Alabama Pharmacy Association
Health and Welfare Plan

(an ERISA wrap plan)

effective October 1, 2014

Plan Sponsor:
Alabama Pharmacy Association
1211 Carmichael Way
Montgomery, AL 63106-3672
Contact: Susie Hicks (334) 271-4222 ext. 1

Plan Number: 501

CONTENTS

Page

HEALTH AND WELFARE PLAN
INTRODUCTION

Alabama Pharmacy Association (the "**Association**"), acting as a bona fide association of employers, hereby adopts the Alabama Pharmacy Association Health and Welfare Plan (the "**Plan**") for the benefit of its employer-members who may offer the Benefit Options under the Plan to their employees. The Plan is effective on the date set forth on its cover page. The Plan was established to combine various fully-insured health and welfare benefits offered by the Association in a single document. The Plan is a multiple employer welfare arrangement ("**MEWA**") subject to ERISA and regulation under state law.

This booklet and the insurance contracts for each Benefit Option constitute the plan document for the Plan. This booklet and each certificate of coverage for each Benefit Option constitute the summary plan description ("**SPD**") for the Plan and for each of the Benefit Options as required by Section 102 of the Employee Retirement Income Security Act of 1974 ("**ERISA**"). The Association intends, for purposes of the annual report requirement (Form 5500) and for compliance with other laws, that this Plan be considered a "wrap" plan. The terms of the insurance contracts and certificates of coverage (as applicable) that provide the terms and conditions of participation under each Benefit Option (referred to as the "**Summaries**") are incorporated by reference. The inclusion of any voluntary insurance coverages in this Plan is intended solely for consolidation purposes and is not intended to indicate that any such coverage is or is not subject to ERISA.

When used in this booklet (unless otherwise noted), the terms "**you**" and "**your**" mean a person who satisfies the eligibility requirements for the Plan and one or more Benefit Options.

From time to time there may be changes in the benefits and/or procedures under one or more of the Benefit Options contained in this Plan. In the case of a material change, the Association will notify you in writing of the change. Announcements will also be provided to you as required by law. Notices and announcements will normally be sent directly to the employee or eligible service provider (for himself or herself and covered family members) at the address that appears in your employer's records. For this reason, it is important that you notify your employer when you have a change of address. You should also keep announcements and notices with this booklet.

GENERAL INFORMATION ABOUT THE PLAN

This Section contains certain general information that you may need to know about the Plan.

General

Plan Name:	Alabama Pharmacy Association Health and Welfare Plan
Plan Number:	501
Effective Date:	October 1, 2014
Plan Year:	October 1 through September 30

Association & Plan Administrator

Alabama Pharmacy Association
1211 Carmichael Way
Montgomery, AL 36106-3672
Attn: Susie Hicks
(334) 271-4222 ext. 1

EIN: 63-0003995

The Plan Administrator keeps the records for the Plan and is responsible for the administration of the Plan. The Plan Administrator will also answer any questions you may have about the Plan. You may contact the Plan Administrator for any further information about our Plan.

Service of Legal Process

The Plan's agent for service of legal process is the contact person for the Association, at the address listed above.

Type of Administration

All Benefit Options are insured, so each Benefit Option is administered by the applicable insurer.

Named Fiduciary (for Benefit Claims)

The Plan Administrator is hereby designated as a "named fiduciary", within the meaning of ERISA Section 402(a), with respect to the operation and administration of the Plan and is responsible, for administering the Plan in accordance with its terms, provided that for each of the insured Benefit Options, the insurance company is a "named fiduciary" with respect to decisions regarding whether a claim for benefits will be paid under the insurance contract.

ERISA Coverage

Most, but not all, of the Benefit Options offered under this Plan are subject to ERISA. If a Benefit Option is not subject to ERISA, it is described as part of the Plan for purposes of convenience and because there may be other applicable laws (for example, the Internal Revenue Code) that require a written document.

Important Disclaimer

Benefits under this Plan are provided pursuant to an insurance contract adopted by the Association. If the terms of this wrap document conflict with the terms of such insurance contract, then the terms of the insurance contract or Benefit Option Summaries will control, rather than this wrap document, unless otherwise required by law.

ARTICLE 1
YOUR ELIGIBILITY & PARTICIPATION

1.1 **Eligibility**. Employers within the meaning of Section 3(5) of ERISA who are members of the Association ("Employers") may offer the Benefit Options to their employees and other service providers. However, the right of each Employer, employee, or service provider to enroll himself or herself and his or her eligible family members in each Benefit Option offered under this Plan is governed by the terms of each Benefit Option's Summary; provided that no Benefit Option may cover individuals other than employees or service providers of an Employer. Eligibility requirements are normally not the same for all Benefit Options, so be sure to review the applicable Summary.

In general, if you are eligible for a Benefit Option, you must complete an application form (available through your Employer) to enroll yourself and/or your eligible family members. You must generally enroll within certain time periods after beginning work for your Employer, as described in the Summary for each Benefit Option. Thereafter, enrollment is generally limited to the annual open enrollment period that occurs before the start of each Plan Year.

1.2 **Special Enrollment Rights.** In certain circumstances and with respect to particular Benefit Options, enrollment may occur at times outside the open enrollment period (this is referred to as "special enrollment"), as explained in the Summary for the applicable Benefit Option and your Employer's cafeteria plan (sometimes called a "**Section 125**" plan), if any.

If you are declining enrollment for yourself or a spouse, children or dependents because of other health insurance or group health plan coverage, you may be able to enroll yourself and a spouse, children or dependents during the Plan Year in one or more Benefit Options under the Plan if you or your spouse, children or dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your spouse, children or dependents' other coverage). However, you must request enrollment within 31 days after your, or the spouse, children or dependents', other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new spouse, child or dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself and your spouse, child or dependents during the Plan Year in one or more Benefit Options under this Plan. However, you must request enrollment within 31 days after the marriage, birth, adoption or placement for adoption.

Also, if you are eligible for but not enrolled in the Plan, you may be able to enroll yourself and your spouse, children or dependents mid-Plan Year if you or your spouse, children or dependents lose eligibility for coverage under a State Medicaid or Children's Health Insurance Program Reauthorization Act ("**CHIP**") or become eligible for premium assistance under Medicaid or CHIP (as described later in this Section). You must request enrollment within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined eligible for premium assistance.

1.3 **Qualified Medical Child Support Orders.** If the Plan receives an order from a court or administrative agency directing the Plan to cover your child under one or more Benefit Options offered under the Plan, the Plan will enroll your child in the Plan as provided in such order if the Plan Administrator determines the order is a Qualified Medical Child Support Order ("**QMCSO"**) and your child would otherwise be an eligible dependent, as required by ERISA Section 609(a). Coverage may continue for the period specified in the QMCSO up to the time the child ceases to satisfy the definition of an eligible dependent under the applicable Benefit Option. If you are required to pay a higher premium to cover the child (e.g. for family coverage), your employer may increase your payroll deductions under its cafeteria plan. During the period the child is covered under the Plan as a result of a QMCSO, all Plan provisions and limits remain in effect with respect to the child's coverage, except as otherwise required by federal law.

The Plan has procedures for determining whether an order qualifies as a QMCSO. You have a right to obtain a copy of those procedures free of charge by contacting the Association.

1.4 **Cessation of Eligibility.** You will cease to participate in the Plan as of the earliest of (a) the date the employee/service provider is no longer eligible to participate in any of the Benefit Options, including but not limited to his or her failure to make a required contribution, (b) the date on which the employee/service provider withdraws, voluntarily or involuntarily, from all of the Benefit Options, (c) the date on which the Plan terminates, or (d) the date your employer no longer offers any Benefit Options to its employees or service providers through the Plan. If you are a covered family member, you will also cease to participate on an earlier date if you are no longer eligible to participate in or withdraw from the Plan. Cessation of eligibility for each Benefit Option may differ, and a specific Benefit Option may terminate independently of whether this Plan terminates. Consult the Summary for the particular Benefit Option for the rules governing cessation of eligibility.

1.5 **Leaves of Absence.** THE FEDERAL FAMILY AND MEDICAL LEAVE ACT OF 1993 AND THE REGULATIONS THEREUNDER ("**FMLA**") APPLIES ONLY IF YOUR EMPLOYER HAS 50 OR MORE EMPLOYEES. If FMLA applies, this Plan will be operated in accordance with it. You may retain coverage for yourself and covered family members under one or more Benefit Options offered under this Plan during a leave taken under FMLA, provided that you continue to pay the applicable premiums in accordance with your employer's FMLA Policies. You should contact your employer's Human Resources department to determine whether it is subject to FMLA, whether a leave qualifies as FMLA leave, and the procedure for paying premiums during your leave.

One or more Benefit Options may also allow you to continue your coverage for up to 30 days during an employer-approved leave of absence, including sick leave, provided that you continue to pay the applicable premiums in accordance with your employer's leave policies. If the leave of absence also qualifies as FMLA leave, the 30-day leave time runs concurrently with the FMLA leave. Contact your employer's Human Resources department to determine whether such leaves of absence are offered and the procedure for paying premiums during leave.

1.6 **Medicaid And Children's Health Insurance Program (Chip) Offer Free Or Low-Cost Health Coverage To Children And Families.** If you are eligible for group health coverage Benefit Options under the Plan, but are unable to afford the premiums, some states have premium assistance programs that can help pay for coverage. These states use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums.

