Summary Plan Description*

for the

IASIS Healthcare Welfare Benefit Plan

January 1, 2015

* This document, together with the benefit program booklets prepared by the providers listed in the section entitled Benefit Programs and Providers for the benefit programs in which you are enrolled, constitutes your Summary Plan Description for the IASIS Healthcare Welfare Benefit Plan.
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ARTICLE I.
INTRODUCTION

IASIS Healthcare, LLC (the “Employer”) maintains the IASIS Healthcare Welfare Benefit Plan (the “Plan”) for the exclusive benefit of its Eligible Employees and their eligible family members. The Plan provides welfare benefits through the benefit programs listed in the Benefit Programs and Providers section of this SPD. That section also includes a listing of the insurance companies and any third party administrators (collectively referred to throughout this document as “providers”) insuring and/or administering the benefit programs under the Plan.

You may not be eligible to choose from all of the benefit programs in the Plan. Eligibility to participate in a particular benefit program may depend on certain things, such as the number of hours you are scheduled to work, etc. You will be provided with information about which benefit programs you may be eligible to participate in when you first become eligible and during the annual open enrollment period. Information is also available in the section entitled Benefit Programs and Providers. You may also contact the Plan Administrator, whose contact information appears in Important Information About the Plan below.

The benefit programs are summarized in certificate of insurance or evidence of coverage booklets issued by insurance companies, or other documents prepared by providers or the Employer. These are collectively referred to throughout this document as “benefit program booklets.” A copy of each such benefit program booklet is available at no charge upon request from the Plan Administrator, whose contact information appears in Important Information About the Plan below.

The benefit program booklets contain important information about the benefit programs. However, they do not contain all of the information required by a federal law called the Employee Retirement Income Security Act of 1974, as amended (“ERISA”) to appear in a summary plan description. Therefore, this document together with the benefit program booklets for the welfare benefits in which you are enrolled, as well as any summaries of material modifications (“SMMs”) to these documents, constitute your Summary Plan Description (or “SPD”) for the Plan, as required by ERISA. These documents should be read together and kept together.

Many of the capitalized terms appearing in this SPD have special meaning and are defined in the Definitions section of this SPD.

ARTICLE II.
IMPORTANT INFORMATION ABOUT THE PLAN

2.1 Plan Name

The Plan is named the IASIS Healthcare Welfare Benefit Plan.
2.2 **Type of Plan**

The Plan is a welfare plan providing the benefit programs listed in the section of this SPD entitled *Benefit Programs and Providers*.

2.3 **Plan Year**

The Plan’s records are kept on a January 1 to December 31 basis.

2.4 **Plan Number**

The ERISA plan number assigned to this Plan by the Plan Sponsor is 501.

2.5 **Effective Date**

The effective date of this Summary Plan Description is January 1, 2015. The Plan has been amended since its original effective date, most recently as of January 1, 2015.

2.6 **Plan Sponsor**

The name and address of the Plan Sponsor are:

IASIS Healthcare, LLC  
117 Seaboard Lane, Building E  
Franklin, Tennessee  37067

2.7 **Plan Sponsor’s Employer Identification Number (EIN)**

The employer identification number assigned by the Internal Revenue Service to the Plan Sponsor is 20-1150104.

2.8 **Insurance Companies and Other Providers**

The names and addresses of the insurance companies and other providers are listed in the *Benefit Programs and Providers* section of this SPD.

2.9 **Plan Administrator**

The name, business address, and business telephone number of the Plan Administrator are:

IASIS Healthcare, LLC  
117 Seaboard Lane, Building E  
Franklin, Tennessee  37067

Telephone: (615) 844-2747

If you have any general questions about the Plan, you may contact Ginger Walker, who acts on behalf of the Plan Administrator on a day-to-day basis, at (615) 467-1231.
2.10 Funding Medium and Type of Plan Administration

Some of the benefit programs under the Plan are self-insured and some are fully-insured. Benefits under the self-insured benefit programs are paid in part by Eligible Employees’ payroll deductions and in part by the Employer out of its general assets.

The fully-insured benefit programs under the Plan are insured under group contracts or policies entered into between the Employer and insurance companies. The insurance companies, not the Employer, are responsible for paying claims under these benefit programs. Insurance premiums for the fully-insured benefit programs are paid in part by Eligible Employees’ payroll deductions and in part by the Employer out of its general assets.

The Plan Administrator provides a schedule of the applicable premium contributions during the initial enrollment and subsequent annual open enrollment periods, and at any time on request, for each of the benefit programs, as applicable. The Employer provides Eligible Employees the opportunity to pay for certain benefit programs on a pre-tax basis through the Employer’s Flexible Benefits Plan, a cafeteria plan within the meaning of Section 125 of the Code (the “Flexible Benefits Plan”), which is a part of this Plan. The benefit programs currently available for pre-tax premium payment under the Flexible Benefits Plan are listed in the Benefit Programs and Providers section of this SPD.

The Employer shares responsibility with the providers for administering these benefit programs, as described under How the Plan is Administered below. More information is also available in the benefit program booklets.

2.11 Treatment of Medical Loss Ratio (“MLR”) Rebates Received by the Employer as Policyholder

If the Employer, as the policyholder of any medical insurance policy under the Plan, receives a MLR rebate from an insurer, the Plan Administrator has the discretion to (a) calculate the applicable portion, if any, of such rebate proceeds as is attributable to participant contributions and (b) determine in its discretion how to use that portion (if any) for the benefit of applicable participants which may include applying the rebate toward future participant premiums or toward future benefit enhancements. Except as determined in (a) above, no other portion of any such rebate will be considered Plan assets for any purpose.

2.12 Agent for Service of Legal Process

The name and address of the Plan’s agent for service of legal process are:

CT Corporation
1201 Peachtree Street N.E.
Team 3
Atlanta, Georgia 30361

Service of legal process may also be made on the Plan Administrator.
2.13 Conflicting Provisions

If the terms of this Summary Plan Description conflict with the terms of the Plan Document or any insurance contract or policy, then the terms of the Plan Document or the insurance contract or policy, rather than this Summary Plan Description, will control, except as required by ERISA.

Except as otherwise specifically provided in the Plan Document, any statement or representation, whether oral, written, electronic, or otherwise, made by the Plan Administrator, a provider (an insurance company or third party administrator), or any other individual or entity that alters, modifies, amends, or is inconsistent with the written terms of the official plan documents of the Plan shall be invalid and unenforceable and may not be relied upon by any employee, participant, beneficiary, provider, or other individual or entity.

2.14 Amendment and Termination

The Plan may be amended or terminated at any time, in the sole and unlimited discretion of the Plan Sponsor without advance notice to any person (except as may be required by law). The policies and contracts may also be amended or terminated at any time in accordance with their terms. No participant or beneficiary shall have any right to continuing benefits except to the extent required by law.

2.15 No Contract of Employment

The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement for employment between you and the Employer.

ARTICLE III.
ELIGIBILITY AND PARTICIPATION

3.1 Eligibility

Eligible Employees
An Eligible Employee under the Plan is an employee who meets the general eligibility requirements of the Plan, described below, and who also meets the eligibility requirements described in the benefit program booklet for the particular benefit(s).

   (a) Eligible Employee – to be eligible under the Plan, you must be a full-time employee who is regularly scheduled to work 36 or more hours per week, or a part-time employee who is regularly scheduled to work 30 to 35 hours per week.

Eligible Dependents
An eligible dependent under the Plan is one who meets the general eligibility requirements of the Plan, described below and in the enrollment materials, and who also meets the eligibility requirements described in the benefit program booklet for the particular benefit(s) (except as otherwise required by law).
(a) Eligible dependent child* – to be eligible under the Plan, the child must be your child ("child" includes your natural child, stepchild, legally adopted child, foster child, or child for whom you have legal guardianship) who has not yet attained age 26. Coverage may also be available beyond this maximum age for a disabled unmarried dependent child. Refer to the benefit program booklet(s) for more information.

(b) Eligible spouse* – to be eligible under the Plan, the spouse must be legally married to you (and must be considered your spouse for federal income tax purposes). The following are not eligible for coverage under the Plan: (1) your spouse if you are legally separated; (2) your spouse if you have been physically separated for six months or more; (3) your former spouse, if you are divorced, even if your divorce decree requires you to cover your former spouse; and (4) your common law spouse, civil union spouse, or domestic partner (of the same or opposite sex).

The Plan, in its sole discretion and at times of its own choosing, reserves the right to audit employees and dependents to ensure that all participants meet the eligibility requirements of the Plan. Specifically, the Plan reserves the right to:

(a) Remove dependents from coverage if they are found to be ineligible during an audit or if they do not comply with audit requests for information and/or verification documents.

(b) Seek repayment of premium and claims incurred for dependents who have been found, during an audit, to be ineligible or who are non-compliant with the audit.

(c) Terminate the employment of employees in case of benefit eligibility fraud.

If removal of an ineligible dependent from the Plan results in you being in a new coverage tier, your premium contributions will not be changed until the next Plan Year begins.

The Plan, in its discretion, may or may not offer COBRA coverage to dependents who are found to be ineligible or non-compliant during the audit.

*Important Note – No Duplication of Coverage: If both you and your spouse are Eligible Employees under the Plan, only one of you may cover your child(ren), and your spouse may be covered either as an employee, or as your dependent, but not both.

3.2 Participation

Certain benefit programs require that you make a timely election to enroll for coverage. Information about enrollment procedures is provided by the Employer when you first become eligible and during the annual open enrollment period. Information about when various benefit programs’ coverage begins is described in the applicable benefit program booklets and is summarized in the section of this SPD entitled Benefit Programs and Providers. Information about when various benefit programs end is also found in the applicable benefit program booklets, and below, under Termination of Participation.
You must generally enroll for coverage under the benefit programs within 30 days of first becoming eligible. If you fail to enroll within 30 days of your initial eligibility date, you may have to wait until the next annual open enrollment period (or later, in the case of some benefit programs) to enroll. Under certain circumstances, however, you and your dependents may be able to enroll in certain benefit programs without waiting for the next annual open enrollment period, as described below.

### 3.3 Special Enrollment Rights

| Important—If you decline medical coverage for yourself and/or other eligible dependents because you and/or they have other coverage in effect, you must waive that coverage during the enrollment process in order to retain certain special enrollment rights under the Plan. Refer to the enrollment materials or contact the Plan Administrator for information. |

**HIPAA Special Enrollment Rights—Loss of Other Group Health Plan Coverage or Acquisition of a New Dependent**

Under HIPAA, a special enrollment period for group health plan coverage may be available if you lose coverage under certain conditions or when you acquire a new dependent by marriage, birth, adoption, or placement for adoption.

If you decline enrollment for yourself or your dependent child(ren) and/or your spouse because of other health insurance coverage or group health plan coverage, you may be able to enroll yourself and your dependents in this Plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your other dependents’ other coverage). However, you must request enrollment within 31 days after your or your dependents’ other coverage ends (or after the employer stops contributing toward the other coverage). If you timely request enrollment, coverage will be effective for those enrolled as of the date your or your dependents’ other coverage ends (or as of the day the employer stops contributing toward other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 31 days after the marriage, birth, adoption, or placement for adoption. If you timely request enrollment, coverage will be effective for those enrolled as of the date of the marriage, birth, adoption, or placement for adoption.

To request HIPAA special enrollment or obtain more information, contact the Plan Administrator, whose contact information appears under Important Information About the Plan above. You must provide supporting documentation when requesting HIPAA special enrollment.

**CHIPRA Special Enrollment Rights—Medicaid- or CHIP-Related Events**

Under CHIPRA, a special enrollment period for group health plan coverage may be available if you or your dependent child(ren) lose coverage under a plan under Title XIX of the Social
Security Act ("Medicaid") or under a state child health plan under Title XXI of the Social Security Act ("CHIP"), if that coverage is terminated due to loss of eligibility; or you or your dependent child(ren) become eligible for financial assistance under Medicaid or CHIP with respect to coverage under this Plan. However, you must request enrollment within 60 days of the occurrence of either of these events. If you timely request enrollment, coverage will be effective for those enrolled as of the date Medicaid or CHIP coverage is terminated due to loss of eligibility or you or your dependent(s) become eligible for financial assistance under Medicaid or CHIP with respect to coverage under the Plan.

To request CHIPRA special enrollment or obtain more information, contact the Plan Administrator, whose contact information appears under Important Information About the Plan above. You must provide supporting documentation when requesting CHIPRA special enrollment.

**Qualified Medical Child Support Orders**

With respect to benefit programs that are group health plans, the Plan will also provide benefits as required by any qualified medical child support order as defined in ERISA ("QMCSO"). The Plan has in place procedures for determining whether an order (which may be in the form of either a medical child support order or a National Medical Support Notice) qualifies as a QMCSO. Participants and beneficiaries can obtain a copy of these procedures on request, without charge, from the Plan Administrator.

**Other Election Changes During the Year**

You may experience certain other events during the Plan Year that will allow you to make certain corresponding Plan election changes during the year, provided you timely notify the Plan of the event. These are discussed in the benefit program booklet for the Flexible Benefits Plan document and in the applicable benefit program booklet(s). Contact the Plan Administrator, whose contact information appears under Important Information About the Plan above, for more information.

