
SUMMARY PLAN DESCRIPTION
FOR
WELLMED EMPLOYEE HEALTH PLAN

For January 1, 2008 to December 31, 2008

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This document is a description of the WellMed Employee Health Plan (the "Plan"). No oral representations, interpretations or modifications can change this Plan. The Plan may only be amended in writing and as provided in the Section entitled, "Amending and Terminating the Plan." The Plan described is designed to protect Covered Persons against certain catastrophic health expenses.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan and reach an Entry Date.

The Plan Sponsor fully intends to maintain this Plan indefinitely. However, it reserves the right to terminate, suspend, discontinue or amend the Plan at any time and for any reason. Changes in the Plan may occur in any or all parts of the Plan, including but not limited to benefit coverage, deductibles, maximums, co-payments, exclusions, limitations, conditions for coverage of particular benefits, definitions and eligibility. If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges Incurred before termination, amendment or elimination.

INITIAL ENROLLMENT

You must return your enrollment forms to the Benefits Manager within 31 days of receipt of the election forms. Failure to return your forms within 31 days of receipt will result in your being automatically enrolled with employee only coverage under Plan A or Plan C (as applicable).

OPEN ENROLLMENT

A Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverage including no coverage if not currently enrolled. A Covered Person who wishes to terminate coverage for self or dependents must actively make the change during Open Enrollment.

Once a selection is made, the Covered Person may not change their selection for the duration of the next calendar year unless they have a "Change in Status" or special enrollment period as defined under The WellMed Medical Management, Inc. Flexible Benefit Cafeteria Plan.

Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as coordination of benefits, subrogation, exclusions, limitations, timeliness of COBRA elections, utilization review or other cost management requirements, lack of Medical Necessity, pre-existing condition exclusions, lack of timely filing of claims or lack of coverage. These provisions are explained in summary fashion in this document; additional information may be available from the Plan Administrator at no cost. Please be sure to read this document carefully to determine what is and is not covered under the Plan.

The Plan only pays benefits for the expenses Incurred while this coverage is in force. No benefits are payable for expenses Incurred before coverage began or after coverage terminated. In general, an expense for a service or supply is Incurred on the date the service or supply is furnished. Please see the definition of "Incurred" for a more detailed explanation of when services and supplies are Incurred under the Plan.

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Defined Terms. Defines those Plan terms that have a specific meaning.

Eligibility, Funding, Effective Date, Termination and Pre-existing Conditions. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates. This applies to Option A, Option B and Option C.

DEFINED TERMS

The following terms have special meanings and, when used in this Plan, will be capitalized. These defined terms apply to Option A, Option B and Option C. **The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document and Summary Plan Description for that information.**

Active Employee (Active Employment) means an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer.

Ambulatory Surgical Center means a licensed facility that is used mainly for performing outpatient surgery, has a staff of Physicians, has continuous Physician and nursing care by registered nurses (R.N.s) and does not provide for overnight stays.

Ancillary Services means anesthesia and technician services.

Birthing Center means any freestanding health facility, place, professional office or institution which is not a Hospital or in a Hospital, where births occur in a home-like atmosphere. This facility must be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where the facility is located.

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Brand Name means a trade name medication.

Calendar Year means January 1st through December 31st of the same year.

Certificate of Creditable Coverage indicates the length of time you have been continuously covered under a qualifying previous healthcare plan and allows waiver of any waiting period related to a pre-existing condition.

Child(ren) means natural children living in the same household as the Employee, adopted children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee's household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee's household, or the natural parent is required to cover the stepchild pursuant to either a Qualified Medical Child Support Order, or a divorce decree entered into prior to August 10, 1993.

Claims Administrator means Benefit Management Administrators, Inc.

Claim Provisions. Explains the rules for filing claims and the claim appeal process. This applies to Option A, Option B and Option C.

COBRA means the continuation of coverage option under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COBRA Continuation Options. Explains when a person's coverage under the Plan ceases as the result of certain events, the continuation options that are available, and the steps you must take to obtain the continuation coverage. This applies to Option A, Option B and Option C.

Coordination of Benefits. Shows the Plan payment order when a Covered Person is covered under more than one plan. This applies to Option A, Option B and Option C.

Cost Management Services. Explains the methods used to curb unnecessary and excessive charges. This applies to Option A and Option B and Option C.

Covered Person means an Employee or Dependent who is covered under this Plan.

Creditable Coverage means prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, a health plan of a foreign government, a state health benefits risk pool, a state's Children's Health Program ("CHIP"), or a health benefit plan under the Peace Corps Act.

Custodial Care means care (including room and board needed to provide that care) that is given principally for personal hygiene or for assistance in daily activities and can, according to generally accepted medical standards, be performed by persons who have no medical training. Examples of Custodial Care are help in walking and getting out of bed; assistance in bathing, dressing or feeding; or supervision over medication, which could normally be self-administered.

Dependent means a person who satisfies the requirements of one of the eligible classes of dependents in this Plan.

Durable Medical Equipment means equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Employee means a person who is a regular Active Employee of the Employer, regularly scheduled to work for the Employer in an employee/employer relationship. Employee shall not include temporary, seasonal or leased employees or independent contractors.

Employer means WellMed Medical Management, Inc. and any employer who adopts this Plan as a Participating Employer.

Enrollment Date means the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

EPO Network Providers means the providers who have agreed to be part of the Princeton Integrated Physicians Association – San Antonio (I), Inc. network of healthcare providers.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

ERISA Information. Explains the Plan's structure and the rights of Covered Persons under the Plan. This applies to Option A, Option B and Option C.

Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of care and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding upon the Plan. The Plan Administrator will be guided by the following principles:

- (1) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed-consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- (3) if the treating facility requires the individual to execute an informed consent form acknowledging the treatment is experimental or if the treatment has not been approved by the treating facility's Institutional Review Board; or
- (4) if the drug device, medical treatment or procedure is not being used in the manner or for the use it was approved; or
- (5) if Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or Investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- (6) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

"Reliable Evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, service, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

Drugs are considered Experimental and/or Investigational if they are not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Family Unit means the covered Employee and the family members who are covered as Dependents under the Plan.

FMLA means the Family and Medical Leave Act of 1993, as amended.

Generic drug means a Prescription Drug that has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Genetic Information means information about genes, gene products and inherited characteristics that may derive from an individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes.

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

Home Health Care Agency means an organization that meets all of these tests: its main function is to provide Home Health Care Services and Supplies; it is federally certified as a Home Health Care Agency; and it is licensed by the state in which it is located, if licensing is required.

Home Health Care Plan must meet these tests: it must be a formal written plan made by the patient's Attending Physician which is reviewed at least every 30 days; it must state the diagnosis; it must certify that the Home Health Care is in place of Hospital confinement; and it must specify the type and extent of Home Health Care required for the treatment of the patient.

Home Health Care Services and Supplies (Home Health Care) include: part-time or intermittent nursing care by or under the supervision of a registered nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency (this does not include general housekeeping services); physical, occupational and speech therapy; medical supplies; and laboratory services by or on behalf of the Hospital.

Hospice Agency means an organization where its main function is to provide Hospice Care Services and Supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan means a plan of terminal patient care that is established and conducted by a Hospice Agency and supervised by a Physician.

Hospice Care Services and Supplies (Hospice Care) are those provided through a Hospice Agency and under a Hospice Care Plan and include inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit means a facility or separate Hospital unit that provides treatment under a Hospice Care Plan and admits at least two unrelated persons who are expected to die within six months.

Hospital means an institution which is engaged primarily in providing medical care and treatment of sick and injured persons on an inpatient basis at the patient's expense and which fully meets these tests: it is accredited as a Hospital by the Joint Commission on Accreditation of Healthcare Organizations or the American Osteopathic Association Healthcare Facilities Accreditation Program; it is approved by Medicare as a Hospital; it maintains diagnostic and therapeutic facilities on the premises for surgical and medical diagnosis and treatment of sick and injured persons by or under the supervision of a staff of Physicians; it continuously provides on the premises 24-hour-a-day nursing services by or under the supervision of registered nurses (R.N.s); and it is operated continuously with organized facilities for operative surgery on the premises.

The definition of "Hospital" shall be expanded to include the following:

- A facility operating legally as a psychiatric Hospital or residential treatment facility for mental health and licensed as such by the state in which the facility operates.
- A facility operating primarily for the treatment of Substance Abuse if it meets these tests: maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 resident patients; has a Physician in regular attendance; continuously provides 24-hour-a-day nursing service by a registered nurse (R.N.); has a full-time psychiatrist or psychologist on the staff; and is primarily engaged in providing diagnostic and therapeutic services and facilities for treatment of Substance Abuse.

Illness means a bodily disorder, disease, physical sickness or Mental Disorder. Illness, in the case of a covered Employee or Spouse, includes Pregnancy, childbirth, miscarriage or complications of Pregnancy.

Incurred means that a Covered Charge is Incurred on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure that includes several steps or phases of treatment, Covered Charges are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Charges for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

Injury means an accidental physical Injury to the body caused by unexpected external means.

Intensive Care Unit means a separate, clearly designated service area that is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a "coronary care unit" or an "acute care unit." It has: facilities for special nursing care not available in regular rooms and wards of the Hospital; special life saving equipment which is immediately available at all times; at least two beds for the accommodation of the critically ill; and at least one registered nurse (R.N.) in continuous and constant attendance 24 hours a day.

Legal Guardian means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child and having custody or the right to determine the child's residence.

Lifetime is a word that appears in this Plan in reference to benefit maximums and limitations. Lifetime is understood to mean while covered under this Plan. Under no circumstances does Lifetime mean during the lifetime of the Covered Person.

Medical Care Facility means a Hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency means a sudden onset of a condition with acute symptoms requiring immediate medical care and includes such conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary means care and treatment that is recommended or approved by a Physician; is consistent with the patient's condition or accepted standards of good medical practice; is medically proven to be effective treatment of the condition; is not performed mainly for the convenience of the patient or provider of medical services; is not conducted for research purposes; and is the most appropriate level of services which can be safely provided to the patient.

All of these criteria must be met; merely because a Physician recommends or approves certain care does not mean that it is Medically Necessary.

The Plan Administrator has full discretionary authority to decide whether care or treatment is Medically Necessary.

Medicare means the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended.

Mental Disorder means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Morbid Obesity means a diagnosed condition in which the body weight either exceeds the medically recommended weight by 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person, or a person whose body mass index (BMI) is 40 or higher.

Network Providers means the providers who have agreed to be part of the Texas True Choice preferred provider organization providing services to Option B, the PPO Benefit Option and Option C, the PPO Benefit Option.

No-Fault Auto Insurance means the basic reparations provision of a law providing for payments without determining fault in connection with automobile accidents.

Non-Network Providers or means the providers who have not agreed to be part of the Texas True Choice Preferred Provider Organization providing services to Option B, the PPO Benefit Option and Option C, the PPO Option for persons residing outside of the San Antonio market area.

Obesity means a person whose body weight is greater than 30% above the ideal or desirable weight on a standard height-weight table such as the one contained in the Merck Manual or for an adult male a body mass index (BMI) of greater than 27.8 and for an adult female a body mass index or BMI of greater than 27.3.

Outpatient Care and/or Services means treatment including services, supplies and medicines provided and used at a Hospital under the direction of a Physician to a person not admitted as a registered bed patient; or services rendered in a Physician's office, laboratory or X-ray facility, an Ambulatory Surgical Center, or the patient's home.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Dental Surgery (D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Registered Nurse Anesthetist (C.R.N.A.), Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Optometrist (O.D.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means the WellMed Medical Management, Inc. Health Plan.

Plan Administrator means an individual appointed by the Plan sponsor, WellMed Medical Management, Inc.

Plan Exclusions. Shows what charges are **not** covered. These exclusions apply to Option A – EPO, Option B – PPO and Option C – PPO.

Plan Sponsor means WellMed Medical Management, Inc.

Plan Year is the 12-month period beginning on January 1 and ending on the next following December 31.

Pre-existing Condition is any Sickness, Illness, disease or Injury (other than Pregnancy), regardless of cause, for which medical advice, diagnosis, care or treatment was recommended or received, by or from a health care provider or practitioner duly licensed to provide such care under applicable state law and operating within the scope of practice authorized by such state law, during the six months immediately prior to the Employee's Enrollment Date. Those conditions will not be covered for a period of twelve months from the date of enrollment. Genetic Information is not a condition. The Enrollment Date is the first day the individual begins the waiting period for coverage, i.e., the first day hired to work 24 or more hours per week.

Pregnancy means childbirth and conditions associated with childbirth, including complications.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; and hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.

Primarily Dependent Upon means dependent upon the covered Employee for support and maintenance as defined by the Internal Revenue Code, and the covered Employee must declare the Child as an income tax deduction. The Plan Administrator may require documentation proving dependency, including birth certificates, tax records, divorce decrees, qualified medical child support orders, other legal documents or initiation of legal proceedings severing parental rights, at any time, and as frequently as the Plan Administrator determines to be necessary.

Privacy Information. Explains the Plan's privacy practices and policies that will be effective on and after April 14, 2004, and will apply to Option A, Option B and Option C.

Reasonable and Customary is a charge that is not higher than the usual charge made by the provider of the care or supply and does not exceed the usual charge made by most providers of like service in the same area. This test will consider the nature and severity of the condition being treated. It will also consider medical complications or unusual circumstances that require more time, skill or experience.

San Antonio Area means Bexar County, Texas and the contiguous counties.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services. There are three separate Benefit Options available under this Plan. A participant must elect which Benefit Option (Option A, Option B, or Option C) to enroll in for the Plan Year. Once a Benefit Option is elected during open enrollment for a Plan Year, it may not be changed until the next open enrollment period for a subsequent Plan Year, unless the Participant has a "Change in Status" as such term is defined under The WellMed Medical Management, Inc. Flexible Benefit Cafeteria Plan or if the Participant has an event triggering a special enrollment period as described herein.

Serious Mental Illness means schizophrenia, paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders and depression in childhood and adolescence.

Sickness is:

For a covered Employee and covered Spouse: Illness, disease or Pregnancy.

For a covered Dependent other than Spouse: Illness or disease, not including Pregnancy or its complications.

Skilled Nursing Facility is a facility that fully meets all of these tests:

- (1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Sickness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) and/or licensed vocational nurse (L.V.N) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
- (2) Its services are provided for compensation and under the full-time supervision of a Physician.
- (3) It provides 24-hour-per-day-nursing services by licensed nurses, under the direction of a full-time registered nurse.
- (4) It maintains a complete medical record on each patient.
- (5) It has an effective utilization review plan.
- (6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, mental retardates, Custodial Care, educational care or care of Mental Disorders.
- (7) It is approved and licensed by Medicare.

This term also applies to charges Incurred in a facility referring to itself as an extended care facility, convalescent nursing home, rehabilitation hospital, long-term acute care facility or any other similar nomenclature.

Spinal Manipulation/Chiropractic Care means skeletal adjustments, manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body. Such treatment is done by a Physician to remove nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Spouse means the person recognized as the covered Employee's husband or wife under the laws of the state where the covered Employee lives. The Plan Administrator may require documentation proving a legal marital relationship.

Substance Abuse is regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) syndrome is the treatment of jaw joint disorders including conditions of structures linking the jawbone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but is not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Third Party Recovery Provision. Explains the Plan's rights to recover payment of charges when a Covered Person has a claim against another person because of injuries sustained. This applies to Option A, Option B and Option C.

Total Disability (Totally Disabled) means: In the case of a Dependent Child, the complete inability as a result of Injury or Sickness to perform the normal activities of a person of like age and sex in good health.

Waiting Period is the time between the first day of employment and the first day of coverage under the Plan.

WEHP means the WellMed Employee Health Plan

ELIGIBILITY, FUNDING, EFFECTIVE DATE, TERMINATION AND PRE-EXISTING CONDITION PROVISIONS

A Covered Person should contact the Plan Administrator or Claim Administrator to obtain additional information, free of charge, about Plan coverage of a specific benefit, particular drug, treatment, test or any other aspect of Plan benefits or requirements. This section applies to Option A, Option B and Option C.

ELIGIBILITY

Eligible Classes. All full and part-time active Employees of the Employer who are either employed in a salaried position or an hourly position and who work at least 24 hours per week.

1. **Eligibility Requirements for Employee Coverage** Employee must be in a salaried or hourly position and scheduled to work at least 24 hours per week. In addition, Employee must be on the regular payroll of the Employer for that work.

Salaried (exempt) Employees complete no waiting period and are eligible for benefits on the first day of active employment.

Hourly (non-exempt) employees must complete a Waiting Period of 30 consecutive days as an Active Employee. The Waiting Period is counted in the Pre-Existing Conditions exclusion time. An Employee shall be deemed an Active Employee if the Employee is absent from work due to a health factor.

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

- (1) A covered Employee's Spouse and unmarried Children from birth to the limiting age of 25 years. The Dependent Children must be unmarried, and Primarily Dependent Upon the covered Employee for

support and maintenance. When the child reaches the limiting age or marries, coverage will end on the last day of the child's birthday month or the last day of the month of marriage.

If a covered Employee is the Legal Guardian of an unmarried child or children, these children may be enrolled in this Plan as covered Dependents.

Any Child of a Covered Person who is an alternate recipient under a Qualified Medical Child Support Order or a National Medical Support Notice shall be considered as having a right to Dependent coverage under this Plan.

Any Child of a Covered Person, who attained the age of 19 years or older by the last day of the preceding Plan Year, shall only be a Dependent to whom coverage shall be available on a pre-tax basis if the Covered Person provides more than ½ of the Child's support for the Calendar Year, the Child's gross income is less than the exempt amount, and provided the Child is not a qualifying child under Code section 152 of any other taxpayer for the Calendar Year.

A Covered Person of this Plan may obtain, without charge, a copy of the procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator.