If you or your spouse, children or dependents are already enrolled in Medicaid or CHIP and you live in a state listed below, you can contact your state Medicaid or CHIP office to find out if premium assistance is available.

If you or your spouse, children or dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your spouse, children or dependents might be eligible for either of these programs, you can contact your state Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask the state if it has a program that might help you pay the premiums for the Plan's health coverage.

Once it is determined that you or your spouse, children or dependents are eligible for premium assistance under Medicaid or CHIP, the Plan is required to permit you and your dependents to enroll in the group health plan Benefit Options under the Plan – as long as you and your dependents are eligible, but not already enrolled in such Benefit Options under the Plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2014. You should contact your state for further information on eligibility –

ALABAMA – Medicaid	**COLORADO** – Medicaid
Website: http://www.medicaid.alabama.gov Phone: 1-855-692-5447	Medicaid Website: http://www.colorado.gov/ Medicaid Phone (In state): 1-800-866-3513 Medicaid Phone (Out of state): 1-800-221-3943
ALASKA – Medicaid	
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	
ARIZONA – CHIP	**FLORIDA** – Medicaid
Website: http://www.azahcccs.gov/applicants Phone (Outside Maricopa County): 1-877-764-5437 Phone (Maricopa County): 602-417-5437	Website: https://www.flmedicaidtplrecovery.com/ Phone: 1-877-357-3268
CALIFORNIA – CHIP	**GEORGIA** – Medicaid
Website: www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx Fax: 916-440-5676 E-mail: HIPP@dhcs.ca.gov	Website: http://dch.georgia.gov/ Click on Programs, then Medicaid, then Health Insurance Premium Payment (HIPP) Phone: 1-800-869-1150
IDAHO – Medicaid	**MONTANA** – Medicaid
Medicaid Website: http://healthandwelfare.idaho.gov/Medical/Medicaid/PremiumAssistance/tabid/1510/Default.aspx Medicaid Phone: 1-800-926-2588	Website: http://medicaidprovider.hhs.mt.gov/clientpages/clientindex.shtml Phone: 1-800-694-3084
INDIANA – Medicaid	**NEBRASKA** – Medicaid
Website: www.in.gov/fssa Phone: 1-800-889-9949	Website: www.ACCESSNebraska.ne.gov Phone: 1-800-383-4278
IOWA – Medicaid	**NEVADA** – Medicaid
Website: www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562	Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900
KANSAS – Medicaid	
Website: http://www.kdheks.gov/hcf/ Phone: 1-800-792-4884	
KENTUCKY – Medicaid	**NEW HAMPSHIRE** – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	**NEW JERSEY** – Medicaid and CHIP
Website: http://www.lahipp.dhh.louisiana.gov Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-977-6740 TTY 1-800-977-6741	
MASSACHUSETTS – Medicaid and CHIP	**NEW YORK –** Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831

MINNESOTA – Medicaid	**NORTH CAROLINA** – Medicaid
Website: http://www.dhs.state.mn.us/ Click on Health Care, then Medical Assistance Phone: 1-800-657-3629	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MISSOURI – Medicaid	**NORTH DAKOTA** – Medicaid
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-800-755-2604
OKLAHOMA – Medicaid and CHIP	**UTAH** – Medicaid and CHIP
Website: http://www.insureoklahoma.org Phone: 1-888-365-3742	Website: http://health.utah.gov/upp Phone: 1-866-435-7414
OREGON – Medicaid	**VERMONT**– Medicaid
Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075	Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427
PENNSYLVANIA – Medicaid	**VIRGINIA** – Medicaid and CHIP
Website: http://www.dpw.state.pa.us/hipp Phone: 1-800-692-7462	Medicaid Website: http://www.dmas.virginia.gov/rcp-HIPP.htm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.famis.org/ CHIP Phone: 1-866-873-2647
RHODE ISLAND – Medicaid	**WASHINGTON** – Medicaid
Website: www.ohhs.ri.gov Phone: 401-462-5300	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
SOUTH CAROLINA – Medicaid	**WEST VIRGINIA** – Medicaid
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Website: www.dhhr.wv.gov/bms/ Phone: 1-877-598-5820, HMS Third Party Liability
SOUTH DAKOTA - Medicaid	**WISCONSIN** – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.badgercareplus.org/pubs/p-10095.htm Phone: 1-800-362-3002
TEXAS – Medicaid	**WYOMING** – Medicaid
Website: https://www.gethipptexas.com/ Phone: 1-800-440-0493	Website: http://health.wyo.gov/healthcarefin/equalitycare Phone: 307-777-7531

To see if any more states have added a premium assistance program since January 31, 2014, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

1.7 **USERRA.** If you are on military leave covered by the Uniformed Services Employment and Reemployment Rights Act of 1994, benefits and service credit with respect to qualified military service will be provided in accordance with the Uniform Services Employment And Reemployment Rights Act and the regulations thereunder ("**USERRA**"). You should contact your employer's Human Resources department for more information about rights to continue coverage under this Plan.

ARTICLE 2
BENEFIT OPTIONS

2.1 **Benefit Options.** This Plan provides benefits through employee welfare benefit plans (as defined in ERISA Section 3(1)) sponsored and approved by the Association for inclusion under this Plan (each is referred to as a **"Benefit Option").** These Benefit Options may be provided by the Association or through contracts with third-party insurers or vendors.

A current list of all Benefit Options under the Plan is attached as **Appendix A**.

Some of these Benefit Options require completion of application forms, annual elections, and/or other administrative forms. The details of these administrative requirements, and the terms of the Benefit Options, are described in the Summary for the applicable Benefit Option.

2.2 **Health Care Reform Notices.** To comply with the Patient Protection and Affordable Care Act, as amended (known as "**Health Care Reform**" or "**PPACA**"), the following rights and benefits are included in this Plan:

(a) Adult Children Are Covered Until Age 26. You can cover your adult children (regardless of financial dependency, student status or residence) under the medical coverage offered through this Plan until they reach age 26 (please see the applicable certificate of coverage (or plan document, if self-insured) to determine whether coverage ends on the child's 26th birthday or at the end of the month or calendar year in which the child reaches age 26, and whether any special rules apply as to the child's eligibility for another employer-sponsored plan). Your adult children whose medical coverage was previously denied or terminated because they exceeded the age limits of the Plan or did not meet its residency, financial dependence or student status requirements, but are now eligible, were allowed at least 30 days in which to elect to enroll (this was explained in more detail in open enrollment materials sent to you prior to the start of the first Plan Year after this new rule took effect).

(b) No Exclusion of Pre-Existing Conditions. Pre-existing conditions are not excluded from medical coverage provided by Benefit Options offered under the Plan.

(c) No Lifetime or Annual Limit. No lifetime or annual limit applies to your medical coverage provided by Benefit Options offered under the Plan, as described in the applicable certificate of coverage or plan document for the coverage.

(d) Primary Care Provider Designations. To the extent that any Benefit Option that provides medical coverage requires or allows for the designation of primary care providers by participants or beneficiaries, you have the right to designate any primary care provider who participates in-network and who is available to accept you or your family members; and to the extent that any Benefit Option that provides medical coverage requires or allows for the designation of a primary care provider for a child, you may designate a pediatrician as the primary care provider for the child.

(e) OB/GYN Designations. To the extent that any Benefit Option that provides medical coverage provides coverage for obstetric or gynecological care and requires the designation by a participant or beneficiary of a primary care provider, you do not need prior authorization from the Plan's network provider or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in-network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals.

(f) No Co-Pay for Preventative Services and Wellness Care. You are not required to pay a co-payment or other cost-sharing under the medical coverage offered through this Plan for preventive services and wellness benefits (as defined in the law), such as routine exams, immunizations,

mammograms, and routine baby care. Please see the schedule of benefits in the applicable certificate of coverage (or plan document, if self-insured) for more information.

(g) Emergency Services. You may seek emergency medical services at an in-network or out-of-network provider under Benefit Options providing medical coverage under this Plan without having to obtain prior authorization. Any out-of-network emergency medical services are subject to the same co-payments and deductibles as in-network emergency services, and the out-of-network provider will be paid at the same level as an in-network provider for the same service. Note, however, that the out-of-network provider may balance bill you for the difference between its charge for the emergency services and the amount paid by this Plan. Please see the applicable certificate of coverage for more information.

2.3 **Newborns' and Mothers' Health Protection Act of 1996.** Benefit Options that provide medical coverage under this Plan 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 insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable).

2.4 **Women's Health and Cancer Rights Act of 1998.** If your medical coverage under any of the Benefit Options includes coverage for mastectomy-related services, then you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 ("**WHCRA**"). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed; surgery and reconstruction of the other breast to produce a symmetrical appearance; prostheses; and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same deductibles and coinsurance applicable to other medical and surgical benefits provided under this Plan. To obtain information on the deductibles and coinsurance that apply, refer to the respective certificate of coverage for the Benefit Option that provides the coverage for mastectomies or contact the insurer of the Benefit Option. If you would like more information on WHCRA benefits, call the Plan Administrator at the number listed in the General Information Section above.