3.4 **Coverage During Certain Leaves of Absence**

The Plan will provide benefit continuation rights as required during a period of qualifying leave under the FMLA and USERRA as described below. Contact the Plan Administrator or refer to the sections below and the Employer's applicable leave of absence policies for more information.

**FMLA Leave**

If you go on a qualifying leave under the FMLA, to the extent required by the FMLA, you may elect to either revoke or continue group health plan coverage during the leave. If you elect to retain coverage, the Employer will first attempt to collect your share of the cost of that coverage during that leave by reducing any taxable compensation payable to you during the leave. If your compensation is not enough to cover your share of contributions, you may (i) pay your contribution with after-tax dollars while on leave, or (ii) prepay all or a portion of your share of the cost for the expected duration of the leave on a pre-tax salary reduction basis out of pre-leave...
compensation (however, pre-tax dollars may not be used to fund coverage during the next Plan Year). Upon return from the FMLA leave, you may generally reenter the Plan on the same terms that applied prior to taking the leave. Refer to the Employer’s FMLA leave of absence policy for more information.

**Military Leave Under USERRA**

If you are absent from employment with the Employer because you are in “uniformed service,” you may elect to continue group health plan coverage under the Plan as required by USERRA. The coverage period may continue for up to 24 months (and will run concurrently with any COBRA continuation coverage, to the extent allowed by law). Refer to the Employer’s USERRA leave of absence policy for more information.

3.5 **Termination of Participation**

Your participation (and the participation of your eligible family members) in the Plan will generally end as of the last day of the payroll period during which your eligibility or your employment with the Employer ends. Coverage will also terminate if you fail to pay your share of an applicable premium, if your hours of service drop below the required hours threshold for the particular benefit, if you make a false representation or commit fraud under or with respect to the Plan (discussed immediately below), or for any other reason described in this SPD or the benefit program booklet(s). Coverage will also end if the Plan is terminated. You should review the benefit program booklet(s) for other termination events and additional information.

**Termination of Coverage for False Representations or Fraud**

If any individual makes a false representation to, or commits any fraud under or with respect to, the Plan, the Plan Administrator has the right to permanently terminate coverage for the individual and his or her dependents, to the extent permitted by law. This may include, for example, submitting falsified claims or covering an individual who is not eligible to participate in the Plan (adding a spouse before the date of marriage or continuing to cover the spouse after a divorce, or adding a child who does not meet the Plan’s definition of an eligible dependent, etc.). To the extent permitted by law, the Plan Administrator may seek reimbursement for all claims or expenses paid by the Plan as a result of the false representation or fraud, and may reduce future benefits as an offset for amounts that should be reimbursed, or pursue legal action against the individual.

With respect to medical coverage under the Plan, any termination of coverage under this provision will generally be effective on a prospective basis. However, in the case of fraud or an intentional misrepresentation of material fact, coverage may be terminated retroactively (called a “rescission” of coverage), in which case the affected individual(s) will receive notice and will be provided the opportunity to appeal the rescission, as required by law (refer to Appendix A of this SPD for information).
3.6 COBRA or Other Continuation Rights

You may be eligible for continuation coverage under COBRA or for conversion policies under state law (if applicable) when your coverage under this Plan terminates. Information about continuation coverage under COBRA is contained in the section of this SPD entitled COBRA Continuation Coverage. Important notice requirements you must follow in order to preserve your rights under COBRA are described in that section. If you have questions about any conversion rights you may have under state law, refer to the applicable benefit program booklet(s) or contact the provider.

ARTICLE IV.
WELFARE BENEFITS UNDER THE PLAN

The Plan provides you and your eligible family members with a choice among the benefit programs listed in Benefit Programs and Providers section of this SPD. A description of the benefits provided under each benefit program of the Plan is set forth in each program’s benefit program booklet.

The benefits under this Plan may be subject to cost-sharing provisions, premiums, deductibles, co-insurance, copayment amounts, annual or lifetime benefit maximums, pre-authorization requirements or utilization review. There may also be limitations on the selection of primary care or network providers, limits on emergency medical care, or limited coverage for preventive services, new or existing prescription drugs, medical tests, medical devices or medical procedures. These limitations are set forth and are explained in the particular benefit program booklet(s). Where a benefit program has a network of providers, instructions on how to obtain a provider list will be furnished.

4.1 Special Rights on Childbirth Under the Newborns’ and Mothers’ Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a normal 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). If you are enrolled in an insured medical benefit program, the laws of your state related to hospital stays in connection with childbirth may differ from these federal requirements. For more information, refer to the applicable medical benefit program booklet or contact the provider of your particular coverage for specific information. Please also see Section 3.3 of this SPD for more information on enrolling your newborn dependent in group health plan coverage in order for his or her coverage to extend beyond the required 48 hours (or 96 hours as applicable).
4.2 Mastectomy-Related Benefits Under the Women’s Health and Cancer Rights Act of 1998

If you have had or are going to have a mastectomy, 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:

(a) All stages of reconstruction of the breast on which the mastectomy was performed;
(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance;
(c) Prostheses; and
(d) 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 the Plan. Your medical benefit program booklet describes these deductibles and coinsurance.

If you would like more information on WHCRA benefits under a particular medical benefit program, contact the provider or the Plan Administrator.

4.3 Wellness Program Under the Plan – Tobacco Surcharge on Medical Premiums

The medical coverage under the Plan includes a tobacco surcharge; that is, if you and/or your spouse use tobacco, you will pay a higher premium for medical coverage under the Plan. You will have the opportunity at least once per Plan Year to complete an affidavit on the Lawson Self-Service Enrollment System, certifying your and your spouse’s tobacco non-use in order to avoid the tobacco surcharge (for example, for the 2015 Plan Year, you may certify to tobacco non-use during the open enrollment period held in late 2014 to avoid the surcharge for the 2015 Plan Year). Please note that if you or your spouse indicate that you do not use tobacco products but in fact do, you will be subject to the tobacco surcharge for the remainder of the year and will also be subject to disciplinary action for falsifying a document.

All employees (and their spouses) have the opportunity to avoid the tobacco surcharge. If you think you and/or your spouse might be unable to certify that you are a non-tobacco user in order to avoid the tobacco surcharge under this program, each of you might qualify for an opportunity to avoid the surcharge by different means, such as through participation in the American Lung Association Freedom from Smoking online program offered by IASIS. Contact your HR Director and he/she will work with you (and, if you wish, with your doctor) to find a wellness program with the same reward that is right for you in light of your health status.

More detailed information about the wellness program is available in the enrollment materials for the Plan, and on the IASIS Healthcare website.
4.4 Availability of Summary Health Information—Summaries of Benefits and Coverage (SBCs) for the Medical Coverages of the Plan

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in the case of illness or injury.

Choosing a medical coverage option is an important decision. To help you make an informed choice, your Plan makes available a Summary of Benefits and Coverage (SBC) for each medical coverage option, which summarizes important information about any health coverage option in a standard format, to help you compare across options.

The SBCs for the medical coverage options available under the Plan are provided in your enrollment materials and at other times as required by law. A paper copy of each such SBC is also available, free of charge, on request from the Plan Administrator.

ARTICLE V.
HOW THE PLAN IS ADMINISTERED

5.1 Plan Administration

The Plan Administrator (named in the Important Information About the Plan section above) is a named fiduciary within the meaning of ERISA and has the sole and unlimited discretionary authority to administer and control the Plan in accordance with its terms, to interpret the Plan, and to determine eligibility for participation and for benefits under the terms of the Plan.

The principal duty of the Plan Administrator is to see that the Plan is carried out in accordance with its terms and for the exclusive benefit of participants and beneficiaries. The administrative duties of the Plan Administrator include, but are not limited to, interpreting the Plan, prescribing applicable procedures, determining eligibility for and the amount of benefits, and authorizing benefit payments and gathering information necessary for administering the Plan. The Plan Administrator may delegate any of these administrative duties among one or more persons or entities.

The insurance companies, HMOs, and other providers listed in the Benefits Programs and Providers section of this SPD may be responsible for any or all of the following: (1) determining eligibility for benefits under their respective benefit programs; (2) determining the amount of any benefits payable under their respective benefit programs; and (3) prescribing claims procedures to be followed and the claim forms to be used by Eligible Employees or beneficiaries under benefit programs they insure and/or administer. Refer to the applicable benefit program booklet for specific information.

5.2 Effect of Determinations Under the Plan

Any determination by the Plan Administrator (or its designee) is final and conclusive, unless arbitrary or capricious. As a condition of coverage under the Plan, you agree that whenever the
Plan Administrator (or its designee) makes a reasonable determination in the administration of the Plan, such determination shall be final and conclusive.

**ARTICLE VI.**
**CIRCUMSTANCES WHICH MAY AFFECT BENEFITS**

**6.1 Denial or Loss of Benefits**

Your benefits (and the benefits of your eligible family members) will cease when your participation in the Plan terminates. See *Termination of Participation* above. Your benefits will also cease on termination of the Plan.

Other circumstances can result in disqualification or ineligibility, or the termination, reduction or denial of benefits. For example, benefits may be denied under the dental benefit program if you have a preexisting condition and incur costs within the exclusionary period. You should consult the benefit program booklet(s) for information.

**6.2 Claims for Benefits**

To claim benefits under the Plan, you (or a beneficiary) must use the Plan’s claims procedures, which are generally described in *Appendix A* to this SPD, and more specifically described in the applicable benefit program booklet(s). Your claims for benefits will be decided in accordance with reasonable claims procedures, as required by ERISA and the Affordable Care Act (if applicable).

*You must fully follow and exhaust the Plan’s claims procedures before you can file a lawsuit in state or federal court.*

**ARTICLE VII.**
**TAX CONSIDERATIONS UNDER THE PLAN**

**7.1 No Guarantee of Tax Consequences**

The Employer does not make any commitment or guarantee that any amounts paid to or for the benefit of any person under the Plan will be excludable from that person’s gross income for federal, state, and/or local income tax purposes, or that any other tax treatment will apply or be available to that person.

**7.2 Your Responsibility Under the Plan**

You are responsible for determining whether each payment or benefit under the Plan is excludable from your gross income for federal, state, and/or local income tax purposes, and to notify the Plan Administrator if you have any reason to believe that such payment is not so excludable.
ARTICLE VIII.
STATEMENT OF ERISA RIGHTS

This Statement of ERISA Rights is required by federal law and regulation. (Note that this Statement of ERISA Rights does not apply to the Flexible Benefits Plan or the Dependent Care Flexible Spending Account offered under the Flexible Benefits Plan.)

As a participant in the Plan, you are entitled to certain rights and protections under ERISA.

ERISA provides that all participants in the Plan shall be entitled to:

8.1 Receive Information About Your Plan and Benefits

(a) Examine, without charge, at the Plan Administrator’s office and at other specified locations, all documents governing the Plan, including insurance contracts 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.

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

(c) Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

8.2 Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents have to pay for such coverage. Review the COBRA Continuation Coverage section of this SPD and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

8.3 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 the employee benefit plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.
8.4 Enforce Your Rights

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 (adjusted for inflation) 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. 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. 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.

8.5 Assistance with Your Questions

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

ARTICLE IX.
COBRA CONTINUATION COVERAGE

It is important that you follow the notification procedures described under Your Notice Obligations below. Failure to follow these notification procedures will result in the loss of your rights under COBRA.

This section explains your rights and responsibilities under COBRA. You and your dependents should read this material carefully and keep it with your records. COBRA is a federal law that requires most group health plans to give Eligible Employees and their eligible family members the opportunity to continue their health care coverage at their own expense for a period of time when there is a “qualifying event” that results in a loss of coverage under the Plan. For
additional information about your rights and responsibilities under the Plan and under federal law, you should contact the Plan Administrator, whose contact information appears in the section entitled Important Information About the Plan. You may also contact the COBRA administrator whose contact information is available in the COBRA notices you receive.

9.1 COBRA Qualifying Events

COBRA continuation coverage is a continuation of coverage under the group health plan when such coverage would otherwise end because of a life event known as a “qualifying event.” After a qualifying event, COBRA continuation coverage must be offered to each person who is a “qualified beneficiary.” Under the group health plan, qualified beneficiaries who elect COBRA continuation coverage must pay for such COBRA continuation coverage.

If you are an Eligible Employee participating in the Plan, you will become a “qualified beneficiary” if you lose your coverage under the group health plan because of one of the following “qualifying events:”

(a) Your employment ends for any reason other than your gross misconduct; or

(b) Your hours of employment are reduced.

If you are on an approved leave of absence subject to the FMLA, only the failure to return to work at the end of the approved leave constitutes a “qualifying event.” If you are on an approved military leave of absence under USERRA for less than 31 days and you fail to return to work at the end of the leave, your “qualifying event” occurs on the first day after you fail to return to work at the end of your leave.

If you are the spouse or dependent child of an Eligible Employee participating in the Plan, you will become a “qualified beneficiary” if you lose your coverage under the group health plan because of any of the following “qualifying events:”

(a) The Eligible Employee dies;

(b) The Eligible Employee’s employment ends for any reason other than his or her gross misconduct;

(c) The Eligible Employee’s hours of employment are reduced;

(d) The Eligible Employee becomes entitled to Medicare benefits (under Part A, Part B, or both);

(e) The Eligible Employee and his or her spouse divorce or legally separate; or

(f) In the case of a dependent child, the child ceases to be a “dependent child” under the terms of the Plan.