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

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

These persons are excluded as Dependents: other individuals living in the covered Employee's home, but who are not eligible as defined; the legally separated or divorced former Spouse of the Employee; any person who is on active duty in any military service of any country, except that such person may maintain coverage as permitted under the Uniformed Services Employment and Reemployment Rights Act ("USERRA"); or any person who is covered under the Plan as an Employee.

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

If both mother and father are Employees, their children will be covered as Dependents of the mother or father, but not of both.

Eligibility Requirements for Dependent Coverage. An immediate family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the immediate family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a Child qualifies or continues to qualify as a Dependent as defined by this Plan.

FUNDING

Cost of the Plan. The Plan Sponsor shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. This Plan's benefits are not funded by an insurance policy. The enrollment application for

coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The Plan Administrator sets the level of any Employee contributions. The Plan Administrator reserves the right to change the level of Employee contributions.

NOTICE REGARDING PRE-EXISTING CONDITION EXCLUSION

This plan imposes a pre-existing condition exclusion. This means that if you have a medical condition before coming to the Plan, you might have to wait a certain period of time before the Plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within a six-month period prior to your becoming eligible for the Plan. Generally, this six-month period ends the day before your coverage becomes effective. However, if you were in a waiting period for coverage under this Plan, the six-month period ends on the day before the waiting period begins. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the Plan within 31 days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage, or, if you were in a waiting period, from the first day of your waiting period. However, you can reduce the length of this exclusion period by the number of days of your prior Creditable Coverage. Most prior health coverage is Creditable Coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of more than 62 days. To reduce the 12-month exclusion period by your Creditable Coverage, you will be required to provide a Certificate of Creditable Coverage acknowledging the prior coverage period.

All questions about the pre-existing condition exclusion and creditable coverage should be directed to Benefit Management Administrators at 210-697-9900 in San Antonio or 1-800-934-6302 for outside San Antonio, Texas.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage within 31 days of their date of hire or within 31 days of being provided the enrollment documents, whichever is later. During the initial enrollment the Employee must indicate in writing the coverage desired for themselves as well as their Eligible Dependents. An Employee's Dependents must be enrolled in the same Option as the Employee. Additionally, any documents required to prove employee's dependent status must be provided within the 31-day enrollment window. If documents are not received within the 31-day window, those dependents will not be eligible for coverage until the next open enrollment period or following a change in status event.

Enrollment Requirements for Newborn Children. For newborns, charges for covered hospital nursery and routine Physician care at birth will be applied toward the Plan of the covered parent for all expenses Incurred prior to or on the date the covered parent is discharged from the Hospital. The newborn must be enrolled by the Employee by completing and returning all applicable forms to the Plan Administrator within 31 days of birth. If the newborn child is not enrolled within 31 days of the date of the birth the child will be ineligible for coverage under the plan until the next open enrollment or following a change in status event. Additionally, any expenses Incurred after the covered parent is discharged will not be covered under the Plan.

SPECIAL ENROLLMENT PERIODS

- (1) **Individuals losing other coverage.** An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll in the Plan if each of the following conditions is met:

- (a) The Employee or Dependent was covered under another group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual.
- (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment.
- (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment), the employer contributions towards the coverage were terminated, the Employee or Dependent was covered under an HMO that does not provide coverage to persons who no longer reside, live, or work in the HMO's Service Area and the Employee or Dependent no longer lives, works, or resides in the HMO Service Area and no other benefit option is available to the individual, the Dependent loses eligibility for coverage as a result of legal separation, divorce, cessation of Dependent status, death of the Employee, termination of employment or reduction in hours worked so he is not eligible for coverage, the Dependent or Employee Incurred a claim that meets or exceeds the Lifetime Limit on benefits under another plan, or the Plan no longer offers any benefits to the class of similarly situated individuals that includes the individual.
- (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above or from the individual's receipt of an explanation of benefits or similar form notifying him that he had exceeded a lifetime limit. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) Dependent special enrollment period. If:

- (a) The Employee is a Covered Person under this Plan (or has met the Waiting Period applicable to becoming a Covered Person under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
- (b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption, then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a Child or the marriage of the Covered Employee, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage.

The Dependent Special Enrollment Period is a period of 31 days and begins on the date of the marriage, birth, adoption or placement for adoption.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

- (a) in the case of marriage, the first day of the first month beginning after the date of the completed request for enrollment is received;
- (b) in the case of a Dependent's birth, as of the date of birth; or

- (c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

A Participant need only attest to the Dependent's status as a Dependent for a dependent special enrollment period. Notwithstanding the above, a Participant may be required to provide proof of Dependent status at any time subsequent to the Dependent's special enrollment period.

EFFECTIVE DATE

Effective Date of Employee Coverage. An hourly or part-time Employee will be covered under this Plan as of the first day of the calendar month following the date that the Employee satisfies both of the following requirements:

- (a) completes 30 days of active employment
- (b) completes the enrollment forms within 31 days of date of hire or date the forms are provided, whichever is later.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the first day that the Dependent satisfied both the eligibility and enrollment requirements of the Plan.

TERMINATION OF COVERAGE

When coverage under this Plan ends, Covered Persons will receive a Certificate of Creditable Coverage that will show the period of coverage under this Plan. You should retain this certificate and provide it to the next group health plan in which you enroll. Please contact the Plan Administrator for further details.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates:

- (1) The date the Plan is terminated.
- (2) The last day of the calendar month in which the covered Employee ceases to be an eligible Employee. This includes death, reduction in hours for part-time or hourly Active Employee below the minimum 24 hours per week, or termination of Active Employment of the covered Employee.
- (3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (4) Immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Options".

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates:

- (1) The date the Plan or Dependent coverage under the Plan is terminated.
- (2) The date that the Employee's coverage under the Plan terminates for any reason including death.
- (3) The date a covered Spouse loses coverage due to loss of dependency status.
- (4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan.

- (5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due.
- (6) Immediately after an Employee or his Dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information to the Plan, including enrollment information.

Except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled "COBRA Continuation Options."

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active Employment ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance (subject to the provisions for continuation during Family and Medical Leave, if applicable).

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person. The covered person may be required to pay the premium during such leave of absence or layoff.

Continuation during Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the FMLA.

During any leave taken under the FMLA, coverage will be maintained under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave, subject to the changes in the coverage as applicable to the work force as a whole. Coverage will be reinstated only if the person(s) had coverage under this 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 effect the work force as a whole. For example, Pre-Existing Condition exclusions and other Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all eligibility and enrollment requirements. However, if the Employee is returning to work directly from WEHP COBRA coverage, this Employee does not have to satisfy any Waiting Period or Pre-Existing Condition provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

- (1) The maximum period of coverage of a person under such an election shall be the lesser of:
 - (a) The 24-month period beginning on the date on which the person's absence begins; or

- (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.
- (2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.
- (3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been Incurred in, or aggravated during, the performance of uniformed service.

OPEN ENROLLMENT

Every year during the Plan's open enrollment period, which is the period specified by the Plan Administrator as the open enrollment period, covered Employees and their covered Dependents will be able to change some of their benefit decisions based upon which benefits and coverage are right for them.

Benefit choices made during the open enrollment period will become effective January 1 and remain in effect until the next January 1 unless there is a special enrollment period or a change in status during the year (birth, death, marriage, divorce, adoption, change in employment, eligibility for Medicare or Medicaid, receipt of a Qualified Medical Child Support Order or National Medical Support Notice, or other event that permits a change in election under the terms of The WellMed Medical Management, Inc. Flexible Benefit Cafeteria Plan or loss of coverage due to loss of a Spouse's employment, incurring expenses in another group health plan that meet or exceed the lifetime limit on total benefits, or exhaustion of COBRA coverage under another plan). To the extent previously satisfied, coverage Waiting Periods and Pre-Existing Condition exclusions will be considered satisfied when changing from one plan to another plan, provided there is not a break in coverage that exceeds 62 days.

A Covered Person who fails to make an election during open enrollment will automatically retain his or her present coverage, including no coverage if not presently enrolled.. .

Eligible Persons will receive detailed information regarding open enrollment from their Employer.

If you wish to decline coverage, you must sign a "Waiver of Benefits".

ENROLLMENT RIGHTS

If you decline coverage during the initial or open enrollment period you may be able to enroll yourself and your dependents in the Plan if you experience a Change in Status and you submit the request to the WellMed Employee Health Plan within 31 days of the event.

To obtain more information, contact the , WellMed Employee Health Plan . at (210)-949-4168, or via U. S. Mail at 8637 Fredericksburg Road, Ste. 360, San Antonio, TX 78240..

SCHEDULE OF BENEFITS - OPTION A – EPO OPTION

(EXCLUSIVE PROVIDER ORGANIZATION)

Verification of Eligibility: To verify eligibility before charges are Incurred, call 210-697-9900 (outside San Antonio, Texas, call 1-800-934-6302). You may only elect Option A if you live in the EPO's service area, currently in the San Antonio area.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Plan provisions, conditions, exclusions (including but not limited to pre-existing condition exclusions) and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are Reasonable and Customary Charges; and that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document. See the Section titled "Plan Exclusions" beginning on page 51 to see the Exclusions from coverage that apply to all of the Options, Option A, Option B and Option C.

All services under the EPO Benefit Option must be accessed through the individual's primary care physician. A specialist may only be seen if the individual's primary care physician refers the individual to the specialist. The primary care physician referral requirement is in addition to the precertification requirements herein. All services must be approved by your primary care physician.

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called "EPO Network Providers. Because these Network Providers have agreed to charge reduced fees to Covered Persons, the Plan can afford to reimburse a higher percentage of their fees. Under Option A – the EPO benefit, the Plan will only pay for coverage obtained from the EPO Network Provider.

Under the following circumstances, the higher in-EPO Network Provider payment will be made for certain non-Network Provider services:

If a Covered Person has no choice of EPO Network Providers in the specialty that the Covered Person is seeking within the EPO Network Provider service area.

If a Covered Person is out of the EPO Network Provider service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives ancillary services by a non-EPO Network Provider at an in-EPO Network Provider facility.

Additional information about this option, as well as a list of EPO Network Providers, will be given to Covered Persons, at no cost, and updated as needed.

Each Covered Person has a free choice of any physician or surgeon within the EPO network, and the physician-patient relationship shall be maintained. The Covered Person, together with his/her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The EPO Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any EPO Network Provider.

Co-payments payable by Covered Persons

Co-payments are dollar amounts that the Covered Person must pay before the Plan pays.

A "co-payment" is the amount of money that is paid each time a particular service is used. There may be co-payments on some services and other services will not have any co-payments.

The "out of pocket maximum" for a Covered Person in the EPO Option is the maximum amount of co-payments (excluding Prescription Drug co-payments) the Covered Person will pay in a Plan Year

EPO - NETWORK PROVIDERS	
MAXIMUM LIFETIME BENEFIT AMOUNT	\$2,000,000
Note: The maximums listed below are the total for EPO Network Provider expenses, emergency out of area expenses and expenses for ancillary providers (e.g., anesthesia) at an EPO network Provider.	
COPAYMENTS	
For all services rendered in the Physician's office there will be only one co-payment taken per visit. All other services ordered by the physician and performed outside of the physician's office are not included under the physician's visit co-payment.	
MAXIMUM OUT-OF-POCKET AMOUNT PER CALENDAR YEAR	
Per Covered Person	\$1,500
Per Family Unit	\$3,000
The Plan will pay the Covered Charges in excess of the Co-payment until out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. Only Co-payments apply toward the out-of-pocket maximum.	
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%:	
Charges excluded from coverage under the Plan Prescription Drug co-payments	
COVERED SERVICES	
Physician Services	
Primary Care Physician Office visits	No co-payment
Pediatrician Physician Office visits	\$20 co-payment per visit
Newborn Care-Inpatient	No co-payment
Specialist Office visits	\$20 co-payment per visit
Maternity Office visit	\$20 co-payment first visit; No co-payment subsequent visits
Immunizations	No co-payment
Inpatient visits	No co-payment
Allergy testing	\$20 co-payment per visit
Allergy serum and injections	No co-payment
Emergency Room Physician	No co-payment
Family Planning Services	
Sterilization (tubal ligation or vasectomy)	Co-payment determined by place of service
Inject able/IUD Birth Control Implants and Devices	\$20 co-payment per visit
Fertility/Infertility Diagnosis	\$20 co-payment per visit
Artificial Insemination	Artificial Insemination is limited to a lifetime maximum of three (3) rounds reimbursed at 50% of allowable expenses. In vitro fertilization is not covered

EPO - NETWORK PROVIDERS	
Hospital Services	
Inpatient Services	\$400 per admission co-payment and any charges exceeding semi-private room rate
Outpatient Surgery Services	\$100 per admission co-payment (the co-payment applies to the facility charge for any procedure, endoscopic or surgical, performed in an outpatient setting, including the outpatient department of a hospital or in an ambulatory surgical facility)
Emergency Room	\$100 per visit co-payment; waived if admitted through ER
Skilled Nursing Facility	\$400 per admission co-payment and any charges exceeding semi-private room rate (limited to 100 days per disability)
Urgent Care	\$50 per visit co-payment
Diagnostic & Preventative Laboratory & X-ray Services	\$20 co-payment per visit if the services are available in the PCP's office but are performed at an external facility
Radiological Services (Dexa, Mammogram, Ultrasound, MRI, MRA, PET, CT, Nuclear Medicine, etc.)	\$20 co-payment per visit
Home Health Care	\$20 co-payment per visit
Durable Medical Equipment (including Oxygen)	No co-payment (the cost of equipment rental goes toward the purchase price of equipment)
Diabetic Supplies	\$20 co-payment per 30 day supply
Physical Therapy, Hearing Therapy, Occupational Therapy, Speech Therapy (any setting)	\$20 co-payment per visit
Prosthetic-Orthopedic Appliances	No co-payment
Dialysis Services	\$20 co-payment per visit
Chemotherapy	\$20 co-payment
Radiation Therapy	No co-payment
Hospice Care	\$20 co-payment per visit
Ambulance Services (medical emergency services only)	\$50 co-payment per trip or visit
Mental Disorders	
Inpatient	\$400 co-payment per admission and charges exceeding average semi-private room rate (Plan coverage is limited to 30 days per Calendar Year)
Outpatient	\$20 co-payment per visit (Plan coverage is limited to 20 visits per Calendar Year)
Serious Mental Illness	
Inpatient	\$400 per admission co-payment and any charges exceeding average semi-private room rate (Plan coverage is limited to 45 days per Calendar Year)
Outpatient	\$20 co-payment per visit (Plan coverage is limited to 60 visits per Calendar Year)
Chemical Dependency / Substance Abuse	
Inpatient	\$400 co-payment per admission and charges exceeding average semi-private room rate
Outpatient	\$20 co-payment per visit

EPO - NETWORK PROVIDERS	
Chemical Dependency or Substance Abuse Treatment is covered by the Plan for a maximum of three (3) series of treatment per Lifetime	
Organ Transplants Limited to human to human organ or tissue transplant procedures	Plan coverage is limited to \$2,000,000 Lifetime maximum
Organ Transplant Donor	Plan coverage is limited to \$5,000 maximum per transplant

PRESCRIPTION DRUG BENEFIT	
Retail Pharmacy – 30 day supply	\$10 co-pay for Generic \$30 co-pay for Brand Name*
Mail order – 90 day supply	\$10 co-pay for Generic \$60 co-pay for Brand Name*

* NOTE: You will be required to use therapeutic prescription drug alternatives when available. Please contact the Pharmacy Benefit Manager at 1-877-469-7879 to determine which drugs qualify for therapeutic alternatives

VISION BENEFIT	
MAXIMUM BENEFIT, PER CALENDAR YEAR	
Per covered person	\$250 combined maximum for exam and eyewear per calendar year.

SCHEDULE OF BENEFITS - OPTION B – PPO OPTION

Verification of Eligibility: Call 210-697-9900 (outside San Antonio, Texas, call 1-800-934-6302). Call this number to verify eligibility for Plan benefits **before** the charge is Incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Plan provisions, exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are limited to the amount the Plan Administrator determines are the Reasonable and Customary Charges; and that services, supplies and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

**Hospitalizations
Skilled Nursing Facility Stays
Outpatient Surgery
Transplants and Transplant Evaluation
Home Health Care**

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called "Network Providers." Because these Network Providers have agreed to charge reduced fees to Covered Persons, the Plan can afford to reimburse a higher percentage of their fees. **Refer to your ID card for information on Network Providers.** When a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a non-Network Provider is used.

Under the following circumstances, the higher in-Network Provider payment will be made for certain non-Network Provider services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the Network Provider service area.

If a Covered Person is out of the Network Provider service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives ancillary services from a non-Network Provider at an in-Network Provider facility.

Additional information about this option, as well as a list of Network Providers, will be given to Covered Persons, at no cost, and updated as needed.

Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, together with his/her physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Network Providers are merely independent contractors; neither the Plan, nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

Deductibles/Coinsurance payable by Covered Persons

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A "deductible" is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Plan, and it must be paid before any money is paid by the Plan for any covered services. Each

January 1st, a new deductible amount is required. Deductibles and Prescription Drug Co-payments do not accrue toward the 100% maximum out-of-pocket payment.

"Coinsurance" is the percentage of the Reasonable and Customary charge (the "R and C") that you must pay of each covered expense.

The "out of pocket maximum" for a Covered Person is the amount of accumulated coinsurance that you must pay during the Plan Year before the coinsurance paid by the Plan is paid at 100%.