ARTICLE 3
FUNDING

3.1 **Funding Through General Assets.** The Plan will be funded through the purchase of insurance from third parties. Unless otherwise required by law, nothing herein shall be construed to require your employer or the Association to maintain any fund or trust, or segregate any amount for the benefit of any person, and no person shall have any claim against, right to, or security or other interest in, any fund, account or asset of the Association or your employer from which any payment under the Plan may be made.

3.2 **Employee Contributions.** Each employee or service provider must pay his/her share of the cost of Benefit Options covering the employee/service provider and his or her covered family members under this Plan, as determined by the Association from time to time, and your employer will pay the remainder (if any) of the cost.

In order for employees to pay this cost through salary reductions on a pre-tax basis, they must satisfy the requirements of their employer's cafeteria plan, which is contained in a separate plan document. In some cases where the employee is not eligible for the employer's cafeteria plan, where persons covered under a Benefit Option selected by the employee do not qualify for pre-tax benefits under the Internal Revenue Code of 1986 ("**Code**"), or where a non-employee service provider is offered coverage in a Benefit Option, the employer in its sole discretion may allow the employee/service provider

to pay all or part of the cost on an after-tax basis outside of the employer's cafeteria plan (in some limited situations described in the cafeteria plan, after-tax payments may be made through the cafeteria plan).

The Association may, from time to time, implement or adopt one or more wellness programs or disease management programs under this Plan that offer you the opportunity to qualify for discounts on the cost of Benefit Options or other financial incentives if you, your spouse, or your dependents participate in the program or satisfy certain health standards. If you, your spouse, or your dependents choose to participate, or stop or otherwise fail to qualify in such a program, any adjustments will be automatically applied to the cost of your Benefit Options and to your salary reductions.

3.3 **Employer Contributions.** Your employer will make its contributions in an amount that (in the Association's sole discretion) is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by your contributions. The Association will forward the employer and employee/service provider contributions to the insurer. Any designation of employer premium amounts in open enrollment or other communications is intended as an estimate, not a fixed dollar amount, of your employer's contributions.

ARTICLE 4
COBRA CONTINUATION COVERAGE RIGHTS

4.1 **Application of COBRA.** If coverage under any Benefit Option that provides medical, dental, or vision coverage for you or your eligible family members under this Plan ceases because of certain "qualifying events" (for example, termination of employment, reduction in hours, divorce, death, or a child's ceasing to meet the definition of an eligible dependent), then you and your eligible family members may have the right to purchase continuation coverage for a temporary period of time under a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1996 ("**COBRA**").

4.2 **Notice.** In the event that a Benefit Option is subject to COBRA, this notice is intended to inform you and your beneficiaries, in summary fashion, of their 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 in the event a Benefit Option is subject to COBRA and does not grant or take away any rights under the law.

The Plan Administrator or its designee is responsible for administering COBRA continuation coverage in the event a Benefit Option is subject to COBRA. Complete instructions on COBRA, as well as election forms and other information, will be provided by the Plan Administrator or its designee to participants in the applicable Benefit Option who become Qualified Beneficiaries under COBRA.

4.3 **COBRA Continuation Coverage**. COBRA continuation coverage is the temporary extension of group health plan coverage (e.g. medical, dental, or vision) under a Benefit Option that must be offered to certain participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the applicable Benefit Option (the "Qualifying Event"). The coverage must be identical to the 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).

4.4 **Qualified Beneficiaries**. In general, a Qualified Beneficiary can be:

- any individual who, on the day before a Qualifying Event, is covered under the Benefit Option by virtue of being on that day either a covered employee, the spouse of a covered employee (as recognized under federal law), or an eligible child of a covered employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the applicable

Benefit Option 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 coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

- Any child who is born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, and any individual who is covered by the Benefit Option as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the applicable Benefit Option 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 coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "**covered employee**" includes any individual who is provided coverage under the Benefit Option due to his or her performance of services for an employer member of the Association who adopts this Plan. However, this provision does not establish eligibility of these individuals. Eligibility for coverage under each Benefit Option shall be determined in accordance with the particular Benefit Option's eligibility provisions.

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 will also not be considered a Qualified Beneficiary by virtue of the relationship to the individual.

A Qualified Beneficiary would not include a domestic or civil union partner or a grandchild of a covered employee although these individuals may be able to obtain continued coverage through the covered employee's COBRA election.

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.

4.5 **Qualifying Events**. A Qualifying Event is any of the following if the Benefit Option provided that the individual 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:

- The death of a covered employee.

- The termination (other than by reason of the employee's gross misconduct), or reduction of hours, of a covered employee's employment.

- The divorce or legal separation of a covered employee from the employee's spouse. If the employee reduces or eliminates the employee's spouse's coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the spouse's coverage was reduced or eliminated before the divorce or legal separation.

- A covered employee's enrollment in any part of the Medicare program.

- A dependent's or child's ceasing to satisfy the Benefit Option's requirements for eligibility (for example, attainment of the maximum age for coverage).

- If the Qualifying Event causes the covered employee, or the covered spouse or an eligible child of the covered employee, to cease to be covered under the Benefit Option under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered employee, or the spouse, or an eligible child of the covered employee, for coverage under the Benefit Option that results from the occurrence of one of the events listed above is a loss of coverage.

- The taking of leave under the Family and Medical Leave Act of 1993 ("**FMLA**") does not constitute a Qualifying Event. A Qualifying Event will occur, 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.

4.6 **Factors To Be Considered**. You should take into account that a failure to continue your group health coverage will affect your rights under federal law. First, if you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. Also, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after coverage ends under a Benefit Option due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

4.7 **Procedure for Obtaining COBRA Coverage**. The Plan conditions the availability of COBRA continuation coverage with respect to any Benefit Option upon the timely election of such coverage. An election is timely if it is made during the election period.

(a) The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Benefit Option. The election period must begin not later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 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. <u>If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited</u>.

Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered spouse or children have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available 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 person who qualifies or thinks that he or she and/or his or her family members may

qualify for assistance under this special provision should contact the Plan Administrator or its designee for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

4.8 **Responsibility for Informing the Plan Administrator of the Occurrence of a Qualifying Event**. The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. Your employer will notify the Plan Administrator or its designee of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

- the end of employment or reduction of hours of employment;
- death of the employee; or
- enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or an eligible child's losing eligibility for coverage as an eligible child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Administrator or its designee.

NOTICE PROCEDURES:

Any notice that you provide must be ***in writing***. Oral notice, including notice by telephone, is not acceptable. You must mail, fax, or hand-deliver your notice to the Association at the address listed in the General Information section above.

If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the **Benefit Options** under which you lost or are losing coverage,
- the name and address of the employee covered under the Benefit Option,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the **Qualifying Event** and the **date** it happened.

If the Qualifying Event is a divorce or legal separation, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

Once the Plan Administrator or its designee receives *timely notice* that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that Plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

4.9 **Effect of a Waiver**. 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 the Plan Administrator or its designee, as applicable.

4.10 **COBRA Where Other Coverage or Medicare Available**. Qualified Beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary's COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

4.11 **When COBRA Coverage May Be Terminated**. During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, 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:

- The last day of the applicable maximum coverage period;
- The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary;
- The date upon which the Association and its affiliates cease to provide any group health plan (including a successor plan) to any employee;
- 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;
- 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);
- In the case of a Qualified Beneficiary entitled to a disability extension, the later of: (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

- 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 a Benefit Option 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.

4.12 **Maximum Coverage Periods**. The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) 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.

(b) 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:

- 36 months after the date the covered employee becomes enrolled in the Medicare program; or

- 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.

(c) 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.

(d) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

(e) 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 and with respect to 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. The Plan Administrator must be notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

(f) 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 Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the

determination and before the end of the original 18-month maximum coverage. This notice must be sent to the Plan Administrator or its designee in accordance with the procedures above.

4.13 **Payment for COBRA Coverage**. For any period of COBRA continuation coverage under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage may be required to pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan Administrator will inform you of the cost. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

The Plan must allow payment for COBRA continuation coverage to be made in monthly installments. The Plan is also permitted to allow for payment at other intervals.

Timely Payment means a payment made no later than 30 days after the first day of the coverage 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 Association and the entity that provides Plan benefits on the Association's behalf, the Association is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not 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 postmarked 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.

4.14 **Availability of Conversion Health Plan at End of COBRA**. If a Qualified Beneficiary's COBRA continuation coverage under a Benefit Option ends as a result of the expiration of the applicable maximum coverage period, the Plan will, 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.

4.15 **If You Have Questions**. If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator or its designee. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act ("**HIPAA**"), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration ("**EBSA**"). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

4.16 **Update Your Address**. In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or its designee.

4.17 **State Laws.** Your state may also require that you be given the right to purchase continued medical or dental coverage under this Plan. For employees of many smaller employers who

are too small to be subject to federal COBRA requirements, these state laws may provide the only continuation rights. If you have questions about your state law continuation rights, see the Summary for the particular Benefit Option.

ARTICLE 5
CLAIMS PROCEDURE

For purposes of determining the amount of, and entitlement to, benefits, the respective insurer is the "named fiduciary" under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance contract.

To obtain benefits from the insurer of a Benefit Option, you must follow the claims procedures under the applicable insurance contract, which may require you to complete, sign, and submit a written claim on the insurer's form. See the Summary for each Benefit Option for more information.