A spouse and/or dependent children who do not have dependent health care coverage under the Plan on the day before a qualifying event are not qualified beneficiaries and are
therefore not generally eligible for COBRA continuation coverage. However, a child born to or placed for adoption with an Eligible Employee during a period of COBRA continuation coverage is a qualified beneficiary. The covered Eligible Employee or family member must notify the Plan within 30 days of the birth or placement for adoption to enroll the child for COBRA continuation coverage. Additionally, a child of the covered Eligible Employee who is receiving benefits under the Plan pursuant to a QMCSO received by the Plan Administrator during the covered Eligible Employee’s period of employment with the Employer is entitled to the same rights under COBRA as a dependent child of the covered Eligible Employee. Finally, if a spouse loses coverage in anticipation of divorce, the spouse may be a qualified beneficiary upon actual divorce despite having been removed from coverage prior to the qualifying event.

9.2 Maximum COBRA Continuation Coverage Period for Each Qualifying Event

For any qualified beneficiary, the COBRA continuation coverage period is up to 18 months if the qualifying event is an Eligible Employee’s termination of employment or reduction in hours. For a spouse or dependent child, the COBRA continuation coverage period is up to 36 months for any qualifying event other than an Eligible Employee’s termination of employment or reduction in hours. These coverage periods may be extended or shortened under the following circumstances:

(a) If an Eligible Employee or covered dependent is disabled at the time of the qualifying event or within the first 60 days of COBRA continuation coverage, an 18 month COBRA continuation coverage period may be extended for all qualified beneficiaries for up to an additional 11 months (29 months in total from the date of the termination of employment or reduction in hours). Pursuant to Title II or Title XVI of the Social Security Act, the Social Security Administration (“SSA”) will determine whether the disability exists and when it began. The Eligible Employee or eligible dependent must give the Plan a copy of this SSA determination within 60 days after the determination is made and within the initial 18 months of COBRA continuation coverage to be eligible for this disability extension.

(b) If a dependent covered under COBRA as a qualified beneficiary experiences a second qualifying event (for example, the Eligible Employee dies, gets divorced or legally separated, or the dependent child stops being eligible under the Plan as a dependent child) within the 18-month or 29-month coverage period, as applicable, the maximum coverage period may be extended to up to a total of 36 months. An event is a “second qualifying event” only if the event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred. An Eligible Employee or eligible dependent must provide notice to the Plan of the second qualifying event within 60 days of the event. A termination of employment that follows a reduction in hours that was a qualifying event is never a second qualifying event resulting in an extension of the maximum coverage period.

(c) If the Eligible Employee is entitled to Medicare prior to a termination of
employment or reduction in hours that is a qualifying event, the Eligible Employee’s spouse and dependent children may extend coverage for up to 36 months from the date of Medicare entitlement. To be eligible for this extension, the qualified beneficiary must provide notice to the Plan of Medicare entitlement and must provide a copy of his or her Medicare card.

9.3 Your Notice Obligations

In order to protect your COBRA rights, you or a dependent must inform the Plan in the following situations:

(a) Disability of a Qualified Beneficiary. To extend the COBRA continuation coverage period to 29 months because of a qualified beneficiary’s disability, you or a dependent must be or become disabled within the first 60 days after the COBRA qualifying event, and you must notify the Plan before the end of the first 18 months of COBRA continuation coverage and within 60 days after the notice of determination of disability by the SSA. A copy of the SSA disability determination must be enclosed with your notification to the Plan.

(b) Qualifying Events and Second Qualifying Events. You or a dependent must inform the Plan about a divorce, legal separation, entitlement to Medicare, a child’s loss of dependent status under the Plan, or a former Eligible Employee’s death. If one of these events happens as a first qualifying event, you must send notice to the Plan within 60 days of the event. Notice of a second qualifying event must be received by the Plan within 60 days of the event and before the end of the initial 18 month COBRA continuation coverage period.

(c) COBRA Terminating Events. You or a dependent must inform the Plan within 30 days about entitlement to Medicare or enrollment in another group health plan if that event would terminate COBRA continuation coverage rights. You must also notify the Plan within 30 days after the SSA’s final determination that you (or your dependent) are no longer disabled. If you fail to provide this notice, the Plan is entitled to reimbursement for expenses paid during periods where you were not entitled to coverage and may impose a lien or reduce future benefit payments to offset for these amounts.

Your notice must be in writing and timely sent to the Plan Administrator (whose contact information appears in the section of the SPD entitled Important Information About the Plan) in the event of a first qualifying event, or to the COBRA administrator for all other events. Your notice must include the name and address of the individual experiencing the event, the name and Social Security Number (SSN) of the Eligible Employee, the group health plan coverage affected, the date of the qualifying event, and the type of qualifying event. If applicable, a copy of the Social Security determination, Medicare card, divorce decree, or other documentation must be included with your notice, and other documentation may be required by the Plan Administrator (or its designee) and/or COBRA administrator.
Also, you must immediately inform the Plan when you or any of your family members have a change of address so that notices can be sent to the correct address. Failure to provide a current address could cause you to lose your COBRA rights.

9.4 COBRA Election

When the Plan Administrator is timely notified that a qualifying event has occurred, the Plan Administrator will in turn notify qualified beneficiaries of their right to elect COBRA continuation coverage. Covered Eligible Employees may elect coverage on behalf of their spouses, and parents may elect coverage on behalf of their children. Each qualified beneficiary has an independent right to make his or her own election, and that right is not dependent on other family members’ elections. Thus, if the Eligible Employee does not elect COBRA continuation coverage, his or her eligible family members who are qualified beneficiaries may still elect (and pay for) COBRA continuation coverage.

You and/or your eligible family members may elect COBRA continuation coverage by filing a COBRA election form with the Plan within 60 days of the later of (1) the date coverage is lost under the Plan because of the qualifying event, or (2) the date you and/or your dependents are notified of the right to elect continuation coverage under COBRA. Election forms may be obtained by contacting the COBRA administrator or the Plan Administrator whose contact information appears under Important Information About the Plan. Election forms should be mailed to the COBRA administrator at the address on the COBRA election form. If a qualified beneficiary does not elect COBRA continuation coverage within this election period, then rights to continue coverage under COBRA will be lost.

Your coverage will be retroactively reinstated to the date that your Plan coverage ended once your election and first COBRA premium payment are received. If a health provider calls for verification of eligibility or benefits during the election period or during a period when you have not made payment by the due date, but you are in your payment grace period (described below), the provider will be told that you do not have coverage, but that coverage will be retroactively reinstated if a proper COBRA election and payment is made.

<table>
<thead>
<tr>
<th>Health Insurance Marketplace Coverage. Note that there may be other coverage options for you and your family. For example, you may be able to buy coverage through the Health Insurance Marketplace. In the Health Insurance Marketplace, you could be eligible for a tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for a tax credit for coverage through the Marketplace. For information, visit <a href="http://www.HealthCare.gov">www.HealthCare.gov</a>.</th>
</tr>
</thead>
</table>

9.5 Premium Payment Requirements

Your cost for COBRA continuation coverage is based upon the current premiums (this includes both the Eligible Employee’s contribution and the Employer’s contribution) for similarly situated active Eligible Employees with similar coverage under the Plan. The cost of COBRA continuation coverage may be 102% of the premium. The cost may be 150% of the premium
during months 19 through 29 for a disabled qualified beneficiary and his or her family members whose COBRA is extended due to disability.

The first COBRA payment must be made not later than 45 days after the date COBRA is timely elected (this is the date the COBRA election form is postmarked, if mailed). If the first payment is not timely made in full, all COBRA rights will be lost. The amount of the first payment is equal to the amount owed for COBRA continuation coverage starting on the day COBRA continuation coverage commences through the month preceding the month in which you make the actual payment. This may be as little as one (1) month or over three (3) months of COBRA continuation coverage, depending on when you elect COBRA and when you make the first payment. Although you are encouraged to call the COBRA administrator if you are unclear about the amount due, you are responsible for making sure that the amount of your first payment is correct.

After you make the first payment, COBRA payments are due on the first day of the month for that month of coverage and are considered late if they are not received within 30 days after the due date. COBRA continuation coverage will be provided for each month as long as payment for that month is made prior to the end of the 30-day grace period for that payment. If any of your COBRA payments are not made prior to the end of the grace period, COBRA continuation coverage will be terminated back to the last day for which the Plan received a full premium payment, and you will lose all of your COBRA continuation coverage rights.

Failure to pay the premium within 45 days of initially electing COBRA continuation coverage, or within 30 days after the due date for subsequent months of coverage, will result in the loss of your COBRA continuation coverage and any rights you may have under COBRA.

Your first payment and all subsequent monthly payments for COBRA continuation coverage should be sent to the COBRA administrator at the address provided in the COBRA election notice.

9.6 End of COBRA Continuation Coverage

COBRA continuation coverage ends when your 18-, 29- or 36-month COBRA continuation coverage period ends, but it may end earlier upon the occurrence of any of the following events:

(a) Your failure to make a timely payment for COBRA continuation coverage;

(b) Your becoming covered under another group health plan that has no preexisting condition exclusions or limitations that apply to you after electing COBRA continuation coverage. If the other plan has applicable exclusions or limitations, your COBRA continuation coverage will terminate when the exclusion or limitation no longer applies (note that there are limitation on plans imposing preexisting condition exclusions and such exclusions became prohibited beginning in 2014 under the Affordable Care Act);

(c) Your becoming entitled to Medicare (Part A and/or Part B) coverage after electing COBRA continuation coverage (this applies only to the person who became
entitled to Medicare, not his or her family members);

(d) If you become entitled to an 11-month extension of coverage period due to the disability of a qualified beneficiary, and a final determination is then made by the SSA that the qualified beneficiary is no longer disabled (however, continuation coverage will not end until the month that begins more than 30 days after the determination);

(e) Any event that would terminate coverage of a participant in the Plan who is not on COBRA (e.g., fraud); or

(f) The Plan’s termination.

9.7 Annual Open Enrollment Period

Qualified beneficiaries are offered the same rights (for example, to change coverage or add/delete eligible dependents) as similarly situated active Eligible Employees during the Plan’s annual open enrollment period. Although a part of the family unit, dependents added during the annual open enrollment period may not be considered qualified beneficiaries under COBRA and will generally not have the same rights as the qualified beneficiaries in the family.

9.8 Consider COBRA Continuation Coverage Carefully

In considering whether to elect COBRA continuation coverage, you should take into account that you have special enrollment rights under federal law. 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 your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of your COBRA continuation coverage period if you get COBRA continuation coverage for the maximum time available to you.

9.9 For More Information

If you have any questions concerning the information in this section, your rights to COBRA continuation coverage, or if you need another copy of the COBRA notice or the SPD for the Plan, you should contact the Plan Administrator (whose contact information appears in the section of the SPD entitled Important Information about the Plan).

For more information about your rights under ERISA, including COBRA, HIPAA, and other laws affecting group health plans, visit the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call their toll-free number at (888) 444-3272. For more information about health insurance options available through a Health Insurance Marketplace, visit www.healthcare.gov.
9.10 **Keep Your Plan Informed of Address Changes**

In order to protect your and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

**ARTICLE X. DEFINITIONS**

Many of the capitalized words used in this SPD have special meanings, and may be defined in the text of the SPD and/or the Plan Document. However, for your convenience, some of the capitalized terms used in this SPD are defined below:

**10.1 AD&D**

“AD&D” means accidental death and dismemberment insurance.

**10.2 Affordable Care Act**

“Affordable Care Act” means the Patient Protection and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010, and as subsequently amended, and the applicable regulations promulgated (and other guidance issued) thereunder from time to time. The Affordable Care Act is also commonly referred to as “PPACA” and “health reform.”

**10.3 CHIPRA**

“CHIPRA” means the Children’s Health Insurance Program Reauthorization Act of 2009, as amended.

**10.4 COBRA**

“COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

**10.5 Code**


**10.6 Eligible Employee**

“Eligible Employee” means a person employed as a regular full-time employee or a regular part-time employee by the Employer and who satisfies the eligibility requirements of the section of this SPD entitled *Eligibility and Participation*. “Eligible Employee” does not include a leased employee, any person who is not treated as an employee of the Employer for employment tax purposes, any person who is a member of a collective bargaining unit for which benefits under this Plan have not been provided pursuant to a collective bargaining agreement with the Employer, a PRN, a temporary employee, a seasonal employee, an independent contractor, or a nonresident alien. A “regular full-time employee” is an Eligible Employee who is regularly
scheduled to work the Employer’s full-time schedule; that is, 36 or more hours per week. A “regular part-time employee” is an Eligible Employee who is regularly scheduled to work 30 to 35 hours per week.

10.7 **Employer**

“Employer” means IASIS Healthcare, LLC, any entity listed in Appendix C of the Plan Document from time to time, and any other entities IASIS Healthcare, LLC allows to participate in, and that effectively adopt, the Plan.

10.8 **ERISA**


10.9 **FMLA**

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

10.10 **HIPAA**

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

10.11 **IRS**

“IRS” means the Internal Revenue Service.

10.12 **LTD**

“LTD” means long term disability insurance.

