቋንቋ አገልግሎቶችን ያለክፍያ ለማግኘት፣ በ 1-800-370-4526 ይደውሉ።.
Arabic -	للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-800-370-4526.
Armenian -	Անվճար լեզվական ծառայություններից օգտվելու համար զանգահարեք 1-800-370-4526 հեռախոսահամարով:
Carolinian (Kapasal Falawasch) -	ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 1-800-370-4526.
Chamorro -	Para un hago' i setbision lengguåhi ni dibåtde para hågu, ågang 1-800-370-4526.
Chinese Traditional -	如欲使用免費語言服務，請致電 1-800-370-4526.
Cushitic-Oromo	Tajaajiloota afaanii garuu bilisaa ati argaachuuf,bilbili 1-800-370-4526.
French -	Afin d'accéder aux services langagiers sans frais, composez le 1-800-370-4526.
French Creole (Haitian)-	Pou jwenn sèvis lang gratis, rele 1-800-370-4526.
German -	Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-800-370-4526 an.
Greek -	Για να επικοινωνήσετε χωρίς χρέωση με το κέντρο υποστήριξης πελατών στη γλώσσα σας, τηλεφωνήστε στον αριθμό 1-800-370-4526.
Gujarati -	તમારેકોઇ જાતના ખર્ચવિના ભાષાની સે વિના ઓની પછોરે માટે, કોલ કરો 1-800-370-4526.
Hindi -	आपकेलिए बिना ककसी कीमत केभाषा सेवाओंका उपयोग करनेकेलिए, 1-800-370-4526 पर कॉल करें।.
Hmong -	Xav tau kev pab txhais lus tsis muaj nqi them rau koj, hu 1-800-370-4526.
Italian -	Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-800-370-4526.
Japanese -	言語サービスを無料でご利用いただくには、1-800-370-4526 までお電話ください。
Karen -	လၢတၢ်ကမၤန့ၢ်ကျိၣ်အတၢ်မၤစၢအတၢ်ဖံးတၢ်မၤတဖၣ်လၢတအိၣ်ဒီးအပူၤလၢကဘၣ်ဟ့ၣ်အိၣ်အဂီၢ်ဘၣ်န့ၣ် ကိး 1-800-370-4526 တက့ၢ်.
Korean -	무료 언어 서비스를 이용하려면 1-800-370-4526 번으로 전화해 주십시오.
Laotian -	ເພື່ອເຂົ້າໃຊ້ການບໍລິການພາສາໂດຍບໍ່ເສຍຄ່າຕໍ່ກັບທ່ານ, ໃຫ້ໂທຫາເບີ 1-800-370-4526.
Mon-Khmer, Cambodian -	ដើម្បីទទួលបានសេវាកម្មភាសាដោយឥតគិតថ្លៃសម្រាប់លោកអ្នក សូមហៅទូរស័ព្ទទៅកាន់លេខ 1-800-370-4526 ។

[illegible]

Aetna PPO Dental Plan (Fully-Insured Program)

Schedule of benefits

Comprehensive dental insurance plan

If this is an ERISA plan, you have certain rights under this plan. If the policyholder is a church group or a government group this may not apply. Please contact the policyholder for additional information.

Prepared for:

Policyholder:	Port of Houston Authority
Policyholder number:	GP-0882919
Schedule of benefits:	1A
Group policy effective date:	January 1, 2022
Plan name:	Comprehensive Dental Plan
Plan effective date:	January 1, 2022
Plan issue date:	November 20, 2025
Plan revision effective date:	January 1, 2026

Underwritten by Aetna Life Insurance Company in the state of Texas



Schedule of benefits

This schedule of benefits lists the **eligible dental services, deductibles, coinsurance**, maximums, and other limits that apply to the services you get under this plan.

How to read your schedule of benefits

- When we say:
 - “**Contracting dental provider coverage**” we mean that you get care from **contracting dental providers**.
 - “**Non-contracting dental provider coverage**” we mean that you can get care from **non-contracting dental providers**.
- The **deductibles** and **coinsurance** listed in the schedule of benefits below reflects the **deductibles** and **coinsurance** amounts under your plan.
- You must pay any **deductibles** and your part of the **coinsurance**.
- The **coinsurance** listed in the schedule of benefits reflects the plan **coinsurance** percentage. This is the **coinsurance** amount the plan pays. You are responsible for paying any remaining **coinsurance**.
- You must pay the full amount of any dental care services you get that are not a **covered benefit** or that exceed your **Calendar Year maximums** or **lifetime maximums**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. They may be combined limits between or separate limits for **contracting dental providers** and **non-contracting dental providers** unless we state otherwise. See later in this schedule of benefits for information about limits.

Important note:

All **covered benefits** are subject to a **Calendar Year deductible** and **coinsurance** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions:

- Register and log onto our self-service website available 24/7 at <https://www.aetna.com/>
- Call us at 1-877-238-6200

The coverage described in this schedule of benefits will be provided under **Aetna Life Insurance Company’s group policy**. This schedule of benefits replaces any schedule of benefits previously in effect under the **group policy**. Keep this schedule of benefits with your booklet-certificate.

General coverage provisions

This section explains the:

- **Deductibles**
- **Maximums**

Calendar Year deductible

Eligible dental services applied to the **non-contracting dental provider deductibles** will be applied to satisfy the **contracting dental provider deductibles**. **Eligible dental services** applied to the **contracting dental provider deductibles** will be applied to satisfy the **non-contracting dental provider deductibles**.

Individual deductible

You pay for **eligible dental services** each **Calendar Year** before this plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Calendar Year**.

Family deductible

You pay for **eligible dental services** each **Calendar Year** before this plan begins to pay. After the amount paid for **eligible dental services** reaches this family **deductible**, this plan starts to pay for **eligible dental services** for the rest of the **Calendar Year**. To satisfy this family **deductible** for the rest of the **Calendar Year**, the combined **eligible dental services** that you and each of your covered dependents incur toward the individual **deductible** must reach this family **deductible** in a **Calendar Year**. When this happens in a **Calendar Year**, the individual **deductibles** for you and your covered dependents are met for the rest of the **Calendar Year**.

Calendar Year maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person in a **Calendar Year** is called the **Calendar Year maximum**.

This **Calendar Year maximum** applies to **eligible dental services** provided by **contracting dental providers** and **non-contracting dental providers** combined.

Specific dental care lifetime maximum

This is the most this plan will pay, after you have paid any **deductible**, for specific dental care treatment expenses incurred by any one covered person during their lifetime for **eligible dental services**.

These specific dental care **lifetime maximums** apply to **eligible dental services** provided by **contracting dental providers** and **non-contracting dental providers** combined.

Any expenses applied to satisfy a specific dental care **lifetime maximum** will not be applied to satisfy any **lifetime maximum**.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

Calendar Year deductible

You have to meet your **Calendar Year deductible** before this plan pays for benefits.

Deductibles	Contracting dental provider coverage Amounts	Non-contracting dental provider coverage Amounts
Calendar Year deductible*	Individual \$50 Family \$150	Individual \$50 Family \$150
*Important note:	The Calendar Year deductible applies to all eligible dental services except Type A expenses.	The Calendar Year deductible applies to all eligible dental services except Type A expenses.

Coinsurance

The **coinsurance** listed below reflects the plan **coinsurance** percentage. This is the **coinsurance** amount that the plan pays. You are responsible for paying any remaining **coinsurance**.

About contracting and non-contracting providers

Your benefits, cost-sharing, and maximums are the same for **contracting dental providers** and **non-contracting dental providers**. However, you might pay more when you use a **non-contracting dental provider**. **Non-contracting dental providers** do not have to accept the **negotiated charge** that the **contracting dental providers** have agreed to be paid. We pay **non-contracting dental providers** based on the **recognized charge**, and they may balance bill you for charges over our **recognized charge**.

Coinsurance

Expenses	Contracting dental provider coverage Coinsurance	Non-contracting dental provider coverage Coinsurance
Type A expenses	100% of the negotiated charge	100% of the recognized charge
Type B expenses	80% of the negotiated charge	80% of the recognized charge
Type C expenses	50% of the negotiated charge	50% of the recognized charge

Orthodontic treatment coinsurance

Expense	Contracting dental provider coverage Coinsurance	Non-contracting dental provider coverage Coinsurance
Orthodontic treatment	50% of the negotiated charge	50% of the recognized charge

Calendar Year maximum

Maximums	Contracting dental provider coverage Amounts	Non-contracting dental provider coverage Amounts
Calendar Year maximum	\$2,000	\$2,000

Specific dental care lifetime maximum

Eligible dental service	Contracting dental provider coverage Amounts	Non-contracting dental provider coverage Amounts
Orthodontic treatment	\$1,500	\$1,500

Eligible dental services

Type A expenses: Diagnostic & preventive care

Visits and exams

- Oral evaluations, (2 routine visits and 2 problem focused visits per year)
- Prophylaxis (cleaning), (2 treatments per year)
- Topical application of fluoride if you are under age 16, (1 application per year)
- Sealants, per tooth (1 application every 3 years for permanent molars only and if you are under age 16)
- Sealant repair - per tooth (for permanent molars only and if you are under age 16)
- Scaling - moderate/severe inflammation, full mouth (2 treatments per year, frequency combined with prophylaxis)
- Application of hydroxyapatite regeneration medicament - per tooth (1 application every 3 years)
- Testing for cracked tooth (frequency combined with oral evaluations)

Space maintainers - Only when needed to preserve space resulting from premature loss of deciduous teeth. (Includes all adjustments within 6 months after installation.)