In-Network providers may not bill above the contracted rates, provided you pay your coinsurance at the time of service or promptly when billed.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	\$2,000,000	
Note: The maximums listed below and above are the total for Network and Non-expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network Providers.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$500	\$1,000
Per Family Unit	\$1,000	\$2,000
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR		
Per Covered Person	\$2,000	\$6,000
Per Family Unit	\$4,000	\$12,000
The Plan will pay the designated percentage of Covered Charges based upon Reasonable and Customary Charge until the maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of the Reasonable and Customary Charge for Covered Charges for the rest of the Calendar Year unless stated otherwise. (In-network and out-of-network expenses toward satisfying the Out-of-Pocket Maximum accumulate separately)		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Prescription Drug Plan co-payments Cost containment or failure to preauthorize penalties Non Covered Services		
FAILURE TO PRE-AUTHORIZE PENALTY – Applies per Service or Supply, Not Pre-Authorized		
Network	\$250	
Non-Network	\$500	
COVERED SERVICES	The Plan pays based upon (1) the Contracted Rate for Network Providers and (2) the Reasonable and Customary Charge for Non-Network Providers. Non-Network Providers charges may exceed the Reasonable and Customary Charge and they may bill you for amounts in excess of the Plan's Reasonable and Customary Charge:	
Physician Services		
Primary Care Physician Office visits	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Pediatrician Physician Office visits	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Newborn Care-Inpatient	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Specialist Office Visits	70% after you satisfy the Deductible	50% after you satisfy the Deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Maternity Office Visit	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Immunizations	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Inpatient visits	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Allergy testing	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Allergy serum and injections	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Emergency Room Physician	70% after you satisfy the Deductible	70% after you satisfy the Deductible
Family Planning Services		
Sterilization (tubal ligation or vasectomy)	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Injectable/IUD Birth Control Implants and Devices	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Fertility/Infertility Diagnosis	Not Covered	Not Covered
Artificial Insemination	Not Covered	Not Covered
Hospital Services		
Inpatient Services	70% of the semi-private room rate after you satisfy the Deductible	50% of the semi-private room rate after you satisfy the Deductible
Outpatient Services	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Outpatient Surgery Services	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Emergency Room	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Skilled Nursing Facility	70% of the facility's semi-private room rate after you satisfy the Deductible; 90 day Calendar Year Max	50% of the facility's semi-private room rate after you satisfy the Deductible; 90 day Calendar Year Max
Urgent Care	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Intensive Care	70% of the Hospital's ICU charge after you satisfy the Deductible	50% of the Hospital's ICU charge after you satisfy the Deductible
Diagnostic & Preventative Laboratory & X-ray Services	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Radiological Services (Dexa, Mammogram, Ultrasound, MRI, MRA, PET, CT, Nuclear Medicine, etc.)	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Home Health Care	70% after you satisfy the Deductible; 60 visit Calendar Year Max	50% after you satisfy the Deductible; 60 visit Calendar Year Max
Durable Medical Equipment (including Oxygen)	70% after you satisfy the Deductible; \$2000	50% after you satisfy the Deductible; \$2000

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
	Calendar Year per Covered Person Max	Calendar Year per Covered Person Max
Diabetic Supplies	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Physical Therapy, Hearing Therapy, Occupational Therapy, Speech Therapy (any setting)	70% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max	50% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
Prosthetic-Orthopedic Appliances	70% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max	50% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
Dialysis Services	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Chemotherapy	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Radiation therapy	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Hospice Care	70% after you satisfy the Deductible; Lifetime Max of \$10,000 for both inpatient and outpatient	50% after you satisfy the Deductible; Lifetime Max of \$10,000 for both inpatient and outpatient
Ambulance Services (medical emergency services only)	70% after you satisfy the Deductible	50% after you satisfy the Deductible
Mental Disorders		
Inpatient	70% after you satisfy the Deductible; 30 day Calendar Year Max	50% after you satisfy the Deductible; 30 day Calendar Year Max
Outpatient	70% after you satisfy the Deductible; 20 visit Calendar Year Max	50% after you satisfy the Deductible; 20 visit Calendar Year Max
Serious Mental Illness		
Inpatient	70% after you satisfy the Deductible; Limited to 45 days per Calendar Year	50% after you satisfy the Deductible; limited to 45 days per Calendar Year
Outpatient	70% after you satisfy the Deductible; Limited to 60 visits per Calendar Year	50% after you satisfy the Deductible; limited to 60 visits per Calendar Year
Chemical Dependency/Substance Abuse		
Inpatient	70% after you satisfy the Deductible Up to 30 days and/or \$5,000 Max per calendar year	50% after you satisfy the Deductible up to \$5,000 Max
Outpatient	70% after you satisfy the Deductible Up to 24 visits Max per calendar year	50% after you satisfy the Deductible up to 24 visits Max
Chemical Dependency or Substance Abuse treatment is limited to three (3) series of treatment per Lifetime and three (3) days of detoxification per admission		
Organ Transplants Limited to human to human organ or	70% after you satisfy the Deductible	50% after you satisfy the Deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
tissue transplant procedures		
Organ Transplant Donor	70% after you satisfy the Deductible; limited to \$5,000 for donor expenses	5% after you satisfy the Deductible; limited to \$5,000 for donor expenses
All other eligible expenses that are Covered Charges and are not excluded:		
70% after you satisfy the Deductible		
50% after you satisfy the Deductible		

PRESCRIPTION DRUG BENEFIT	
Retail Pharmacy – 30 day supply	\$10 co-pay for Generic \$30 co-pay for Brand Name*
Mail order – 90 day supply	\$10 co-pay for Generic \$60 co-pay for Brand Name*

* NOTE: You will be required to use therapeutic prescription drug alternatives when available. Please contact the Pharmacy Benefit Manager at 1-877-469-7879 to determine which drugs qualify for therapeutic alternatives

SCHEDULE OF BENEFITS - OPTION C – PPO OPTION

Verification of Eligibility: To verify eligibility before charges are Incurred, call 210-697-9900 (outside San Antonio, Texas, call 1-800-934-6302).

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the Plan provisions, exclusions and limitations described more fully herein including, but not limited to, the Plan Administrator's determination that: care and treatment is Medically Necessary; that charges are limited to the amount the Plan Administrator determines are the Reasonable and Customary Charges; and that services, supplies and care are not Experimental and/or Investigational.

Note: The following services must be pre-certified or reimbursement from the Plan may be reduced.

Hospitalizations
Skilled Nursing Facility Stays
Outpatient Surgery
Transplants and Transplant Evaluation
Home Health Care

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are Network Providers. Because these Network Providers have agreed to charge reduced fees to Covered Persons, the Plan can afford to reimburse a higher percentage of their fees. **Refer to your ID card for information on Network Providers.** When a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a non-Network Provider is used.

Under the following circumstances, the higher Network Provider payment will be made for certain Non-Network Provider services:

If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the Network Provider service area.

If a Covered Person is out of the Network Provider service area and has a Medical Emergency requiring immediate care.

If a Covered Person receives ancillary services from a Non-Network Provider at a Network Provider facility.

Additional information about this option, as well as a list of Network Providers, will be given to Covered Persons, at no cost, and updated as needed.

Each Covered Person has a free choice of any physician or surgeon, and the physician-patient relationship shall be maintained. The Covered Person, together with his physician, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Network Providers are merely independent contractors; neither the Plan nor the Plan Administrator make any warranty as to the quality of care that may be rendered by any Network Provider.

Deductibles/Coinsurance payable by Covered Persons

Deductibles are dollar amounts that the Covered Person must pay before the Plan pays.

A "deductible" is an amount of money that is paid once a Calendar Year per Covered Person. Typically, there is one deductible amount per Benefit Option, and it must be paid before any money is paid by the Plan for any covered

services. Each January 1st, a new deductible amount is required. Co-payments and Prescription Drug Co-payments do not accrue toward the 100% maximum out-of-pocket payment.

"Coinsurance" is the percentage of the Contracted Charges or of the Reasonable and Customary Charges for a Non-Network Provider.

"Co-payments" are dollar amounts that the Covered Person must pay before the Plan pays. A "co-payment" is a smaller amount of money that is paid each time a particular service is used. Typically, there may be co-payments on some services and other services will not have any co-payments.

Network Providers may not bill above the contracted rates, provided you pay your coinsurance at the time of service or promptly when billed.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
MAXIMUM LIFETIME BENEFIT AMOUNT	\$2,000,000	
Note: The maximums listed below are the total for Network and Non-Network expenses. For example, if a maximum of 60 days is listed twice under a service, the Calendar Year maximum is 60 days total which may be split between Network and Non-Network Providers.		
Co-payments		
For all services rendered in the physician's office there will be only one co-payment taken per visit. All other services ordered by the physician and performed outside of the physician's office are not included under the physician's visit co-payment.		
DEDUCTIBLE, PER CALENDAR YEAR		
Per Covered Person	\$250	\$500
Per Family Unit	\$500	\$1,000
Network and Non-Network deductibles accumulate separately		
MAXIMUM OUT-OF-POCKET AMOUNT, PER CALENDAR YEAR	The Network calendar year deductible and Network co-insurance paid by you apply toward the Network Out-of-Pocket Maximum	The Non-Network deductible and Non-Network co-insurance paid by you apply toward the Non-Network Out-of-Pocket Maximum
Per Covered Person	\$1,500	\$3,000
Per Family Unit	\$3,000	\$6,000
The Plan will pay the designated percentage of the Reasonable and Customary Charge for Covered Charges until maximum out-of-pocket amounts are reached, at which time the Plan will pay 100% of the remainder of Covered Charges for the rest of the Calendar Year unless stated otherwise. Network and Non-Network expenses toward satisfying the Out-of-Pocket Maximum accumulate separately. A Non-Network Provider may also charge you amounts he charges for a service that exceed what the plan determines to be the Reasonable and Customary Charge.		
The following charges do not apply toward the out-of-pocket maximum and are never paid at 100%: Prescription Drug Plan co-payments Cost containment or failure to preauthorize penalties Non Covered Services		
FAILURE TO PREAUTHORIZE PENALTY		
Network	\$250	
Non-Network	\$500	
Applies to each service or supply for which preauthorization is required but was not obtained		

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
The co-payment for Physician visits and Urgent Care Centers applies to all services rendered in a physician's office, including all laboratory and x-ray associated with the visit. Complex Imaging, as defined, and chemotherapy services/supplies and radiation therapy services/supplies are subject to the Calendar Year deductible and co-insurance.		
Physician Office Visits	\$20 co-payment	Deductible and co-insurance
Urgent Care Center	\$50 co-payment	Deductible and co-insurance
Emergency Room	\$100 co-payment (covers the facility and physician charges)	\$300 co-payment (covers the facility and physician charges)
The Emergency room co-payment is waived if the patient is admitted to the Hospital and deductible and co-insurance will apply. The utilization review administrator, Medical Cost Management, must be notified at 1-800-367-9938 within 48 hours of the admission, even if the patient is discharged within 48 hours of the admission.		
COVERED SERVICES	The Plan pays based upon (1) the Contracted Rate for Network Providers and (2) the Reasonable and Customary Charge for Non-Network Providers. Non-Network Providers charges may exceed the Reasonable and Customary Charge and they may bill you for amounts in excess of the Plan's Reasonable and Customary Charge. All amounts paid using co-insurance are based on the Reasonable and Customary Charge:	
Physician Services		
Primary Care Physician Office visits	100% after \$20 co-payment	60% after you satisfy the Deductible
Pediatrician Physician Office visits	100% after \$20 co-payment	60% after you satisfy the Deductible
Newborn Care-Inpatient	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Specialist Office Visits	100% after \$20 co-payment	60% after you satisfy the Deductible
Maternity Office Visit	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Immunizations	100% after \$20 co-payment	60% after you satisfy the Deductible
Inpatient visits	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Allergy testing	100% after \$20 co-payment	100% after you satisfy the Deductible
Allergy serum and injections	100% after you satisfy the Deductible	100% after you satisfy the Deductible
Emergency Room Physician	90% after you satisfy the Deductible	60% after you satisfy the Deductible

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
FAMILY PLANNING SERVICES		
Sterilization (tubal ligation or vasectomy)	Benefit determined by place of service	60% after you satisfy the Deductible
Injectable/IUD Birth Control Implants and Devices	\$20 co-payment per visit	60% after you satisfy the Deductible
Fertility/Infertility Diagnosis	100% after \$20 co-payment	60% after you satisfy the Deductible
Artificial Insemination	50% of Allowable Expenses after you satisfy the Deductible, limited to 3 rounds per Lifetime. In vitro Fertilization is not Covered.	30% of Allowable Expenses after you satisfy the Deductible, limited to 3 rounds per Lifetime. In vitro Fertilization is not Covered.
HOSPITAL SERVICES		
Inpatient Services	90% of the semi-private room rate after you satisfy the Deductible	60% of the semi-private room rate after you satisfy the Deductible
Outpatient Services	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Outpatient Surgery Services	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Emergency Room	\$100 per visit co-payment	\$300 per visit co-payment
Skilled Nursing Facility	90% of the facility's semi-private room rate after you satisfy the Deductible; 100 day Calendar Year Max	60% of the facility's semi-private room rate after you satisfy the Deductible; 100 day Calendar Year Max
Urgent Care	\$50 co-payment	60% after you satisfy the Deductible
Intensive Care	90% of the Hospital's ICU charge after you satisfy the Deductible	60% of the Hospital's ICU charge after you satisfy the Deductible
Diagnostic & Preventative Laboratory & X-ray Services	\$20 co-payment at facility (when not performed in physician's office)	60% after you satisfy the Deductible
Radiological Services (Dexa, Mammogram, Ultrasound, MRI, MRA, PET, CT, Nuclear Medicine, etc.)	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Home Health Care	90% after you satisfy the Deductible; 60 visit Calendar Year Max	60% after you satisfy the Deductible; 60 visit Calendar Year Max
Durable Medical Equipment (including Oxygen)	90% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max	60% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
Diabetic Supplies	Covered under the terms of the RX program and/or Disease Management program	60% after you satisfy the Deductible
Physical Therapy, Hearing Therapy, Occupational Therapy, Speech Therapy (any setting)	90% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max	60% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Prosthetic-Orthopedic Appliances	90% after you satisfy the Deductible; \$5000 Calendar Year per Covered Person Max	60% after you satisfy the Deductible; \$2000 Calendar Year per Covered Person Max
Dialysis Services	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Chemotherapy	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Radiation therapy	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Hospice Care	90% after you satisfy the Deductible; Lifetime Max of \$10,000 for both inpatient and outpatient	60% after you satisfy the Deductible; Lifetime Max of \$10,000 for both inpatient and outpatient
Ambulance Services (medical emergency services only)	\$50 co-payment per trip or visit	\$50 co-payment per trip or visit
Mental Disorders		
Inpatient (limited to 30 days per admission)	90% after you satisfy the Deductible; 30 day Calendar Year Max	60% after you satisfy the Deductible; 30 day Calendar Year Max
Outpatient (limited to 20 visits)	90% after you satisfy the Deductible; 20 visit Calendar Year Max	60% after you satisfy the Deductible; 20 visit Calendar Year Max
Serious Mental Illness		
Inpatient	90% after you satisfy the Deductible; limited to 45 days per Calendar Year	60% after you satisfy the Deductible; limited to 45 days per Calendar Year
Outpatient	90% after you satisfy the Deductible; limited to 60 visits per Calendar Year	60% after you satisfy the Deductible; limited to 60 visits per Calendar Year
Chemical Dependency/Substance Abuse		
Inpatient (limited to 30 days Max)	90% after you satisfy the Deductible up to \$5,000 Max	60% after you satisfy the Deductible up to \$5,000 Max
Outpatient (limited to 30 days Max)	90% after you satisfy the Deductible up to 24 visits Max	60% after you satisfy the Deductible up to 24 visits Max
Chemical Dependency or Substance Abuse treatment is limited to three (3) series of treatment per Lifetime and three (3) days of detoxification per admission		
Organ Transplants Limited to human to human organ or tissue transplant procedures	90% after you satisfy the Deductible	60% after you satisfy the Deductible
Organ Transplant Donor	90% after you satisfy the Deductible; limited to \$5,000 for donor expenses	60% after you satisfy the Deductible; limited to \$5,000 for donor expenses
All other eligible expenses that are Covered Expenses and not Excluded 90% after you satisfy the Deductible 60% after you satisfy the Deductible		

PRESCRIPTION DRUG BENEFIT	
Retail Pharmacy – 30 day supply	\$10 co-pay for Generic \$30 co-pay for Brand Name*
Mail order – 90 day supply	\$10 co-pay for Generic

	\$60 co-pay for Brand Name*
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* NOTE: You will be required to use therapeutic prescription drug alternatives when available. Please contact the Pharmacy Benefit Manager to determine which drugs qualify for therapeutic alternatives

VISION BENEFIT	
MAXIMUM BENEFIT, PER CALENDAR YEAR	
Per covered person	\$250 combined maximum for exam and eyewear

MEDICAL BENEFITS

Medical Benefits apply when Covered Charges are Incurred by a Covered Person for care of an Injury or Sickness and while the person is covered for these benefits under the Plan. These provisions apply to Option A, Option B and Option C, except when noted otherwise herein.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Calendar Year, a Covered Person must meet the deductible shown in the Schedule of Benefits for Option B or Option C.

This amount will not accrue toward the 100% maximum out-of-pocket payment.

Family Unit Limit. When the maximum amount shown in the Schedule of Benefits has been Incurred by members of a Family Unit toward their Calendar Year deductibles, the deductibles of all members of that Family Unit will be considered satisfied for that Calendar Year.

BENEFIT PAYMENT

Each Calendar Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible and any Co-payments. Payment will be made at the percentages shown in the Schedule of Benefits. No benefits will be paid in excess of the Maximum Benefit Amount or any listed limit of the Plan.

COPAYMENT

Co-payment means the set dollar amount a Covered Person must pay at the time of service for the benefits received.

OUT-OF-POCKET LIMIT OR MAXIMUM

Covered Charges are payable at the percentages shown in the Schedule of Benefits each Calendar Year until the out-of-pocket limit shown in the Schedule of Benefits is reached. Then, Covered Charges Incurred by a Covered Person will be payable at 100% (except for the charges excluded and the charges for services subject to a Co-payment) for the rest of the Calendar Year.

When a Family Unit reaches the Out-of-Pocket Limit, Covered Charges for that Family Unit will be payable at 100% (except for the charges excluded and the charges for service subject to a Co-payment) for the rest of the Calendar Year.