10.13 **Plan**

“Plan” means the IASIS Healthcare Welfare Benefit Plan.

10.14 **Plan Administrator**

“Plan Administrator” means IASIS Healthcare, LLC or the person or committee appointed by IASIS Healthcare, LLC to administer the Plan. The Plan Administrator’s contact information appears under **Important Information About the Plan** above.

10.15 **Plan Document**

“Plan Document” means the IASIS Healthcare Welfare Benefit Plan, as restated effective January 1, 2015 (and as amended from time to time), and the insurance contracts and policies and other coverage documents incorporated by reference into that document.
10.16 **Summary Plan Description or SPD**

“Summary Plan Description” or “SPD” means the summary plan description (as required by ERISA), which summarizes the Plan, and includes this document, any summaries of material modifications (SMMs) to this document, and the benefit program booklets prepared for participants under the Plan.

10.17 **USERRA**

# ARTICLE XI.
**BENEFIT PROGRAMS AND PROVIDERS**

LISTING OF BENEFIT PROGRAMS AND PROVIDERS FOR THE WELFARE BENEFITS OFFERED UNDER THE PLAN

Summary of Employee Eligibility and Participation Provisions

Effective January 1, 2015

<table>
<thead>
<tr>
<th>PROVIDER</th>
<th>PROGRAM/COVERAGE TYPE</th>
<th>ELIGIBLE FOR PRE-TAX CONTRIBUTIONS?</th>
<th>POLICY OR GROUP #</th>
<th>WHO IS ELIGIBLE/WHEN ELIGIBILITY FOR PARTICIPATION BEGINS*</th>
<th>FOR QUESTIONS, OR TO FILE A CLAIM, CONTACT:</th>
</tr>
</thead>
</table>
| Meritain Health | Medical | Yes | 14092 | Eligible Employees/see benefit program booklet | Meritain Health  
P.O. Box 41790  
Minneapolis, MN 55441-0790  
(800) 925-2272  
www.meritain.com |
| WageWorks | Health Care FSA | Yes | 28458 | Eligible Employees/see benefit program booklet | (877) 924-3967  
www.wageworks.com |
| EnvisionRx | Prescription Drug | Yes | Rx BIN 009893 | Eligible Employees/see benefit program booklet | (844) 293-4755  
www.envisionrx.com |
| The Guardian Life Insurance Company of America (Guardian) | Vision | Yes | 00504123 | Eligible Employees/see benefit program booklet | The Guardian Life Insurance Company of America  
Group Quality Assurance - Northeast  
P.O. Box 2457  
Spokane, WA 99210-2457  
(800) 541-7846 |
| Guardian | Dental | Yes | 00504123 | Eligible Employees/see benefit program booklet | The Guardian Life Insurance Company of America  
Group Quality Assurance - Northeast  
P.O. Box 2457  
Spokane, WA 99210-2457  
(800) 541-7846 |

*The eligibility and participation provisions described here are intended only as a summary. Refer to the Eligibility and Participation section of this SPD and the applicable benefit program booklet for more information about, and the exact terms of, eligibility under each benefit program, including which family members may be enrolled, and any terms and conditions of enrollment.
<table>
<thead>
<tr>
<th>Provider</th>
<th>Program/Coverage Type</th>
<th>Eligible For Pre-Tax Contributions?</th>
<th>Policy or Group #</th>
<th>Who Is Eligible/When Eligibility for Participation Begins*</th>
<th>For Questions, or To File A Claim, Contact:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reliance Standard Life Insurance Company (Reliance Standard)</td>
<td>Life and AD&amp;D (basic, optional and dependent plans)</td>
<td>No</td>
<td>Basic: GL 668964</td>
<td>Eligible Employees/see benefit program booklet</td>
<td>Reliance Standard Life Insurance Company 3340 Peachtree Road, N.E., Suite 2650 Atlanta, GA 30326 (800) 535-6018 <a href="http://www.reliancestandard.com">www.reliancestandard.com</a></td>
</tr>
<tr>
<td>Reliance Standard</td>
<td>LTD</td>
<td>No</td>
<td>LTD 669918</td>
<td>Eligible Employees/see benefit program booklet</td>
<td>Reliance Standard Life Insurance Company 3340 Peachtree Road, N.E., Suite 2650 Atlanta, GA 30326 (800) 535-6018 <a href="http://www.reliancestandard.com">www.reliancestandard.com</a></td>
</tr>
<tr>
<td>MHSA</td>
<td>Employee assistance program (EAP) (employer provided)</td>
<td>N/A</td>
<td>_____</td>
<td>All Employees/see benefit program booklet</td>
<td>(800) 767-5320</td>
</tr>
</tbody>
</table>

16193863.3
APPENDIX A

BENEFIT CLAIM DETERMINATIONS UNDER ERISA

This Appendix A generally describes benefit claim procedures under the Plan, as required by ERISA. Specific claim filing information is described in the applicable benefit program booklet(s)—therefore, you should first consult the applicable benefit program booklet to address your specific claim situation.

How to File a Claim for Benefits

Where you submit your claim for benefits and the deadline for filing your claim depend on the benefit program under which you are submitting your claim for benefits. In some benefit programs, if you go to a network or contracted provider, the provider will file a claim for you. Otherwise, you will need to file a claim yourself. Generally, you should file a claim as soon as possible (even if you have not met your deductible, if applicable under such benefit program). If you do not file a proper claim within the particular benefit program’s claim filing deadline, your claim for benefits will generally be denied. Specific claim filing information is described in the applicable benefit program booklets.

The claims administrators and/or the Plan Administrator have the right to request repayment if they overpay a claim for any reason (or pay a claim in error).

ERISA Benefit Claim Review Process and Applicable Time Periods

The benefit programs of the Plan have a claim review process that is followed whenever you submit a claim for benefits. When you file a claim for benefits, the claims administrator for the particular benefit program reviews your claim and makes a decision either to approve or deny the claim, in whole or in part. If your claim is approved, benefits will be paid either to you or on your behalf. If your claim is denied, or if the claims administrator needs more information before it can approve your claim, you will be notified in writing within certain time periods. If your claim is denied, you can appeal. For more information, see the section below entitled If Your Claim for Benefits Is Denied. A participant or beneficiary must exhaust the Plan’s reasonable claims procedures prior to bringing any court action to obtain Plan benefits.

The claims administrator processes payments for claims, answers questions, and reviews appeals according to the particular benefit program’s provisions. Except where the Plan Administrator has retained this authority, the ERISA claims administrator is the named fiduciary that serves as the final review committee and, in its sole discretion, has the authority to interpret Plan provisions as well as facts and other information related to claims and appeals.

The following chart will help you determine which time periods (outlined in the Claims and Appeals Timetable below) apply under ERISA for claims administrators’ decisions about your claims and appeals, depending on:

(a) The particular benefit program to which you are submitting the claim; and
(b) In the case of some benefit programs, the **type of claim** you are submitting.

<table>
<thead>
<tr>
<th>If you submit a claim for benefits under the following benefit program(s) (lists are not exhaustive):</th>
<th>And your claim is of the following type:</th>
<th>Then refer to this section of the Claims and Appeals Timetable (below) for the applicable time periods for receiving claim and appeal decisions:</th>
</tr>
</thead>
<tbody>
<tr>
<td>medical (including prescription drug) coverage</td>
<td><strong>Urgent Care</strong>, which means a pre-service claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care decisions could seriously jeopardize your life or health or your ability to regain maximum function or which, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.</td>
<td>See the section of the Claims and Appeals Timetable (below) entitled <strong>Urgent Care Claims</strong>.</td>
</tr>
<tr>
<td>vision coverage</td>
<td><strong>Pre-Service</strong>, which means any claim for a benefit with respect to which the terms of the Plan condition the receipt of the benefit, in whole or in part, on the approval of the benefit in advance of obtaining medical care.</td>
<td>See the section of the Claims and Appeals Timetable (below) entitled <strong>Pre-Service Claims</strong>.</td>
</tr>
</tbody>
</table>
| dental coverage | **Post-Service**, which means any claim for a benefit that is not a pre-service claim; that is, it does not require approval in advance of obtaining medical care, and a claim for such benefits is filed after the medical care has been received.  

*All claims submitted for reimbursement under the health care FSA are post-service claims.* | See the section of the Claims and Appeals Timetable (below) entitled **Post-Service Claims**. |
<p>| health care FSA (under the Flexible Benefits Plan) called “<strong>group health coverage(s)</strong>” in this Appendix | <strong>Concurrent Care</strong>, which means that the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, and there is a reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments. | See the section of the Claims and Appeals Timetable (below) entitled <strong>Concurrent Care Claims</strong>. |
| LTD called “<strong>disability coverage(s)</strong>” in this Appendix | Any claim for benefits under the disability coverage(s). | See the section of the Claims and Appeals Timetable (below) entitled <strong>Claims for Disability Benefits</strong>. |</p>
<table>
<thead>
<tr>
<th>If you submit a claim for benefits under the following benefit program(s) (lists are not exhaustive):</th>
<th>And your claim is of the following type:</th>
<th>Then refer to this section of the Claims and Appeals Timetable (below) for the applicable time periods for receiving claim and appeal decisions:</th>
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</table>
| • life insurance  
• AD&D called “other coverage(s)” in this Appendix | Any claim for benefits under the other coverage(s). | See the section of the Claims and Appeals Timetable (below) entitled Claims for Other Benefits. |

If Your Claim for Benefits is Denied or Your Medical Benefit Program Coverage is Rescinded

If your claim for a benefit payment is denied, in whole or in part (or if your medical benefit program coverage is rescinded), you will receive a written notice of the adverse benefit determination from the claims administrator within the applicable time period outlined in the Claims and Appeals Timetable below. (Note, however, that if your claim is an urgent care claim, this notice may be given to you orally within the applicable time period, and a written or electronic notice will follow within three days of such oral notice.) The denial notice will include:

(a) The specific reason(s) for the adverse determination;

(b) References to specific Plan provisions on which the determination is based;

(c) A description of any additional material or information necessary for you to perfect your claim and an explanation of why the material or information is necessary; and

(d) An explanation of the steps you must take if you disagree with the determination and wish to have the determination reviewed.

In the case of an adverse benefit determination under a group health coverage or disability coverage, your written notice will also include:

(a) A copy of any internal rule, guideline, protocol or other similar criterion relied upon in making the adverse determination, or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy of such rule, guideline, protocol, or other criterion free of charge; and

(b) If the adverse determination is based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination, applying the terms of the Plan to your medical circumstances, or a statement that you can request the explanation free of charge.
In the case of an adverse benefit determination under a **medical coverage** to which the Affordable Care Act applies, your written notice will also include the following, as well as any other information required from time to time under the Affordable Care Act, as applicable:

(a) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), etc., and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(b) The denial code and its corresponding meaning that corresponds to the specific reason(s) for the adverse determination and a description of the Plan’s standard, if any, that was used in denying the claim;

(c) A description of any available internal appeals and external review processes, including information describing how to initiate an appeal; and

(d) A description of the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the claims and appeals and review process.

**How to Request Review of an Adverse Benefit Determination**

If you do not agree with the adverse determination (including a rescission of your medical benefit program coverage) made by the claims administrator, you (or your authorized representative) may request that the determination be reviewed by the ERISA claims administrator, in accordance with the reasonable claims procedures described here and in the applicable benefit program booklet. Addresses of these claims administrators are available in the applicable benefit program booklets. Unless the applicable benefit program booklet provides otherwise, you must file your written request for review of any **group health coverage** or **disability coverage** adverse benefit determination within **180 days** after you receive the written notification of the determination. Written requests for review of any **other coverage** adverse benefit determination must be filed within **60 days** after you receive the written notification of the benefit denial (unless the applicable benefit program booklet provides otherwise). Your request for review must be in writing and must include the following:

(a) A description of your claim sufficient to identify the claim (for example, for a claim for benefits under a group health coverage, the patient’s name and identification number from the ID card, the date(s) of medical service(s), and the provider’s name);

(b) A summary of all the reasons why you believe the benefits should be paid (or medical coverage should not be rescinded), including any documents, records or other information relating to or that support your claim; and

(c) Any issues or comments that you think are pertinent to your claim.
During the time limit for requesting an appeal, upon request and free of charge, you will be given reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits.

Your claim and the adverse benefit determination will be reviewed fairly and fully, and a decision will be made within the time period outlined in the **Claims and Appeals Timetable** below (for the applicable coverage and claim type) following receipt of your review request. As described in the **Claims and Appeals Timetable**, if additional time is needed to render a decision, you will be notified of the reasons why the extension is needed and the date by which you may expect a decision.

In the case of a claim for benefits under a **group health coverage** or **disability coverage**, the party considering the appeal will not give deference to the initial adverse benefit determination and the review will be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial adverse benefit determination nor his or her subordinate. Additionally, if a **group health coverage** or **disability coverage** determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate), the fiduciary deciding the appeal will consult with an appropriate health care professional (who was not consulted during the initial adverse benefit determination and is not subordinate to a professional consulted during the initial adverse benefit determination). Upon your request, the claims administrator will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial, without regard to whether the advice was relied upon in making the benefit determination.