- Fixed or removable (unilateral or bilateral)
- Recementation or removal

Images and pathology

- Bitewing images (1 set per year)
- Entire dental series, including bitewings or panoramic film (1 set every 3 years)
- Vertical bitewing images (1 set every 3 years)
- Periapical images

Type B expenses: Basic restorative care

Visits and exams

- Office visit after hours (we will pay either for the office visit charge or for the **eligible dental services** performed, whichever is more)
- Emergency palliative treatment, per visit

Images and pathology

- Intra-oral, occlusal view
- Extra-oral
- Accession of tissue

Restorative - Excluding inlays, onlays and crowns. Multiple restorations in 1 surface will be considered as a single restoration.

- Amalgam restorations
- Resin-based composite restorations, (other than for molars)
- Placement of interim direct restoration
- Reattachment of tooth fragment, incisal edge or cusp
- Pin retention, per tooth, in addition to restoration
- Prefabricated crowns (primary teeth only, excludes temporary crowns)
- Recementation
- Excavation of a tooth resulting in the determination of non-restorability

Oral surgery

- Extractions - coronal remnants - deciduous tooth
- Extractions erupted tooth or exposed root
- Surgical removal of erupted tooth
- Removal of impacted tooth
 - Soft tissue
- Surgical removal of residual tooth roots
- Primary closure of a sinus perforation
- Oroantral fistula closure
- Tooth transplantation
- Surgical access of unerupted tooth
- Mobilization of erupted or malpositioned tooth to aid eruption
- Placement of device to facilitate eruption of impacted tooth
- Biopsy of oral tissue
- Exfoliative cytological sample collection
- Alveoloplasty
- Removal of odontogenic cysts or tumors
- Removal of exostosis
- Removal of torus
- Surgical reduction of osseous tuberosity
- Incision and drainage of abscess
- Removal of foreign body
- Sequestrectomy
- Suture of wounds
- Frenectomy/frenuloplasty
- Excision of hyperplastic tissue per arch
- Excision of pericoronal gingiva
- Surgical reduction of fibrous tuberosity
- Sialolithotomy
- Closure of salivary fistula
- Excisional biopsy of minor salivary glands

Periodontics

- Periodontal maintenance procedures following active therapy (2 per year)
- Occlusal adjustment, (other than with an appliance or by restoration)
- Root planing and scaling, 1 to 3 teeth per quadrant, (1 per site every 2 years)
- Root planing and scaling, 4 or more teeth per quadrant, (4 separate quadrants every 2 years)
- Surgical revision procedure, per tooth
- Gingivectomy/gingivoplasty, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingivectomy/gingivoplasty, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Gingival flap procedure, 1 to 3 teeth per quadrant, (1 per site every 3 years)
- Gingival flap procedure, 4 or more teeth per quadrant, (1 per quadrant every 3 years)
- Apically positioned flap
- Unscheduled dressing change (by someone other than treating **dentist** or their staff)

Endodontics

- Pulp cap
- Pulpal debridement
- Pulpal therapy
- Pulpotomy
- Apexification/recalcification
- Apicoectomy
- Root canal therapy and retreatment
 - Anterior
 - Bicuspid
- Pulpal regeneration
- Hemisection
- Retrograde filling
- Root amputation

Type C expenses: Major restorative care

Restorative - Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only as treatment for decay or acute traumatic **injury**, and only when teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge. Coverage is limited to 1 per tooth every 8 years. (See the *Replacement rule*.)

- Inlays
- Onlays
- Labial veneers
- Crowns
- Post and core
- Repairs - inlay, onlay, veneer, crown
- Removal of an indirect restoration on a natural tooth
- Core Build Up

Endodontics

- Root canal therapy and retreatment
 - Molar

Periodontics

- Osseous surgery, (including flap and closure), 1 to 3 teeth per quadrant (1 per site every 3 years)
- Osseous surgery, (including flap and closure), 4 or more per teeth per quadrant (1 per quadrant every 3 years)
- Soft tissue graft procedures
- Full mouth debridement (1 per lifetime)
- Clinical Crown Lengthening – Hard Tissue

Prosthodontics - Replacement of existing bridges or dentures is limited to 1 every 8 years. (See the *Replacement rule*.)

- Bridge abutments
- Pontics
- Dentures and partials (fees for dentures and partial dentures include relines, rebases and adjustments within 6 months after installation. Fees for relines and rebases include adjustments within 6 months after installation. Specialized techniques and characterizations are not eligible).
 - Complete upper and lower denture
 - Partial upper and lower (including any conventional clasps, rests and teeth)
 - Removable unilateral partial denture
- Stress breakers
- Interim partial denture (stayplate), anterior only
- Reline (partial or complete)
- Rebase, per denture
- Special tissue conditioning, per denture
- Repairs, full and partial denture
- Adding teeth and clasps to existing partial denture
- Repairs, bridges
- Occlusal guard for bruxism (1 every 3 years)
- Adjustments, repair or reline of occlusal guard
- Cleaning and inspection of a removable appliance
- Accessing and retorquing loose implant screw - per screw
- Cleaning and inspection of occlusal guard - per appliance

Oral surgery

- Removal of impacted tooth
 - Partially bony
 - Completely bony
- Coronectomy

General anesthesia and intravenous sedation

- General anesthesia and intravenous sedation are covered when provided as part of a covered surgical procedure
- Evaluation by anesthesiologist for deep sedation or general anesthesia

Dental care services and anesthesia in a hospital or surgery center

Eligible dental services include dental care and anesthesia in a hospital or surgery center only if your **provider** tells us you:

- Have a physical, mental, or medical condition that requires you be treated in a hospital or surgery center
- Are developmentally disabled
- Are in poor health and have a medical need for general anesthesia

Infiltration of a sustained release therapeutic when provided as part of an eligible dental service - Only for impacted wisdom teeth procedure

Type: Orthodontics treatment expenses

- Limited **orthodontic treatment**
- Comprehensive **orthodontic treatment** of adolescent dentition
- Comprehensive **orthodontic treatment** of adult dentition
- Fixed appliance therapy
- Removable appliance therapy
- Orthodontic retention

Important note:

The following apply:

- Inlays, onlays, labial veneers and crowns (excludes temporary crowns) are covered only:
 - As treatment for decay or acute traumatic **injury**.
 - When teeth cannot be restored with a filling material or when the tooth is an abutment to a fixed bridge.
- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).
- General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

Additional eligible dental services

We will provide additional **eligible dental services** if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

The additional **eligible dental services** are:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing (limited to 1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

Payment of benefits

We will waive the **Calendar Year deductible** and **coinsurance** for the additional **eligible dental services** above.

The plan **coinsurance** applied to the additional **eligible dental services** will be:

Expense	Contracting dental provider coverage Coinsurance	Non-contracting dental provider coverage Coinsurance
Additional eligible dental services	100%	100%

Aetna DMO Dental Plan (Fully-Insured Program)

Schedule of benefits

Managed dental insurance plan

If this is an ERISA plan, you have certain rights under this plan. If the policyholder is a church group or a government group this may not apply. Please contact the policyholder for additional information.

Prepared for:

Policyholder:	Port of Houston Authority
Policyholder number:	GP-0866256-A
Schedule of benefits:	2A
Group policy effective date	January 1, 2022
Plan name:	Dental Maintenance Organization
Plan effective date:	January 1, 2022
Plan issue date:	November 20, 2025
Plan revision effective date:	January 1, 2026

Underwritten by Aetna Life Insurance Company in the state of Oklahoma



**151 Farmington Avenue
Hartford, Connecticut 06156**

Schedule of benefits

This schedule of benefits lists the **eligible dental services**, **deductibles**, office visit **copayments**, maximums, and any limits that apply to the services you get under this plan.

How to read your schedule of benefits

- When we say:
 - “In-network coverage” we mean that you get care from **in-network providers**.
 - “Out-of-network coverage” we mean that you can get care from **out-of-network providers**.
- You must pay any **deductibles** and any office visit **copayment** and your part of the **copayment**.
- You must pay the full amount of any dental care services you get that is not a **covered benefit** or that exceed your **lifetime maximum**.
- This plan also has limits for some **covered benefits**. For example, these could be visit limits. See later in this schedule of benefits for more information about limits.

Important note:

All **covered benefits** are subject to a **deductible**, office visit **copayment** and **copayment** unless otherwise noted in the schedule of benefits below.

How to contact us for help

We are here to answer your questions:

- Register and log onto our self-service website available 24/7 at <https://www.aetna.com/>
- Call us at 1-877-238-6200

Aetna Life Insurance Company's group policy provides the coverage described in this schedule of benefits. This schedule replaces any schedule of benefits previously in use. Keep it with your booklet-certificate.

General coverage provisions

This section explains the:

- **Calendar Year out-of-network deductible**
- Lifetime out-of-network **orthodontic treatment deductible**
- **Dental emergency services maximum**

Calendar Year out-of-network deductible

You pay for out-of-network **eligible dental services** each **Calendar Year** before this plan begins to pay. This individual **deductible** applies separately to you and each covered dependent. After the amount paid reaches the individual **deductible**, this plan starts to pay for out-of-network **eligible dental services** for the rest of the **Calendar Year**.

Lifetime out-of-network orthodontic treatment deductible

This is the amount you owe for **eligible dental services** provided by **out-of-network providers** for **orthodontic treatment** during your lifetime before the plan begins to pay.

Charges that you incur for out-of-network **eligible dental services** for **orthodontic treatment** will not be applied to satisfy the plan's **Calendar Year** out-of-network **deductible**.

This lifetime **orthodontic treatment deductible** is separate from any other **deductible** for the plan and applies to you and each of your covered dependents.