The insurer will decide your claim in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. The insurer has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide your claim. If the insurer denies your claim in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

If your claim is denied, you may appeal to the insurer for a review of the denied claim. The insurer will decide your appeal in accordance with its reasonable claims procedures, as required by ERISA (if ERISA applies) and other applicable law. If you do not appeal on time, you will lose your right to file suit in a state or federal court, because you will not have exhausted your internal administrative appeal rights (which generally is a prerequisite to bringing suit in state or federal court). Note that under certain circumstances, you may also have the right to obtain external review (that is, review outside of the Plan).

See the Certificate of Coverage for each Benefit Option for more information. If the Benefit Option's claims procedure, or its claims procedure does not comply with law, the Claims Procedure attached at **Appendix B** shall govern.

Failure to insist upon compliance with any provision of a claims procedure at any given time or times or under any given set or sets of circumstances does not operate to waive or modify such provisions, or in any matter whatsoever to render the procedures unenforceable, whether the circumstances are, or are not, the same.

ARTICLE 6
HIPAA PRIVACY & SECURITY

6.1 **HIPAA Generally**. The confidentiality of your personal health information is important to us. Under a federal law called the Health Insurance Portability and Accountability Act of 1996 (**"HIPAA"**), certain of the Benefit Options offered under Plans such as this one, or their insurers, are generally required to limit the use and disclosure of your protected health information to treatment, payment, and health care operations and to put in place appropriate safeguards to protect your protected health information. This section explains some of HIPAA's requirements. Additional information is contained in the Plan's notice of privacy practices if the Plan offers self-insured health Benefit Options. You may request a copy of this notice by contacting the Association.

The Plan will not create or receive protected health information other than summary health information and enrollment and disenrollment information. As a result, the Plan is exempt from some of the notice and other administrative requirements imposed by HIPAA. The applicable insurer of each Benefit Option that provides health benefits will provide you a HIPAA notice of privacy practices. You may request a copy of this notice by contacting the applicable insurer.

6.2 **Disclosures of Protected Health Information to Association.** In order for your benefits to be properly administered, the Plan needs to share your protected health information with the Association, as plan sponsor. Your personal health information includes any and all information relating to your genes and/or genetic background.

(a) Following are circumstances under which the Plan may disclose your protected health information to the Association:

- The Plan may inform the Association whether you are enrolled in the Plan.
- The Plan may disclose summary health information to the Association. The Association must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying you.
- The Plan may disclose your protected health information to the Association for Plan administrative purposes. This is because employees of the Association perform some of the administrative functions necessary for the management and operation of the Plan.

(b) Following are the restrictions that apply to the Association's use and disclosure of your protected health information:

- The Association will only use or disclose your protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the Association discloses any of your protected health information to any of its agents or subcontractors, the Association will require the agent or subcontractor to execute a HIPAA compliance business associate agreement and to comply with applicable HIPAA regulations.
- The Association will not use or disclose your protected health information for employment-related actions or decisions or in connection with any other benefit or benefit Plan of the Association.

(c) Following are the restrictions that apply to the Plan Administrator's use and disclosure of your protected health information:

- The Plan Administrator will promptly report to the Plan any use or disclosure of your protected health information that is inconsistent with the uses or disclosures allowed in this section of this booklet.
- The Plan Administrator will allow you or the Plan to inspect and copy any protected health information about you that is in the Association's custody and control. The HIPAA regulations set forth the rules that you and the Plan must follow in this regard. There are some exceptions.
- The Plan Administrator will amend, or allow the Plan to amend, any portion of your protected health information to the extent permitted or required under the HIPAA regulations.

- With respect to some types of disclosures, the Plan Administrator will keep a disclosure log. The disclosure log will go back for six years or such other period required by HIPAA regulations or law. You have a right to see the disclosure log. The Plan Administrator does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.

- The Plan Administrator will make its internal practices, books, and records, relating to its use and disclosure of your protected health information available to the Plan and to the U.S. Department of Health and Human Services, or its designee.

- The Plan Administrator will, if feasible, return or destroy all of your protected health information in the Plan Administrator's custody or control that the Plan Administrator has received from the Plan or from any business associate (or its subcontractors) when the Plan Administrator no longer needs your protected health information to administer the Plan. If it is not feasible for the Plan Administrator to return or destroy your protected health information, the Plan Administrator will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

6.3 **Authorized Workforce Members.** The following classes of employees or other workforce covered persons under the control of the Association or other persons designated as have access to protected health information under the applicable HIPAA policies and procedures for a Benefit Option may use or disclose your protected health information in accordance with the HIPAA regulations that have just been explained:

- HIPAA Privacy Officer (if any)

- HIPPA Security Officer

- Benefit Administrators

If any of the foregoing employees or workforce covered persons of the Association use or disclose your protected health information in violation of the rules that are explained above, the employees or workforce covered persons will be subject to disciplinary action and sanctions, which may include termination of employment or service. If the Association becomes aware of any such violation, it will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to relieve any harmful effects to you.

6.4 **HIPAA Security.** Regardless of whether the Plan is exempted from some of the privacy requirements as described above, the following restrictions will apply to the Plan Administrator's storage and transmission of your electronic protected health information that comes into the possession of the Plan Administrator or its agents or subcontractors in the course of administering the Plan:

- The Plan Administrator will have in place appropriate administrative, physical and technical safeguards to protect the confidentiality, integrity and availability of your electronic protected health information, as well as to ensure that only those classes of employees or other workforce covered persons of the Plan Administrator described above have access to use or disclose your electronic protected health information in accordance with the HIPAA regulations,

- If the Plan Administrator discloses any of your electronic protected health information to any of its agents or subcontractors, the Plan Administrator will

require the agent or subcontractor to execute a HIPAA-compliance business associate agreement and comply with applicable HIPAA regulations, and

- The Plan Administrator will report any security incident of which it becomes aware in accordance with the HIPAA regulations.

6.5 **Use and Disclosure of your Personal Health Information**. As business associates of the Plan, the insurers and third-party administrators who service the Benefit Options that provide group health benefits have agreements with the Plan that allow them to use your personal health information for treatment, payment, health care operations, and other purposes permitted or required by HIPAA. In addition, by applying for coverage and participating in the Plan, you agree that such insurers and administrators may obtain, use and release all records about you and your minor family members that is needed to administer the Plan or to perform any function authorized or permitted by law. You further direct all persons to release all records to such insurers and administrators about you and your minor children or other family members that it needs in order to administer Benefit Options or deliver benefits under the Plan.

If you have any questions regarding your rights under HIPAA, you should contact 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.

ARTICLE 7
YOUR RIGHTS UNDER ERISA

7.1 Plan participants, eligible employees and all other employees of the Association may be entitled to certain rights and protections under ERISA and the Code. These laws provide that participants, eligible employees and all other employees are entitled to:

(a) **Receive Information About Your Plan and Benefits.**

- Examine, without charge, at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements (if any), and a copy 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 copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may charge a reasonable fee for the copies.

(b) **COBRA and HIPAA Rights.**

- Continue health coverage for a participant or covered dependents if there is a loss of coverage under the Plan as a result of a qualifying event. Participants or covered dependents may have to pay for such coverage. Review this booklet and the Summary for each Benefit Option for the rules governing COBRA continuation rights.

7.2 **Prudent Actions by Plan Fiduciaries.** In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of an employee benefit plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the best interest of you and other Plan participants.

No one, including your employer, the Association, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

If your claim for a 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.

If you have a claim for benefits which 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 medical child support order, you may file suit in federal court.

7.3 **Enforcement.** Under ERISA there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may request 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 which is denied or ignored, in whole or in part, you may file suit in a state or 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 should 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.

7.4 **Assistance with Your Questions.** If you have any questions about the Plan, you should contact the Plan Administrator at the address and phone listed in the General Information Section at the beginning of this booklet. If you have any questions about this statement, or about your rights under ERISA or HIPAA or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the 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.

ARTICLE 8
ADMINISTRATION

8.1 **The Plan Administrator.** The Plan is currently administered by the Alabama Pharmacy Association as the Plan Administrator. The Plan Administrator may adopt such rules as it deems desirable for the administration of the Plan or any of the Benefit Options. The Plan Administrator may engage one or more third parties to assist in the administration of the Plan and the Benefit Options, and may delegate any of its duties or powers to a third party.

8.2 **Powers of the Plan Administrator.** The Plan Administrator has full discretionary authority to administer and interpret the Plan, including discretionary authority to interpret its terms, make determinations of fact, and determine eligibility for participation and benefits under the Plan and any Benefit Option. The Plan Administrator may, however, delegate its discretionary authority and such duties and responsibilities as the Plan Administrator deems appropriate to facilitate the day-to-day administration of the Plan or any Benefit Option. Any determination of the Plan Administrator or its delegate is binding, final and conclusive upon all persons. In carrying out its duties with respect to the general administration of the Plan, the Plan Administrator has, in addition to the foregoing powers and any other powers conferred by this Plan, the Summary, or by law, the following powers:

(a) to construe the terms of the Plan and the Benefit Options and to determine all questions arising in its administration, interpretation, application or operation;

(b) to decide all questions relating to the eligibility of individuals to participate in the benefits provided under the Plan or its Benefit Options;

(c) to determine the benefits under the Plan or its Benefit Options to which any person may be entitled;

(d) to keep records of all acts and determinations of the Plan Administrator and to keep all such records, books, accounts, data and other documents as may be necessary for the proper administration of the Plan;

(e) to make and publish such rules for the administration of the Plan as are not inconsistent with its terms;

(f) to prepare and distribute to all participants and covered family members information concerning the Plan, the Benefit Options, and the rights of the participants and covered family members under the Plan, including, but not limited to, all information which is required to be distributed under the Internal Revenue Code, ERISA, or their regulations;

(g) to file with the Secretary of Labor or the Secretary of the Treasury any and all reports or information required to be filed under the Internal Revenue Code or ERISA, and their regulations;

(h) to employ counsel, accountants and other consultants to aid in exercising its powers and carrying out its duties under the Plan; and

(i) to perform any other acts necessary and proper for the administration of the Plan.