In the case of a claim for benefits under a **medical coverage** that is subject to the requirements of the Affordable Care Act, as part of its full and fair review, you must be provided (free of charge) with the new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with your claim as soon as possible and sufficiently in advance of the date on which the final adverse benefit determination is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date. In addition, before the Plan can issue a final adverse benefit determination based on a new or additional rationale, you must be provided (free of charge) with the rationale as soon as possible and sufficiently in advance of the date on which the final adverse benefit determination is required to be provided to you, in order to give you a reasonable opportunity to respond prior to that date.

**Notice of Decision on Appeal**

If the claims administrator determines that your explanation and additional information support the payment of your claim, the claims administrator will process your claim, in accordance with the reasonable claims procedures described here and in the applicable benefit program booklet. Benefits are generally paid to you or your beneficiary unless, in the case of a **group health coverage**, the provider notifies the claims administrator that you have assigned benefits directly to that provider.
If the original adverse benefit determination is upheld in whole or in part, you will receive a written notice within the time period outlined in the **Claims and Appeals Timetable** below (for the applicable coverage and claim type) stating:

(a) The specific reason(s) for the adverse determination;

(b) References to specific Plan provisions on which the benefit determination is based;

(c) A statement that you will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information (other than legally or medically privileged documents) relevant to your claim for benefits; and

(d) A statement describing any voluntary appeal procedures offered by the Plan and your right to bring an action under Section 502(a) of ERISA following an adverse determination after completion of all levels of appeal required by the particular benefit program.

In the case of a claim for benefits under a **group health coverage** or **disability coverage**, your written notice will also include:

(a) A copy of any internal rule, guideline, protocol or other similar criterion relied upon to determine the claim, or a statement that the rule, guideline, protocol, or other criterion was used and that you can request a copy of such rule, guideline, protocol, or other criterion free of charge; and

(b) If the denial of your claim is based on a medical necessity, experimental treatment or similar exclusion or limit, an explanation of the scientific or clinical judgment for the medical determination, or a statement that you can request the explanation free of charge.

In the case of an adverse benefit determination under a **medical coverage** to which the Affordable Care Act applies, your written notice will also include the following, as well as any other information required from time to time under the Affordable Care Act, as applicable:

(a) Information sufficient to identify the claim involved, including the date of service, the health care provider, the claim amount (if applicable), etc., and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning;

(b) The denial code and its corresponding meaning that corresponds to the specific reason(s) for the adverse determination and a description of the Plan’s standard, if any, that was used in denying the claim, including a discussion of the decision;

(c) A description of any available internal appeals and external review processes; and
(d) A description of the availability of, and the contact information for, any applicable office of health insurance consumer assistance or ombudsman to assist you with the claims and appeals and review process.

If, on the first appeal, the claims administrator upholds the denial of your claim for benefits, and the claims administrator allows two levels of internal appeal, you may file a second appeal within **90 days** after receiving the notice of denial of your first appeal (unless the applicable benefit program booklet provides otherwise). The second appeal will follow the same procedures as outlined above for the initial appeal. Note that even if a claims administrator allows for two levels of appeal, *there is typically only one level of appeal for an urgent care claim*. Refer to the applicable benefit program booklet, or contact the particular claims administrator or the Plan Administrator, to determine whether a particular benefit program allows for two levels of appeal.
ERISA CLAIMS AND APPEALS TIMETABLE

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<th>Timing and Notification of Appeal Decision(s)</th>
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<td>Urgent Care Claims</td>
<td>As soon as possible, taking into account the medical exigencies, but not later than <strong>72 hours</strong> after receipt of your claim by the claims administrator. If you fail to provide sufficient information with your claim to determine whether, or to what extent, benefits are covered or payable from the Plan, you will be notified no later than <strong>24 hours</strong> after the claims administrator receives your claim of the specific information you need to submit. You will have at least <strong>48 hours</strong> to provide this information. You will be notified of the claim decision as soon as possible, but not later than <strong>48 hours</strong> after the earlier of: (a) the claims administrator’s receipt of the specified information or (b) the deadline to provide this information passes. <strong>If you fail to follow proper claim procedures with respect to a pre-service urgent care claim:</strong> If you fail to follow the proper claims procedures, you will be notified of the failure as soon as possible, but not later than <strong>24 hours</strong> after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 24-hour time period only applies if your claim is made to the proper person and names a specific claimant; his or her specific medical condition or symptom; and the specific treatment, service, or product for which approval is requested.</td>
<td>As soon as possible, taking into account the medical exigencies, but not later than <strong>72 hours</strong> after receipt of your request for review by the claims administrator.</td>
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<td>Pre-Service Claims</td>
<td>Within a reasonable period of time appropriate to the medical circumstances but not later than <strong>15 days</strong> after receipt of your claim by the claims administrator, unless an extension of up to an additional <strong>15 days</strong> is necessary due to matters beyond the control of the claims administrator. <strong>Extension of time for processing claim:</strong> If an extension is needed, you will be notified before the end of the first 15-day period why the extension is necessary and when the claims administrator expects to render a decision. If an extension is necessary because you failed to submit necessary information, the notice will specify what information is necessary, and you will have at least <strong>45 days</strong> to provide it. You will be notified of the claims administrator’s decision within <strong>15 days</strong> after its receipt of the additional information. <strong>If you fail to follow proper claim procedures:</strong> If you do not follow the proper claims procedures, you will be notified of the failure to follow the proper claims procedures as soon as possible, but no later than <strong>5 days</strong> after your claim was received by the claims administrator. The notice will describe the proper procedures for filing a claim. The 5-day time period only applies if your claim is made to the proper person and names a specific claimant; his or her specific medical condition or symptom; and the specific treatment, service, or product for which approval is requested.</td>
<td>If the benefit program allows one level of appeal: A reasonable period of time appropriate to the medical circumstances, but not later than <strong>30 days</strong> after receipt of your request for review by the claims administrator. <strong>If the benefit program allows two levels of appeal:</strong> A reasonable period of time appropriate to the medical circumstances, but not later than <strong>15 days</strong> after receipt of your request for first or second review by the claims administrator.</td>
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<td>Timing for Claim Decision</td>
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<tr>
<td>Post-Service Claims</td>
<td>Within a reasonable period of time, but not later than <strong>30 days</strong> after receipt of your claim by the claims administrator, unless an extension of up to an additional <strong>15 days</strong> is necessary due to matters beyond the control of the claims administrator. <strong>Extension of time for processing claim:</strong> If an extension is needed, you will be notified before the end of the initial 30-day period why the extension is necessary and when the claims administrator expects to render a decision. If an extension is necessary because you failed to submit necessary information, the notice will specify what information is necessary, and you will have at least <strong>45 days</strong> to provide it. You will be notified of the claims administrator’s decision within <strong>15 days</strong> after its receipt of the additional information or within <strong>15 days</strong> after the 45-day deadline to provide the additional information passes, whichever is sooner.</td>
<td>If the benefit program allows <strong>one level of appeal:</strong> A reasonable period of time, but not later than 60 days after receipt of the request for review by the claims administrator. <strong>If the benefit program allows two levels of appeal:</strong> A reasonable period of time appropriate to the medical circumstances, but not later than <strong>30 days</strong> after receipt of your request for first or second review by the claims administrator.</td>
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<td>Concurrent Care Claims</td>
<td>If there is a reduction or termination of treatment (other than by Plan amendment or termination), the claims administrator must notify you sufficiently in advance to allow you to appeal and obtain a determination on review before the treatment is reduced or terminated. If the treatment involves <strong>urgent care</strong> and you request an extension of the course of treatment, the claims administrator must notify you of its determination as soon as possible, taking into account the medical exigencies, but generally no later than <strong>24 hours</strong> after receipt of the claim. Your request must be made within <strong>24 hours</strong> prior to the expiration of the prescribed period of time or number of treatments. <strong>To the extent required by law, the Plan will provide continued coverage for an ongoing course of treatment pending the outcome of internal appeals.</strong></td>
<td>If it is a <strong>non-urgent</strong> claim for ongoing care, the timing of the notice of decision on review will be handled under either the <strong>Pre-Service Claim</strong> or <strong>Post-Service Claim</strong> time periods outlined above, as appropriate for the type of claim. If it is an <strong>urgent care</strong> claim for ongoing care, as soon as possible, taking into account the medical exigencies, but not later than <strong>72 hours</strong> after receipt of your request for review by the claims administrator.</td>
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<td>Type of Claim</td>
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<td><strong>Claims for Disability Benefits</strong></td>
<td>Within a reasonable period of time, but not later than <strong>45 days</strong> after receipt of your claim by the claims administrator, unless an extension of up to an additional <strong>30 days</strong> is necessary due to matters beyond the control of the claims administrator. <strong>Extension of time for processing claim:</strong> If an extension is needed, you will be notified before the end of the initial 45-day period why the extension is necessary and when the claims administrator expects to render a decision. If, due to matters beyond the claims administrator’s control, a decision cannot be made within this 30-day extension period, the claims administrator may extend the determination period for an additional <strong>30 days</strong>, provided you are notified prior to the end of the initial 30-day extension. The notice will explain the circumstances requiring the extension and the date when the claims administrator expects to make a decision. If you file a disability claim that is not complete, the claims administrator will notify you within <strong>45 days</strong> after receiving your claim of the information that is necessary to complete the claim. You will have <strong>45 days</strong> to provide the additional information. The claims administrator will notify you of its decision within <strong>30 days</strong> after receiving the additional information or within <strong>30 days</strong> after the 45-day deadline to provide the additional information passes, whichever is sooner.</td>
<td>A reasonable period of time, but not later than <strong>45 days</strong> after receipt of your request for review by the claims administrator. If necessary due to special circumstances, the period may be extended for an additional <strong>45 days</strong>. In this case, you will be notified in writing prior to the extension of the special circumstances and the date a decision will be rendered. A decision shall be made as soon as possible, but no later than <strong>90 days</strong> after receipt of the request for review.</td>
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<tr>
<td><strong>Claims for Other Benefits</strong></td>
<td>Within a reasonable period of time, but not later than <strong>90 days</strong> after receipt of your claim by the claims administrator. <strong>Extension of time for processing claim:</strong> If special circumstances require an extension of time for processing the claim, you will receive a written notice before the end of the initial 90-day period, and this extension will not exceed an additional <strong>90 days</strong>. The notice will explain why an extension of time is necessary and when the claims administrator expects to render a decision.</td>
<td>A reasonable period of time, but not later than <strong>60 days</strong> after receipt of the request for review by the claims administrator. If necessary, the period may be extended for an additional <strong>60 days</strong>. In this case, you will be notified in writing prior to the extension of the special circumstances and the date a decision will be rendered. A decision shall be made as soon as possible, but no later than <strong>120 days</strong> after receipt of the request for review.</td>
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Medical
IASIS Healthcare, LLC Welfare Benefit Plan

Group No.: 14092

Plan Document and Summary Plan Description

Originally Effective: January 1, 1999
Amended and Restated Effective: January 1, 2016

MERITAIN HEALTH

P.O. Box 27267
Minneapolis, MN 55427-0267
(866) 209-2929
www.meritain.com
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ESTABLISHMENT OF THE PLAN

IASIS Healthcare, LLC (the “Employer” or the “Plan Sponsor”) has adopted this amended and restated Plan Document and Summary Plan Description effective as of January 1, 2016, for the IASIS Healthcare, LLC Welfare Benefit Plan (hereinafter referred to as the “Plan” or “Summary Plan Description”), as set forth herein for the exclusive benefit of its Employees and their eligible Dependents. The Plan was originally adopted by the Employer effective as of January 1, 1999.

Purpose of the Plan
The Plan Sponsor has established the Plan for your benefit and for the benefit of your eligible Dependents, on the terms and conditions described herein. The Plan Sponsor’s purpose in establishing the Plan is to help to protect you and your family by offsetting some of the financial problems that may arise from an Injury or Illness. To accomplish this purpose, the Plan Sponsor must attempt to control health care costs through effective plan design and the Plan Administrator must abide by the terms of the Plan Document and Summary Plan Description, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to manage their healthcare costs.

The Plan is not a contract of employment between you and your Employer and does not give you the right to be retained in the service of your Employer.

The purpose of this Plan is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain health care expenses. This Plan is maintained by the Plan Administrator and may be inspected at any time during normal working hours by you or your eligible Dependents.

Adoption of this Plan Document and Summary Plan Description
The Plan Sponsor, as the settlor of the Plan, hereby adopts this Plan Document and Summary Plan Description (SPD) as the written description of the Plan. This Plan represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, as amended from time to time. This Plan Document and SPD amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document and Summary Plan Description to be executed as of the date set forth below.

IASIS Healthcare, LLC

Dated: ________________________________ By: __________________________

Name: _______________________________

Title: _______________________________
GENERAL OVERVIEW OF THE PLAN

The Plan Administrator has entered into an agreement with Aetna Choice® POS II and Altius for Utah Employees (the “Network”). This Network offers you health care services at discounted rates. Using a Network provider will normally result in a lower cost to the Plan as well as a lower cost to you. There is no requirement for anyone to seek care from a provider who participates in the Network. The choice of provider is entirely up to you.

If a Covered Person receives goods or services from a Participating Provider whose contract between the provider and the provider’s Network provides for reimbursement to the provider for those goods or services of amounts not otherwise reimbursable under this Plan, the Plan benefit payable shall be the amount specified in the contract between the provider and the Network, rather than the amount otherwise reimbursable under this Plan.