Dental emergency services maximum

The most the plan will pay for **eligible dental services** incurred by any one covered person for any one **dental emergency** is called the **dental emergency services maximum**.

Your financial responsibility and determination of benefits provisions

Your financial responsibility for the cost of services is based on when the service or supply is provided, not when payment is made. Benefits will be pro-rated to account for treatment that occurs in more than one **Calendar Year**. Determinations regarding when benefits are covered are subject to the terms and conditions of the booklet-certificate.

Plan features

In-network plan features

Expense	Copayment
Office visit	\$5 per visit

Expense	Copayment
Comprehensive orthodontic treatment of adolescent and adult dentition	\$2,400

Maximums	Amounts
Dental emergency services maximum	\$100

Eligible dental services

In-network coverage

This dental care schedule applies to **eligible dental services** provided by **primary care dentists (PCDs)** and other **in-network providers** upon **referral** from your **PCD**. The plan covers only the **eligible dental services** listed below.

Eligible Dental Services	Limitations	Copayment Amounts
Periodic oral evaluation - established patient	4 visits per year for all oral evaluations combined	\$0
Limited oral evaluation - problem focused		\$0
Oral evaluation for a patient under three years of age and counseling with a primary caregiver		\$0
Comprehensive oral evaluation - new or established patient		\$0
Detailed and extensive oral evaluation - problem focused, by report		\$0
Re-evaluation - limited, problem focused (established patient; not post-operative visit)		\$0
Comprehensive periodontal evaluation - new or established patient		\$0
Intraoral - complete series of radiographic images	1 image per 3 years, combined with other radiographic images	\$0
Intraoral - periapical, first radiographic image		\$0
Intraoral - periapical, each additional radiographic image		\$0
Intraoral - occlusal radiographic image		\$0
Extra-oral, first radiographic image		\$0
Extra-oral, posterior radiographic image		\$0
Bitewing - single radiographic image	1 image per year, combined with other radiographic images	\$0
Bitewings - 2 radiographic images		\$0
Bitewings - 3 radiographic images		\$0
Bitewings - 4 radiographic images		\$0
Vertical bitewings - 7 to 8 radiographic images	1 set every 3 years	\$0
Panoramic radiographic image	1 image per 3 years, combined with other radiographic images	\$0
Interpretation of diagnostic image by a practitioner not associated with capture of the image, including report		\$0
Testing for cracked tooth	Combined frequency with oral evaluations	\$0
Diagnostic casts		\$0
Accession of tissue, gross examination, preparation and transmission of written report		\$0
Accession of tissue, gross and microscopic examination, preparation and transmission of written report		\$0

Accession of tissue, gross and microscopic exam, including assessment of surgical margins for presence of disease, preparation and transmission of written report		\$0
Prophylaxis - adult	2 visits per year	\$0
Prophylaxis - child	2 visits per year	\$0
Topical application of fluoride varnish if you are under age 16	1 treatment per year	\$0
Topical application of fluoride - excluding varnish if you are under age 16		\$0
Oral hygiene instruction		\$0
Sealant - per tooth if you are under age 16	1 application every 3 years for permanent molars, combined frequency for all sealants	\$0
Sealant repair - per tooth, if you are under age 16	For permanent molars	\$0
Application of caries arresting medicament - per tooth if you are under age 16	1 application every 3 years for permanent molars, combined frequency for all sealants	\$0
Caries preventive medicament application - per tooth if you are under age 16	1 application every 3 years for permanent molars, combined frequency for all sealants	\$0
Space maintainer - fixed - unilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	\$0
Space maintainer - fixed - bilateral, maxillary	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	\$0
Space maintainer - fixed - bilateral, mandibular	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	\$0
Space maintainer - removable - unilateral - per quadrant	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	\$0
Space maintainer - removable - bilateral, maxillary	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	\$0

Space maintainer - removable - bilateral, mandibular	Only when needed to preserve space resulting from premature loss of deciduous teeth; includes all adjustments within 6 months after installation	\$0
Re-cement or re-bond bilateral space maintainer - maxillary		\$12
Re-cement or re-bond bilateral space maintainer - mandibular		\$12
Re-cement or re-bond unilateral space maintainer - per quadrant		\$6
Removal of fixed unilateral space maintainer - per quadrant		\$6
Removal of fixed bilateral space maintainer - maxillary		\$12
Removal of fixed bilateral space maintainer - mandibular		\$12
Distal shoe space maintainer - fixed - unilateral - per quadrant		\$0
Amalgam - 1 surface, primary or permanent		\$0
Amalgam - 2 surfaces, primary or permanent		\$0
Amalgam - 3 surfaces, primary or permanent		\$0
Amalgam - 4 or more surfaces, primary or permanent		\$0
Resin-based composite - 1 surface, anterior		\$0
Resin-based composite - 2 surfaces, anterior		\$0
Resin-based composite - 3 surfaces, anterior		\$0
Resin-based composite - 4 or more surfaces, anterior		\$40
Resin-based composite crown, anterior		\$40
Resin-based composite - 1 surface, posterior		\$35
Resin-based composite - 2 surfaces, posterior		\$45
Resin-based composite - 3 surfaces, posterior		\$55
Resin-based composite - 4 or more surfaces, posterior		\$75
Inlay - metallic - 1 surface		\$190
Inlay - metallic - 2 surfaces		\$190
Inlay - metallic - 3 or more surfaces		\$190
Onlay - metallic - 2 surfaces		\$200
Onlay - metallic - 3 surfaces		\$200
Onlay - metallic - 4 or more surfaces		\$200
Inlay, porcelain/ceramic - 1 surface		\$190
Inlay, porcelain/ceramic - 2 surfaces		\$190
Inlay, porcelain/ceramic - 3 or more surfaces		\$190
Onlay, porcelain/ceramic - 2 surfaces		\$200
Onlay, porcelain/ceramic - 3 surfaces		\$200
Onlay, porcelain/ceramic - 4 or more surfaces		\$200

Inlay, resin based composite - 1 surface		\$190
Inlay, resin based composite - 2 surfaces		\$190
Inlay, resin based composite - 3 or more surfaces		\$190
Onlay, resin based composite - 2 surfaces		\$200
Onlay, resin based composite - 3 surfaces		\$200
Onlay, resin based composite - 4 or more surfaces		\$200
Crown - resin-based composite, indirect		\$225
Crown - 3/4 resin-based composite, indirect		\$180
Crown - resin with high noble metal		\$225
Crown - resin with predominantly base metal		\$225
Crown - resin with noble metal		\$225
Crown - porcelain/ceramic		\$225
Crown - porcelain fused to high noble metal		\$225
Crown - porcelain fused to predominantly base metal		\$225
Crown - porcelain fused to noble metal		\$225
Crown - porcelain fused to titanium and titanium alloys		\$225
Crown - 3/4 cast high noble metal		\$225
Crown - 3/4 cast predominantly base metal		\$225
Crown - 3/4 cast noble metal		\$225
Crown - 3/4 cast porcelain/ceramic		\$225
Crown - full cast high noble metal		\$225
Crown - full cast predominantly base metal		\$225
Crown - full cast noble metal		\$225
Crown - titanium and titanium alloys		\$225
Re-cement or re-bond inlay, onlay, veneer or partial coverage restoration		\$5
Re-cement or re-bond indirectly fabricated or prefabricated post and core		\$3
Re-cement or re-bond crown		\$5
Reattachment of tooth fragment, incisal edge or cusp		\$4
Prefabricated porcelain/ceramic crown - primary tooth		\$0
Prefabricated stainless steel crown - primary tooth		\$0
Prefabricated stainless steel crown - permanent tooth		\$40
Prefabricated esthetic coated stainless steel crown - primary tooth		\$0
Placement of interim direct restoration		\$0
Core buildup, including any pins when required		\$60
Pin retention - per tooth, in addition to restoration		\$10

Post & core in addition to crown, indirectly fabricated		\$80
Excavation of a tooth resulting in the determination of non-restorability		\$0
Resin infiltration of incipient smooth surface lesions if you are under age 16	1 application every 3 years, combined frequency for all sealants	\$0
Application of hydroxyapatite regeneration medicament - per tooth		\$0
Pulp cap - direct (excluding final restoration)		\$0
Pulp cap - indirect (excluding final restoration)		\$0
Therapeutic pulpotomy (excluding final restoration)		\$0
Pulpal debridement, primary and permanent teeth		\$10
Partial pulpotomy for apexogenesis - permanent tooth with incomplete root development		\$0
Pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)		\$0
Pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)		\$0
Endodontic therapy, anterior tooth (excluding final restoration)		\$50
Endodontic therapy, premolar tooth (excluding final restoration)		\$70
Endodontic therapy, molar tooth (excluding final restoration)		\$175
Treatment of root canal obstruction; non-surgical access		\$50
Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth		\$35
Internal root repair of perforation defects		\$40
Retreatment of previous root canal therapy - anterior		\$150
Retreatment of previous root canal therapy - premolar		\$170
Retreatment of previous root canal therapy - molar		\$275
Apicoectomy - anterior		\$65
Apicoectomy - premolar (first root)		\$65
Apicoectomy - molar (first root)		\$80
Apicoectomy - each additional root		\$40
Retrograde filling - per root		\$20
Root amputation - per root		\$60
Surgical repair of root resorption - anterior		\$29
Surgical repair of root resorption - premolar		\$39
Surgical repair of root resorption - molar		\$49