The Out-of-Pocket Maximum for Option A includes co-payments other than co-payments for Prescription Drugs. The Out-of-Pocket Maximum for Option B and Option C considers coinsurance, but not penalties or the deductible. Option A, Option B, and Option C all do not consider any failure to pre-certify penalties or any other cost containment penalties as applying toward satisfaction of the Out-of-Pocket Maximum.

MAXIMUM BENEFIT AMOUNT

The Maximum Benefit Amount is shown in the Schedule of Benefits. It is the total amount of benefits that will be paid under the Plan for all Covered Charges Incurred by a Covered Person.

Series of Treatments means a planned, structured and organized program to promote chemical free status, which may include different facilities or modalities, and is complete (a) when the Covered Person is discharged on medical advice from Inpatient detoxification, Inpatient rehabilitation/treatment, partial hospitalization or intensive Outpatient or a series of these levels of treatments without a lapse in treatment, or (b) when the Covered Person fails to materially comply with the treatment program for a period of 30 days.

COVERED CHARGES

"Covered Charges" are the Medically Necessary, Reasonable and Customary Charges that are Incurred for the following items of service and supply. These charges are subject to the benefit limits, exclusions (including the pre-existing condition exclusion) and other provisions of this Plan.

- (1) **Ambulance Services.** Medically necessary land or air ambulance service will be a Covered Charge only if the service is to the nearest Hospital or Skilled Nursing Facility where Medically Necessary treatment can be provided unless the Plan Administrator finds a longer trip was Medically Necessary.
- (2) **Anesthesia services.**
- (3) **Birth control implants and devices.** Services or supplies in connection with birth control implants and devices including their removal.
- (4) **Blood and blood derivatives.** Charges for these services will be covered to the extent that they are not donated or replaced.
- (5) **Cardiac rehabilitation.** Charges for these services when determined to be Medically Necessary, provided the services are rendered (a) under the supervision of a Physician; (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery; (c) initiated within 12 weeks after other treatment for the medical condition ends; and (d) in an approved Medical Care Facility.
- (6) **Chemotherapy.** Charges for chemotherapy services that are not Experimental.
- (7) **Contact lenses/glasses.** Charges for the initial contact lenses or glasses following cataract surgery.
- (8) **Diabetic Supplies.** Charges for diabetic lancets, diabetic glucose testing strips, and glucose monitors.
- (9) **Durable Medical Equipment or surgical equipment.** Charges for the rental or purchase of equipment when it is determined to be Medically Necessary. These items are normally rented but may be purchased rather than rented with the cost not to exceed the fair market value of the equipment at the time of purchase, but only if agreed to in advance by the Plan Administrator. Additionally, any fees paid for rental will be applied to the purchase price.
- (10) **Home Health Care Services and Supplies.** Charges for Home Health Care Services and Supplies are covered only for care and treatment of an Injury or Sickness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the Attending Physician and be contained in a Home Health Care Plan.

Benefit payment for nursing, home health aide and therapy services is subject any applicable limitations as described in the Schedule of Benefits.

A Home Health Care visit is a periodic visit by a nurse, a home health aid or a therapist.

- (11) **Hospice Care Services and Supplies.** Charges for Hospice Care Services and Supplies are covered only when the Attending Physician has diagnosed the Covered Person's condition as being terminal,

determined that the person is not expected to live more than six months and placed the person under a Hospice Care Plan.

- (12) **Hospital Care.** The medical services and supplies furnished by a Hospital or Ambulatory Surgical Center or a Birthing Center. Covered Charges for room and board will be payable as shown in the Schedule of Benefits. After 23 observation hours, a confinement will be considered an inpatient confinement.
- (13) **Intravenous injections and solutions.** Charges for these services will be covered as well as the administration of them.
- (14) **Laboratory Studies.**
- (15) **Maternity Stay.** 48 hours following a vaginal delivery, or 96 hours following a cesarean section. Federal law restricts benefits for any hospital length of stay in connection with childbirth for the mother or newborn less than 48 hours following a vaginal delivery or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's Attending Physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).
- (16) **Mental Disorders and Substance Abuse/Serious Mental Illness.** Covered charges for care, supplies and treatment of Mental Disorders and Substance Abuse will be limited as follows:
 - (a) Physician's visits are limited to one treatment or visit per day.
 - (b) Psychiatrists (M.D.), psychologists (Ph.D.), counselors (Ph.D.) or Masters of Social Work (M.S.W.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of, and must bill the Plan through, these professionals. Serious Mental Illness Care is described below.
 - (c) **Serious Mental Illness Care** is care or treatment for schizophrenia; paranoid and other psychotic disorders; bipolar disorders (hypomanic, manic, depressive and mixed); major depressive disorders (single episode or recurrent); schizo-affective disorders (bipolar or depressive); pervasive developmental disorders; obsessive-compulsive disorders; and depression in childhood and adolescence. Only the providers listed in (c) above are eligible for reimbursement under the plan for treatment of Serious Mental Illness.
- (17) **Occupational therapy.** Therapy must be ordered by a Physician, result from an Injury or Sickness and improve a body function. Services must be rendered by a licensed Occupational Therapist. Covered Charges do not include recreational programs, maintenance therapy or supplies used in occupational therapy.
- (18) **Oral Surgery.** Charges for Injury to or care of the mouth, teeth, gums and alveolar processes will be Covered Charges under Medical Benefits only if that care is for the following oral surgical procedures:

Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.

Emergency repair due to Injury to sound natural teeth.

Surgery needed to correct accidental Injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth.

Excision of benign bony growths of the jaw and hard palate.

External incision and drainage of cellulitis.

Incision of sensory sinuses, salivary glands or ducts.

Removal of impacted teeth.

- (19) **Organ transplants.** Charges otherwise covered under the Plan that are Incurred for the care and treatment due to an organ or tissue transplant are subject to these limits:

The transplant must be performed to replace an organ or tissue.

Charges for obtaining donor organs or tissues are Covered Charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by those payable under the donor's plan.

Donor charges include those for:

Evaluating the organ or tissue;

Removing the organ or tissue from the donor; and

Transportation of the organ or tissue from within the United States and Canada to the place where the transplant is to take place.

- (20) **Oxygen.**

- (21) **Physical therapy.** The therapy must be in accord with a Physician's exact orders as to type, frequency and duration and for conditions, which are expected to improve through short-term therapy. Services must be rendered by a licensed Physical Therapist.

- (22) **Physician Care.** The professional services of a Physician for surgical or medical services.

Charges for **multiple surgical procedures** will be a covered expense subject to the following provisions:

- (i) If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Reasonable and Customary Charge that is allowed for the primary procedures; 50% of the Reasonable and Customary Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;
- (ii) If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Reasonable and Customary Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Reasonable and Customary Charge allowed for that procedure; and
- (iii) If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the surgeon's Reasonable and Customary Charge.

- (23) **Pregnancy.** The Reasonable and Customary Charges for the care and treatment of Pregnancy are covered the same as any other Sickness for a covered Employee or covered Spouse.

- (24) **Prescription Drugs.** Coverage is subject to the limits and exclusions provided herein.

- (25) **Private Duty Nursing Care.** The private duty nursing care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered Charges for this service will be included to this extent:

- (a) **Inpatient Nursing Care.** Charges are covered only when care is Medically Necessary, not Custodial Care, and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit.
 - (b) **Outpatient Nursing Care.** Charges are covered only when care is Medically Necessary and not Custodial Care. The only charges covered for Outpatient Care are those shown below, under Home Health Care Services and Supplies.
- (26) **Prosthetic Devices.** The initial purchase, fitting and repair of **artificial devices** which replace natural body parts.
- (27) **Radiation therapy.**
- (28) **Reconstructive Surgery.** Correction of abnormal congenital conditions and reconstructive mammoplasties following a Medically Necessary mastectomy will be considered Covered Charges.
- This mammoplasty coverage will include reimbursement for:
- (i) reconstruction of the breast on which a mastectomy has been performed,
 - (ii) surgery and reconstruction of the other breast to produce a symmetrical appearance, and
 - (iii) coverage of prostheses
 - (iv) physical complications during all stages of mastectomy, including treatment for lymphedemas, in a manner determined in consultation with the Attending Physician and the patient.
- (29) **Routine Preventive Care.** Covered Charges under Medical Benefits are payable for routine preventive care.
- (30) **Skilled Nursing Facility Care.** The room and board and nursing care furnished by a Skilled Nursing Facility will be payable if and when:
- (a) the patient is confined as an inpatient in the facility;
 - (b) the Attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
 - (c) the Attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.
- (31) **Speech therapy.** Therapy must be ordered by a Physician and follow either: (i) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy); (ii) an Injury; or (iii) a Sickness that is other than a learning or Mental Disorder. Therapy must be rendered by a licensed Speech Therapist.
- (32) **Sterilization** procedures
- (33) **Surgical dressings, splints, casts and other devices** used in the reduction of fractures and dislocations.

(34) **Vision Care Expenses.** Expenses for routine vision care including annual eye exams, glasses, and contact lenses under Option A – EPO and Option C –PPO only.

(35) **Well Newborn Nursery/Physician Care.**

Charges for Routine Nursery Care. Routine well newborn nursery care and Physician care is care while the newborn is Hospital-confined after birth and includes room, board and other normal care for which a Hospital or a Physician makes a charge.

This coverage is only provided if a parent is a Covered Person who was covered under the Plan at the time of the birth and the newborn child is an eligible Dependent and is neither injured nor ill.

The benefit is limited to Reasonable and Customary Charges for nursery care for the newborn child while Hospital confined as a result of the child's birth.

Charges for covered routine nursery care, from both the Hospital and the Physician, will be applied toward the Plan of the covered parent until the covered parent is discharged following the newborn's birth.

Coverage for the newborn child after the Covered Parent's discharge following birth continues only if the child is added to the Plan within 31 days of the newborn's date of birth.

(36) **X-rays.** Medically necessary diagnostic x-rays when ordered by a Physician.

PRESCRIPTION DRUG BENEFITS

This applies to Option A, Option B, and Option C.

Pharmacy Benefit Manager (PBM)

Prescription drug expenses are handled through a PBM contracted with by the Plan. Information will be furnished to you regarding the name of the PBM and how to access services. The PBM has contracted with the Plan to provide Covered Persons with access to covered prescription drugs.

Co-payments

Any amount paid as a co-payment under the Prescription drug plan is not covered under the Medical Plan. The prescription drug co-payments and cost differentials do not accumulate toward satisfying the maximum out-of-pocket per Calendar Year.

Emergency/Out-of Area

If you are out of the area and require Prescription Drugs as a result of the emergency at such out of area location, you will pay only the applicable co-pay.

Mail Order Drugs/Maintenance Medication

Maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, high cholesterol, etc.) will be provided through a mail order service through the PBM.

Covered Prescription Drugs

- (1) All drugs prescribed by a Physician that require a prescription either by federal or state law except for those drugs stated as not covered under this Plan. See "Expenses Not Covered" section of this document.
- (2) All compounded prescriptions containing at least one prescription ingredient in a therapeutic quantity.
- (3) Insulin and other diabetic supplies when prescribed by a Physician

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

- (1) Refills only up to the number of times specified by a Physician.
- (2) Refills only up to one year from the date of order by a Physician.

Any one pharmacy prescription is limited to a 30-day supply. Any one mail order prescription is limited to a 90-day supply.

PRESCRIPTION DRUG EXPENSES NOT COVERED

This benefit will not cover a charge for any of the following:

- (1) **Appetite suppressants.** Appetite suppressants, dietary supplements or vitamin supplements except for prenatal vitamins requiring a prescription or prescription vitamin supplements containing fluoride.
- (2) **Consumed on premises.** Any drug or medicine that is consumed or administered at the place where it is dispensed.
- (3) **Devices.** Devices of any type even though such devices may require a prescription. These include (but are not limited to) therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- (4) **Dietary Supplements.** Charges for dietary supplements including vitamins (except prenatal) and fluoride supplements.
- (5) **Drugs administered by the prescriber.** Charges for medications or drugs delivered or administered by the prescriber.
- (6) **Drugs used for cosmetic purposes.** Charges for drugs used for cosmetic purposes such as anabolic steroids, Retin A or medications for hair growth or removal.
- (7) **Elective Enhancement.** Elective or voluntary enhancement procedures, services, supplies and medications including, but not limited to, weight loss, hair growth, sexual performance, cosmetic purposes, anti-aging, and mental performance including medicines to treat erectile dysfunction, impotency, anorgasmy or hyporgasmy.
- (10) **Experimental.** Experimental and/or Investigational drugs and medicines, even though a charge is made to the Covered Person.
- (11) **Growth hormones.** Charges for drugs to enhance physical growth, athletic performance or appearance.
- (12) **Immunization.** Immunization agents or biological sera.
- (13) **Impotence medication.**
- (14) **Infertility medication.** A charge for infertility medication including injectable infertility drugs.
- (15) **Inject able supplies.** A charge for hypodermic syringes and/or needles (other than for insulin).
- (16) **Inpatient medication.** A drug or medicine that is to be taken by the Covered Person, in whole or in part, while Hospital confined. This includes being confined in any institution that has a facility for the dispensing of drugs and medicines on its premises.
- (17) **Investigational.** A drug or medicine labeled: "Caution - limited by federal law to investigational use".
- (18) **Lost or stolen prescriptions.** A charge to replace a lost or stolen prescription.
- (19) **Medical exclusions.** A charge excluded under Medical Plan Exclusions.
- (20) **No charge.** A charge for Prescription Drugs that may be properly received without charge under local, state or federal programs.
- (21) **Non-legend drugs.** A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

- (22) **Non-FDA approved drugs.** Any drug not approved by the United States Food and Drug Administration.
- (23) **No prescription.** A drug or medicine that can legally be bought without a written prescription including non-prescription contraceptive shields, ointments or forms. This does not apply to injectable insulin. This also applies to drugs for which there is a non-prescription equivalent available even if ordered by a physician.
- (24) **Refills.** Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.
- (25) **Saline.** Any charge for saline and medications for irrigation.
- (26) **Smoking cessation.** A charge for prescription drugs used for smoking cessation.
- (27) **Therapeutic devices or appliances.** A charge for a therapeutic device or appliance including, but not limited to, hypodermic needles, syringes, support garments, other non-medicinal substances, pen fills, pen needles, insulin pen devices, insulin pumps and related supplies (other than diabetic supplies).
- (28) **While Not Covered.** A charge for a drug or medication purchased and received prior to the date the Covered Person became covered or after the Covered Person's coverage ceased under the Plan.
- (29) **Workers' Compensation.** A charge for a medicine for which the cost is recoverable under workers' compensation or occupational disease law or any state or government agency or any medication furnished by any other drug or medical service for which no charge is made to the patient.

COST MANAGEMENT SERVICES

Cost Management Services apply to Option A, Option B and Option C. See the description for each Benefit Option below for specific differences.

Cost Management Services – Option A-EPO

UTILIZATION REVIEW

Utilization review is a monitoring program designed to help insure that all Covered Persons receive Medically Necessary and appropriate health care while avoiding unnecessary expenses. This review is performed by the WEHP RN Case Manager in conjunction with a panel of physicians. The WEHP RN Case Manager can be reached at 210-617-4745.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the Attending Physician or other health care provider.

If a particular course of treatment or medical service is not authorized, it means that either the Plan will not pay for the charges or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was authorized before incurring charges.

Role of the Primary Care Physician:

Under Plan A, the Primary Care Physician (“PCP”) directs the covered person’s care, referring the individual to a specialist for care the PCP cannot provide. The PCP must approve all procedures and hospitalizations at facilities contracted within the Exclusive Provider Organization. Non-network providers may be considered if no provider is available within the EPO network.

EXCEPTION: Covered persons may self-refer to WEHP contracted OB/GYN provider for an annual well-woman exam, without prior approval of the PCP.

EXCEPTION: Covered persons may self-refer to a mental health provider in the Texas True Choice Network without prior approval of the PCP.

Prospective Review:

The following referrals must be presented to the Utilization Management Committee of the WellMed Employee Health Plan in accordance with the Utilization Management Plan:

- Home Health Care
- Hospice Care
- Durable Medical Equipment, which is high cost
- Electrophysiology referrals
- Hyperbaric referrals
- Transplant requests
- Non-Contracted providers
- Pain Management
- Requests for non-covered services and exclusions

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not

prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Retrospective Review: Services for Medical Necessity provided on an emergency basis without authorization will be reviewed by the PCP and the Utilization Management Committee. The PCP must be notified within 48 hours of emergency treatment.

Concurrent Review: A case manager is available to assist when inpatient admission is required. This assistance includes but is not limited to case management and coordination of services.

CASE MANAGEMENT

Case Management is a program whereby a case manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The case manager consults with the patient, the family and the Attending Physician in order to develop a plan of care for approval by the patient's Attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient;
- contacting the family to offer assistance and support;
- monitoring Hospital or Skilled Nursing Facility;
- determining alternative care options; and
- assisting in obtaining any Medically Necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan. If the patient and the Case Manager agree that the alternate benefit is beneficial to the patient, and the Plan concurs, the Plan will cover the alternative benefit subject to satisfaction of applicable Deductibles, Co-payments, Coinsurance and the Out-of-Pocket Maximum.

The case manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan Administrator, Attending Physician, patient and patient's family must all agree to the alternate treatment plan.

Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

Cost Management Services – Options B and C -PPO

Cost Management Services Phone Number: Please call Benefit Management Administrators at 1-210-697-9900 in San Antonio, Texas, and 1-800-934-6302 for outside of San Antonio, Texas.

The patient or family member must call this number to receive certification of certain Cost Management Services. This call must be made at least 7 days in advance of non-emergency services being rendered or within 48 hours after an emergency.

Any reduced reimbursement or failure to pre-certify penalty due to failure to follow cost management procedures will not accrue toward the out-of-pocket maximum.