8.3 **Insurance Control Clause.** All Benefit Options offered under the Plan are fully insured. Benefits are provided under a group insurance contract entered into between the Association and the insurance company. Claims for benefits are sent to the insurance company. The insurance company is responsible for determining and paying claims, not the Plan Administrator. As the "named fiduciary" for benefit determinations under fully-insured Benefit Options, the insurance company has the discretionary authority to interpret the Plan in order to make benefit determinations. The insurance company also has the authority to require eligible persons to furnish it with such information as the insurance company determines necessary for the proper administration of the Plan. In the event of a conflict between the terms of this Plan and the terms of the insurance contract, the terms of the insurance contract shall control as to those persons receiving coverage under such Benefit Option. For this purpose, the insurance contract shall control in defining the persons eligible for the Benefit Option, the dates of their eligibility, the conditions which must be satisfied to become insured or otherwise participate in the Benefit Option, if any, the benefits that all persons covered by that Benefit Option are entitled to, and the circumstances under which the eligibility for the Benefit Option, and the underlying insurance, terminates.

8.4 **Indemnification.** To the maximum extent permitted by law, in the event the Plan Administrator is a person other than the Association, the Association agrees to indemnify and hold harmless the Plan Administrator against any and all expenses and liabilities including, without limitation, the amount of any settlement or judgment, costs, counsel fees and related charges reasonably incurred in connection with a claim asserted or a proceeding brought against him, her, or it, or the settlement thereof, which may be incurred in the course of his, her or its relation with the Plan and the Benefit Options and which arises out of his, her or its actions or failure to act in executing the duties assigned under the Plan. The Association may purchase fiduciary liability insurance to insure its obligations under this Section. This right of indemnification is in addition to any other rights to which the Plan Administrator may be entitled. The Association may, at its own expense, settle any claim asserted or proceeding brought against the Plan Administrator when such settlement appears to be in the best interest of the Association.

8.5 **Delegation.** The Plan Administrator may establish procedures for the designation of persons other than named fiduciaries to carry out fiduciary responsibilities (other than trustee responsibilities) under the Plan. If any fiduciary responsibility is allocated or delegated to any person, no named fiduciary is liable for any act or omission of such person, except as provided in ERISA Section 405(c).

8.6 **Expenses of the Plan Administrator.** The Plan Administrator serves without compensation for its services. The Association will pay all reasonable expenses, including, but not limited to, fees of legal counsel, accountants and other specialists, plan communication and recordkeeping costs, plan audit fees, claims review (such as IROs), and vendor searches incurred by the Plan Administrator or its delegates in the performance of their duties. The Association may charge participating employers for their allocable share of these costs.

8.7 **Electronic Forms.** To facilitate efficient operation of the Plan, the Plan may allow forms (including, for example, election forms and notices), whether required or permissive, to be sent and/or made by electronic means.

8.8 **Nondiscrimination Requirement.** It is the intent of this Plan not to discriminate in violation of the Code or applicable law. If the Plan Administrator deems it necessary to avoid discrimination under the Code or applicable law, it may, but shall not be required to, either aggregate or separate any Benefit Options included within this Plan as needed in order to comply with the nondiscrimination provisions of the Code or applicable law in the manner prescribed and allowed by such provisions and within the timeframe such provisions are effective. Any act taken by the Plan Administrator under this Section will be carried out in a uniform and nondiscriminatory manner.

ARTICLE 9
MISCELLANEOUS

9.1 **Association Protective Clauses.** Upon the failure of any participant, person or the Association to obtain the insurance contemplated by this Plan (whether as a result of negligence, gross neglect, or otherwise), benefits shall be limited to the insurance premium(s), if any, that remain unpaid for the coverage under the Benefit Option for the period in question and the actual insurance proceeds, if any, received by the Association or you as a result of your claim. The Association shall not be responsible for the validity of any insurance contract issued under the Plan or for the failure on the part of the insurer to make payments provided for under any insurance contract. Once insurance is applied for or obtained, the Association shall not be liable for any loss which may result from the failure to pay premiums to the extent premium notices are not received by the Association.

9.2 **No Guarantee of Tax Consequences.** The Association does not make any commitment or guarantee that any amounts paid to or for your benefit under the Plan will be excludable from your gross income for federal or state income tax purposes, or that any other Federal or state tax treatment will apply to or be available to you. It is your obligation to determine whether each payment under the Plan is excludable from your gross income for federal and state income tax purposes, and to notify the Association if you have reason to believe that any such payment is not so excludable.

9.3 **Indemnification of Association by Participants.** If you receive one or more payments or reimbursements under the Plan that are not for a permitted benefit under the Plan, you must indemnify and reimburse the Association for any liability the Association may incur for failure to withhold Federal or state income tax or Social Security tax from such payments or reimbursements. However, such indemnification and reimbursement shall not exceed the amount of additional Federal and state income tax (plus any penalties) that you would have owed if the payments or reimbursements had been made to you as regular cash compensation, plus your share of any Social Security tax that would have been paid on such compensation, less any such additional income and Social Security tax actually paid by the participant.

9.4 **Association's Right to Distributions.** To the fullest extent permitted by ERISA and other applicable law, any distribution from an insurance issuer or similar payment, such as an insurance company, to its policyholders shall be payable solely to the Association. Distributions for this purpose shall include, but not be limited to, refunds, dividends, demutualization payments, rebates and excess surplus distributions, but shall not include payments or reimbursement for a Participant's claims for benefits.

9.5 **Affiliates.** Unless the context requires otherwise (such as designations of the plan sponsor and Plan Administrator, and granting of powers to amend and terminate the Plan), references to the Association include any U.S. subsidiary or U.S. affiliate of the Association. "**Affiliate**" means any entity which is a member of a controlled group of corporations with the Association; under common control with the Association; or a member of an affiliated service group with the Association, as such terms are defined in Code Section 414.

9.6 **Governing Law.** The construction and operation of the Plan are governed by the laws of the United States and, to the extent that such laws do not apply, by those of the State of Alabama.

9.7 **Severability.** If any provision of this Plan is held illegal or invalid for any reason, the remaining provisions are to remain in full force and effect and to be construed and enforced in accordance with the purposes of the Plan as if the illegal or invalid provision did not exist.

9.8 **Undefined Terms.** Unless the context clearly requires another meaning, any term not specifically defined in this Plan shall be interpreted by the Plan Administrator, whose interpretation shall be final and binding on all participants.

9.9 **Headings.** The headings of articles, sections and subsections are for the convenience of reference only and are not to be regarded as part of the Plan nor utilized in construing the Plan.

9.10 **Singular and Plural.** Unless clearly inappropriate, singular terms refer also to the plural and vice versa.

9.11 **Plan Not a Contract of Employment.** The adoption and maintenance of the Plan does not constitute a contract of employment between your employer and you and is not a consideration for the employment of any person. Nothing herein contained gives you the right to be retained in the employ of your employer or derogates from the right of your employer to discharge or take other appropriate action against you at any time without regard to the effect of such discharge or action upon your rights under the Plan.

9.12 **No Third-Party Rights under Plan.** Nothing in this Plan, express or implied, is intended, or shall be construed, to confer upon or give to any person, firm, association, or corporation, other than the parties hereto and their successors in interest, any right, remedy, or claim under or by reason of this Plan or any covenant, condition, or stipulation hereof, and all covenants, conditions and stipulations in this Plan, by or on behalf of any party, are for the sole and exclusive benefit of the parties hereto.

9.13 **Nontransferability of Interests.** Except as otherwise required by law, your rights to benefits under this Plan are not subject to your debts or other obligations and may not be voluntarily or involuntarily sold, transferred, alienated, assigned or encumbered.

9.14 **Facility of Payment.** If at any time you are, in the judgment of the Plan Administrator, legally, physically or mentally incapable of receiving any distribution or benefits due to you, the distribution or benefit may, if the Plan Administrator so directs and the law allows, be made to your guardian or legal representative, or, if none exists, to any other person or institution that, in the Plan Administrator's judgment, will apply the distribution in your best interests.

9.15 **Prohibition on Rescissions**. The Benefit Options that are subject to PPACA as "group health plans" will not rescind coverage with respect to any individual once the individual is covered under the Benefit Option, except where the individual has committed an act of fraud, intentional misrepresentation of material fact, or other permitted circumstances, all as described in PPACA. Where coverage is permitted to be cancelled, the Association, as Plan Administrator, or its delegate will provide prior notice of cancellation to the individual as required by PPACA.