Surgical exposure of root surface without apicoectomy or repair of root resorption - anterior		\$54
Surgical exposure of root surface without apicoectomy or repair of root resorption - premolar		\$72
Surgical exposure of root surface without apicoectomy or repair of root resorption - molar		\$90
Gingivectomy or gingivoplasty - 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$100
Gingivectomy or gingivoplasty - 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$30
Gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	1 per quadrant every 3 years	\$12
Gingival flap procedure, including root planing - 4 or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$110
Gingival flap procedure, including root planing - 1-3 contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$66
Apically positioned flap		\$90
Clinical crown lengthening - hard tissue		\$150
Osseous surgery (including elevation of a full thickness flap and closure) - four or more contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$250
Osseous surgery (including elevation of a full thickness flap and closure) - one to three contiguous teeth or tooth bounded spaces per quadrant	1 per quadrant every 3 years	\$150
Surgical revision procedure, per tooth		\$100
Pedicle soft tissue graft procedure		\$190
Autogenous connective tissue graft procedure (including donor and recipient surgical sites) first tooth, implant or edentulous tooth position		\$115
Non-autogenous connective tissue graft (including recipient site and donor material) first tooth, implant, or edentulous tooth position in graft		\$230
Combined connective tissue and pedicle graft, per tooth		\$190
Free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant, or edentulous tooth position in graft		\$82
Free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant, or edentulous tooth position in same graft site		\$41

Autogenous connective tissue graft procedure (including donor and recipient surgical sites) - each additional contiguous tooth, implant or edentulous tooth position in same graft site		\$63
Non-autogenous connective tissue graft procedure (including recipient surgical site and donor material) - each additional contiguous tooth, implant or edentulous tooth position in same graft site		\$127
Periodontal scaling and root planing, 4 or more teeth per quadrant	4 separate quadrants every 2 years	\$50
Periodontal scaling and root planing - 1-3 teeth per quadrant	4 per site every 2 years	\$30
Scaling in presence of generalized moderate or severe gingival inflammation - full mouth, after oral evaluation	2 treatments per year combined with prophylaxis	\$30
Full mouth debridement to enable a comprehensive oral evaluation and diagnosis on a subsequent visit	1 per lifetime	\$60
Periodontal maintenance, following active therapy	2 per year	\$30
Unscheduled dressing change (by someone other than treating dentist or their staff)		\$10
Complete denture - maxillary	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$275
Complete denture - mandibular	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$275
Immediate denture - maxillary	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$325
Immediate denture - mandibular	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$325
Maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$275
Mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$275
Maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$325

Mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$325
Immediate maxillary partial denture - resin base (including retentive/clasping materials, rests and teeth)	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$316
Immediate mandibular partial denture - resin base (including retentive/clasping materials, rests and teeth)	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$316
Immediate maxillary partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$374
Immediate mandibular partial denture - cast metal framework with resin denture bases (including retentive/clasping materials, rests and teeth)	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$374
Maxillary partial denture - flexible base (including any clasps, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$330
Mandibular partial denture - flexible base (including any clasps, rests and teeth)	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$330
Immediate maxillary partial denture - flexible base (including any clasps, rests and teeth)	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$330
Immediate mandibular partial denture - flexible base (including any clasps, rests and teeth)	Relines/rebases are separately eligible within 6 months of placement of the immediate denture	\$330
Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests, and teeth), maxillary	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$275
Removable unilateral partial denture one piece cast metal (including retentive/clasping materials, rests, and teeth), mandibular	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$275
Removable unilateral partial denture - one-piece flexible base (including retentive/clasping materials, rests, and teeth) - per quadrant	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$165

Removable unilateral partial denture - one-piece resin (including retentive/clasping materials, rests, and teeth) - per quadrant	Relines/rebases/adjustments are not separately eligible within 6 months of placement of the denture	\$138
Adjust complete denture - maxillary	Includes all adjustments within 6 months after insertion	\$10
Adjust complete denture - mandibular	Includes all adjustments within 6 months after insertion	\$10
Adjust partial denture - maxillary	Includes all adjustments within 6 months after insertion	\$10
Adjust partial denture - mandibular	Includes all adjustments within 6 months after insertion	\$10
Repair broken complete denture base, mandibular		\$30
Repair broken complete denture base, maxillary		\$30
Replace missing or broken teeth - complete denture - per tooth		\$35
Repair resin partial denture base, mandibular		\$35
Repair resin partial denture base, maxillary		\$35
Repair cast partial framework, mandibular		\$35
Repair cast partial framework, maxillary		\$35
Repair or replace broken retentive/clasping materials - per tooth		\$35
Replace missing or broken teeth - partial denture - per tooth		\$35
Add tooth to existing partial denture - per tooth		\$35
Add clasp to existing partial denture - per tooth		\$40
Replace all teeth and acrylic on cast metal framework - maxillary		\$100
Replace all teeth and acrylic on cast metal framework - mandibular		\$100
Rebase complete maxillary denture	Includes all adjustments within 6 months after insertion	\$100
Rebase complete mandibular denture	Includes all adjustments within 6 months after insertion	\$100
Rebase maxillary partial denture	Includes all adjustments within 6 months after insertion	\$100
Rebase mandibular partial denture	Includes all adjustments within 6 months after insertion	\$100
Rebase hybrid prosthesis	Includes all adjustments within 6 months after insertion	\$100
Reline complete maxillary denture (direct)	Includes all adjustments within 6 months after insertion	\$40
Reline complete mandibular denture (direct)	Includes all adjustments within 6 months after insertion	\$40
Reline maxillary partial denture (direct)	Includes all adjustments within 6 months after insertion	\$40
Reline mandibular partial denture (direct)	Includes all adjustments within 6 months after insertion	\$40

Reline complete maxillary denture (indirect)	Includes all adjustments within 6 months after insertion	\$90
Reline complete mandibular denture (indirect)	Includes all adjustments within 6 months after insertion	\$90
Reline maxillary partial denture (indirect)	Includes all adjustments within 6 months after insertion	\$90
Reline mandibular partial denture (indirect)	Includes all adjustments within 6 months after insertion	\$90
Soft liner for complete or partial removable denture - indirect		\$90
Interim partial denture (including retentive/clasping materials, rests and teeth), maxillary	Included in permanent	\$90
Interim partial denture (including retentive/clasping materials, rests and teeth), mandibular	Included in permanent	\$90
Tissue conditioning, maxillary	Inclusive with prosthesis within 6 months after insertion	\$40
Tissue conditioning, mandibular	Inclusive with prosthesis within 6 months after insertion	\$40
Add metal substructure to acrylic complete denture - per arch		\$30
Abutment supported porcelain/ceramic crown		\$225
Abutment supported porcelain fused to metal crown (high noble metal)		\$225
Abutment supported porcelain fused to metal crown (predominantly base metal)		\$225
Abutment supported porcelain fused to metal crown (noble metal)		\$225
Abutment supported cast metal crown (high noble metal)		\$225
Abutment supported cast metal crown (predominantly base metal)		\$225
Abutment supported cast metal crown (noble metal)		\$225
Implant supported porcelain/ceramic crown		\$225
Implant supported porcelain fused to metal crown (titanium, titanium alloy or high noble metal)		\$225
Implant supported metal crown (titanium, titanium alloy or high noble metal)		\$225
Abutment supported retainer for porcelain/ceramic FPD		\$225
Abutment supported retainer for porcelain fused to metal FPD (high noble metal)		\$225
Abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)		\$225
Abutment supported retainer for porcelain fused to metal FPD (noble metal)		\$225

Abutment supported retainer for cast metal FPD (high noble metal)		\$225
Abutment supported retainer for cast metal FPD (predominantly base metal)		\$225
Abutment supported retainer for cast metal FPD (noble metal)		\$225
Implant supported retainer for ceramic FPD		\$225
Implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy or high noble metal)		\$225
Implant supported retainer for cast metal FPD (titanium, titanium alloy or high noble metal)		\$225
Implant supported crown - porcelain fused to predominantly base alloys		\$225
Implant supported crown - porcelain fused to noble alloys		\$225
Implant supported crown - porcelain fused to titanium and titanium alloys		\$225
Implant supported crown - predominantly base alloys		\$225
Implant supported crown - noble alloys		\$225
Implant supported crown - titanium and titanium alloys		\$225
Abutment supported crown (titanium)		\$225
Abutment supported crown - porcelain fused to titanium and titanium alloys		\$225
Implant supported retainer - porcelain fused to predominantly base alloys		\$225
Implant supported retainer for FPD - porcelain fused to noble alloys		\$225
Implant/abutment supported removable denture for edentulous arch - maxillary		\$275
Implant/abutment supported removable denture for edentulous arch - mandibular		\$275
Implant/abutment supported removable denture for partially edentulous arch - maxillary		\$275
Implant/abutment supported removable denture for partially edentulous arch - mandibular		\$275
Implant/abutment supported fixed denture for edentulous arch - maxillary		\$275
Implant/abutment supported fixed denture for edentulous arch - mandibular		\$275
Implant/abutment supported fixed denture for partially edentulous arch - maxillary		\$275
Implant/abutment supported fixed denture for partially edentulous arch - mandibular		\$275
Implant supported retainer - porcelain fused to titanium and titanium alloys		\$225