UTILIZATION REVIEW

Utilization review is a program designed to help insure that all Covered Persons receive Medically Necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

- (a) Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:
 - Hospitalizations
 - Substance Abuse/Mental Disorder treatments
 - Skilled Nursing Facility stays
 - Home Health Care
 - Hospice Care
 - Transplant Evaluations/surgery
 - Outpatient surgery
- (b) Retrospective review of the Medical Necessity of the services provided on an emergency basis;
- (c) Concurrent review, based upon the admitting diagnosis, of the services requested by the Attending Physician; and
- (d) Certification of services and planning for discharge from a Medical Care Facility or cessation of medical treatment.

The purpose of the program is to determine what charges may be eligible for payment by the Plan. This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the Attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that either the Plan will not pay for the charges, the Plan will impose a failure to pre-certify a penalty or the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan. The patient is urged to find out why there is a discrepancy between what was requested and what was certified before incurring charges.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Pre-certification. Before a Covered Person enters a Medical Care Facility on a non-emergency basis or receives other medical services, the utilization review administrator will, in conjunction with the Attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a Medical Care Facility is one that must be scheduled in advance.

The utilization review program is set in motion by a telephone call from the Covered Person. Contact the utilization review administrator at the telephone number on your ID card **at least 7 days before** non-emergency services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the covered Employee
- The name, Social Security number and address of the covered Employee
- The name of the Employer
- The name and telephone number of the Attending Physician

- The name of the Medical Care Facility, proposed date of admission, and proposed length of stay
- The diagnosis and/or type of surgery
- The proposed rendering of listed medical services

If there is an **emergency** admission to the Medical Care Facility, the patient, patient's family member, Medical Care Facility or Attending Physician must contact the utilization review administrator **within 48 hours** following the first business day after the admission.

The utilization review administrator will determine the number of days of Medical Care Facility confinement or use of other medical services authorized for payment. **Failure to follow this procedure may reduce reimbursement received from the Plan.**

If the Covered Person does not receive authorization as explained in this section, the benefit payment will be reduced by \$250 if a Network Provider is used and \$500 if a Non-Network Provider is used

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a Medical Care Facility are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Medical Care Facility stay or use of other medical services and coordinate with the Attending Physician, Medical Care Facilities and Covered Person either the scheduled release or an extension of the Medical Care Facility stay or extension or cessation of the use of other medical services.

If the Attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the Medical Care Facility for a greater length of time than has been pre-certified, the Attending Physician must request approval of the additional services or days.

The Utilization Review Organization ("URO") is designated by the Plan Administrator to assist you in receiving the proper care and treatment for your Injury or Illness. When you are in an accident or diagnosed with an Illness, you are encouraged to contact the URO within 24 hours. The URO will provide you the names and addresses of qualified providers, information regarding your condition, and assist you in your treatment plan. In order for the URO to properly assist you, the URO may need access to your medical records and claims data. By participating in the Plan or requesting benefits under this Plan, the disclosure of your medical records/claims information to the URO for Case Management purposes is permitted as a permitted disclosure under HIPAA.

PLAN EXCLUSIONS

The exclusions apply to Option A, Option B, and Option C unless otherwise explicitly noted.

Note: All exclusions related to Prescription Drugs are shown in the Prescription Drug Plan.

For all Medical Benefits shown in the Schedule of Benefits, a charge for the following is not covered:

- (1) **Abortion.** Services, supplies, care or treatment in connection with an abortion unless the life of the mother is endangered by the continued Pregnancy or the Pregnancy is the result of rape or incest.
- (2) **Acupuncture or Acupressure.** Services or supplies in connection with acupuncture or acupressure.
- (3) **Alcohol.** Services, supplies, care or treatment to a Covered Person for an Injury or Sickness that occurred while the Covered Person illegally used alcohol. The arresting officer's determination of inebriation based on field sobriety tests or breath analysis, or a blood alcohol content in excess of the applicable legal limit will be sufficient for this exclusion to apply. Expenses will be covered for injured Covered Persons other than the person illegally using alcohol, and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (4) **Behavioral modification.** Services, supplies, care or treatment for behavioral modification, communication delays, conduct problems, education therapy, developmental delays, autism, special education, counseling, therapy or training.
- (5) **Breast Reduction surgery.** Any charges Incurred in connection with surgery for breast reduction whether or not it is deemed to be medically necessary.
- (6) **Chelation or Metallic ion therapy.** Services or supplies in connection with chelation or metallic ion therapy except for treatment of acute metal poisoning.
- (7) **Chiropractic or Spinal Manipulation.** Any charges Incurred for chiropractic services or spinal manipulation services.
 - (8) **Circumcision.** Any charge for services or supplies in connection with a circumcision, unless services are for a child under the age of two or Medically Necessary as determined by the Plan.
- (8) **Complications of or from non-covered treatments.** Care, services or treatment required as a result of complications from a treatment that was not a Covered Charge under the Plan are not covered.
- (9) **Cosmetic Surgery or Treatment.** Charges Incurred in connection with the care or treatment of, or operations which are performed for Cosmetic purposes of any kind including treatment or surgery for complications or correction of cosmetic surgery or treatment, except: (a) to correct a congenital anomaly in a child born, adopted or placed for adoption and which is covered as a Dependent and to whom no pre-existing condition exclusion or limit applies; (b) for reconstructive breast surgery following a mastectomy; (c) or from Injuries sustained in an accident.
- (10) **Custodial care.** Services or supplies provided mainly as a rest care maintenance or Custodial Care.
- (11) **Dental care.** A charge for any medical care in connection with dental treatment unless such cure is:
 - (a) required for repair or replacement of sound natural teeth damaged by an Injury; or
 - (b) in connection with congenital defects malformations or abnormalities present at birth.

- (12) **Educational or vocational testing.** Services for educational or vocational testing or training.
- (13) **Employment or insurance testing.** A charge Incurred for an employment or insurance purpose.
- (14) **Excess charges.** The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Reasonable and Customary Charge.
- (15) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (16) **Experimental or not Medically Necessary.** Care and treatment that is Experimental and/or Investigational or not Medically Necessary.
- (17) **Eye care.** Radial keratotomy, LASIK or other eye surgery to correct refractive disorders. Also included are orthoptic, keratimileusis, and keratophakai.

Under Plan B, routine eye examinations, including refractions, lenses for the eyes and exams for their fitting. This exclusion does not apply to aphakic patients and soft lenses or sclera shells intended for use as corneal bandages or as may be covered under the well adult or well child sections of this Plan.

- (18) **Eye exercises (vision therapy).** Services or supplies in connection with eye exercises for correcting faulty eye coordination (orthoptics).
- (19) **Foot care.** Treatment of weak, strained, flat, unstable or unbalanced feet, metatarsalgia or bunions (except open cutting operations), and treatment of corns, calluses or toenails (unless needed in treatment of a metabolic or peripheral-vascular disease).
- (20) **Foreign travel.** Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services.
- (21) **Gene manipulation therapy.** Services or supplies in connection with gene manipulation therapy.
- (22) **Generally accepted standards of medical practice.** A charge for services or supplies that do not meet generally accepted standards of medical practice.
- (23) **Genetic testing.** Counseling or treatment except in connection with an existing Pregnancy.
- (24) **Government coverage.** Routine care, treatment or supplies furnished by a program or agency funded by any government. This does not apply to Medicaid or when otherwise prohibited by law.
- (25) **Hair loss.** Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth whether or not prescribed by a Physician. However, coverage will be provided for an initial evaluation and diagnosis of hair loss for a possible medical condition.
- (26) **Hair Loss Treatment.** Medication or drugs used for the treatment of alopecia.
- (27) **Hearing aids and exams.** Charges for services or supplies in connection with hearing aids or exams for their fitting, except as may be covered under the well adult or well child sections of this Plan. Charges for hearing disorders including cochlear implants.
- (28) **Holistic and naturopathic medicines.** Services or supplies in connection with holistic or naturopathic treatment.

- (29) **Hospital employees.** Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (30) **Hypnotherapy, sleep therapy (unless sleep apnea or narcolepsy is the diagnosis) and similar programs.**
- (31) **Illegal acts.** Charges for services received as a result of Injury or Sickness that occurred while the Covered Person was engaging in an illegal act or occupation, committing or attempting to commit any crime, criminal act, assault or other felonious behavior or participating in a riot or public disturbance. This exclusion does not apply if the Injury or Sickness resulted from an act of domestic violence or a medical (including both physical and mental health) condition. This exclusion applies even if the individual is not charged, convicted, or arrested if the Plan Administrator obtains knowledge of facts that could give rise to a charge for an illegal act or occupation or that the individual attempted to commit or committed any crime, criminal act, assault, or other felonious behavior or participated in a riot or public disturbance.
- (32) **Illegal drugs or medications.** Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (33) **Impotence.** Care, treatment, services, supplies or medication in connection with treatment for impotence, erectile dysfunctions, sexual dysfunctions or inadequacies. This exclusion includes care, treatment, supplies, medications, implants and devices, whether or not Medically Necessary or following surgery.
- (34) **Infertility.** In vitro fertilization
- (35) **Late Filed Claims.** Any claim for any medical care, service or supply that is received by the Plan's Claim Administrator more than twelve (12) months from the date on which the service(s) were rendered or Incurred or the supplies or equipment were provided; except that any claim by the Center for Medicare and Medicaid Services, the Department of Health and Human Services or one of their contractors under the Medicare Secondary Payer statute must be submitted within three (3) years of the date on which the claim was Incurred.
- (36) **Marriage or Family counseling.** Services or supplies in connection with marriage or family counseling.
- (37) **Massage therapy or rolfing.** Services or supplies in connection with massage therapy or rolfing.
- (38) **Military duty.** A charge Incurred while the Covered Person was on active military duty.
- (39) **More than one OB/GYN annual exam visit per year.** Routine gynecological exams in excess of one (1) per twelve (12) month period unless ordered by a Covered Person's physician.
- (40) **Motorized wheelchairs and beds.** A charge for a motorized wheelchair or bed or any other Durable Medical Equipment not covered within the limits of the Schedule of Benefits.
- (41) **Nerve or muscle stimulators.** Services or supplies in connection with nerve or muscle stimulators. This includes electronic brain stimulators for the diagnosis of Parkinson's disease, dorsal column stimulators, and implantable pain pumps.

- (42) **No charge.** Care and treatment for which there would not have been a charge if no coverage had been in force.
- (43) **No obligation to pay.** Charges Incurred for which the Plan has no legal obligation to pay.
- (44) **No Physician recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. "Regular care" means on-going medical supervision or treatment that is appropriate care for the Injury or Sickness.
- (45) **Not specified as covered.** Non-traditional medical services, treatments and supplies which are not specified as covered under this Plan. Any treatment, service or supply not described as covered under this Plan.
- (46) **Obesity.** Weight reduction surgery and surgery alternatives for treatment of Obesity or Morbid Obesity whether or not it is, in any case, a part of the treatment plan for another sickness which may be helped by weight reduction. Weight loss or dietary control programs are not covered.
- (47) **Occupational.** Care and treatment of an Injury or Sickness that is occupational – that is, arises from work for wage or profit including self-employment, for which the Covered Person is entitled to benefits under any worker's compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation or policy, whether or not such policy is actually in force.
- (48) **Orthodontics.** Dental and oral surgical procedures and orthodontic care of the teeth, periodontal disease, and preparing the mouth for fitting of or continued use of dentures.
- (49) **Orthotics.** Charges in connection with orthotics, unless determined to be medically necessary for diabetic foot disease with neuropathy.
- (50) **Orthognathic Surgery.** All orthognathic surgical procedures.
- (51) **Outpatient Disposable or Consumable Medical Supplies, Food or Nutritional Supplements.** Charges for outpatient disposable or consumable medical supplies, food or nutritional supplements.
- (52) **Outside U.S.** A charge Incurred outside the United States when the Covered Person traveled to the location for the purpose of obtaining drugs, services or supplies.
- (53) **Personal comfort items.** Personal comfort items or other equipment, such as, but not limited to, air conditioners, air-purification units, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-Prescription Drugs and medicines, and first-aid supplies and non-hospital adjustable beds.
- (54) **Plan design exclusions.** Charges excluded by the Plan design as set forth in this document, such as Pre-existing Conditions during the Pre-existing Condition Exclusion period that applies to the Covered Person.
- (55) **Pregnancy of daughter.** Care and treatment of Pregnancy and complications of Pregnancy for a dependent daughter.
- (56) **Private Duty Nursing.** A charge for private duty nursing.
- (57) **Psychological Testing.** Charges for psychological testing including I.Q. testing

- (58) **Psychosurgery.** Charges for psychosurgery.
- (59) **Relative giving services.** Professional services performed or authorized by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person as a Spouse, parent, child, brother or sister, whether the relationship is by blood or exists in law.
- (60) **Replacement braces.** Replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional.
- (61) **Reversal of Sterilization.** Charges resulting from or in connection with the reversal of a sterilization procedure or any form of contraceptive, unless specified in the Schedule of Benefits.
- (62) **Riot or Insurrection.** Any charge Incurred as the result of participation in a riot or insurrection.
- (63) **Routine care.** Charges for routine or periodic examinations, screening examinations, evaluation procedures, preventive medical care, or treatment or services not directly related to the diagnosis or treatment of a specific Injury, Sickness or Pregnancy-related condition which is known or reasonably suspected, unless such care is specifically covered in the Schedule of Benefits.
- (64) **Self-Inflicted.** Any loss due to an intentionally self-inflicted Injury. This exclusion does not apply if the Injury resulted from an act of domestic violence or a medical (including both physical and mental health) condition.
- (65) **Services before or after coverage.** Care, treatment or supplies for which a charge was Incurred before a person was Covered under this Plan or after coverage ceased under this Plan.
- (66) **Sex changes.** Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
- (67) **Sexual Dysfunction.** Any medicine or treatment for or related to sexual dysfunction.
- (68) **Sleep disorders.** Care and treatment for sleep disorders unless deemed Medically Necessary.
- (69) **Smoking cessation.** Care and treatment for smoking cessation programs, including smoking deterrent patches, unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.
- (70) **Surgical sterilization reversal.** Care and treatment for reversal of surgical sterilization.
- (71) **Surrogate parenting.** Care, supplies, services and treatment for surrogate parenting.
- (72) **Temporomandibular Joint Syndrome.** All diagnostic and treatment services related to the treatment of jaw joint problems including temporomandibular joint (TMJ) syndrome.
- (73) **Travel or accommodations.** Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.
- (74) **War.** Any loss that is due to a declared or undeclared act of war including police actions; provided, however, that this exclusion shall not apply to any Covered Person who is not a member of the armed forces.

CERTAIN CLAIMS INFORMATION

HOW TO SUBMIT A CLAIM FOR A BENEFIT UNDER OPTION A, OPTION B, OR OPTION C

When a Covered Person has a claim to submit for payment, that person must:

- (1) Obtain a claim form from the Benefits Department.
- (2) Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED.
- (3) Have the Physician complete the provider's portion of the form.
- (4) For Plan reimbursements, attach bills for services rendered. ALL BILLS MUST SHOW:
 - Name of Plan
 - Employee's name
 - Name of patient
 - Name, address, telephone number of the provider of care
 - Diagnosis
 - Type of services rendered, with diagnosis and/or procedure codes
 - Date of services
 - Charges
- (5) Send the above to the Claims Administrator at this address:

Benefit Management Administrators, Inc.
11550 IH 10 West, Suite 220
San Antonio, Texas 78230
210-697-9900
800-934-6302

All claims and questions regarding health claims should be directed to the Claims Administrator. The Plan Administrator shall be ultimately and finally responsible for adjudicating such claims and for providing full and fair review of the decision on such claims in accordance with the following provisions and with ERISA. Benefits under the Plan will be paid only if the Plan Administrator decides in its discretion that the Covered Person is entitled to them. The responsibility to process claims in accordance with the Plan may be delegated to the Third Party Administrator; provided, however, that the Third Party Administrator is not a fiduciary of the Plan and does not have the authority to make decisions involving the use of discretion.

Each Covered Person claiming benefits under the Plan shall be responsible for supplying, at such times and in such manner as the Plan Administrator in its sole discretion may require, written proof that the expenses were Incurred or that the benefit is covered under the Plan. If the Plan Administrator in its sole discretion shall determine that the Covered Person has not Incurred a covered expense or that the benefit is not covered under the Plan, or if the Covered Person shall fail to furnish such proof as is requested, no benefits shall be payable under the Plan.

A call from a provider who wants to know if an individual is covered under the Plan, or if a certain procedure is covered by the Plan, prior to providing treatment is not a "claim," since an actual claim for benefits is not being filed with the Plan. These are simply requests for information, and any response is not a guarantee of benefits, since payment of benefits is subject to all Plan provisions, limitations and exclusions. Once treatment is rendered, a claim

must be filed with the Plan (which will be a "Post-service Claim"). At that time, a determination will be made as to what benefits are payable under the Plan.

According to Federal regulations that apply to the Plan, there are four types of claims: Pre-service (Urgent and Non-urgent), Concurrent Care and Post-service. However, as noted below, because of this Plan's design, there are no Pre-service Urgent Care Claims that may be filed with the Plan.

1. Pre-service Claims. A "Pre-service Claim" is a claim for a benefit under the Plan where the Plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care. However, if the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no "Pre-service Claim." The Covered Person simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

A "Pre-service Urgent Care Claim" is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person or the Covered Person's ability to regain maximum function, or, in the opinion of a physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

It is important to remember that, if a Covered Person needs medical care for a condition that could seriously jeopardize his life there is no need to contact the Plan for prior approval. The Covered Person should obtain such care without delay.

The Plan does not require the Covered Person to obtain approval of any urgent care or emergency medical services or admissions prior to getting treatment for an urgent care or emergency situation, so there are no "Pre-service Urgent Care Claims" under the Plan. The Covered Person simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

Pre-admission certification of a non-emergency Hospital admission is a "claim" only to the extent of the determination made – that the type of procedure or condition warrants Inpatient confinement for a certain number of days, or if pre-certification is required by the Plan and there is any reduction in the benefit as the result of failure to pre-certify. The rules regarding Pre-service Claims will apply to that determination only. Once a Covered Person has the treatment in question, the claim for benefits relating to that treatment will be treated as a Post-service Claim.