Non-Participating Provider Exceptions
Covered services rendered by a Non-Participating Provider will be paid at the Participating Provider level when a:

(1) Covered Person has no choice of a Participating Provider.
(2) Covered Person has an Emergency Medical Condition requiring immediate care.
(3) Covered Person receives services by a Non-Participating Provider (e.g. anesthesiologists, radiologists, pathologists, etc.) who is under agreement with a Network facility.
(4) Participating Provider submits a specimen to a Non-Participating Provider laboratory.
(5) Covered Person receives services from a Network surgeon who uses a non-Network Assistant Surgeon.
(6) Participating Provider is not available within a 50 mile radius of the Covered Person’s residence.

Not all providers based in Network Hospitals or medical facilities are Participating Providers. It is important when you enter a Hospital or medical facility that you request that ALL Physician services be performed by Participating Providers. By doing this, you will always receive the greater Participating Provider level of benefits.

A current list of Participating Providers is available, without charge, through the Third Party Administrator at www.meritain.com. If you do not have access to a computer at your home, you may contact your Employer or the Network at the phone number on the Employee identification card to obtain a paper copy of the Participating Providers available.

You have a free choice of any provider and you, together with your provider, are ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The Participating Providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any Participating Provider.

Costs
You must pay for a certain portion of the cost of Covered Expenses under the Plan, including (as applicable) any Copay, Deductible and Coinsurance percentage that is not paid by the Plan, up to the Out-of-Pocket Maximum set by the Plan. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Coinsurance
Coinsurance is the percentage of eligible expenses the Plan and the Covered Person are required to pay. The amount of Coinsurance a Covered Person is required to pay is the difference from what the Plan pays as shown in the Medical Schedule of Benefits.

There may be differences in the Coinsurance percentage payable by the Plan depending upon whether you are using a Participating Provider or a Non-Participating Provider. These payment levels are also shown in the Medical Schedule of Benefits.
Copay
A Copay is the portion of the medical expense that is your responsibility, as shown in the Medical Schedule of Benefits. A Copay is applied for each occurrence of such covered medical service and is not applied toward satisfaction of the Deductible.

Deductible
A Deductible is the total amount of eligible expenses as shown in the Medical Schedule of Benefits, which must be Incurred by you during any Calendar Year before Covered Expenses are payable under the Plan. The family Deductible maximum, as shown in the Medical Schedule of Benefits, is the maximum amount which must be Incurred by the covered family members during a Calendar Year. However, each individual in a family is not required to contribute more than one individual Deductible amount to a family Deductible.

Out-of-Pocket Maximum
An Out-of-Pocket Maximum is the maximum amount you and/or all of your family members will pay for eligible expenses Incurred during a Calendar Year before the percentage payable under the Plan increases to 100%.

The single Out-of-Pocket Maximum applies to a Covered Person with single coverage. When a Covered Person reaches his or her Out-of-Pocket Maximum, the Plan will pay 100% of additional eligible expenses for that individual during the remainder of that Calendar Year.

The family Out-of-Pocket Maximum applies collectively to all Covered Persons in the same family. The family Out-of-Pocket Maximum, if applicable, is the maximum amount that must be satisfied by covered family members during a Calendar Year. The entire family Out-of-Pocket Maximum must be satisfied; however each individual in a family is not required to contribute more than the single Out-of-Pocket amount to the family Out-of-Pocket Maximum before the Plan will pay 100% of covered expenses for any Covered Person in the family during the remainder of that Calendar Year.

Your Out-of-Pocket Maximum may be higher for Non-Participating Providers than for Participating Providers. Please note, however, that not all Covered Expenses are eligible to accumulate toward your Out-of-Pocket Maximum. The types of expenses, which are not eligible to accumulate toward your Out-of-Pocket Maximum, (“non-accumulating expenses”) include:

1. Charges over Usual and Customary Charges for Non-Participating Providers.
2. Charges this Plan does not cover.

Reimbursement for these non-accumulating expenses shown in number (1) will continue at the percentage payable shown in the Schedule of Benefits, subject to the Plan maximums.

The Plan will not reimburse any expense that is not a Covered Expense. In addition, you must pay any expenses that are in excess of the Usual and Customary Charges for Non-Participating Providers. This could result in you having to pay a significant portion of your claim. None of these amounts will accumulate toward your Out-of-Pocket Maximum.

Once you have paid the Out-of-Pocket Maximum for eligible expenses Incurred during a Calendar Year, the Plan will reimburse additional eligible expenses Incurred during that year at 100%.

If you have any questions about whether an expense is a Covered Expense or whether it is eligible for accumulation toward your Out-of-Pocket Maximum, please contact Meritain Health, Inc. for assistance.

Integration of Deductibles and Out-of-Pocket Maximums
If you use a combination of Tier 1 and Tier 2 Providers, your total Deductible amount and Out-of-Pocket Maximum amount required to be paid will not exceed the amount shown for Tier 2 Providers. In other words, the amount of the Deductible expense and Out-of-Pocket Maximum you pay for Tier 1 and Tier 2 will be combined and the total will not exceed the amount shown for Tier 2 Providers during a single Calendar Year.

Tier 3 and Tier 4 Provider Deductible and Out-of-Pocket Maximum amounts are separate amounts and do not integrate with Tier 1 and 2 Providers. In addition, Tier 3 and Tier 4 Provider Deductible and Out-of-Pocket Maximum amounts are separate amounts and do not integrate. In other words, you will be required to satisfy the Deductible amount and Out-of-Pocket Maximum amount for Tier 3 and Tier 4 Providers separately.
Transitional Care (New Employees Only Due to an Acquisition)
Certain Covered Expenses may be paid at the applicable Participating Provider benefit level if the Covered Person is currently under a treatment plan, as listed below, by a Physician who was a member of this Plan’s previous Network but who is not a member of this Plan’s current Network. In order to ensure continuity of care for certain medical conditions already under treatment, you must complete a Transition of Care Request Form and return to Meritain Health, Inc. This form represents a formal request to your health plan to cover continuing care from an out-of-network treating Physician for a specified period of time. You will receive a coverage determination by mail. If this coverage request is not approved, care by the out-of-network provider after the Plan’s effective date will be processed at the out-of-network level (based on your specific plan).

Please note this form is to be completed only if:

1. You or a covered family member are using a Physician who does not participate in your primary preferred network of Physicians or Hospitals and you are currently undergoing a course of active treatment.

2. You or a covered family member are currently in their third trimester of Pregnancy and your Physician and the Hospital are not in your primary preferred network.

3. You or a covered family member have an upcoming scheduled Surgery or planned Hospital admission at a facility not in your primary preferred network.

Active courses of treatment that may be approved for transition:

1. Patient is confined in an Inpatient facility on the effective date.

2. Patient has completed 31 weeks of Pregnancy and began receiving prenatal care prior to the effective date.

3. Patient is in a post operative, or post-traumatic, period of treatment of defined length.

4. Patient is receiving outpatient treatment for a Mental Disorder or Substance Use Disorder and has had at least one treatment session prior to the effective date.

5. Patient is involved in a course of chemotherapy, radiation therapy, cancer therapy, or is terminally ill with less than 6 months to live.

6. Patient is a candidate for, or recipient of, an organ or bone marrow transplant and is actively on the waiting list as of the effective date.

7. Patient is in the process of staged surgery, such as cleft palate or microsurgery for skin cancer.

Routine procedures, treatment for stable chronic conditions, minor Illnesses and elective Surgical procedures will not be covered by transitional level benefits.
MEDICAL MANAGEMENT PROGRAM

You, your eligible Dependents or a representative acting on your behalf, must call the Medical Management Program Administrator to receive certification of Inpatient admissions (other than admissions for an Emergency Medical Condition), as well as other non-Emergency Services listed below. This call must be made at least 48 hours in advance of Inpatient admissions or receipt of the non-Emergency Services listed below. If the Inpatient admission is with respect to an Emergency Medical Condition, you must notify the Medical Management Program Administrator within 48 hours or if later, by the next business day after the Emergency Medical Condition admission. Failure to obtain precertification or notify the Medical Management Program Administrator within the time frame indicated above may result in eligible expenses being reduced or denied. Please refer to the penalty section below.

Medical Management is a program designed to help ensure that you and your eligible Dependents receive necessary and appropriate healthcare while avoiding unnecessary expenses. The program consists of:

(1) Precertification of Medical Necessity. The following items and/or services must be precertified before any medical services are provided:
   (a) Advanced imaging, including CT/MRA/MRI/PET scans, nuclear medicine and other similar technologies
   (b) Chemotherapy
   (c) Cochlear implants
   (d) Dialysis – all settings including services rendered in a Physician’s office
   (e) Durable Medical Equipment (other than breast pumps covered as a preventive service) over $1,500
   (f) Home Health Care, including home infusion therapy
   (g) Hospice Care
   (h) Implantable medications or devices except for Imitrex, insulin, glucagon kits and bee sting kits, implantable contraceptive drugs/devices
   (i) Inpatient admissions, including inpatient admissions to a Skilled Nursing Facility, Extended Care Facility, Rehabilitation Facility, and inpatient admissions due to a Mental Disorder or Substance Use Disorder
   (j) Outpatient Surgical Procedures
   (k) Radiation therapy – all settings including services rendered in a Physician’s office
   (l) Sleep studies
   (m) Transplants

(2) Concurrent Review for continued length of stay and assistance with discharge planning activities.

(3) Retrospective review for Medical Necessity where precertification is not obtained or the Medical Management Program Administrator is not notified.

Medical Management Does Not Guarantee Payment
All benefits/payments are subject to the patient’s eligibility for benefits under the Plan. For benefit payment, services rendered must be considered an eligible expense under the Plan and are subject to all other provisions of the Plan.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other healthcare provider.
How the Program Works

Precertification
Before you or your eligible Dependents are admitted to a medical facility or receive items or services that require precertification on a non-Emergency Medical Condition basis (that is an Emergency Medical Condition is not involved), the Medical Management Program Administrator will, based on clinical information from the provider or facility, certify the care according to the Medical Management Program Administrator’s policies and procedures.

The Medical Management Program is set in motion by a telephone call from you, the patient or a representative acting on your behalf or on behalf of the patient.

To allow for adequate processing of the request, contact the Medical Management Program Administrator at least 48 hours before receiving any item or service that requires precertification or an Inpatient admission for a Non-Emergency Medical Condition with the following information:

(1) Name, identification number and date of birth of the patient;
(2) The relationship of the patient to the covered Employee;
(3) Name, identification number, address and telephone number of the covered Employee;
(4) Name of Employer and group number;
(5) Name, address, Tax ID # and telephone number of the admitting Physician;
(6) Name, address, Tax ID # and telephone number of the medical facility with the proposed date of admission and proposed length of stay;
(7) Proposed treatment plan; and
(8) Diagnosis and/or admitting diagnosis.

If there is an Inpatient admission with respect to an Emergency Medical Condition, you, the patient or a representative acting on your behalf or on behalf of the patient, including, but not limited to, the Hospital or admitting Physician, must contact the Medical Management Program Administrator within 48 hours after the start of the confinement or on the next business day, whichever is later.

Hospital stays in connection with childbirth for either the mother or newborn may not be less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother.

You, the patient and the providers are NOT REQUIRED to obtain precertification for a maternity delivery admission, unless the stay extends past the applicable 48- or 96-hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth. If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified with the Medical Management Program Administrator or a penalty will be applied.

The Medical Management Program Administrator, in coordination with the facility and/or provider, will make a determination on the number of days certified based on the Medical Management Program Administrator’s policies, procedures and guidelines. If the confinement will last longer than the number of days certified, a representative of the Physician or the facility must call the Medical Management Program Administrator before those extra days begin and obtain certification for the additional time. If the additional days are not requested and certified, room and board expenses will not be payable for any days beyond those certified.

If the patient does not obtain precertification for their Inpatient admission at least 48 hours in advance of the admission or notify the Medical Management Program Administrator within 48 hours after an Emergency Medical Condition admission or if precertification is obtained or notification received outside the time frames specified, eligible expenses may be reduced or denied. Please refer to the penalty section below.
Penalty
If you fail to obtain precertification or fail to notify the Medical Management Program Administrator within the time periods described above, benefits under the Plan will be reduced as follows:

(1) Covered Expenses will be reduced by 30% per occurrence.

If the Plan's required review procedures are not followed, a retrospective review will be conducted by the Medical Management Program Administrator to determine if the services provided met all other Plan provisions and requirements. If the review concludes the services were Medically Necessary and would have been approved had the required phone call been made, benefits will be considered, subject to the penalty outlined above. However, any charges not deemed Medically Necessary will be denied.

Concurrent Review, Discharge Planning
Discharge planning needs is part of the Medical Management Program. The Medical Management Program Administrator will assist and coordinate the initial implementation of any services the patient will need post hospitalization with the attending Physician and the facility. If the attending Physician feels that it is Medically Necessary for a patient to stay in the medical care facility for a greater length of time than has been precertified, the attending Physician or the medical facility must request the additional service or days.