Implant supported retainer for metal FPD - predominantly base alloys		\$225
Implant supported retainer for metal FPD - noble alloys		\$225
Implant supported retainer for metal FPD - titanium and titanium alloys		\$225
Abutment supported retainer - porcelain fused to titanium and titanium alloys		\$225
Replacement of restorative material used to close an access opening of a screw-retained implant supported prosthesis, per implant		\$35
Pontic - indirect resin based composite		\$225
Pontic - cast high noble metal		\$225
Pontic - cast predominantly base metal		\$225
Pontic - cast noble metal		\$225
Pontic - titanium		\$225
Pontic - porcelain fused to high noble metal		\$225
Pontic - porcelain fused to predominantly base metal		\$225
Pontic - porcelain fused to noble metal		\$225
Pontic - porcelain fused to titanium and titanium alloys		\$225
Pontic - porcelain/ceramic		\$225
Pontic - resin with high noble metal		\$225
Pontic - resin with predominantly base metal		\$225
Pontic - resin with noble metal		\$225
Retainer - cast metal for resin-bonded fixed prosthesis		\$190
Retainer - porcelain/ceramic for resin-bonded fixed prosthesis		\$190
Resin retainer - for resin bonded fixed prosthesis		\$113
Retainer inlay - porcelain/ceramic, 2 surfaces		\$190
Retainer inlay - porcelain/ceramic, 3 or more surfaces		\$190
Retainer inlay - cast high noble metal, 2 surfaces		\$210
Retainer inlay - cast high noble metal, 3 or more surfaces		\$210
Retainer inlay - cast predominantly base metal, 2 surfaces		\$190
Retainer inlay - cast predominantly base metal, 3 or more surfaces		\$190
Retainer inlay - cast noble metal, 2 surfaces		\$210
Retainer inlay - cast noble metal, 3 or more surfaces		\$210
Retainer onlay - porcelain/ceramic, 2 surfaces		\$200
Retainer onlay - porcelain/ceramic, 3 or more surfaces		\$200
Retainer onlay - cast high noble metal, 2 surfaces		\$220

Retainer onlay - cast high noble metal, 3 or more surfaces		\$220
Retainer onlay - cast predominantly base metal, 2 surfaces		\$200
Retainer onlay - cast predominantly base metal, 3 or more surfaces		\$200
Retainer onlay - cast noble metal, 2 surfaces		\$220
Retainer onlay - cast noble metal, 3 or more surfaces		\$220
Retainer inlay - titanium		\$210
Retainer onlay - titanium		\$220
Retainer crown - indirect resin based composite		\$225
Retainer crown - resin with high noble metal		\$225
Retainer crown - resin with predominantly base metal		\$225
Retainer crown - resin with noble metal		\$225
Retainer crown - porcelain/ceramic		\$225
Retainer crown - porcelain fused to high noble metal		\$225
Retainer crown - porcelain fused to predominantly base metal		\$225
Retainer crown - porcelain fused to noble metal		\$225
Retainer crown - porcelain fused to titanium and titanium alloys		\$225
Retainer crown - 3/4 cast high noble metal		\$225
Retainer crown - 3/4 cast predominantly base metal		\$225
Retainer crown - 3/4 cast noble metal		\$225
Retainer crown - 3/4 porcelain/ceramic		\$225
Retainer crown - 3/4 titanium and titanium alloys		\$225
Retainer crown - full cast high noble metal		\$225
Retainer crown - full cast predominantly base metal		\$225
Retainer crown - full cast noble metal		\$225
Retainer crown - titanium		\$225
Re-cement or re-bond fixed partial denture		\$15
Extraction, coronal remnants - primary tooth		\$0
Extraction, erupted tooth or exposed root (elevation and/or forceps removal)		\$0
Extraction, erupted tooth requiring removal of bone and/or sectioning of tooth and including elevation of mucoperiosteal flap if indicated		\$0
Removal of impacted tooth - soft tissue		\$0
Removal of impacted tooth - partially bony		\$45
Removal of impacted tooth - completely bony		\$70
Removal of impacted tooth - completely bony, with unusual surgical complications		\$70

Removal of residual tooth roots (cutting procedure)		\$15
Coronectomy - intentional partial tooth removal, impacted teeth only		\$35
Exposure of an unerupted tooth		\$26
Mobilization of erupted or malpositioned tooth to aid eruption		\$30
Placement of device to facilitate eruption of impacted tooth		\$6
Excisional biopsy of minor salivary glands		\$75
Incisional biopsy of oral tissue - hard (bone, tooth)		\$50
Incisional biopsy of oral tissue - soft		\$50
Exfoliative cytological sample collection		\$25
Alveoloplasty in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant		\$18
Alveoloplasty in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant		\$9
Alveoloplasty not in conjunction with extractions - 4 or more teeth or tooth spaces, per quadrant		\$25
Alveoloplasty not in conjunction with extractions - 1 to 3 teeth or tooth spaces, per quadrant		\$13
Incision and drainage of abscess - intraoral soft tissue		\$10
Incision and drainage of abscess - intraoral soft tissue - complicated		\$11
Buccal/labial frenectomy (frenulectomy)		\$24
Lingual frenectomy (frenulectomy)		\$24
Frenuloplasty		\$25
Palliative (emergency) treatment of dental pain - minor procedure		\$10
Administration of deep sedation/general anesthesia - first 15 minute increment, or any portion thereof		\$104
Administration of deep sedation/general anesthesia - each subsequent 15 minute increment, or any portion thereof		\$83
Administration of general anesthesia with advanced airway - first 15 minute increment, or any portion thereof		\$120
Administration of general anesthesia with advanced airway - each subsequent 15 minute increment, or any portion thereof		\$95
Administration of moderate sedation - intravenous - first 15 minute increment, or any portion thereof		\$104
Administration of moderate sedation - intravenous - each subsequent 15 minute increment, or any portion thereof		\$83

Administration of moderate sedation - non-intravenous parenteral - first 15 minute increment, or any portion thereof		\$62
Administration of moderate sedation - non-intravenous parenteral - each subsequent 15 minute increment, or any portion thereof		\$50
Consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	For second opinions only	\$0
Consultation with a medical health care professional		\$0
Cleaning and inspection of removable complete denture, maxillary		\$25
Cleaning and inspection of removable complete denture, mandibular		\$25
Cleaning and inspection of removable partial denture, maxillary		\$25
Cleaning and inspection of removable partial denture, mandibular		\$25
Cleaning and inspection of occlusal guard - per appliance		\$15
Repair and/or reline of occlusal guard		\$18
Occlusal guard adjustment	Fee for occlusal guard includes adjustments performed within 6 months of placement	\$13
Occlusal guard - hard appliance, full arch	Covered for bruxism only (1 every 3 years)	\$115
Occlusal guard - soft appliance, full arch		\$100
Occlusal guard - hard appliance, partial arch		\$60
Occlusal adjustment - limited	Not covered when performed in conjunction with a restoration, root canal therapy or appliance	\$20
Occlusal adjustment - complete		\$80
Full mouth rehabilitation, per unit (6 or more covered units of crowns and/or pontics under one treatment plan)		\$125

Out-of-network coverage

When services shown in the preceding schedule of **eligible dental services** are provided by **out-of-network providers**, you pay the **coinsurance** percentage after the **Calendar Year deductible** or lifetime **deductible** shown below for **eligible dental services**.

Out-of-network plan features

Deductible	Amount
Out-of-network Calendar Year deductible	\$500
*Important note: This deductible does not apply to orthodontic treatment services and out-of-area dental emergency services care.	

Expenses	
Primary care services	Coinsurance
Type A expenses	30%
Type B expenses	55%
Type C expenses	65%
Specialty care services	Coinsurance
Type B expenses	55%
Type C expenses	65%

Expenses	
Orthodontic treatment expenses	Amounts
Lifetime deductible	\$1,000
Coinsurance	0%

Important note:

The following apply:

- There is an extra charge for **eligible dental services** that use high noble metals (ex. gold or titanium).
- General anesthesia and sedation are **covered benefits** when part of a covered surgical procedure.

Additional eligible dental services

We will provide additional **eligible dental services** if you have at least one of the following conditions:

- Pregnancy
- Coronary artery disease/cardiovascular disease
- Cerebrovascular disease
- Diabetes

The additional **eligible dental services** are:

- Prophylaxis (cleaning) (one additional per **Calendar Year**)
- Scaling and root planing, (4 or more teeth), per quadrant
- Scaling and root planing, (1 to 3 teeth), per quadrant
- Full mouth debridement
- Periodontal maintenance

Payment of benefits

We will waive the out-of-network **Calendar Year deductible, coinsurance** and **copayment** for the additional **eligible dental services** above.

Your **coinsurance** applied to the additional **eligible dental services** will be:

Expense	In-network coverage Coinsurance	Out-of-network coverage Coinsurance
Additional eligible dental services	0%	0%

Aetna Vision Preferred Plan (Fully-Insured Program)