9.16 **Amendment of the Plan.** The Association, as the sponsor of the Plan, has the general right to amend or terminate the Plan any time. The Plan may be amended or terminated by a written instrument signed by the Association's Insurance Committee, which is authorized in the Association's Bylaws to amend or terminate the Plan and to sign insurance contracts with the insurance companies, including amendments to those contracts. Note, for this purpose, that an insurance contract is not necessarily the same as the Plan. (An insurance contract is how benefits under a particular component program offered through the Plan are provided.) Consequently, termination of an insurance contract does not necessarily terminate the Plan.

Unless prohibited by law, amendments may take effect retroactively, including the provisions of the Summary to the degree not precluded thereby. No amendment requires the consent of any participant, any participant's spouse, family members or beneficiary, or any other person.

IN WITNESS WHEREOF, the Association has caused this Plan to be executed by its duly authorized officer.

Date: _____ **ALABAMA PHARMACY ASSOCIATION**

By: _____
Name: _____
Title: _____

APPENDIX A

BENEFIT OPTIONS

The following fully-insured Benefit Options are currently offered to Participants:

Type of Benefit Option	Funding
Medical	Insured
Dental	Insured
Group Life/AD&D	Insured

The terms and conditions of these Benefit Options are documented in the applicable Summaries, including the insurance contracts purchased to provide benefits. The Benefit Options are specifically approved by the Association for inclusion under this Plan. The insurance contracts and certificates of coverage setting forth the terms and conditions of each Benefit Option are incorporated by reference into this Plan.

The Association may add or remove Benefit Options provided as a component of this Plan at any time. The Association may also choose to offer one or more wellness programs or disease management programs from time to time as a part of this Plan, as described in Section 3.2 and as communicated to participants. This **Appendix A** should be appropriately revised to reflect such Benefit Option changes.

APPENDIX B

CLAIMS PROCEDURES

B.1. Claims

These procedures apply only if the Benefit Option does not contain procedures that comply with law.

Entitlement to benefits under the Plan is determined by the provisions of all documents forming part of the Plan. If a claim or dispute concerning benefits payable under a Benefit Option arises, the claim or dispute shall be disposed of in accordance with the Summary for such Benefit Option, including all time limitations thereunder. Where an insurance contract exists, the insurance company shall be the "named fiduciary" for purposes of such Benefit Option. If there is no such procedure under the applicable Summary that governs the disposition of a claim or dispute, or such procedure violates applicable law, then the claims procedure described in these procedures shall govern.

Claims for benefits must be made in a timely manner and as provided by the Plan. If your claim for benefits under any Benefit Option offered under this Plan is denied, in whole or in part, the Association (or its delegate) must give you a written notice of the denial within a reasonable amount of time after the claim is received.

If your claim is denied and you want to appeal that decision, it is important to follow the appeal procedure explained below. If you do not follow these procedures, you may be giving up important legal rights, such as the ability to file a claim in a court of law. If the procedures below are exhausted and you are not satisfied with the decision that has been made, you have the right to file a lawsuit.

These review and appeal procedures are governed by federal regulations. If anything described below is contrary to what federal regulations and other federal guidance would require, the federal information will control. Definitions applicable to these procedures appear at the end of the procedures.

These procedures are different depending on the type of benefit that is involved. Generally, one set of rules applies to non-medical/non-disability claims, and another set of rules applies to medical and disability claims. These differences are explained below.

B.2. All Claims Except Medical and Disability Claims

The claims procedures set forth in this Section B.2 of this Appendix are intended to satisfy the applicable requirements of ERISA and the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (together, the "**Health Care Reform Law**") and are to be construed in accordance with ERISA's requirements, the Health Care Reform Law, and the related regulations and guidance (including any such regulations and guidance issued subsequent to the effective date of this Appendix and which are applicable to the Plan). The Plan Administrator has the right to secure independent medical advice and to require such other evidence as it deems necessary in order to decide claims under the Plan.

Notice After a Claim Is Filed.

(a) *This Paragraph Applies to All Claims Except Medical and Disability.* If your claim is wholly or partially denied (a denial is also referred to as an Adverse Determination), you will be notified of the Adverse Determination within 90 days after the claim is received, unless special circumstances require an extension of time. If an extension is required, you will be given written notice of the extension before the 90 day period is over. The extension notice will indicate the special circumstances that require an extension of time and the date by which a decision of the claim is expected. The extension period will not exceed another 90 days to decide the claim.

(b) *Rules for Disability Claims.* If there an Adverse Determination on a claim for disability benefits, you will be notified within a reasonable period of time, but no later than 45 days after your claim is received, unless an extension of up to 30 days is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the 45-day period is over. The extension notice will indicate the circumstances requiring the extension of time and the date by which a decision on the claim is expected. If a decision cannot be made within the first 30-day extension period because of matters beyond the control of the Plan, the period for making the decision may be extended a second time for up to 30 days, provided that you are given notice before the first extension period is over. The notice of any second 30-day extension will indicate the circumstances requiring the extension and the date by which a decision on the claim is expected. Any extension notice will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues. You will be given up to 45 days to provide the additional information, and the period of time for deciding your claim will be tolled until the required information is provided. If the information is not timely provided, your claim may be decided without the information that has been requested.

Content of an Adverse Determination Notice. *This Paragraph Applies to All Adverse Determination Notices.* You will be given written or electronic notice of an Adverse Determination. The notice will:

(a) provide the specific reason or reasons for Adverse Determination,

(b) refer to the specific Plan provisions on which the determination is based,

(c) describe any additional material or information necessary for you to perfect your claim and explain why such material or information is necessary, and

(d) describe the Plan's review procedures and the time limits applicable to the review procedures. The description of the review procedures will include a statement of your right to bring a civil action under ERISA Section 502(a) following an Adverse Determination if you choose to appeal the Adverse Determination.

Additional Rules for Notices Relating to Medical and Disability Claims. The notice will also include the following:

(a) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, you will be notified of either the specific rule, guideline, protocol, or other similar criterion; or will be given a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request; or

(b) If the Adverse Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, you will be given either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request. If there is an Adverse Determination for a medical claim that concerns Urgent Care, you will be given a description of any expedited appeal and review process. An Adverse Determination on an Urgent Care claim may be provided orally, and the oral notice will be followed by written notification within three days after the oral notice is given.

Appeal Procedure if There Is an Adverse Determination on your Claim.

(a) *This Paragraph Applies to All Claims Where There Has Been an Adverse Determination.* You will be given a reasonable opportunity to appeal the determination, and the appeal will be given a full and fair review. An appeal must be submitted in writing to the Plan to the address set forth in the beginning of this booklet under the heading, "General Information About the Plan." The written appeal must be submitted within the time frame described below for the type of claim. You may include written

comments, documents, records, and other information relating to the claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. The review of an appeal will take into account all comments, documents, records, and other information you submit relating to the claim, without regard to whether that information was submitted or considered in the initial determination.

(b) *Deadline to Appeal All Claims Except Medical and Disability.* You must submit your written appeal within 60 days after you receive the notice of an Adverse Determination.

(c) *Deadline to Appeal Disability Claims*. You must submit your written appeal within 180 days after you receive your notice of an Adverse Determination. The review given to your appeal will not afford deference to the initial Adverse Determination and will be conducted by an appropriate fiduciary who is not the individual who made the Adverse Determination that is the subject of the appeal, nor the subordinate of such individual. If the appeal involves an Adverse Determination that is based in whole or in part on a medical judgment, including determinations of whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved or in medical judgment. This professional will be an individual who was not consulted in connection with the Adverse Determination that is the subject of the appeal nor a subordinate of any such individual. The Plan will provide for the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the Adverse Determination, without regard to whether the advice was relied upon in making the determination.

Review of the Appeal you Submit.

(a) *This Paragraph Applies to the Review of All Appeals Except Medical and Disability.* Except as provided below regarding decisions by a committee or board, you will be notified of the benefit determination on review no later than 60 days after receipt of the appeal, unless it is determined that special circumstances (for example, the need to hold a hearing) require an extension of time for processing the appeal. If it is determined that an extension of time is required, written notice of the extension will be furnished before the end of the initial 60-day review period. The extension will not exceed an additional 60 days. The extension notice will indicate the special circumstances requiring and extension of time and the date by which a decision on the appeal is expected. If the extension is necessary because of your failure to submit information necessary to decide the appeal, the period for making the decision will be tolled from the date on which the notice of the extension is sent, until the date you respond to the request for additional information. If the requested information is not provided, the appeal will be decided without the necessary information.

(b) *If a Committee or Board Decides an Appeal (This Paragraph Does Not Apply to Medical or Disability Appeal).* In the case that the Association appoints a committee or board to decide an appeal and that committee/board holds regularly scheduled meetings at least quarterly, a decision will be made no later than the date of the meeting that immediately follows the Plan's receipt of an appeal, unless the appeal is filed within 30 days before the meeting, in which event the decision will be made no later than the date of the second meeting after the Plan's receipt of the appeal. If special circumstances require a further extension of time for processing, a decision will be made no later than the third meeting of the committee or board following the Plan's receipt of appeal. If an extension of time is required because of special circumstances, you will be given a written notice of the extension, describing the special circumstances and the date by which a decision will be made. The extension notice will be provided before the extension period begins. Notice of the decision will be provided no later than five days after a decision has been made.