2. Concurrent Claims. A "Concurrent Claim" arises when the Plan has approved an on-going course of treatment to be provided over a period of time or number of treatments, and either:
 - a. The Plan determines that the course of treatment should be reduced or terminated; or
 - b. The Covered Person requests extension of the course of treatment beyond that which the Plan has approved.

If the Plan does not require the Covered Person to obtain approval of a medical service prior to getting treatment, then there is no need to contact the Plan Administrator to request an extension of a course of treatment. The Covered Person simply follows the Plan's procedures with respect to any notice that may be required after receipt of treatment, and files the claim as a Post-service Claim.

3. Post-service Claims. A "Post-service Claim" is a claim for a benefit under the Plan after the services have been rendered.

WHEN HEALTH CLAIMS MUST BE FILED

Health claims must be filed with the Claims Administrator within 90 days of the date charges for the service were Incurred. Benefits are based upon the Plan's provisions at the time the charges were Incurred. If a pharmacy refuses to fill a prescription, a claim must be filed with the Plan. A pharmacy's refusal to fill a prescription is not a claim denial and a request to fill a prescription to a pharmacy or mail order pharmacy is not a claim. **Claims filed later than that date shall be denied, unless it was not reasonably possible to submit the claim in that time and the claim is submitted within one year from the date the claim was Incurred.** This one-year time period will not apply when the Covered Person is not legally capable of submitting the claim. The 90 day and one year limits shall not apply to any claim for benefits by the Department of Health and Human Services, or one of its agencies or contractors, under the Medicare Secondary Payer statute, instead such claims must be filed within three (3) years of the date on which they were Incurred.

A Pre-service Claim (including a Concurrent Claim that also is a Pre-service Claim) is considered to be filed when the request for approval of treatment or services is made and received by the Claims Administrator in accordance with the Plan's procedures. However, a Post-service Claim is considered to be filed when the following information is received by the Claims Administrator, the claim is filed in either the standard electronic transaction format or in a paper claim, together with a Form HCFA or Form UB92:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges, which reflect any applicable PPO repricing;
6. The name of the Plan;
7. The name of the covered employee; and
8. The name of the patient.

Upon receipt of this information, the claim will be deemed to be filed with the Plan. The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested as provided herein. The Claims Administrator must receive this additional information within 45 days from receipt by the Covered Person of the request for additional information. **Failure to do so may result in claims being declined or reduced.**

Timing of Claim Decisions

The Plan Administrator shall notify the Covered Person, in accordance with the provisions set forth below, of any adverse benefit determination (and, in the case of Pre-service Claims and Concurrent Claims, of decisions that a claim is payable in full) within the following timeframes:

1. Pre-service Non-urgent Care Claims:
 - a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - b. If the Covered Person has not provided all of the information needed to process the claim, then the Covered Person will be notified as to what specific information is needed as soon as possible, but not later than 5 days after receipt of the claim. The Covered Person will be notified of a determination of benefits in a reasonable period of time appropriate to the medical circumstances, either prior to the end of the extension period (if additional information was requested during the initial processing period), or by the date agreed to by the Plan Administrator and the Covered Person (if additional information was requested during the extension period).

2. Concurrent Claims:
 - a. Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Covered Person of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Covered Person will be notified sufficiently in advance of the reduction or termination to allow the Covered Person to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
 - b. Request by Covered Person Involving Non-urgent Care. If the Plan Administrator receives a request from the Covered Person to extend the course of treatment beyond the period of time or number of treatments that is a claim not involving Urgent Care, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim (either as a Pre-service Non-urgent Claim or a Post-service Claim).
3. Post-service Claims:
 - a. If the Covered Person has provided all of the information needed to process the claim, in a reasonable period of time, but not later than 30 days after receipt of the claim, unless an extension has been requested, then prior to the end of the 15-day extension period.
 - b. If the Covered Person has not provided all of the information needed to process the claim and additional information is requested during the initial processing period, then the Covered Person will be notified of a determination of benefits prior to the end of the extension period, unless additional information is requested during the extension period, then the Covered Person will be notified of the determination by a date agreed to by the Plan Administrator and the Covered Person.
4. Extensions – Pre-service Non-urgent Care Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 15-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
5. Extensions – Post-service Claims. This period may be extended by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the Covered Person, prior to the expiration of the initial 30-day processing period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.
6. Calculating Time Periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is deemed to be filed in accordance with the procedures of the Plan.

NOTIFICATION OF AN ADVERSE BENEFIT NOTIFICATION

The Plan Administrator shall provide a Covered Person with a notice, either in writing or electronically, containing the following information:

1. A reference to the specific portion(s) of the Plan Document and Summary Plan Description upon which a denial is based;
2. Specific reason(s) for a denial;
3. A description of any additional information necessary for the Covered Person to perfect the claim and an explanation of why such information is necessary;
4. A description of the Plan's review procedures and the time limits applicable to the procedures, including a statement of the Covered Person's right to bring a civil action under Section 502(a) of ERISA following an adverse benefit determination on final review;

5. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Covered Person's claim for benefits;
6. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
7. Any rule, guideline, protocol or similar criterion that was relied upon in making the determination (or a statement that it was relied upon and that a copy will be provided to the Covered Person, free of charge, upon request); and
8. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental and/or Investigational), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, or a statement that such explanation will be provided to the Covered Person, free of charge, upon request.

APPEAL OF ADVERSE BENEFIT DETERMINATIONS

Full and Fair Review of All Claims

In cases where a claim for benefits is denied, in whole or in part, and the Covered Person believes the claim has been denied wrongly, the Covered Person must appeal the denial and review pertinent documents. The claims procedures of this Plan provide a Covered Person with a reasonable opportunity for a full and fair review of a claim and adverse benefit determination. More specifically, the Plan provides:

1. Covered Persons at least 180 days following receipt of a notification of an initial adverse benefit determination within which they must appeal the determination;
2. Covered Persons the opportunity to submit written comments, documents, records, and other information relating to the claim for benefits;
3. For a review that does not afford deference to the previous adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan, who shall be neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
4. For a review that takes into account all comments, documents, records, and other information submitted by the Covered Person relating to the claim, without regard to whether such information was submitted or considered in the prior benefit determination;
5. That, in deciding an appeal of any adverse benefit determination that is based in whole or in part upon a medical judgment, the Plan fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual;
6. For the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, even if the Plan did not rely upon their advice; and
7. That a Covered Person will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits in possession of the Plan Administrator or the Claims Administrator; information regarding any voluntary appeals procedures offered by the Plan; any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination; and an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances.

REQUIREMENTS FOR APPEAL

The Covered Person must file an appeal of a claim in writing within 180 days following receipt of the notice of an adverse benefit determination. To file an appeal in writing, the Covered Person's appeal must be addressed as follows:

For Pre-service Claims for the PPO:

Benefit Management Administrators, Inc.
Attention: Claims Appeals
11550 IH 10 West, Suite 220
San Antonio, Texas 78230

For Post-service Claims for the PPO or EPO:

Benefit Management Administrators, Inc.
Attention: Claims Appeals
11550 IH 10 West, Suite 220
San Antonio, Texas 78230

It shall be the responsibility of the Covered Person to submit proof that the claim for benefits is covered and payable under the provisions of the Plan. Any appeal must include:

1. The name of the Employee/Covered Person;
2. The Employee/Covered Person's social security number;
3. The group name or identification number;
4. All facts and theories supporting the claim for benefits. **Failure to include any theories or facts in the appeal will result in their being deemed waived. In other words, the Covered Person will lose the right to raise factual arguments and theories which support this claim if the Covered Person fails to include them in the appeal;**
5. A statement in clear and concise terms of the reason or reasons for disagreement with the handling of the claim; and
6. Any material or information that the Covered Person has which indicates that the Covered Person is entitled to benefits under the Plan.

If the Covered Person provides all of the required information, it may be that the expenses will be eligible for payment under the Plan.

Timing of Notification of Benefit Determination on Review

The Plan Administrator shall notify the Covered Person of the Plan's benefit determination on review within the following timeframes:

1. Pre-service Non-urgent Care Claims: Within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt of the appeal.
2. Concurrent Claims: The response will be made in the appropriate time period based upon the type of claim – Pre-service Non-urgent or Post-service.
3. Post-service Claims: Within a reasonable period of time, but not later than 60 days after receipt of the appeal.
4. Calculating Time Periods. The period of time within which the Plan's determination is required to be made shall begin at the time an appeal is filed in accordance with the procedures of this Plan, without regard to whether all information necessary to make the determination accompanies the filing.

Manner and Content of Notification of Adverse Benefit Determination on Review

The Plan Administrator shall provide a Covered Person with notification, in writing or electronically, of a Plan's adverse benefit determination on review, setting forth:

1. The specific reason or reasons for the denial;
2. Reference to the specific portion(s) of the Plan Document and Summary Plan Description on which the denial is based;

3. The identity of any medical or vocational experts consulted in connection with the claim, even if the Plan did not rely upon their advice;
4. A statement that the Covered Person is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Covered Person's claim for benefits;
5. If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the Covered Person upon request;
6. If the adverse benefit determination is based upon a medical judgment, a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Covered Person's medical circumstances, will be provided free of charge upon request;
7. A statement of the Covered Person's right to bring an action under section 502(a) of ERISA, following an adverse benefit determination on final review; and
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

Furnishing Documents in the Event of an Adverse Determination

In the case of an adverse benefit determination on review, the Plan Administrator shall provide such access to, and copies of, documents, records, and other information described in items 3 through 6 of the section relating to "Manner and Content of Notification of Adverse Benefit Determination on Review" as appropriate.

Decision on Review to be Final

If, for any reason, the Covered Person does not receive a written response to the appeal within the appropriate time period set forth above, the Covered Person may assume that the appeal has been denied. The decision by the Plan Administrator or other appropriate named fiduciary of the Plan on review will be final, binding and conclusive and will be afforded the maximum deference permitted by law. **All claim review and appeal procedures provided for in the Plan must be exhausted before any legal action is brought. Any legal action for the recovery of any benefits must be commenced within two years after the Plan's claim and review procedures have been exhausted and no legal action may be brought until the Plan's claim and review processes have been exhausted. Any action filed in court regarding a denied claims appeal must be filed no later than two years after the claim appeal was denied.**

Any claim alleging a breach of fiduciary duty must be first made through the claim and review process before it can be litigated.

APPOINTMENT OF AUTHORIZED REPRESENTATIVE

A Covered Person is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a Covered Person to a provider will not constitute appointment of that provider as an authorized representative. To appoint such a representative, the Covered Person must complete a form that can be obtained from the Plan Administrator or the Claims Administrator. However, in connection with a claim involving Urgent Care, the Plan will permit a health care professional with knowledge of the Covered Person's medical condition to act as the Covered Person's authorized representative without completion of this form. In the event a Covered Person designates an authorized representative, all future communications from the Plan will be with the representative, rather than the Covered Person, unless the Covered Person directs the Plan Administrator, in writing, to the contrary.

PHYSICAL EXAMINATIONS

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose condition, Sickness or Injury is the basis of a claim. All such examinations shall be at the expense of the Plan. This right may

be exercised when and as often as the Plan may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.

AUTOPSY

The Plan reserves the right to have an autopsy performed upon any deceased Covered Person whose condition, Sickness, or Injury is the basis of a claim. This right may be exercised only where not prohibited by law.

PAYMENT OF BENEFITS

All benefits under this Plan are payable, in U.S. Dollars, to the covered Employee whose Sickness or Injury, or whose covered Dependent's Sickness or Injury, is the basis of a claim. In the event of the death or incapacity of a covered Employee and in the absence of written evidence to this Plan of the qualification of a guardian for his estate, this Plan may, in its sole discretion, make any and all such payments to the individual or institution which, in the opinion of this Plan, is or was providing the care and support of such Employee.

Assignments

Benefits for medical expenses covered under this Plan may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Employee, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits that have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the covered Employee and the assignee, has been received before the proof of loss is submitted.

No Covered Person shall at any time, either during the time in which he is a Covered Person in the Plan, or following his termination as a Covered Person, in any manner, have any right to assign his right to sue to recover benefits under the Plan, to enforce rights due under the Plan or to any other causes of action which he may have against the Plan or its fiduciaries.

Non-U.S. Providers

Medical expenses for care, supplies, or services which are rendered by a provider whose principal place of business or address for payment is located outside the United States (a "Non-U.S. Provider") are payable under the Plan, subject to all Plan exclusions, limitations, maximums and other provisions, under the following conditions:

1. Benefits may not be assigned to a Non-U.S. Provider;
2. The Covered Person is responsible for making all payments to Non-U.S. Providers, and submitting receipts to the Plan for reimbursement;
3. Benefit payments will be determined by the Plan based upon the exchange rate in effect on the Incurred Date;
4. The Non-U.S. Provider shall be subject to, and in compliance with, all U.S. and other applicable licensing requirements; and
5. Claims for benefits must be submitted to the Plan in English.

Plan Assets

No Plan assets shall leave the Plan's trust to pay a Plan benefit until the check written to pay the benefit has been negotiated (cashed). This shall not apply to benefit payments in a form other than a check. Any uncashed Plan check shall be void on the date two years after the date on the check will not be honored after that date. The Plan will not pay unclaimed benefits over to any state merely because the benefits have not been claimed or the check has not been cashed.

RECOVERY OF PAYMENTS

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment that has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. In anticipation of obtaining a recovery in Subrogation if a Covered Person fails to comply with the provisions stated in the "Third Party Recovery, Subrogation and Reimbursement" section; or
6. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational Injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a covered Employee or by any of his covered Dependents if such payment is made with respect to the covered Employee or any person covered or asserting coverage as a Dependent of the covered Employee. The Plan's right of recovery in subrogation shall be prior to and without regard to whether the individual has made a full recovery and shall not be reduced for any expenses Incurred by the individual in obtaining the recovery. The Plan's right of recovery shall not be altered or reduced by any "make whole" doctrine or any similar doctrine.

MEDICAID COVERAGE

A Covered Person's eligibility for any state Medicaid benefits will not be taken into account in determining or making any payments for benefits to or on behalf of such Covered Person. Any such benefit payments will be subject to the state's right to reimbursement for benefits it has paid on behalf of the Covered Person, as required by the state Medicaid program; and the Plan will honor any Subrogation rights the state may have with respect to benefits which are payable under the Plan.

COORDINATION OF BENEFITS

This applies to Option A, Option B, or Option C.

Coordination of the benefit plans. Coordination of benefits sets out rules for the order of payment of Covered Charges when two or more plans -- including Medicare -- are paying. When a Covered Person is covered by this Plan and another plan, or the Covered Person's Spouse is covered by this Plan and by another plan or the couple's covered Children are covered under two or more plans, the plans will coordinate benefits when a claim is received.

The plan that pays first according to the rules will pay as if there were no other plan involved. The secondary and subsequent plans may pay the balance due up to 100% of the total allowable expenses, depending upon the provisions of the plans paying secondary. When this Plan pays secondary, it will only pay a benefit if the primary plan paid a benefit which is less than the benefit provided under this Plan and it will only pay an amount that when added to the benefit provided under the first plan will equal the benefit this Plan would have paid if it were the primary plan.

Benefit plan. This provision will coordinate the medical benefits of a benefit plan. The term "benefit plan" means this Plan or any one of the following plans:

- (1) Group or group-type plans, including franchise or blanket benefit plans.
- (2) Blue Cross and Blue Shield group plans.
- (3) Group practice and other group prepayment plans.
- (4) Any coverage under labor-management trustee plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans.
- (5) Any government plans or programs. This includes Medicare and U.S. military coverage, including Tri-Care.
- (6) Other plans required or provided by law. This does not include Medicaid or any benefit plan like it that, by its terms, does not allow coordination.
- (7) Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of injuries arising out of a motor vehicle accident, and any other medical and liability benefits received under any automobile policy.

The term "benefit plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

Allowable charge. For a charge to be allowable it must be a Reasonable and Customary Charge and at least part of it must be covered under this Plan. Benefits payable under any other benefit plan include the benefits that would have been payable had claim been duly made therefore.

In the case of the EPO or other in-network-only plans: This Plan will not consider any charges in excess of what an EPO or network provider has agreed to accept as payment in full. Also, when an EPO or network plan is primary and the Covered Person does not use an EPO or network provider, this Plan will not consider as an allowable charge any charge that would have been covered by the EPO or network plan had the Covered Person used the services of an EPO or network provider.

In the case of service-type plans where services are provided as benefits, the reasonable cash value of each service will be the allowable charge.

Automobile limitations. When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. This Plan shall always be considered the secondary carrier regardless of the individual's election under PIP (personal injury protection) coverage with the auto carrier.

Benefit plan payment order. When two or more benefit plans provide benefits for the same allowable charge, benefit payment will follow these rules:

- (1) Benefit plans that do not have a coordination provision, or one like it, will pay first. Benefit plans with such a provision will be considered after those without one.
- (2) Benefit plans with a coordination provision will pay their benefits up to the allowable charge:
 - (a) The benefits of the benefit plan which covers the person directly (that is, as an employee, member or subscriber) ("Plan A") are determined before those of the benefit plan which covers the person as a dependent ("Plan B").
 - (b) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired are determined before those of a benefit plan which covers that person as a laid-off or retired employee. The benefits of a benefit plan which covers a person as a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers a person as a dependent of a laid off or retired employee. If the other benefit plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule does not apply.
 - (c) The benefits of a benefit plan which covers a person as an employee who is neither laid off nor retired or a dependent of an employee who is neither laid off nor retired are determined before those of a benefit plan which covers the person as a COBRA beneficiary.
 - (d) When a child is covered as a dependent and the parents are not separated or divorced, these rules will apply:
 - (i) The benefits of the benefit plan of the parent whose birthday falls earlier in a year are determined before those of the benefit plan of the parent whose birthday falls later in that year;
 - (ii) If both parents have the same birthday, the benefits of the benefit plan that has covered the patient for the longer time are determined before those of the benefit plan which covers the other parent.
 - (e) When a child's parents are divorced or legally separated, these rules will apply:
 - (i) This rule applies when the parent with custody of the child has not remarried. The benefit plan of the parent with custody will be considered before the benefit plan of the parent without custody.
 - (ii) This rule applies when the parent with custody of the child has remarried. The benefit plan of the parent with custody will be considered first. The benefit plan of the stepparent that covers the child as a dependent will be considered next. The benefit plan of the parent without custody will be considered last.
 - (iii) This rule will be in place of items (i) and (ii) above when it applies. A court decree may state which parent is financially responsible for medical and dental benefits of the child. In this case, the benefit plan of that parent will be considered before other plans that cover the child as a dependent.