Concurrent Inpatient Review
Once the Inpatient setting has been precertified, the on-going review of the course of treatment becomes the focus of the program. Working directly with your Physician, the Medical Management Program Administrator will identify and approve the most appropriate and cost-effective setting for the treatment as it progresses.

To File a Complaint or Request an Appeal to a Non-Certification
Verbal appeal requests and information regarding the appeal process should be directed to the Medical Management Program Administrator as identified on the General Plan Information page of this Plan.

Case Management
When a catastrophic condition, such as a spinal cord injury, cancer, AIDS or a premature birth occurs, a person may require long-term, perhaps lifetime care. After the patient’s condition is diagnosed, the patient might need extensive services or might be able to be moved into another type of care setting, even to the patient’s home.

Case management is a program whereby a Case Manager contacts the patient to obtain consent for case management services. The Case Manager monitors the patient and explores, discusses and recommends coordinated and/or alternate types of appropriate medical care. The Case Manager consults with the patient, family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient.

This plan of care may include some or all of the following:

(1) Personal support to the patient;
(2) Contacting the family to offer assistance and support;
(3) Monitoring Hospital or skilled nursing care or home health care;
(4) Determining alternative care options; and
(5) Assisting in obtaining any necessary equipment and services.

Case management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the case management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan staff, attending Physician, patient and patient’s family must all agree to the alternate treatment plan.

Case management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.
Medical Management will not interfere with your course of treatment or the Physician-patient relationship. All decisions regarding treatment and use of facilities will be yours and should be made independently of this Program.

The Medical Management Program Administrator contact information for this Plan is identified on the Employee identification card and also on the General Plan Information page of this Plan.
MEDICAL SCHEDULE OF BENEFITS – TIERED $500 PLAN
(Not Available in Arizona and Utah Locations)

<table>
<thead>
<tr>
<th></th>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3 PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>LIFETIME MAXIMUM BENEFIT</td>
<td>Unlimited</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CALENDAR YEAR MAXIMUM BENEFIT</td>
<td>Unlimited</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

HOSPITAL AND FACILITY BASED BENEFITS

<table>
<thead>
<tr>
<th>CALENDAR YEAR DEDUCTIBLE (combined with non-Hospital/facility based/professional fees)</th>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3 PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$500</td>
<td>$1,500</td>
<td>$3,000</td>
<td>Unavailable</td>
</tr>
<tr>
<td>Family</td>
<td>$1,000</td>
<td>$3,000</td>
<td>$6,000</td>
<td>Unavailable</td>
</tr>
</tbody>
</table>

CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductibles, Copays, Coinsurance, precert penalties - combined with non-Hospital/facility based and Prescription Drug Card)

<table>
<thead>
<tr>
<th>CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductibles, Copays, Coinsurance, precert penalties - combined with non-Hospital/facility based and Prescription Drug Card)</th>
<th>Single</th>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3 PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Room and Board Allowance</td>
<td>$5,750</td>
<td>$1,500</td>
<td>$3,000</td>
<td>$3,000</td>
<td>$3,000</td>
</tr>
<tr>
<td>Room and Board Allowance</td>
<td>$11,500</td>
<td>$3,000</td>
<td>$6,000</td>
<td>$6,000</td>
<td>$6,000</td>
</tr>
</tbody>
</table>

ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.

<table>
<thead>
<tr>
<th>Hospital Expenses or Long-Term Acute Care Facility/ Hospital (facility charges)</th>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3 PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
</tr>
<tr>
<td>Room and Board Allowance</td>
<td>Semi-Private Room Rate*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>ICU/CCU Room Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Services &amp; Supplies</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.
<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 IASIS Provider</th>
<th>Tier 2 Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3 Participating Providers - Services Are Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehab (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td>30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Diagnostic Testing, X-Ray and Lab Services (outpatient)</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible (Hospital)</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td></td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services/Emergency Room Services (facility charges)</td>
<td>$150 Copay, then</td>
<td>80% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemodialysis (outpatient Hospital)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Mental Disorders and Substance Use Disorders</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>$2,500 Copay per admission, then 40%</td>
<td>$2,500 Copay per admission, then 40%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$25 Copay, then</td>
<td>$35 Copay, then</td>
<td>$35 Copay, then</td>
<td>$35 Copay, then</td>
</tr>
<tr>
<td>NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morbid Obesity (surgical)</td>
<td>IASIS Facility: $2,500 Copay per occurrence, then 100%; Deductible waived* Any Other Facility: Not Covered</td>
<td>Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>* Practitioner charges performed by an Aetna or IASIS provider will be considered at 100% as long as the Surgery is done at an IASIS facility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Complications covered only if original Surgery was performed at an IASIS facility and approved by the Plan.

Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.
<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 IASIS Provider</th>
<th>Tier 2 Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3 Participating Providers - Services Are Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td>Physical Therapy (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td>Pulmonary Therapy (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td>Radiation Therapy (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Preventive Services and Routine Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)</td>
<td></td>
<td>100%; Deductible waived</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td>Speech Therapy (outpatient)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Surgery (outpatient)</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
</tr>
<tr>
<td>Transplants</td>
<td>90% after Deductible</td>
<td>80% after Deductible*</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
</tr>
</tbody>
</table>

* Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.
<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3 PARTICIPATING PROVIDERS - SERVICES AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urgent Care Facility</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td></td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>*Copay applies per visit regardless of what services are rendered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Eligible Hospital/Facility Based Medical Expenses</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

*Copay applies per visit regardless of what services are rendered.
<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2 &amp; TIER 3</th>
<th>TIER 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASIS PROVIDER</td>
<td>PARTICIPATING PROVIDERS</td>
<td>NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
</tr>
</tbody>
</table>

**NON-HOSPITAL AND FACILITY BASED BENEFITS AND PROFESSIONAL FEES**

**CALENDAR YEAR DEDUCTIBLE**
(combined with Hospital/facility based)
- Single $500
- Family $1,000
- $1,500
- $3,000

**CALENDAR YEAR OUT-OF-POCKET MAXIMUM**
(includes Deductibles, Copays, Coinsurance, pre-cert penalties - combined with non-Hospital/ facility based and Prescription Drug Card)
- Single $5,750
- Family $11,500
- Unlimited
- Unlimited

**ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.**

<table>
<thead>
<tr>
<th>Service</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>TIER 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Allergy Serum, Injections &amp; Testing</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Cardiac Rehab (Outpatient)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Chemotherapy (Outpatient)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>All Other Outpatient Locations</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic Care/Spinal Manipulation</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Diagnostic Testing, X-Ray and Lab Services (Outpatient – not performed in a Physician's office)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** 3D mammograms are covered only when rendered at a Tier 1 facility.

<table>
<thead>
<tr>
<th>Service</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>TIER 4</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Durable Medical Equipment (DME)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Emergency Services/Emergency Room Services</strong></td>
<td>90% after Deductible</td>
<td>80% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hemodialysis (Outpatient)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
</tbody>
</table>

Calendar Year Maximum Benefit:
- **30 visits**
- **20 visits**
- **60 visits**
<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 IASIS PROVIDER</th>
<th>Tier 2 &amp; Tier 3 Participating Providers</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospice Care</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Infertility (Testing Only)</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maternity (professional fees)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Prenatal and Breastfeeding Support (other than lactation consultations)</td>
<td>100%; Deductible waived</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td></td>
<td>100%; Deductible waived</td>
<td></td>
</tr>
<tr>
<td>All Other Prenatal and Postnatal Care</td>
<td>100%; Deductible waived ( $25 Copay to determine pregnancy)</td>
<td>100%; Deductible waived ( $35 Copay to determine pregnancy)</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Delivery</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

* See Eligible Medical Expenses for limitations.

| Medical Supplies                     | 90% after Deductible  | 75% after Deductible                   | 40% after Deductible                                                     |
| Mental Disorders and Substance Use Disorders (professional fees) |                       |                                         |                                                                          |
| Inpatient                           | 90% after Deductible  | 80% after Deductible                   | 40% after Deductible                                                     |
| Outpatient                          | $25 Copay, then 100%; Deductible waived | $35 Copay, then 100%; Deductible waived | 40% after Deductible |

**NOTE:** Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.

| Morbid Obesity (surgical)           | IASIS Facility: $2,500 Copay per occurrence, then 100%; Deductible waived* | Not Covered |
|                                     | Any Other Facility: Not Covered                                             |             |
| Lifetime Maximum Benefit            | 1 surgery (unless Medically Necessary)                                      | N/A          |

* Practitioner charges performed by an Aetna or IASIS provider will be considered at 100% as long as the Surgery is done at an IASIS facility.

**NOTE:** Complications covered only if original surgery was performed at IASIS facility and approved by the Plan. Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.

<p>| Occupational Therapy (Outpatient)   | 90% after Deductible  | 75% after Deductible                   | 40% after Deductible                                                     |
|                                     | Calendar Year Maximum Benefit 30 visits                                    |                                         |                                                                          |
| Physical Therapy (PT) (Outpatient)  | 90% after Deductible  | 75% after Deductible                   | 40% after Deductible                                                     |
|                                     | Calendar Year Maximum Benefit 30 visits                                    |                                         |                                                                          |</p>
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Tier 1 IASIS PROVIDER</th>
<th>Tier 2 &amp; Tier 3 Participating Providers</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician's Services</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Services</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Visits:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician</td>
<td>$25 Copay*, then 100%; Deductible waived</td>
<td>$35 Copay*, then 100%; Deductible waived</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Specialist</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages. Office Surgery will be paid under the outpatient Surgery benefit.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services and Routine Care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services</td>
<td>100%; Deductible waived</td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>(includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Care</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>(includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prosthetics</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Pulmonary Therapy (Outpatient)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility and Rehabilitation Facility</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Combined Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Speech Therapy (Outpatient)</strong></td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Surgery (Outpatient)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional Services</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Miscellaneous</td>
<td>90% after Deductible</td>
<td>80% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Service</td>
<td>Tier 1 IASIS PROVIDER</td>
<td>Tier 2 &amp; Tier 3 Participating Providers</td>
<td>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Transplants</td>
<td>90% after Deductible</td>
<td>80% after Deductible*</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Transportation and Lodging</td>
<td>$50 per day per person ($150 per day maximum) per transplant*</td>
<td>$10,000 per transplant*</td>
<td></td>
</tr>
<tr>
<td>Daily Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>*Copay applies per visit regardless of what services are rendered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Eligible Medical Expenses</td>
<td>90% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>
PRESCRIPTION DRUG SCHEDULE OF BENEFITS – TIERED $500 PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong></td>
<td></td>
</tr>
<tr>
<td>(includes Copays - combined with major medical)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$5,750</td>
</tr>
<tr>
<td>Family</td>
<td>$11,500</td>
</tr>
<tr>
<td><strong>Retail Pharmacy: 30-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$10.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>$55.00 Copay, then 100%</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>$90.00 Copay, then 100%</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$175.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$25.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>$137.50 Copay, then 100%</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>$225.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
</tbody>
</table>

**Mandatory Generic Program**
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

**Mandatory Maintenance Drugs**
All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
### MEDICAL SCHEDULE OF BENEFITS – TIERED $750 PLAN

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2*</th>
<th>TIER 3*</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASIS PROVIDER AND UT: PRIMARY CHILDREN'S HOSPITAL</td>
<td>PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</td>
<td>PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</td>
<td>(Subject to Usual and Customary Charges)</td>
</tr>
</tbody>
</table>

*UT: Tiers 2 & 3 include University of Utah only from a facility standpoint; all Altius contracted Physicians.

### LIFETIME MAXIMUM BENEFIT

<table>
<thead>
<tr>
<th></th>
<th>Unlimited</th>
</tr>
</thead>
</table>

### CALENDAR YEAR MAXIMUM BENEFIT

<table>
<thead>
<tr>
<th></th>
<th>Unlimited</th>
</tr>
</thead>
</table>

### HOSPITAL AND FACILITY BASED BENEFITS

#### CALENDAR YEAR DEDUCTIBLE

(combined with non-Hospital/facility based/professional fees)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIER 1</td>
<td>$750</td>
<td>$1,500</td>
</tr>
<tr>
<td>TIER 2*</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
<tr>
<td>TIER 3*</td>
<td>$2,250</td>
<td>$4,500</td>
</tr>
</tbody>
</table>

#### CALENDAR YEAR OUT-OF-POCKET MAXIMUM

(includes Deductibles, Copays, Coinsurance, precert penalties - combined with non-Hospital/facility based and Prescription Drug Card)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>TIER 1</td>
<td>$6,250</td>
<td>$12,500</td>
</tr>
<tr>
<td>TIER 2*</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>TIER 3*</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.

<table>
<thead>
<tr>
<th>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</th>
<th>Inpatient</th>
<th>Room and Board Allowance</th>
<th>Intensive Care Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>85% after Deductible</td>
<td>Semi-Private Room Rate*</td>
<td>ICU/CCU Room Rate</td>
</tr>
<tr>
<td>Inpatient</td>
<td>75% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### Miscellaneous Services & Supplies

<table>
<thead>
<tr>
<th>Tier</th>
<th>Inpatient</th>
<th>Room and Board Allowance</th>
<th>Intensive Care Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>85% after Deductible</td>
<td>Semi-Private Room Rate*</td>
<td>ICU/CCU Room Rate</td>
</tr>
<tr>
<td></td>
<td>75% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.
<table>
<thead>
<tr>
<th>Service</th>
<th>TIER 1 IASIS PROVIDER AND UT: PRIMARY CHILDREN’S HOSPITAL</th>
<th>TIER 2* PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3* PARTICIPATING PROVIDERS - SERVICES AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehab (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td>30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Diagnostic Testing, X-Ray and Lab Services (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.