Summary of Benefits for Port Of Houston Authority Aetna VisionSM Preferred

Effective Date: 01/01/2026		
Frequency (Exam/Frame/Lens): 12/12/12 Standard Plan Current Plan 929105 - Package A	In Network Member Cost Aetna Vision Network	Out of Network Member Reimbursement*
Exam		
Eye Exam with Dilation as Necessary	\$10 Copay	\$10 Reimbursement
Retinal Imaging	Member pays discounted fee of \$39	Not Covered
Standard Contact Lens Fit /Follow Up ¹	Member pays discounted fee of \$40	Not Covered
Premium Contact Lens Fit /Follow Up ¹	10% off retail price	Not Covered
Frames		
Any Frame available, including frames for prescription sunglasses	\$0 Copay; \$150 Allowance**, 20% off balance over allowance	\$70 Reimbursement
Standard Plastic Lenses		
Single Vision	\$25 Copay	\$30 Reimbursement
Bifocal	\$25 Copay	\$50 Reimbursement
Trifocal	\$25 Copay	\$65 Reimbursement
Lenticular	\$25 Copay	\$100 Reimbursement
Standard Progressive Lens (copay includes bifocal cost)	\$90 Copay	\$50 Reimbursement
Premium Progressive Lens (copay includes bifocal cost) ²	\$90 Copay; 80% of Charge less \$120 allowance**	\$50 Reimbursement
Lens Options		
UV Treatment	Member pays discounted fee of \$15	Not Covered
Tint (Solid And Gradient)	Member pays discounted fee of \$15	Not Covered
Standard Plastic Scratch Coating	Member pays discounted fee of \$15	Not Covered
Polycarbonate Lenses - Adult	Member pays discounted fee of \$40	Not Covered
Polycarbonate Lenses - Children to age 19	\$0 Copay	\$5 Reimbursement
Standard Anti-Reflective Coating	Member pays discounted fee of \$45	Not Covered
Photochromic/Transitions Plastic - Adult	20% off retail price	Not Covered
Photochromic/Transitions Plastic - Children to age 19	20% off retail price	Not Covered
Other Add-Ons	20% off retail price	Not Covered
Contact Lenses		
Conventional	\$0 Copay; \$150 Allowance**, 15% off balance over allowance	\$105 Reimbursement
Disposable	\$0 Copay; \$150 Allowance	\$105 Reimbursement
Medically Necessary	Covered in Full	\$210 Reimbursement
Frequency	Children to age 19	Adults age 19 and over
Exam	once every Calendar Year	once every Calendar Year
Frame	once every Calendar Year	once every Calendar Year
Lenses	once every Calendar Year	once every Calendar Year
Contact Lenses	once every Calendar Year	once every Calendar Year
Lens Coverage can be used for eyeglass lenses OR 1 order of contact lenses		

In Network Discounts	
Discounts cannot be combined with any other discounts or promotional offers and may not be available on all brands	
Additional pairs of eyeglasses or prescription sunglasses ³	Up to 40% off prescription eyeglasses/sunglasses and 15% off conventional contact lenses once the funded benefit has been used
Non-covered Items ⁴	20% off retail price
Lasik Laser vision correction or PRK from U.S. Laser Network ⁵ . Call 1-800-422-6600	15% discount off retail price or 5% discount off promotional price
Hearing Discounts ⁶ - two ways to save: Hearing Care Solutions 1-866-344-7756 Amplifon Hearing Health Care 1-877-301-0840	Save on hearing aids, exams, batteries, repairs and more

Partial list of exclusions and limitations

Enrolled members can access our secure member website once their plan becomes effective. Enrolled subscribers will receive a welcome packet with ID card mailed to their home within 15 business days after enrollment is processed.

*Out of network coverage is available. To receive reimbursement up to the amounts listed above, a claim form with itemized receipt is required. Reimbursement will not exceed the providers actual charge. Claims forms can be found at aetnavision.com or by calling customer service Monday through Sunday at 1-877-973-3238. Completed claim forms can be submitted electronically or mailed to Aetna, PO Box 8504 Mason, OH 45040-7111. You also have access to Allied Providers, such as Costco Vision, who will apply your out-of-network benefits at the point of service and handle the claim submission process for you.

**Allowances are one-time use benefits. No remaining balances may be used. The plan does not provide a declining balance benefit.

¹Contact lens fit and two follow-up visits are allowed once an eye exam has been completed.

²Premium progressives and premium anti-reflective Brand designations are subject to annual review and change based on market conditions. Ask your eye care provider for more information. Premium Progressive Lens cost includes bifocal cost.

³Additional pair discount applies to purchases made after the plan allowances have been exhausted. Discounts are not insurance.

⁴Non covered discounts may not be available in all states.

⁵Lasik or PRK from the US Laser Network, owned and operated by LCA Vision.

⁶Aetna does not endorse any vendor, product or service associated with these discount offers. Vendors are independent of Aetna, not agents or employees. Programs, products and services may not be available at all times. Certain offers may not be available in some states. Products and services are provided by Hearing Care Solutions and Amplifon Hearing Health Care (formerly HearPO).

Policies and plans are insured and/or administered by Aetna Life Insurance Company (Aetna). Certain claims administration services are provided by First American Administrators, Inc. and certain network administration services are provided through EyeMed Vision Care ("EyeMed"), LLC.

Not all services are covered. See plan documents for a complete description of benefits, exclusions and limitations of coverage. Plan features and availability may vary by location and are subject to change. These are the plan's main exclusions and limitations. See the booklet-certificate for a complete description. The plan does not cover: special vision procedures, such as orthoptics, vision therapy or vision training; vision services or supplies that do not meet professionally accepted standards; plano (nonprescription) lenses; nonprescription sunglasses; two pair of glasses in lieu of bifocals; medical and/or surgical treatment of the eyes; cosmetic services; lost or broken lenses, frames, glasses or contact lenses.

Providers in the Aetna Vision network are contracted and credentialed through EyeMed Vision Care, LLC according to EyeMed's requirements. EyeMed and Aetna are independent contractors and not agents of each other. Provider participation may change without notice.

Refer to Aetna.com for more information about Aetna® plans.

Aetna complies with applicable Federal civil rights laws and does not discriminate, exclude or treat people differently based on their race, color, national origin, sex, age, or disability. Aetna provides free aids/services to people with disabilities and to people who need language assistance. If you need a qualified interpreter, written information in other formats, translation or other services, call 877-973-3238. 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 Civil Rights Coordinator by contacting: Civil Rights Coordinator, P.O. Box 14462, Lexington, KY 40512. 1-800-648-7817, TTY: 711, Fax: 859-425-3379, 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). Help for those who speak another language and for the hearing impaired.

For language assistance in your language call 877-973-3238. Para obtener asistencia lingüística en español, llame sin cargo al número que figura en su tarjeta de identificación.

Salaried employees may earn compensation on the sale of Aetna products. The compensation varied depending on a number of factors, including customer segment and product selected. Combining all factors, compensation for each product quoted averages less than 8% of the total first year annual premium. Aetna offers additional bonus programs, which may also apply. Neither Aetna nor the employee has material ownership interest in the other. The employee may not alter the amount of compensation received from Aetna. You may obtain additional information about the compensation expected to be received by eligible employees, based in whole or in part on the sale of an Aetna product, or alternative options presented, by contacting Aetna at www.aetna.com/about-us/forms/employee-compensation-disclosure.html.

TTY: 711

To access language services at no cost to you, call 1-888-982-3862 .

Para acceder a los servicios de Idiomas sin costo, llame al 1-888-982-3862 . (Spanish)

如欲使用免費語言服務，請致電 1-888-982-3862 。（Chinese）

Afin d'accéder aux services langagiers sans frais, composez le 1-888-982-3862 . (French)

Para ma-access ang mga serbisyo sa wika nang wala kayong babayaran, tumawag sa 1-888-982-3862 . (Tagalog)

Um auf für Sie kostenlose Sprachdienstleistungen zuzugreifen, rufen Sie 1-888-982-3862 an. (German)

للحصول على الخدمات اللغوية دون أي تكلفة، الرجاء الاتصال على الرقم 1-888-982-3862 . (Arabic)

Pou jwenn sèvis lang gratis, rele 1-888-982-3862 . (French Creole-Haitian)

Per accedere ai servizi linguistici, senza alcun costo per lei, chiami il numero 1-888-982-3862 . (Italian)

言語サービスを無料でご利用いただくには、1-888-982-3862 までお電話ください。 (Japanese)

무료 언어 서비스를 이용하려면 1-888-982-3862 번으로 전화해 주십시오. (Korean)

برای دسترسی به خدمات زبان به طور رایگان، با شماره 1-888-982-3862 تماس بگیرید. (Persian-Farsi)

Aby uzyskać dostęp do bezpłatnych usług językowych proszę zadzwonoć 1-888-982-3862 . (Polish)

Para acessar os serviços de idiomas sem custo para você, ligue para 1-888-982-3862 . (Portuguese)

Для того чтобы бесплатно получить помощь переводчика, позвоните по телефону 1-888-982-3862 . (Russian)

Nếu quý vị muốn sử dụng miễn phí các dịch vụ ngôn ngữ, hãy gọi tới số 1-888-982-3862 . (Vietnamese)

Securian Life Insurance Company (Subsidiary of
Securian Financial Group, Inc.)
Basic Life Insurance Program (Fully-Insured Program)



Port of Houston Authority Group Term Life and Accidental Death and Dismemberment (AD&D) Insurance

Insurance products issued by Minnesota Life Insurance Company or Securian Life Insurance Company and administered by Ochs.

Life Insurance Coverage Available - No Health Questions!

There are many reasons to consider Supplemental Life Insurance and there are certain times in which you can enroll for coverage without answering health questions. **Below is a summary of those options.**

Looking for a higher amount of coverage? A full list of your life Insurance coverage options is outlined on the following pages. To apply for coverage other than the amounts listed below, health questions and underwriting approval is required.

NEW HIRE OPPORTUNITY

New hire eligibility refers to when you are hired and become eligible for benefits.

- ✓ **Employee** - up to **\$350,000**
- ✓ **Spouse** - up to **\$50,000**
- ✓ **Child** - **all coverage**

ANNUAL ENROLLMENT OPPORTUNITY

Available during your employer's annual enrollment period.

- ✓ **Child** - **all coverage**

QUALIFIED STATUS CHANGE

If you experience an employment or family status change, check with your employer within 31 days to confirm guaranteed coverage availability.



Your Basic and Supplemental Life Insurance Coverages:

Basic Life Coverage - 100% employer paid & automatically enrolled

Basic term life

1.5x annual salary
Maximum **\$750,000**

✓ Includes a matching AD&D benefit

Supplemental Life Coverage - 100% employee paid

Supplemental term life

Elect in **\$10,000** increments
Maximum **\$750,000**

Spouse term life

Elect in **\$5,000** increments
Maximum **\$250,000**

✓ Cannot exceed 100% of employee's basic & supplemental coverage combined

Child term life

Elect **\$10,000, \$15,000** or **\$20,000**

If your spouse or child is eligible for employee coverage, they cannot be covered as a dependent. Only one employee may cover a dependent child. It is the employee's responsibility to notify their employer when dependents are no longer eligible.