- (iv) If the specific terms of the court decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the child, the plans covering the child shall follow the order of benefit determination rules outlined above when a child is covered as a dependent and the parents are not separated or divorced.
- (v) For parents who were never married to each other, the rules apply as set out above as long as paternity has been established.
- (f) If there is still a conflict after these rules have been applied, the benefit plan which has covered the patient for the longer time will be considered first. When there is a conflict in coordination of benefit rules, the plan will never pay more than 50% of allowable charges when paying secondary.
- (3) Medicare will pay primary, secondary or last to the extent stated in federal law. When Medicare is to be the primary payer, this Plan will base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of these parts.
- (4) If a Covered Person is under a disability extension from a previous benefit plan, that benefit plan will pay first and this Plan will pay second.

Claims determination period. Benefits will be coordinated on a Calendar Year basis. This is called the "claims determination period."

Right to receive or release necessary information. To make this provision work, this Plan may give or obtain needed information from another insurer or any other organization or person. This information may be given or obtained without the consent of or notice to any other person. A Covered Person will give this Plan the information it asks for about other plans and their payment of allowable charges.

Facility of payment. This Plan may repay other plans for benefits paid that the Plan Administrator determines it should have paid. That repayment will count as a valid payment under this Plan.

Right of recovery. This Plan may pay benefits that should be paid by another benefit plan. In this case, this Plan may recover the amount paid from the other benefit plan or the Covered Person. That repayment will count as a valid payment under the other benefit plan.

Further, this Plan may pay benefits that are later found to be greater than the allowable charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid.

THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT

This applies to Option A, Option B, or Option C.

Benefits Subject to This Provision

This provision shall apply to all benefits provided under any section of this Plan.

When This Provision Applies

A Covered Person may incur medical or other charges related to Injuries or Illness caused by the act or omission of another person; or Another Party may be liable or legally responsible for payment of charges Incurred in connection with the Injuries or Illness (the "Claim"). If so, the Covered Person may have a claim against that other person or Another Party for payment of the medical or other charges. In that event, the Plan will be secondary, not primary, and the Plan will be Subrogated to all rights the Covered Person may have against that other person or Another Party and will be entitled to Reimbursement. In addition, the Plan shall have the first lien against any Recovery to the extent of benefits paid or to be paid and expenses Incurred by the Plan in enforcing this provision. The Plan's first lien supercedes any right that the Covered Person may have to be "made whole." In other words, the Plan is entitled to the right of first Reimbursement out of any Recovery the Covered Person procures or may be entitled to procure regardless of whether the Covered Person has received compensation for any of his damages or expenses, including any of his attorneys' fees or costs. Additionally, the Plan's right of first Reimbursement will not be reduced for any reason, including attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise. As a condition to receiving benefits under the Plan, the Covered Person agrees that acceptance of benefits is constructive notice of this provision.

The Covered Person must:

1. Execute and deliver a Subrogation and Reimbursement Agreement;
2. Authorize the Plan to sue, compromise and settle in the Covered Person's name to the extent of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and the expenses Incurred by the Plan in collecting this amount, and assign to the Plan the Covered Person's rights to Recovery when this provision applies;
3. Immediately Reimburse the Plan, out of any Recovery made from Another Party, 100% of the amount of medical or other benefits paid for the Injuries or Illness under the Plan and expenses (including attorneys' fees and costs of suit, regardless of an action's outcome) Incurred by the Plan in collecting this amount (without reduction for attorneys' fees, costs, comparative negligence, limits of collectibility or responsibility, or otherwise);
4. 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
5. Cooperate fully with the Plan in its exercise of its rights under this provision, do nothing that would interfere with or diminish those rights and furnish any information required by the Plan: and
6. Hold any amount recovered from Another Party in a constructive trust for the benefit of the Plan until any issues related to the amount over to the Plan are resolved.

When a right of recovery exists, and as a condition to any payment by the Plan (including payment of future benefits for other Illnesses or Injuries), the Covered Person will execute and deliver all required instruments and papers, including a Subrogation and Reimbursement 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 Injuries or Illness. Any amounts recovered by the Covered Person related to the Claim shall be held by the Covered Person in a constructive trust for the benefit of the

Plan. This Plan may require the Covered Person to hold the proceeds in a segregated account. If the Plan pays any medical or other benefits for the Injuries or Illness before these papers are signed and things are done, the Plan still will be entitled to Subrogation and Reimbursement. In addition, the Covered Person will do nothing to prejudice the Plan's right to Subrogation and Reimbursement and acknowledges that the Plan precludes operation of the made-whole and common-fund doctrines.

The Plan Administrator has maximum discretion to interpret the terms of this provision and to make changes as it deems necessary.

Amount Subject to Subrogation or Reimbursement

Any amounts recovered will be subject to Subrogation or Reimbursement. In no case will the amount subject to Subrogation or Reimbursement exceed the amount of medical or other benefits paid for the Injuries 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 collectibility or responsibility, or otherwise, even if the Covered Person does not receive full compensation for all of his charges and expenses.

"Another Party"

"Another Party" shall mean any individual or organization, other than the Plan, who is liable or legally responsible to pay expenses, compensation or damages in connection with a Covered Person's Injuries or Illness.

"Another Party" shall include the party or parties who caused the Injuries or Illness; the insurer, guarantor or other indemnifier of the party or parties who caused the Injuries or Illness; a Covered Person's own insurer, such as uninsured, underinsured, medical payments, no-fault, homeowner's, renter's or any other liability insurer; a workers' compensation insurer; and any other individual or organization that is liable or legally responsible for payment in connection with the Injuries or Illness.

"Recovery"

"Recovery" shall mean any and all monies paid to the Covered Person by way of judgment, settlement or otherwise (no matter how those monies may be characterized, designated or allocated) to compensate for any losses caused by, or in connection with, the Injuries or Illness. Any Recovery shall be deemed to apply, first, for Reimbursement.

"Subrogation"

"Subrogation" shall mean the Plan's right to pursue the Covered Person's claims for medical or other charges paid by the Plan against Another Party.

"Reimbursement"

"Reimbursement" shall mean repayment to the Plan for medical or other benefits that it has paid toward care and treatment of the Injury or Illness and for the expenses Incurred by the Plan in collecting this benefit amount.

When a Covered Person Retains an Attorney

If the Covered Person retains an attorney, that attorney must sign the Subrogation and Reimbursement Agreement as a condition to any payment of benefits and as a condition to any payment of future benefits for other Illnesses or Injuries. Additionally, the Covered Person's attorney must recognize and consent to the fact that the Plan precludes the operation of the "made-whole" and "common fund" doctrines, and the attorney must agree not to assert either doctrine in his pursuit of Recovery. The Plan will neither pay the Covered Person's attorneys' fees and costs associated with the recovery of funds, nor reduce its reimbursement pro rata for the payment of the Covered Person's attorneys' fees and costs. Attorneys' fees will be payable from the Recovery only after the Plan has received full Reimbursement.

A Covered Person or his attorney who receives any Recovery (whether by judgment, settlement, compromise, or otherwise) has an absolute obligation to immediately tender the Recovery to the Plan under the terms of this provision. A Covered Person or his 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 the Covered

Person or his attorney is not the rightful owner of the Recovery and should not be in possession of the Recovery until the Plan has been fully reimbursed.

When the Covered Person is a Minor or is Deceased

These provisions apply to the parents, trustee, guardian or other representative of a minor Covered Person and to the heir or personal representative of the estate of a deceased Covered Person, regardless of applicable law and whether or not the minor's representative has access or control of the Recovery.

When a Covered Person Does Not Comply

When a Covered Person does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for 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 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 Covered Person to enforce this provision, then that Covered Person agrees to pay the Plan's attorneys' fees and costs, regardless of the action's outcome.

COBRA CONTINUATION OPTIONS

This applies to Option A, Option B, or Option C.

A federal law, COBRA, requires that most employers sponsoring a group health plan offer employees and their families covered under their health plan the opportunity for a temporary extension of health coverage (called "COBRA continuation coverage") in certain instances where coverage under the plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of the rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator to Plan Participants who become Qualified Beneficiaries under COBRA.

Note: Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 1974. These employees must have made petitions for certification to apply for TAA on or after November 4, 2002. The employees, if they do not already have COBRA coverage, are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any employee who qualifies or may qualify for assistance under this special provision should contact his or her Plan Administrator for further information.

What is COBRA continuation coverage? COBRA continuation coverage is group health plan coverage that an employer must offer to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of one of certain enumerated events that result in the loss of coverage under the terms of the employer's plan (the "Qualifying Event"). The coverage must be identical to the plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who is a Qualified Beneficiary? In general, a Qualified Beneficiary is:

- (i) Any individual who, on the day before a Qualifying Event, is covered under a plan by virtue of being on that day either a covered employee, the spouse of a covered employee, or a dependent child of a covered employee. If, however, an individual is denied or not offered coverage under the plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (ii) Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage. If, however, an individual is denied or not offered coverage under the plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.
- (iii) A covered Employee who retired on or before the date of substantial elimination of plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the employer, as is the spouse, surviving spouse or dependent child of such a covered employee if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse or dependent child was a beneficiary under the plan.

The term "covered employee" includes not only common-law employees (whether part-time or full-time) but also any individual who is provided coverage under the plan due to his or her performance of services for the employer sponsoring the Plan.

An individual is not a Qualified Beneficiary if the individual's status as a covered employee is attributable to a period in which the individual was a nonresident alien who received from the individual's employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a spouse or dependent child of the individual is not considered a Qualified Beneficiary by virtue of the relationship to the individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

What is a Qualifying Event? A Qualifying Event is any of the following if the plan provided that the plan participant would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

- (i) The death of a covered employee.
- (ii) The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment.
- (iii) The divorce or legal separation of a covered employee from the employee's spouse.
- (iv) A covered employee's enrollment in the Medicare program.
- (v) A dependent child's ceasing to satisfy the plan's requirements for a dependent child (for example, attainment of the maximum age for dependency under the plan).
- (vi) 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.

If the Qualifying Event causes the covered employee, or the spouse or a dependent child of the covered employee, to cease to be covered under the plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the employer, any substantial elimination of coverage under the plan occurring within 12 months before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met. Any increase in contribution that must be paid by a covered employee, or the spouse, or a dependent child of the covered employee, for coverage under the plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the FMLA does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that 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.

You must notify WellMed Medical Management's WEHP Benefits Department at 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240, within 31 days of your divorce, your dependent ceasing to satisfy the plan's requirements to be a dependent child or the date you receive notice that you or one of your covered dependents

qualifies as disabled under the Social Security Act by receiving a letter determining you or he/she are disabled from the Social Security Administration.

What is the election period and how long must it last? An election period is the time period within which the Qualified Beneficiary can elect COBRA continuation coverage under the employer's plan. An election of COBRA continuation coverage is a timely election if it is made during the election period, which is 60 days after your coverage, ends or you receive notice of your right to elect COBRA. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends the date that is 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. **You must send your completed election form to the WEHP Benefits Department at WellMed Medical Management at 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240, within 60 days of the date it was postmarked.**

Is a covered employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? In general, the employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

- (i) A dependent child's ceasing to be a dependent child under the generally applicable requirements of the Plan.
- (ii) The divorce or legal separation of the covered employee.

The plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of the date of the Qualifying Event, or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

Is a waiver before the end of the election period effective to end a Qualified Beneficiary's election rights? 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 need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). **Waivers and revocations of waivers are considered made on the date they are sent to Benefit Management Administrators, Inc. (BMA), 11550 IH10 West, Suite 220, San Antonio, TX 78230.**

When may a Qualified Beneficiary's COBRA continuation coverage be terminated? COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

- (i) The last day of the applicable maximum coverage period.
- (ii) The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary.
- (iii) The date upon which the employer ceases to provide any group health plan (including successor plans) to any employee.
- (iv) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

- (v) The date, after the date of the election that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier).
- (vi) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (a) (i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or
 - (b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

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

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

- (i) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension.
- (ii) In the case of a covered employee's enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered employee ends on the later of:
 - (a) 36 months after the date the covered employee becomes enrolled in the Medicare program; or
 - (b) 18 months (or 29 months, if there is a disability extension) after the date of the covered employee's termination of employment or reduction of hours of employment.
- (iii) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered employee ends on the date of the retired covered employee's death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or dependent child of the retired covered employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered employee.
- (iv) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage 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.
- (v) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18- or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event.

How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the **Benefit Management Administrators, Inc. (BMA), 11550 IH10 West, Suite 220, San Antonio, TX 78230.**

with the notice of the disability determination as of the date within 60 days of your original Qualifying Event and within 60 days after the date of the determination (the date on your letter from the Social Security Administration) and before the end of the original 18-month maximum coverage.

Can a plan require payment for COBRA continuation coverage? Yes. For any period of COBRA continuation coverage, a plan can require the payment of an amount that does not exceed 102% of the applicable premium except the plan may require the payment of an amount that does not exceed 150% of the applicable premium for any period of COBRA continuation coverage covering a disabled Qualified Beneficiary that would not be required to be made available in the absence of a disability extension. A group health plan can terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which Timely Payment is not made to the plan with respect to that Qualified Beneficiary.

Must the plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? "Timely Payment" means payment that is made to the plan by the date that is 30 days after the first day of that period. Payment that is made to the plan by a later date is also considered Timely Payment if either under the terms of the plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period, or under the terms of an arrangement between the employer and the entity that provides plan benefits on the employer's behalf, the employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, a plan cannot require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is sent to the plan.

If Timely Payment is made to the plan in an amount that is not significantly less than the amount the plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the plan's requirement for the amount to be paid, unless the plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. A shortfall in a Timely Payment is not significant if it is no greater than the lesser of \$50 or 10% of the required amount.

Must a qualified beneficiary be given the right to enroll in a conversion health plan at the end of the maximum coverage period for COBRA continuation coverage? If a Qualified Beneficiary's COBRA continuation coverage under a group health plan ends as a result of the expiration of the applicable maximum coverage period, the plan must, during the 180-day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the plan. If such a conversion option is not otherwise generally available, it need

not be made available to Qualified Beneficiaries. No conversion option is available under this Plan, under either Option A or Option B.

What are my other obligations?

- (1) In order to protect your family's rights, you should keep the WEHP Benefits Department at WellMed Medical Management, 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240, (210) 617-4705, informed of any changes in the addresses of family members.
- (2) After you pay your initial premiums for coverage since your qualifying event on a timely basis, you must pay your premium for each subsequent month of the coverage on or before the first day of each month.

What if I am absent due to military leave? If you are on COBRA as the result of a military leave protected by the Uniformed Services Employment and Reemployment Rights Act, you will only be required to pay the employee's cost of the premium for the tier of coverage you elect (e.g., if you elected family coverage Option B, you will pay the same premium as an active employee who elected family coverage and Option B) for the first 31 days. If you continue coverage while you are on military leave, you may continue coverage for up to 24 months.

Are there any other special rules related to continuation coverage? If your event that qualified you for COBRA coverage was either a reduction in hours or termination of employment and your employment termination or reduction was due to reduced sales due to increased imports and it was certified by the U.S. Department of Labor so that you are a Trade Adjustment Act eligible individual, then you may be eligible for a second chance to elect COBRA continuation coverage. You are only eligible for the second chance to elect COBRA coverage if all of the events described in this paragraph occurred within six (6) months of your loss of coverage. If you are a TAA eligible individual, you must elect coverage within six (6) months of the date you lost coverage. If you do not elect within six (6) months of the date you lost coverage, you lose the right to elect COBRA coverage as a TAA eligible individual.

RESPONSIBILITIES FOR PLAN ADMINISTRATION

This applies to Option A, Option B, and Option C.

Plan Administrator

The Plan is administered by the Plan Administrator in accordance with the provisions of ERISA. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved, or is removed from the position, the Plan Sponsor shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. The Plan Administrator shall have the authority to delegate any of its duties to another party, including but not limited to construing and interpreting the terms of the Plan and deciding dispute and interpreting the Plan. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to a Covered Person's rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan, or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that the Covered Person is entitled to them.

Duties of the Plan Administrator

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person's rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a third party administrator to pay claims;
9. To perform all necessary reporting as required by ERISA;
10. To establish and communicate procedures to determine whether a medical child support order is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan's administration.

Amending and Terminating the Plan

The Plan Sponsor expects to maintain this Plan indefinitely; however, as the settlor of the Plan, the Plan Sponsor, through its directors and officers, may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust Agreement (if any).

Any such amendment, suspension or termination shall be enacted, if the Plan Sponsor is a corporation, by resolution of the Plan Sponsor's directors and officers, which shall be acted upon as provided in the Plan Sponsor's Articles of Incorporation or Bylaws, as applicable, and in accordance with applicable federal and state law. Notice shall be provided as required by ERISA. In the event that the Plan Sponsor is a different type of entity, then such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents. In the event that the Plan Sponsor is a sole proprietorship, then such action shall be taken by the sole proprietor, in his own discretion.

If the Plan is terminated, the rights of the Covered Persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

This applies to Option A, Option B, Option C.