(c) *Review of Disability Claim Appeals.* Notice of the decision made on the appeal will be given no later than 45 days after receipt of the appeal, unless special circumstances require an extension of time for processing the appeal. If an extension of time is required, written notice of the extension will be given before the end of the initial 45-day review period. The extension period will not exceed another 45 days The extension notice will indicate the special circumstances requiring an extension of time and

the date by which a decision on the appeal is expected. If the extension is necessary because of your failure to submit information necessary to decide the appeal, the period for making the decision will be tolled from the date on which the notice of the extension is sent, until the date you respond to the request for additional information. If the requested information is not provided, your appeal may be decided without the necessary information.

Content of Notice of Decision Made on the Appeal.

(a) *This Paragraph Applies to Notice for All Appeal Decisions.* You will be provided written or electronic notification of the decision that has been made. If the decision is an Adverse Determination, the notice will:

(i) provide the specific reason or reasons for the Adverse Determination,

(ii) refer to the specific plan provisions on which the determination is based,

(iii) include a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim,

(iv) include a statement describing any voluntary appeal procedures offered and your right to obtain formation about a voluntary appeal, and

(v) include a statement of your right to bring an action under ERISA Section 502(a).

(b) *This Paragraph Applies to Notices for Appeal Decisions Related to Medical and Disability Claims*. In addition to the above, the notice will also include the following:

(i) if an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Determination, either the specific rule, guideline, protocol, or other similar criterion will be given; or 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 you upon request;

(ii) if the Adverse Determination is based upon a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

(iii) 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."

Definitions.

(a) *Adverse Determination:* Any of the following: a denial, reduction, termination of, or failure to provide or make payment (in whole or part) for a benefit. This includes denials, etc., based on a determination of eligibility to participate. For a medical plan, it also includes a denial, etc., resulting from the application of any utilization review, as well as failure to cover an item/service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

(b) *Concurrent Care:* Care that involves an ongoing course or number of treatment(s) to be provided over a period of time.

(c) *Post-Service Claim:* Any claim for a benefit under a group medical plan in which receipt of the benefit, in whole or in part, is conditioned upon approval of the benefit in advance of obtaining medical care.

(d) *Urgent Care:* Care under a group medical plan where application of the time periods for making non-urgent determinations (i) could seriously jeopardize your life or health or your ability to regain maximum function, or (ii) in the opinion of a physician with knowledge of your medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

(e) *Relevant:* The document, record, or other information (i) was relied upon in making the benefit determination; (ii) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon; (iii) demonstrates compliance with administrative processes and safeguards; or (iv) in the case of a group medical plan or a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

B.3. All Other Claims, including Medical and Disability Claims

The following claims procedures shall apply (instead of Section B.2) to Benefit Options through "a group health plan" is defined by section 2791(a) of the Public Health Service Act (*i.e.,* an ERISA welfare benefit plan that provides health benefits), whether insured or self-insured.

Notices under this section will be provided to individuals in a "culturally and linguistically appropriate manner" as required by the Health Care Reform Law.

Claims Procedure.

If you believe that you are entitled to receive a benefit under the Plan, including one greater than that initially determined by the Association or another authorized entity, you may file a claim in writing at the address set forth in this booklet under the heading, "General Information About the Plan." References to the Association hereunder shall be deemed to apply to a third-party claims administrator to the extent that the Association has delegated responsibility for review of the claim to such claims administrator by insurance contract or otherwise.

(a) This Section of these claims procedures applies to Adverse Determinations, which are also sometimes referred to in these procedures as "claim denials." For purposes of the claim and appeal processes under this Section of these procedures, an "Adverse Determination" includes a denial, reduction, termination of, failure to provide or make payment (in whole or part) for a benefit, including any such denial, reduction, termination, or failure to provide or make a payment that is based on:

(i) a determination of your eligibility to participate in the Plan or any Benefit Option;

(ii) a determination that a benefit is not a covered benefit;

(iii) the imposition of a preexisting condition exclusion, source-of-inquiry exclusion, network exclusion, or other limitation on otherwise covered benefits; or

(iv) a determination that a benefit is experimental, investigational, or not medically-necessary or appropriate.

A denial, reduction, or termination of, or a failure to provide or make a payment (in whole or in part) for a benefit can include both pre-service claims as well as post-service claims. Failure to make a payment in whole or in part includes any instance where the Plan pays less than the total amount of expenses

submitted with regard to a claim, including a denial of part of the claim due to the terms of the Plan regarding copayments, deductibles, or other cost-sharing requirements. An Adverse Determination also includes any rescission of coverage. For purposes of this Section of these procedures, a "rescission" is a cancellation or discontinuance of coverage that has retroactive effect; provided, however, a cancellation or discontinuance shall not be a "rescission" if (1) the cancellation or discontinuance of coverage has only prospective effect, or (2) the cancellation or discontinuance of coverage is effective retroactively to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

(b) Review of Claims. Except as provided with respect to group health plan claims as described below, a claim will be denied or allowed, in writing within ninety (90) days of the receipt of the claim.

(c) Full and Fair Review. You will be entitled to review your claim file and to present evidence and testimony as part of the claim and appeal process. In addition to complying with the requirements of 29 CFR 2560.503-1(h)(2),

(i) The Plan will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim; such evidence to be provided as soon as possible and sufficiently in advance of the date on which the notice of final Adverse Determination is required to be provided under 29 CFR 2560.503-1(i) to give you a reasonable opportunity to respond prior to that date; and

(ii) Before the Plan can issue a final Adverse Determination based on a new or additional rationale, the claimant shall be provided, free of charge, with the rationale, as soon as possible and sufficiently in advance of the date on which the notice of final benefit determination is required to be provided under 29 CFR 2560.503-1(i) to give the claimant a reasonable opportunity to respond prior to that date.

In addition to the requirements of 29 CFR 2560.503-1(b) - (h) regarding full and fair review, the Plan will ensure that all claims and appeals are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decision. Accordingly, decisions regarding hiring, compensation, termination, promotion, or other similar matters with respect to any individual (such as a claims adjudicator or medical expert) will not be made based upon the likelihood that the individual will support the denial of benefits.

(d) Content of Notice of Claim Denial. A denial of a claim will be written in a manner calculated to be understood by a claimant and will include:

(i) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meaning of the codes;

(ii) the specific reason or reasons for the denial, including the denial code and an explanation of the code, and a description of the standard, if any, that was used in denying the claim;

(iii) specific references to pertinent Plan provisions on which the denial is based;

(iv) a description of any additional material or information necessary for you to perfect the claim and an explanation of why such material or information is necessary;

(v) an explanation of the Plan's Claim and Appeal Procedure, available external review process, and the applicable time limits. The description of the review procedures shall include information regarding how to initiate an appeal and a statement of your

right to bring a civil action under Section 502(a) of ERISA following a claim denial if you choose to appeal the claim denial;

(vi) the contact information for any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you;

(vii) any specific rule, guideline or protocol that was relied upon, or a statement that such rule, guideline or protocol was relied upon and that you may request a copy of such rule, guideline or protocol free of charge;

(viii) if the denial of a claim is based on a medical necessity or experimental treatment exclusion, an explanation of the scientific or clinical judgment, or a statement that you may request such explanation free of charge; and

(ix) in the case of an urgent care claim (as defined below, a description of the expedited review process.

(e) Access to Documents Upon Request. You may request and receive, free of charge, reasonable access to and copies of relevant documents, records and other information in the Plan's possession. Relevant documents, records and other information are those that:

(i) were relied on in making the benefit determination;

(ii) were submitted, considered, or generated in the course of making the benefit determination;

(iii) demonstrate compliance with the Plan's or Benefit Option's administrative processes or safeguards; or

(iv) in the case of a group health plan claim, constitute a statement of the Plan's or Benefit Option's policy or guideline regarding the benefits for your diagnosis, whether or not relied upon.

(f) Appeal of Claim Denial. If your claim is denied, you (or your duly authorized representative) may, within sixty (60) calendar days, or within such other times for group health plan claims as are set forth herein after receipt of denial of the claim:

(i) submit a written request for review to the Plan Administrator;

(ii) review pertinent documents; and

(iii) submit issues and comments in writing.

(g) Continued Coverage During Appeal. You will be entitled to continued coverage pending the outcome of your appeal to the extent mandated by the Health Care Reform Law. For this purpose, the Plan will comply with the requirements of ERISA Section 2560.503-1(f)(2)(ii), which generally provides that benefits for an ongoing course of treatment cannot be reduced or terminated without providing advance notice and an opportunity for advance review. If you are receiving urgent care or an ongoing course of treatment, you may be allowed to proceed with an expedited external review at the same time as the Plan's appeals process, under either a state external review process or the federal external review process, in accordance with the Uniform Health Carrier External Review Model Act promulgated by the National Association of Insurance Commissioners, as applicable.

(h) Review of Appeal of Claim Denial. You will be notified of the Plan's decision on review within sixty (60) calendar days after the Plan's receipt of a request for review. In the case of a group health plan claim, you will be notified within the applicable period as set forth herein.