Monthly Cost:

Employee or Spouse Supplemental Life		
Age	Rate per \$1,000 Employee	Rate per \$1,000 Spouse
<25	\$0.05	\$0.03
25-29	\$0.06	\$0.04
30-34	\$0.08	\$0.06
35-39	\$0.10	\$0.07
40-44	\$0.12	\$0.08
45-49	\$0.18	\$0.12
50-54	\$0.29	\$0.19
55-59	\$0.51	\$0.31
60-64	\$0.73	\$0.52
65-69	\$1.24	\$0.91
70-74*	\$2.10	\$1.53

*Rates beyond age 74 are available upon request.
Rates increase with age and all rates are subject to change.

Here's how to calculate your monthly premium:

Total supplemental term life coverage amount \$ _____
÷ 1,000 \$ _____
× your rate (based on your age) \$ _____
= Monthly premium \$ _____

Here's how Riley calculated their monthly premium:

Riley elected a total supplemental term life coverage amount of \$150,000. \$150,000
÷ 1,000 \$150.00
× Riley's rate (based on their age of 42) \$0.12
= Riley's monthly premium **\$18.00**

Child Life		
\$10,000	\$15,000	\$20,000
\$0.83	\$1.25	\$1.66

One premium covers all eligible children



Why Life Insurance?

No matter where you are in life, there are many reasons to consider Life Insurance. Group Life Insurance protects you and your family from the unexpected loss of life and income during working years. If you die, Life Insurance benefits are disbursed to your beneficiaries to help pay for things like:

- ✓ Your mortgage or rent
- ✓ Childcare or education costs
- ✓ Medical bills or other expenses
- ✓ Funeral and burial costs

How much Life Insurance do I need?

To estimate the amount of Life Insurance you need, you'll want to determine what you must protect in the event of your death. Determine your needs today.

Check out our Life Insurance calculator: [click here.](#)

Or scan here:



Naming a Beneficiary:

Naming a beneficiary is an important right of Life Insurance ownership; this determines who receives the death benefit. It is recommended that you review and update your beneficiaries periodically. Events such as marriage, birth/adoption of children, divorce or death may change how you want your Life Insurance benefit paid.

Continuation:

If you are no longer eligible for coverage as an active employee, you may be eligible to continue your coverage after employment. No health questions are needed and rates are generally higher than active rates. If you would like to continue your coverage, be sure to enroll within 31 days of your current coverage ending.

Questions? Contact Ochs. Email: ochs@ochsinc.com Phone: 800-392-7295

Insurance products are issued by Minnesota Life Insurance Company or Securian Life Insurance Company, a New York authorized insurer. Minnesota Life Insurance Company is not an authorized New York insurer and does not do insurance business in New York. Both companies are headquartered in St. Paul, MN. Product availability and features may vary by state. Each insurer is solely responsible for the financial obligations under the policies or contracts it issues.

Products are offered under policy form series MHC-96-13180.42.

Securian Financial is the marketing name for Securian Financial Group, Inc. and its subsidiaries. Securian Life Insurance Company and Minnesota Life Insurance Company are subsidiaries of Securian Financial Group, Inc.

Ochs, Inc.

A Securian Financial Company

400 Robert Street N, Ste. 1880, St. Paul, MN 55101

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Voya Financial Short Term Disability
Insurance Program (Fully-Insured Program)

Short Term Disability Income Insurance

Explore Your Benefits & Costs



Group Name: Port of Houston Authority
Employee Benefits Customer Service: (800) 955-7736
Group Number: 740454
Class: All active full-time benefits eligible employees working 30 or more hours per week.

Life doesn't stop when you're unable to work. If a maternity leave, planned surgery, or unexpected illness or injury affect your income, **Short Term Disability Income Insurance** can help. This document includes cost and coverage information about Short Term Disability Income Insurance. As you explore, keep in mind:



Guaranteed Issue Coverage



Basic coverage at no cost to you



One dedicated claim analyst guides you throughout your claim

Without their main source of income, only 27 percent of U.S. households could cover expenses for more than six months, while 21 percent could cover expenses for less than two weeks.¹ Help keep a portion of your income protected with the Short-Term Disability Income Insurance that's available to you through your employer.

¹ "Marketing Ends Meet in 2022," Consumer Financial Protection Bureau, 2022.

ReliaStar Life Insurance Company
a member of the Voya® family of companies

PLAN | INVEST | PROTECT



Get basic coverage at no cost

Your employer is providing basic Short Term Disability Income Insurance to you at no cost to you. This means that if a disabling illness or injury prevents you from working, you'll still be able to replace a portion of your income.

Coverage Amount

60% of your weekly earnings

(\$25 minimum weekly benefit/\$2,500 maximum weekly benefit)

When you become disabled, you must complete a waiting period before benefits are payable. Learn more about this and amount of coverage for which you are eligible below:



Waiting period

Waiting period

If you become disabled, you must complete a waiting period before Weekly Income Benefits are payable.

- The benefit waiting period for a disability caused by an accidental injury is 7 days
- The benefit waiting period for a disability caused by a sickness is 7 days



How long benefit payments last

Short Term Disability Income Insurance is intended to replace income for a disability that lasts just a few weeks. The maximum amount of time that you're able to receive Short Term Disability benefit payments is 12 weeks.

Evidence of Insurability (health questions)

You do not need to provide evidence of insurability to be covered.



Questions?

If you have additional questions, please call:

Voya Employee Benefits Customer Service at 800-955-7736

This is a summary of benefits only. A complete description of benefits limitations exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents the policy documents will govern. To keep coverage in force premiums are payable up to the date of coverage termination. Short Term Disability Income Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis MN) a member of the Voya® family of companies. Policy form HP08GP and/or HP13GP (may vary by state).

GRP-STD

Date Prepared: 10/5/2023

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Exclusions and limitations

We won't pay benefits if your disability is caused by, contributed to by, or results from any of the following:

- Subject to the applicable law in the state where the Policy is delivered or issued for delivery, commission or attempt to commit a felony or illegal activity.
- Engaging in any illegal occupation, work or employment.
- Operating a motorized vehicle while under the influence of alcohol as evidenced by a blood alcohol level at or in excess of the state legal intoxication limit as defined by the state law where the disability occurs.
- Intentionally self-inflicted harm.
- Attempted suicide, regardless of mental capacity.
- Participation in a war, declared or undeclared, or any act of war. An act of war is military activity by one or more national governments and does not include terrorist acts, other random acts of violence not perpetrated by you, or civil war or community faction.
- Active duty as a member of the armed forces of any nation. However, we will refund, upon written notice of such service, any Premium which has been accepted for any period not covered as a result of this exclusion.
- Active participation in a riot, insurrection or terrorist activity, but not including civil commotion, disorder, injury as an innocent bystander, or injury because of self-defense.
- Subject to the applicable law in the state where the Policy is delivered or issued for delivery, voluntary intake of any narcotic or other controlled substance, unless the narcotic or controlled substance is taken under the direction of and as directed by a doctor.
- Voluntary intake of poison, drugs or fumes, unless a direct result of an occupational accident.
- Cosmetic surgery except when required for your appropriate care as a result of your injury or sickness; cosmetic surgery shall not include (1) reconstructive surgery when the surgery is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part, (2) reconstructive surgery because of congenital disease or anomaly resulting in a functional defect and (3) surgery necessitated by gender dysphoria.
- Traveling in any aircraft other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
- Traveling in any aircraft (or device) used for testing or an experimental purpose, used by or for any military authority, or used for travel beyond the earth's atmosphere.
- Hang-gliding, skydiving, parachuting, ultralight, soaring, ballooning and parasailing.
- Participation in recreational motor sports events, racing, speed or endurance contest (auto, truck, cycle or boat), rock or mountain climbing, skin or scuba diving, or bungee jumping.
- Participation in any sport for wage, compensation or profit.

If your employer's plan covers only non-occupational injuries, then the following exclusion also applies:

- Occupational sickness or injury

We will not pay a benefit for any period of Disability during which you are incarcerated.

Your benefits may be reduced by other income you are eligible to receive while disabled.

*Limitations and exclusions will vary by state and by your employer's benefit plan.

Voya Financial Long Term Disability
Insurance Program (Fully-Insured Program)

Long Term Disability Income Insurance

Explore Your Benefits & Costs



PORT HOUSTON™

Group Name: Port of Houston Authority
Employee Benefits Customer Service: (800) 955-7736
Group Number: 740454
Class: All Full Time Salaried and Hourly Employees

It can take time to recover from a disabling illness or injury. When that time extends past your Short Term Disability coverage, **Long Term Disability Income Insurance can help.** This document includes cost and coverage information about Long Term Disability Income Insurance. As you explore, keep in mind:



No medical questions or tests are required for coverage



Basic coverage at no cost to you



Work with your own dedicated claim analyst throughout your claim

The probability of becoming disabled between age 20 and normal retirement age is 25 percent.¹ Help to keep a portion of your income protected with the Long-Term Disability Income Insurance that's available through your employer.

¹ 2022 OASDI Trustees Report, Social Security Administration, 2022

ReliaStar Life Insurance Company
a member of the Voya® family of companies

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Get basic coverage at no cost

Your employer is providing basic Long Term Disability Income Insurance at no cost to you. This means that if a disabling illness or injury prevents you from working, and your Short Term Disability coverage has run out, you'll still be able to replace a portion of your income.