Clerical Error/Delay

Clerical errors made on the records of the Plan and delays in making entries on such records shall not invalidate coverage nor cause coverage to be in force or to continue in force. Rather, the effective dates of coverage shall be determined solely in accordance with the provisions of this Plan regardless of whether any contributions with respect to Covered Persons have been made or have failed to be made because of such errors or delays. Upon discovery of any such error or delay, an equitable adjustment of any such contributions will be made.

Conformity with Applicable Laws

This Plan shall be deemed to automatically be amended to conform as required by any applicable law, regulation or the order or judgment of a court of competent jurisdiction governing provisions of this Plan, including, but not limited to, stated maximums, exclusions or limitations. In the event that any law, regulation or the order or judgment of a court of competent jurisdiction causes the Plan Administrator to pay claims which are otherwise limited or excluded under this Plan, such payments will be considered as being in accordance with the terms of this Plan Document. It is intended that the Plan will conform to the requirements of ERISA, as it applies to employee welfare plans, as well as any other applicable law.

Fraud

The following actions by any Covered Person, or a Covered Person's knowledge of such actions being taken by another, constitute fraud and will result in immediate termination of all coverage under this Plan for the entire Family Unit of which the Covered Person is a member:

1. Attempting to submit a claim for benefits (which includes attempting to fill a prescription) for a person who is not a Covered Person in the Plan;
2. Attempting to file a claim for a Covered Person for services which were not rendered or drugs or other items which were not provided;
3. Providing false or misleading information in connection with enrollment in the Plan;
4. Providing any false or misleading information to the Plan; or
5. Attempting to enroll or enrolling a person who is not eligible to be a Dependent under the Plan.

Gender

The use of masculine pronouns in this Plan Document and Summary Plan Description shall apply to persons of both sexes unless the context clearly indicates otherwise.

Headings

The headings used in this Plan Document and Summary Plan Description are used for convenience of reference only. Covered Persons are advised not to rely on any provision because of the heading.

Limitation on Actions

No action at law or in equity shall be instituted to recover under this Plan prior to exhaustion of the claim and appeal procedures specified in this Plan. Any action at law or in equity must be filed within 3 years of the date on which the appeal of the individual's claim denial is either denied or deemed denied under the terms of this Plan. Any action with respect to a fiduciary's breach of any responsibility, duty or obligation hereunder must be brought within three years after the alleged injury from the breach occurred or after the expenses due to Injury or Sickness are Incurred or are alleged to have been Incurred. Any limitation on actions regarding claims for benefits shall be as provided in the "Certain Claims Information" section.

No Waiver or Estoppel

No term, condition or provision of this Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of this Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein,

and each such waiver shall operate only as to the specific term or condition waived and shall not constitute a waiver of such term or condition for the future or as to any act other than the one specifically waived.

Right to Receive and Release Information

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or Covered Person for benefits from this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

Written Notice

Any written notice required under this Plan that, as of the effective date, is in conflict with the law of any governmental body or agency that has jurisdiction over this Plan shall be interpreted to conform to the minimum requirements of such law.

Right of Recovery

Whenever payments have been made by this Plan in a total amount, at any time, in excess of the maximum amount of benefits payable under this Plan, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person's legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such amount, and any future benefits payable to the Covered Person or his Dependents.

Plan is not an Employment Contract

The Plan is not to be construed as a contract for or of employment.

CERTAIN PLAN PARTICIPANTS RIGHTS UNDER ERISA

This applies to Option A, Option B, and Option C.

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan Covered Persons are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls (if any), all documents governing the Plan, including insurance contracts, collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Reduction or elimination of exclusionary periods of coverage for Pre-existing Conditions under your group health plan, if you have Creditable Coverage from another plan. You should be provided a certificate of coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-existing Condition exclusion for 12 months after your Enrollment Date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Covered Persons and beneficiaries. No one, including your Employer, your union (if any), or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it

should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administration, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA PRIVACY INFORMATION

Effective as of April 14, 2004

This Notice is effective as of April 14, 2004, and applies to health information received about you by the WellMed Medical Management, Inc. Health Plan (the "Plan"). You may receive notices about your medical information and how it is handled by other plans or insurers. The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") mandated the issuance of regulations to protect the privacy of individually identifiable health information which were issued at 45 CFR Parts 160 through 164 (the "Privacy Regulations"). As a participant or beneficiary of the Plan, you are entitled to receive a notice of the Plan's privacy procedures with respect to your health information that is created or received by the Plan (your "Protected Health Information" or "PHI"). This notice is intended to inform you about how the Plan will use or disclose your Protected Health Information, your privacy rights with respect to the Protected Health Information, the Plan's duties with respect to your Protected Health Information, your right to file a complaint with the Plan or with the Secretary of HHS and the office to contact for further information about the Plan's privacy practices. The following uses and disclosures of your Protected Health Information may be made by the Plan:

For Payment. Your Protected Health Information may be used or disclosed to obtain payment, including disclosures for coordination of benefits paid with other plans and medical payment coverages, disclosures for subrogation in order for the plan to pursue recovery of benefits paid from parties who caused or contributed to the injury or illness, disclosures to determine if the claim for benefits are covered under the Plan, and disclosures to obtain reimbursement under insurance, reinsurance or stop loss policies providing reimbursement for the benefits paid under the Plan on your behalf. Your Protected Health Information may be disclosed to other health plans maintained by WellMed Medical Management, Inc. for any of the purposes described above.

For Treatment. Your Protected Health Information may be used or disclosed by the Plan for purposes of treating you. For example, if your doctor requests information on what other drugs you are currently receiving.

For the Plan's Operations. Your Protected Health Information may be used as part of the Plan's health care operations. Health care operations would include quality assurance, underwriting and premium rating to obtain renewal coverage or securing or placing a contract for reinsurance of risk, including stop loss insurance, reviewing the competence and qualification of health care providers and conducting cost management and customer service and resolution of internal grievances.

When Required by Law. The Plan may also be required to disclose or use your Protected Health Information for certain other purposes. For example, if certain types of wounds occur that require reporting, or a disclosure to comply with a court order, a warrant, a subpoena, a summons, or a grand jury subpoena.

For Workers' Compensation. The Plan may disclose your Protected Health Information as authorized by you or your representative and to the extent necessary to comply with laws relating to workers' compensation and similar programs providing benefits for work-related injuries or illnesses if either (1) the health care provider provides health care to the individual at the request of the employer to determine if the individual has a work-related illness or injury or to provide medical surveillance of the workplace and the health care provider is employed by the employer, or (3) you authorize the disclosure. You must authorize the disclosure in writing and you will receive a copy of any authorization you sign.

Pursuant to Your Authorization. Any other use or disclosure of your Protected Health Information will be made only with your written authorization and you may revoke that authorization in writing, except your revocation cannot be effective to the extent the Plan has taken any action relying on your authorization for disclosure. The revocation of your authorization may not be revoked if your authorization was obtained as a condition for obtaining insurance coverage and any law provides the insurer with the right to contest a claim under the policy or the policy itself.

For Appointment Reminders and Health Plan Operations. Your Protected Health Information may be used so that the Plan, or one of its contracted service providers, may contact you to provide appointment reminders, information

on treatment alternatives, or other health related benefits and services that may be of interest to you, such as case management, disease management, wellness programs, or employee assistance programs.

To the Plan Sponsor. Information may be provided to the sponsor of the Plan provided that the sponsor has certified that this information will not be used for any other benefits, employee benefit plans or employment related activities.

Other Uses or Disclosures of Protected Health Information

Uses and disclosures that require that you be given an opportunity to agree or disagree prior to the use or release:

Disclosure of your Protected Health Information to family members, other relatives and your close personal friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- you have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and disclosures for which authorization or opportunity to object is not required:

Use and disclosure of your Protected Health Information is allowed without your authorization or any opportunity to agree or object under the following circumstances:

- when required by law.
- when permitted for purposes of public health activities, including when necessary to report product defects, to permit product recalls and to conduct post-marketing surveillance. Protected Health Information may also be used or disclosed if you have been exposed to a communicable disease or are at risk of spreading a disease or condition, if authorized or required by law.
- when authorized or required by law to report information about abuse, neglect or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made.
- Disclosure may generally be made to the minor's parents or other representatives, although there may be circumstances under federal or state law when the parents or other representatives may not be given access to a minor's Protected Health Information.
- The Plan may disclose your Protected Health Information to a public health oversight agency for oversight activities authorized or required by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate Medicare or Medicaid fraud).
- The Plan may disclose your Protected Health Information when required for judicial or administrative proceedings. For example, your Protected Health Information may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or any raised were resolved in favor of disclosure by the court or tribunal.

- For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person or to report certain types of wounds. Disclosures for law enforcement purposes include disclosing information about an individual who is or is suspected to be a victim of a crime, but only if the individual agrees to the disclosure, or the Plan is unable to obtain the individual's agreement because of emergency circumstances
- When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized or required by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.
- The Plan may use or disclose Protected Health Information for research, subject to certain conditions.
- When consistent with applicable law and standards of ethical conduct, if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization. State laws may provide you with additional rights or protections.

Rights You May Exercise

To Request Restrictions on Disclosures and Uses. You have the right to request restrictions on certain uses and disclosures of your protected health information in writing. However, the Plan is not required to agree to any restriction you may request. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made to the WEHP Privacy Officer, 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240.

To Access. You have the right to request access to your Protected Health Information and to inspect and copy your Protected Health Information in the designated record set under the policies and procedures established by the Plan. The designated record set is the series of codes that make up each electronic claim. This does not include psychotherapy notes and any information compiled in reasonable anticipation of or for the use of civil, criminal, or administrative actions or proceedings or Protected Health Information that is maintained by a covered entity that is a clinical laboratory. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline.

You or your personal representative will be required to complete a form to request access to the Protected Health Information in your designated record set. Requests for access to Protected Health Information should be made to the WEHP Privacy Officer, Fredericksburg Road, Suite 360, San Antonio, TX 78240. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

To Amend. You have the right to request an amendment to your Protected Health Information in writing under the policies established by the Plan. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your Protected Health Information. Requests for amendment of Protected Health Information in a designated record set should be made to the WEHP Privacy Officer, 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240. You or your personal representative will be required to complete a written form to request amendment of the Protected Health Information in your designated record set.

To Receive an Accounting. You have the right to receive an accounting of any disclosures of your Protected Health Information, other than those for payment, treatment and health care operations. At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your Protected Health Information during the six years prior to the date of your request. However, such accounting need not include Protected Health Information disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own Protected Health Information; (3) pursuant to a valid authorization; (4) incident to a use or disclosure otherwise permitted or required under the Privacy Regulations; (5) as part of a limited data set; or (6) prior to the date the Privacy Regulations were effective for the Plan on April 14, 2004.

If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

To Obtain a Paper Copy of this Notice. An individual who receives an electronic Notice of Privacy Practices has the right to obtain a paper copy of the Notice of Privacy Practices from the Plan upon request. To obtain a paper copy of this Notice, contact the WEHP Privacy Officer , 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240.

To Request Confidential Communication. You have the right to request to receive confidential communications of your Protected Health Information. This may be provided to you by alternative means or at alternative locations if you clearly state that the disclosure of all or part of the information could endanger you. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. Such requests should be made to the WEHP Privacy Officer, 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240.

A Note About Personal Representatives

You may exercise your rights through a personal representative (e.g., having your spouse call for you). Your personal representative will be required to produce evidence of his/her authority to act on your behalf before that person will be given access to your Protected Health Information or allowed to take any action for you. Proof of such authority may take one of the following forms:

- a power of attorney for health care purposes, notarized by a notary public;
- a signed authorization completed by you;
- a court order of appointment of the person as the conservator or guardian of the individual; or
- an individual who is the parent of a minor child.

The Plan retains discretion to deny access to your Protected Health Information to a personal representative to provide protection to those vulnerable people who depend on others to exercise their rights under these rules and who may be subject to abuse or neglect. This also applies to personal representatives of minors.

The Plan is required to abide by the terms of the notice that is currently in effect. The Plan reserves the right to make amendments or changes to any and all of its privacy policies and practices described in this notice and to apply such changes to all Protected Health Information the Plan maintains. Any Protected Health Information that the Plan previously received or created will be subject to such revised policies and practices and the Plan may make the changes applicable to all Protected Health Information it receives or maintains.

Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing Protected Health Information or when requesting Protected Health Information from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of Protected Health Information necessary to accomplish the intended purpose of the use, disclosure or request.

However, the minimum necessary standard will not apply in the following situations: (1) disclosures to or requests by a health care provider for treatment; (2) uses or disclosures made to the individual; (3) disclosures made to the Secretary of the U.S. Department of Health and Human Services; (4) uses or disclosures made pursuant to an authorization you signed; (5) uses or disclosures in the designated record set; (6) uses or disclosures that are required by law; (7) uses or disclosures that are required for the Plan's compliance with legal regulations; and (8) uses and disclosures made pursuant to a valid authorization.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual is not individually identifiable health information.

The Plan may use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA. The Plan may use or disclose a "Limited Data Set" which may be used by the Plan provided the Plan enters into a Limited Data Set agreement with the recipient of the Limited Data Set. Disclosures of a Limited Data Set need not be included in any accounting of disclosures by the Plan.

You have the right to file a complaint with the Plan or to the Secretary of Health and Human Services if you believe that your privacy rights have been violated. You may file a complaint with the Plan by filing a written notice with the Privacy Complaint Officer, 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240, describing when you believe the violation occurred, and what you believe the violation was. You will not be retaliated against for filing a complaint.

You may also file a complaint with the appropriate regional office of the Office for Civil Rights of the U.S. Department of Health and Human Services, within 180 days of any alleged violation. You may obtain the address of the appropriate regional office of the Office for Civil Rights from the Privacy Complaint Officer. If you would like to receive further information, you should contact the Privacy Officer, 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240, or the Privacy Complaint Officer 8637 Fredericksburg Road, Suite 360, San Antonio, TX 78240. This notice will first be in effect on April 14, 2004, and shall remain in effect until you are notified of any changes, modifications or amendments.

Important Notice from WellMed Medical Management, Inc. About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with WellMed Medical Management, Inc. and prescription drug coverage available January 1, 2007 for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

- 1. Beginning on January 1, 2006, Medicare prescription drug coverage was available to everyone with Medicare.**

2. WellMed Medical Management, Inc. has determined that the prescription drug coverage offered by the WellMed Employee Health Plan is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.
3. Read this notice carefully – it explains the options you have under Medicare prescription drug coverage, and can help you decide whether or not you want to enroll.

You may have heard about Medicare's new prescription drug coverage, and wondered how it would affect you. WellMed Medical Management, Inc. has determined that your prescription drug coverage with WellMed Medical Management, Inc. is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Starting January 1, 2006, prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans will provide at least a standard level of coverage set by Medicare. Some plans might also offer more coverage for a higher monthly premium.

Because your existing coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep this coverage and not pay extra if you later decide to enroll in Medicare coverage.

Every year you can choose to join a Medicare prescription drug plan between November 15th through December 31st.

If you do decide to enroll in a Medicare prescription drug plan and drop your WellMed Medical Management, Inc. prescription drug and medical coverage, be aware that you may not be able to get this coverage back.

If you drop your coverage with WellMed Medical Management, Inc. and enroll in a Medicare prescription drug plan, you may not be able to get this coverage back until the next plan year. You should compare your current coverage, including which drugs are covered, with the coverage and cost of the plans offering Medicare prescription drug coverage in your area.

The prescription drug coverage under this Plan is described in the Schedule of Benefits for each Option above. You can only obtain prescription drug coverage under this Plan if you have medical coverage under this Plan. In addition, your current coverage pays for other health expenses, in addition to Prescription Drugs, and you will not still be eligible to receive all of your current health and prescription drug benefits if you choose to enroll in a Medicare prescription drug plan.

You should also know that if you drop or lose your coverage with WellMed Medical Management, Inc. and don't enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that's at least as good as Medicare's prescription drug coverage; your monthly premium will go up at least 1% per month for every month after your initial enrollment period that you did not have that coverage. For example, if you go nineteen months without coverage, your premium will always be at least 19% higher than what most other people pay. You'll have to pay this higher premium as long as you have Medicare coverage. In addition, you may have to wait until next November to enroll.

For more information about this notice or your current prescription drug coverage . . .

NOTE: You may receive this notice at other times in the future such as before the next period you can enroll in Medicare prescription drug coverage, and if this coverage changes. You also may request a copy.

**For more information about your options under
Medicare prescription drug coverage . . .**

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in one of the plans approved by Medicare which offer prescription drug coverage after December 31, 2006, you may need to give a copy of this notice when you join the Plan to show that you are not required to pay a higher premium amount.

GENERAL PLAN INFORMATION

TYPE OF ADMINISTRATION

The Plan is a self-funded group health plan established pursuant to, and governed by, ERISA. The claims administration and other ministerial functions are provided through a third party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

PLAN NAME: WellMed Employee Health Plan

PLAN NUMBER: 502

PLAN SPONSOR TAX ID NUMBER: 74-2786364

PLAN EFFECTIVE DATE: January 1, 2004

PLAN YEAR ENDS: December 31

PLAN TYPE: Medical, Prescription Drug

PARTICIPATING EMPLOYERS:

WellMed Medical Management, Inc.
Princeton Medical Group P.A.
Comfort Care Transportation, LLC
Physicians Health Choice

PLAN SPONSOR:

WellMed Medical Management, Inc.
8637 Fredericksburg Road, Suite 360
San Antonio, TX 78240
(210) 617-4030

PLAN ADMINISTRATOR (NAMED FIDUCIARY):

WellMed Medical Management, Inc.
8637 Fredericksburg Road, Suite 360
San Antonio, TX 78240
(210) 617-4030

CLAIMS ADMINISTRATOR:

Benefit Management Administrators, Inc.
11,550 IH 10 West, Suite 220
San Antonio, Texas 78230
210-697-9900
800-934-6302

LEGAL ENTITY; SERVICE OF PROCESS: The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

PLAN FUNDING: This plan is self-insured and is not funded by an insurance policy.

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