(i) Content of Notice of Claim Denial on Appeal. The decision on review will be written in a manner calculated to be understood by a claimant and will include:

(i) information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), the diagnosis code, the treatment code, and the corresponding meaning of these codes;

(ii) the specific reason or reasons for claim denial, including the denial code and an explanation of the code, a description of the standard, if any, that was used in denying the claim, and in the case of a final internal claim denial, a discussion of the decision;

(iii) specific references to pertinent Plan provisions on which the decision is based;

(iv) a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim;

(v) a statement describing any voluntary appeal procedures offered and your right to obtain information about a voluntary appeal, and the applicable time limits;

(vi) a statement of the Plan's external review process, and the applicable time limits, including information regarding how to initiate the process;

(vii) a statement of your right to bring an action under Section 502(a) of ERISA;

(viii) the contact information any applicable consumer assistance office established under Section 2793 of the Public Health Service Act to assist you with these Claim and Appeal Procedures;

(ix) The review of your claim must be performed by someone who is neither the original decision-maker nor the subordinate of the original decision-maker. In reviewing the initial decision, the decision-maker may not give deference to the initial decision, and he or she must consider all information relevant to your claim, regardless of whether such information was relied upon or available when the original decision was made. The decision-maker must also consider any information submitted by you; and

(x) If denial of the group health plan claim was based on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not medically-necessary or appropriate, the decision-maker reviewing your claim will consult with a health care professional with appropriate training and experience in the field of medicine involved in the medical judgment. Medical or vocational experts whose advice was obtained on the Plan's behalf in connection with denial of a claim will be identified for you. If a health care professional is engaged for purposes of consultation in deciding an appeal of denial of a claim, such professional will not be the same individual (or the subordinate of such individual) who was consulted in the initial denial of your claim.

(j) Extension of Review Period. The 90-day and 60-day periods described above, may be extended at the discretion of the Plan Administrator for a second 90- or 60-day period, as the case may be, provided that written notice of the extension is furnished to you prior to the termination of the initial

period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected. Extension of review periods for group health plan benefit claims are described below.

(k) Special Requirements for Group Health Plan Claims. In addition to the foregoing requirements, this paragraph will apply to claims for benefits arising under a group health plan Benefit Option.

(i) Definitions. The following definitions are used for the purposes of this section (k).

(i) Pre-service claims. A pre-service claim is any claim for a benefit under a group health plan with respect to which the applicable Benefit Option requires you to obtain approval in advance of receiving the medical care.

(ii) Urgent-care claims. An urgent care claim is any claim for medical care under a group health plan with respect to which the applicable time periods for the Plan Administrator to make a non-urgent service claim determination could either (x) seriously jeopardize (1) your life or health; or (2) your ability to regain maximum function; or (y) in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without urgent care or treatment.

(iii) Post-service claims. A post-service claim is any claim for a benefit for medical care previously rendered to you.

(iv) Concurrent care claims. A concurrent care claim is a claim for which the Plan Administrator approves ongoing treatment to be provided over a period of time.

(ii) Time Period for Submission of Claims. You must submit claims for all group health plan benefits to the Plan Administrator (or its delegate) within one year from the date service was provided. If you do not submit claims for group health plan benefits within one year from the date service was provided, you will be ineligible to receive reimbursement from the applicable Benefit Option for any expenses incurred, and you will be responsible for payment of all expenses incurred.

(iii) Time Period for Review of Claims. An initial determination will be made with respect to any claim for benefits under a group health plan Benefit Option within the following deadlines:

(i) Pre-service claims. With respect to pre-service claims that are not urgent care claims, an initial decision will be made within fifteen (15) calendar days after the claim is filed. If insufficient information is provided to enable the Plan Administrator to make a determination on a pre-service claim, the Plan Administrator shall notify you of the Benefit Option's requirements for a pre-service claim unless you do not specify a medical condition or symptom and specific treatment, service, or product for which a determination is requested. The 15-day period for making a decision may be extended, at the discretion of the Plan Administrator, for a second 15-day period, provided that written notice is furnished to you prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected. Pre-service claims for urgent care will be treated as urgent care claims in accordance with section (k)(iii)(2).

(ii) Urgent-care claims. With respect to urgent care claims (including pre-service claims for urgent care), an initial determination will be made as soon as possible, taking into account the medical circumstances, but no later than twenty-four (24) hours after the claim is filed. If insufficient information is provided to enable the Plan Administrator to make a determination regarding whether, or to what extent, benefits are covered or payable under the Plan on an urgent care claim, the Plan Administrator shall notify you as soon as possible, but no later than twenty-four (24) hours after its receipt of the urgent care claim, of the specific information necessary to enable the Plan Administrator to make a decision on your claim. You must provide the requested information within a reasonable amount of time, but no less than forty-eight (48) hours after notification by the Plan Administrator of the deficiency. The Plan Administrator shall then notify you of its determination within forty-eight (48) hours after the earlier of its receipt of the requested information or the end of the period within which you were requested to provide such additional information.

(iii) Post-service claims. With respect to post-service claims, an initial determination will be made on the claim within thirty (30) calendar days after the claim is filed. The 30-day period for making a decision may be extended, at the discretion of the Plan Administrator for a second 30-day period, provided that written notice is furnished to you prior to the termination of the initial period, indicating the special circumstances requiring such extension of time and the date by which a final decision is expected.

(iv) Concurrent care claims. In general, concurrent care claims are treated as pre-service care claims pursuant to section (k)(iii)(2), above. However, if a group health plan Benefit Option reduces or no longer covers a previously-approved treatment or course of treatments prior to the end of the approved period of time for the treatment or course of treatments, you will be notified of the reduction or termination of coverage sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination before such benefit is reduced or terminated. See section (k)(iv)(4), below regarding appeals of such adverse determinations.

(iv) Appeal of Adverse Determinations. Appeals of adverse determinations with respect to benefits under a group health plan Benefit Option must be made in writing (except for urgent care claims, which may be made orally as well) to the Association's address (set forth in the beginning of this booklet under the heading, "General Information About the Plan") and must contain the reasons that you believe that you are entitled to such benefits as well as any additional information or documentation to support your claim for benefits. Such appeals shall be subject to the following requirements:

(i) Pre-service claims. Decisions on appeals of pre-service claims must be made within thirty (30) calendar days following receipt of the appeal of the adverse determination.

(ii) Urgent-care claims. Appeals of adverse determinations of urgent care claims may be submitted orally or in writing. Decisions on appeals of adverse decisions must be made within seventy-two (72) hours following receipt of the appeal of the adverse determination.

(iii) Post-service claims. Decisions on appeals of pre-service claims must be made within thirty (30) calendar days following receipt of the appeal of the adverse determination.

(iv) Concurrent care claims. If you wish to extend a treatment or course of treatments that was previously approved by the Plan Administrator, but a group health plan Benefit Option subsequently reduces or terminates coverage of such treatment or course of treatments prior to the expiration of the period of time or number of treatments for which such treatment or course of treatment was approved, you may appeal the reduction or termination of coverage as an Adverse Determination. If such appeal would be an urgent care claim, as defined above in section (k)(i)(2), you should notify the Plan Administrator at least twenty-four (24) hours prior to the expiration of the previously-approved period of time or number of treatments to request extended coverage. If you adhere to the deadlines in the previous sentence, a decision on such appeal must be made within twenty-four (24) hours after its receipt by the Plan Administrator. In all other instances, appeals regarding an Adverse Determination involving concurrent care claims shall be treated, as applicable, as pre-service claim appeals, urgent care claim appeals, or post-service claims appeals, and subject to sections (k)(iv)(1), (2), or (3), as applicable.

The "full and fair review" requirements provided above shall apply to the internal appeal procedures.

(l) Finality of Review on Appeal. You will not be entitled to challenge the Plan Administrator's determinations in judicial or administrative proceedings without first complying with these claims procedures. The decisions made pursuant to these procedures are final and binding on you, your beneficiaries and any other party; provided, however, that if you have exhausted the administrative claims procedure set forth in the Plan, you may seek review of your claim before a court of competent jurisdiction within twelve (12) months after the date your claim is finally denied.

(m) Strict Compliance Required. The Plan intends to strictly comply with the applicable Health Care Reform Law requirements and federal regulations relating to internal claims and appeals processes.

(n) External Review. Following a claim denial, other than a claim denial relating to you or your beneficiary's eligibility, you may also be entitled to initiate a claim for an external review under either state or federal external review procedures. This Plan intends to comply with the state and federal external review procedures, as applicable, and you will be provided with information describing your rights to file a request for an external review of a claim denial in accordance with these procedures.

(o) Communications. For purposes of these procedures, communications to the Plan Administrator may be addressed to the "claims administrator" designated in the Summary materials for the applicable Benefit Option. If none is designated, then to the address set forth in the beginning of this booklet under the heading "General Information About the Plan.":

Proof of Loss.

Except to the extent that a different date is provided in the Summary for the Benefit Option or in this Appendix B, written proof covering the occurrence, the character, and the extent of loss must be furnished to the Plan Administrator by the end of the calendar year following the calendar year in which loss occurred. Failure to furnish notice of proof within the required time will not invalidate nor reduce any claim if it is shown that you gave notice or proof as soon as was reasonably possible, but in no event later than one year from the time proof is otherwise requested. The Plan Administrator will furnish such forms as are usually furnished by it for filing proofs of loss.

Failure to insist upon compliance with any provision of this procedure at any given time or times or under any given set or sets of circumstances does not operate to waive or modify such provisions, or in any matter whatsoever to render the procedures unenforceable, whether the circumstances are, or are not, the same.