Coverage Amount

60% of your monthly earnings
(>\$50 or 10% minimum monthly benefit/\$12,000 maximum monthly benefit)



Waiting period

Waiting period: 90 consecutive days within 180 calendar days.

Any days that you are able to work after the start of your disability will not count toward your waiting (elimination) period. You may be eligible for Short Term Disability payments during this time or you may use your available time off and/or sick time during this waiting period.

Evidence of Insurability (health questions)

You do not need to provide evidence of insurability to be covered.



How long benefit payments last

Long Term Disability Income benefits are available until you recover from your disability, or until you reach the maximum period of payment listed below.

For a disability which begins before you reach age 60, the maximum period of payment will be until the Social Security Normal Retirement Age (SSNRA), as shown in the following table:

Year of birth	Social Security retirement age (SSNRA)*
Before 1938	65 years
1938	65 years and 2 months
1939	65 years and 4 months
1940	65 years and 6 months
1941	65 years and 8 months
1942	65 years and 10 months
1943-1954	66 years
1955	66 years and 2 months
1956	66 years and 4 months
1957	66 years and 6 months
1958	66 years and 8 months
1959	66 years and 10 months
After 1959	67 years

For a disability which starts on or after you reach age 60, the maximum period of payment will be determined according to the following table:

Age when Disability begins	Maximum period of payment
60	60 months or to SSNRA*, whichever is greater
61	48 months or to SSNRA*, whichever is greater
62	42 months or to SSNRA*, whichever is greater
63	36 months or to SSNRA*, whichever is greater
64	30 months or to SSNRA*, whichever is greater
65	24 months
66	21 months
67	18 months
68	15 months
69 and over	12 months

*Age at which you are entitled to unreduced Social Security benefits based on the Social Security Amendments of 1983.

What else is included?

The Long-Term Disability Income Insurance available through your employer includes the following additional benefits. For a complete description of your available benefits, along with applicable provisions, exclusions and limitations, see your certificate of insurance and any riders.



Maintain coverage at no cost

Waiver of Premium

While you're receiving Long Term Disability Income Insurance benefits from us, you won't need to pay premiums.



Get help filing for Social Security

Social Security Disability Income (SSDI) filing assistance

When appropriate, we will help you file for SSDI benefits, which can be a very difficult process.



Leave a benefit behind for a loved one

Survivor Benefit

If you pass away while receiving Disability benefits, we may pay your eligible survivor a lump-sum benefit equal to three times your monthly payment.



Prepare for a return to work

Vocational rehabilitation

We have vocational rehabilitation services available to assist you in returning to work when possible. If applicable, we will provide you with a written plan developed specifically for you.

Workplace modification

Modifications may be made to your workplace in order to help you return to work.

Exclusions & Limitations

Benefits are not payable if your disability is caused by, contributed to or resulting from:

- Loss of a professional or occupational license or certification
- Commission of or attempt to commit a felony
- Intentionally self-inflicted injuries
- Attempted suicide, regardless of mental capacity
- Being legally intoxicated or being under the influence of any narcotic, unless taken under the direction of and as directed by a doctor
- Participation in a war, declared or undeclared, or any act of war
- Active military duty
- Active participation in a riot
- Engaging in any illegal or fraudulent occupation, work or employment
- Commission of a crime for which you have been convicted
- Elective surgery, except when required for your appropriate care as a result of your injury or sickness

Traveling or flying on an aircraft operated by or under the authority of military or any aircraft being used for experimental purposes

Your benefits may be limited to a shorter time period, such as 24 months during your lifetime, if:

- The disability is due to a mental illness, alcoholism or drug abuse.

Your benefits will be reduced by other income (deductible sources of income) you are eligible to receive while disabled. These include but aren't limited to:

- Income received from any form of employment
- Unemployment benefits and any type of income replacement provided by your employer
- Workers' Compensation benefits or benefits from similar programs
- Judgments or settlements you receive related to disability
- Disability or retirement payments under Social Security or other federal and state plans
- Disability income payments under automobile liability insurance benefits
- Disability income payments payable under any other group insurance policy and certain retirement payments provided under your employer's retirement plan

*Limitations and exclusions will vary by state and by your employer's benefit plan.



Questions?

If you have additional questions, please call:
Voya Employee Benefits Customer Service at (800) 955-7736

This is a summary of benefits only. A complete description of benefits, limitations, exclusions and termination of coverage will be provided in the certificate of insurance and riders. All coverage is subject to the terms and conditions of the group policy. If there is any discrepancy between this document and the group policy documents, the policy documents will govern. To keep coverage in force, premiums are payable up to the date of coverage termination. Disability Income Insurance is underwritten by ReliaStar Life Insurance Company (Minneapolis, MN), a member of the Voya® family of companies. Policy form HP08GP and/or HP13GP (may vary by state).

GRP-LTD

Date Prepared: 10/5/23

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202592-040123

Employee Assistance Program (EAP)
Resources for Living
(Fully-Insured Program)

Anytime support



Resources for Living is an employer-sponsored program, available at no cost to you and all members of your household. Children living away from home can access services up to age 26.

Services are confidential and available 24 hours a day, 7 days a week.

Emotional wellbeing support



- Anxiety
- Relationship support
- Depression
- Stress management
- Work/life balance
- Family issues
- Grief and loss
- Self-esteem and personal development
- Substance misuse and more

Find care



It's easy to find a counselor you'd like to work with. You can:

- View provider options — images, bios, specialties and more
- Compare details — ethnicity, gender, language and more
- See which providers are open to new patients and when they're available
- Find options to schedule your first appointment online
- Get started quickly without any added steps or calls

Daily life assistance



Competing day-to-day needs can make it tough to know where to start. Call us for personalized guidance. We'll help you find resources for:

- Child care, parenting and adoption
- Care for older adults
- Caregiver support
- Special needs
- Pet care
- Community resources/basic needs
- Summer programs for kids
- Household services and more

Legal services



You can get a free 30-minute consultation with a participating attorney for each new legal topic. Some of the areas of law and issues covered include:

- Family or domestic law
- Civil and criminal law
- Wills and estate planning
- Real estate and more

If you opt for services beyond the initial consultation you can get a 25 percent discount. You also have free access to legal documents and forms on your member website.

*Services must be related to the employee or an eligible household member. Exclusions include work-related and lack of merit issues. Discount does not include flat legal fees, contingency fees and plan mediator services.

Financial services



Simply call for a free 30-minute phone consultation for each new financial topic related to:

- Budgeting
- Retirement or other financial planning
- Mortgages and refinancing
- Credit and debt issues
- College funding
- Tax and IRS questions

You can get a 25 percent discount on standard tax preparation services. You also have access to financial articles, calculators and a financial assessment on your member website.

*Services must be for financial matters related to the employee or an eligible household member.

Online resources



Your member website offers a full range of tools and resources to help with emotional wellbeing, work/life balance and more. You'll find:

- Videos and podcasts
- Articles, blogs and self-assessments
- Mobile app
- Child and adult care provider search tool
- Live and on-demand webinars and more

Discount Center

Find deals on brand name products and services including electronics, entertainment, gifts and flowers, travel, fitness, nutrition and more.

Additional services



For legal disclaimers, visit rfl.com/Disclaimers.

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

APPENDIX C

As of January 1, 2026, the following third party entities serve as Claims Administrators and Claims Fiduciaries under the Plan with respect to the following Welfare Programs:

Welfare Program	Claims Administrator / Claims Fiduciary
Aetna Open Access Medical Plan (Self-Insured Program)	<i>Medical Claims</i> Aetna PO Box 981106 El Paso, TX 79998-1106 <i>Prescription Drug Mail Order Program</i> CVS Caremarkk P. O.OBoxx659541 San Antonio, TX 78265-9541
Aetna Kelsey Care Medical Plan (Self-Insured Program)	<i>Medical Claims</i> Aetna PO Box 981106 El Paso, TX 79998-1106 <i>Prescription Drug Mail Order Program</i> Aetna Rx Home Delivery Kansas City P.O. Box 219484 Kansas City, MO 64121-9484
Aetna PPO Dental Plan (Fully-Insured Program)	Aetna Dental Plan P.O. Box 14462 Lexington, KY 40512
Aetna DMO Dental Plan (Fully-Insured Program)	Aetna Dental Plan P.O. Box 14462 Lexington, KY 40512
Aetna Vision Preferred Program (Fully-Insured Program)	Aetna P.O. Box 8504 Mason, OH 45040-7111

Welfare Program	Claims Administrator / Claims Fiduciary
Securian Life Insurance Basic Employee Life/AD&D, Supplemental and Dependent Life Insurance Program (Fully-Insured Program)	Securian Life Insurance Company (Subsidiary of Securian Financial Inc.) 400 Robert Street North St. Paul, Minnesota 55101-2098
Voya Short Term Disability Insurance Program (Fully-Insured Program)	Voya Financial P.O. Box 1222 Minneapolis, MN, 55440-0122440-0122
Voya Long Term Disability Insurance Program (Fully-Insured Program)	Voya Financial P.O. Box 122 Minneapolis, MN, 55440-0122440-0122
Employee Assistance Program (EAP) Resources for Living (Fully-Insured Program)	Aetna Behavioral Health, LLC Aetna Resources for Living P.O. Box 818048 Cleveland, OH 44181-8048

The COBRA Administrator for the Plan is:

WEX Health Inc.
 4321 20th Avenue S
 Fargo, ND 58103

**SUMMARY PLAN DESCRIPTION OF THE
PORT OF HOUSTON AUTHORITY
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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.