<table>
<thead>
<tr>
<th>Emergency Services/ Emergency Room Services (facility charges)</th>
<th>$150 Copay, then 100%; Deductible waived</th>
<th>75% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</th>
</tr>
</thead>
</table>

NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.

<table>
<thead>
<tr>
<th>Mental Disorders and Substance Use Disorders</th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>$2,500 Copay per admission, then 40%</td>
<td>$2,500 Copay per admission, then 40%</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 Copay, then 100%; Deductible waived</td>
<td>$40 Copay, then 100%; Deductible waived</td>
<td>$40 Copay, then 100%; Deductible waived</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.

<table>
<thead>
<tr>
<th>Morbid Obesity (surgical)</th>
<th>IASIS Facility: $2,500 Copay per occurrence, then 100%; Deductible waived* Only Other Facility: Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Practitioner charges performed by an Aetna or IASIS provider will be considered at 100% as long as the Surgery is done at an IASIS facility.

Complications covered only if original Surgery was performed at an IASIS facility and approved by the Plan.

Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.
<table>
<thead>
<tr>
<th></th>
<th>Tier 1 IASIS Provider and UT: Primary Children’s Hospital</th>
<th>Tier 2* Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3* Participating Providers - Services Are Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Occupational Therapy</strong> (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong> (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td><strong>Pulmonary Therapy</strong> (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td><strong>Radiation Therapy</strong> (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td>Preventive Services and Routine Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td></td>
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</tr>
<tr>
<td>NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>Speech Therapy</strong> (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td><strong>Surgery</strong> (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
</tr>
</tbody>
</table>

* Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.

*UT: Tiers 2 & 3 include University of Utah only from a facility standpoint; all Altius contracted Physicians.
<table>
<thead>
<tr>
<th>Tier Level</th>
<th>IASIS Provider and UT: Primary Children's Hospital</th>
<th>Tier 2* Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3* Participating Providers - Services Are Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1</td>
<td>Urgent Care Facility</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Located in Utah</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
</tr>
<tr>
<td></td>
<td>All Other Locations</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>*Copay applies per visit regardless of what services are rendered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NOTE: Utah locations, Tier 1 benefits are available only at Medallus Urgent Care facilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 2*</td>
<td>All Other Eligible Hospital/Facility Based Medical Expenses</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Service</td>
<td>TIER 1 IASIS PROVIDER</td>
<td>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</td>
<td>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------</td>
<td>------------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>NON-HOSPITAL AND FACILITY BASED BENEFITS AND PROFESSIONAL FEES</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR DEDUCTIBLE</strong> (combined with Hospital/facility based)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$750</td>
<td></td>
<td>$2,250</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$1,500</td>
<td></td>
<td>$4,500</td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong> (includes Deductibles, Copays, Coinsurance, precert penalties - combined with non-Hospital/ facility based and Prescription Drug Card)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$6,250</td>
<td></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$12,500</td>
<td></td>
<td>Unlimited</td>
<td></td>
</tr>
<tr>
<td><strong>ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Allergy Serum, Injections &amp; Testing</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Cancer Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>All Other Outpatient Locations</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care/Spinal Manipulation</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Cancer Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing, X-Ray and Lab Services (Outpatient – not performed in a Physician's office)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Emergency Services/Emergency Room Services</td>
<td>85% after Deductible</td>
<td>75% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemodialysis (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Cancer Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>Tier 1 Participating Providers</td>
<td>Tier 2 &amp; Tier 3 Participating Providers</td>
<td>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</td>
<td></td>
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<tr>
<td>---------------------</td>
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<td>--------------------------------------------------------------------------</td>
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</tr>
<tr>
<td><strong>Infertility (Testing Only)</strong></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td><strong>Maternity (professional fees)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Prenatal and Breastfeeding Support (other than lactation consultations)</td>
<td>100%; Deductible waived</td>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Prenatal and Postnatal Care</td>
<td>100%; Deductible waived ($30 Copay to determine pregnancy)</td>
<td>100%; Deductible waived ($40 Copay to determine pregnancy)</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>* See Eligible Medical Expenses for limitations.</td>
<td></td>
<td></td>
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</tr>
<tr>
<td><strong>Medical Supplies</strong></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td><strong>Mental Disorders and Substance Use Disorders (professional fees)</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>$30 Copay, then 100%; Deductible waived</td>
<td>$40 Copay, then 100%; Deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.</td>
<td></td>
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</tr>
<tr>
<td><strong>Morbid Obesity (surgical)</strong></td>
<td>IASIS Facility: $2,500 Copay per occurrence, then 100%; Deductible waived*</td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Any Other Facility:</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>* Practitioner charges performed by an Aetna or IASIS provider will be considered at 100% as long as the Surgery is done at an IASIS facility.</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> Complications covered only if original surgery was performed at IASIS facility and approved by the Plan. Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.</td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td><strong>Occupational Therapy (Outpatient)</strong></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Physical Therapy (PT) (Outpatient)</strong></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>TIER 1 IASIS PROVIDER</td>
<td>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</td>
<td>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
<td></td>
</tr>
<tr>
<td>-----------------------</td>
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<td>------------------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Physician’s Services</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Services</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Office Visits: Primary Care Physician</td>
<td>$30 Copay*, then 100%; Deductible waived</td>
<td>$40 Copay*, then 100%; Deductible waived</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages. Office Surgery will be paid under the outpatient Surgery benefit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

| Preventive Services and Routine Care | 100%; Deductible waived | Not Covered |
| Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately) | | |
| Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above) | 85% after Deductible | 75% after Deductible | Not Covered |

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.

| **Prosthetics** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| **Pulmonary Therapy (Outpatient)** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| **Radiation Therapy** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| **Skilled Nursing Facility and Rehabilitation Facility** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| Combined Calendar Year Maximum Benefit | 60 days | |
| **Speech Therapy (Outpatient)** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| Calendar Year Maximum Benefit | 30 visits | |
| **Surgery (Outpatient)** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| Professional Services | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| Miscellaneous | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| **Transplants** | 85% after Deductible | 75% after Deductible | 40% after Deductible |
| Transportation and Lodging Daily Maximum Benefit | $50 per day per person ($150 per day maximum) per transplant* | | |
| Transportation and Lodging Maximum Benefit | $10,000 per transplant* | | |

* Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.
<table>
<thead>
<tr>
<th></th>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Located in Utah</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
</tr>
<tr>
<td>All Other Locations</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
</tr>
</tbody>
</table>

*Copay applies per visit regardless of what services are rendered.

**NOTE:** Utah locations, Tier 1 benefits are available only at Medallus Urgent Care facilities.

| All Other Eligible Medical Expenses | 85% after Deductible | 75% after Deductible | 40% after Deductible |

*UT: Tiers 2 & 3 include University of Utah only from a facility standpoint; all Altius contracted Physicians.
### BENEFIT DESCRIPTION

<table>
<thead>
<tr>
<th>CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Copays - combined with major medical)</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$6,250</td>
</tr>
<tr>
<td>Family</td>
<td>$12,500</td>
</tr>
</tbody>
</table>

### Retail Pharmacy: 30-day supply

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>$10.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>$55.00 Copay, then 100%</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>$90.00 Copay, then 100%</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$175.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
</tbody>
</table>

### Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply

<table>
<thead>
<tr>
<th>Benefit Description</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>$25.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>$137.50 Copay, then 100%</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>$225.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
</tbody>
</table>

### Mandatory Generic Program

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

### Mandatory Maintenance Drugs

All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
# MEDICAL SCHEDULE OF BENEFITS – TIERED $1,000 PLAN

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2*</th>
<th>TIER 3*</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASIS PROVIDER AND UT: PRIMARY CHILDREN’S HOSPITAL</td>
<td>PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</td>
<td>PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</td>
<td>(Subject to Usual and Customary Charges)</td>
</tr>
</tbody>
</table>

*UT: Tiers 2 & 3 include University of Utah only from a facility standpoint; all Altius contracted Physicians.

## LIFETIME MAXIMUM BENEFIT
Unlimited

## CALENDAR YEAR MAXIMUM BENEFIT
Unlimited

## HOSPITAL AND FACILITY BASED BENEFITS

### CALENDAR YEAR DEDUCTIBLE (combined with non-Hospital/facility based/professional fees)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASIS PROVIDER AND UT: PRIMARY CHILDREN’S HOSPITAL</td>
<td>$1,000</td>
<td>$2,000</td>
</tr>
<tr>
<td>TIER 2*</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>TIER 3*</td>
<td>$3,000</td>
<td>$6,000</td>
</tr>
<tr>
<td>TIER 4 NON-PARTICIPATING PROVIDERS</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### CALENDAR YEAR OUT-OF-POCKET MAXIMUM (includes Deductibles, Copays, Coinsurance, precert penalties - combined with non-Hospital/ facility based and Prescription Drug Card)

<table>
<thead>
<tr>
<th>Tier</th>
<th>Single</th>
<th>Family</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASIS PROVIDER AND UT: PRIMARY CHILDREN’S HOSPITAL</td>
<td>$6,850</td>
<td>$13,700</td>
</tr>
<tr>
<td>TIER 2*</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
<tr>
<td>TIER 3*</td>
<td>Unlimited</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

## ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.

### Hospital Expenses or Long-Term Acute Care Facility/ Hospital (facility charges)

<table>
<thead>
<tr>
<th>Item</th>
<th>TIER 1</th>
<th>TIER 2*</th>
<th>TIER 3*</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
</tr>
<tr>
<td>Room and Board Allowance</td>
<td>Semi-Private Room Rate*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>ICU/CCU Room Rate</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Services &amp; Supplies</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.
<table>
<thead>
<tr>
<th>Service Type</th>
<th>Tier 1 IASIS Provider and UT: Primary Children's Hospital</th>
<th>Tier 2* Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3* Participating Providers - Services Are Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehab (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td></td>
<td></td>
<td></td>
<td>30 visits</td>
</tr>
<tr>
<td>Chemotherapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Diagnostic Testing, X-Ray and Lab Services (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.

| Emergency Services/ Emergency Room Services (facility charges) | $150 Copay, then 100%; Deductible waived | 75% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit |
|---------------------------------------------------------------|---------------------------------------------------------------|

NOTE: The Copay will be waived if the person is admitted directly as an Inpatient to the Hospital.

| Hemodialysis (outpatient Hospital) | 85% after Deductible | 75% after Deductible | 75% after Deductible | 40% after Deductible |

**Mental Disorders and Substance Use Disorders**

<table>
<thead>
<tr>
<th>Inpatient</th>
<th>85% after Deductible</th>
<th>75% after Deductible</th>
<th>$2,500 Copay per admission, then Deductible, then 40%</th>
<th>$2,500 Copay per admission, then Deductible, then 40%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient</td>
<td>$35 Copay, then 100%; Deductible waived</td>
<td>$45 Copay, then 100%; Deductible waived</td>
<td>$45 Copay, then 100%; Deductible waived</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>

NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.

<table>
<thead>
<tr>
<th>Morbid Obesity (surgical)</th>
<th>IASIS Facility: $2,500 Copay per occurrence, then 100%; Deductible waived* Any Other Facility: Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Practitioner charges performed by an Aetna or IASIS provider will be considered at 100% as long as the Surgery is done at an IASIS facility.

Complications covered only if original Surgery was performed at an IASIS facility and approved by the Plan.

Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.
<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 IASIS PROVIDER AND UT: PRIMARY CHILDREN'S HOSPITAL</th>
<th>Tier 2* PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>Tier 3* PARTICIPATING PROVIDERS - SERVICES AVAILABLE AT IASIS</th>
<th>Tier 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Physical Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Pulmonary Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Radiation Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Preventive Services and Routine Care</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.

<table>
<thead>
<tr>
<th>Service</th>
<th>Tier 1 IASIS PROVIDER AND UT: PRIMARY CHILDREN'S HOSPITAL</th>
<th>Tier 2* PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>Tier 3* PARTICIPATING PROVIDERS - SERVICES AVAILABLE AT IASIS</th>
<th>Tier 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Speech Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Surgery (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
<td>$500 Copay per occurrence, then Deductible, then 40%</td>
</tr>
<tr>
<td>Transplants</td>
<td>85% after Deductible</td>
<td>75% after Deductible*</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
<td>$2,500 Copay per admission, then Deductible, then 40%</td>
</tr>
</tbody>
</table>

* Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.
<table>
<thead>
<tr>
<th>Urgent Care Facility</th>
<th>Tier 1 IASIS Provider and UT: Primary Children's Hospital</th>
<th>Tier 2* Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3* Participating Providers - Services Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Located in Utah</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
</tr>
<tr>
<td>All Other Locations</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
</tr>
</tbody>
</table>

*Copay applies per visit regardless of what services are rendered.

NOTE: Utah locations, Tier 1 benefits are available only at Medallus Urgent Care facilities.

<table>
<thead>
<tr>
<th>All Other Eligible Hospital/Facility Based Medical Expenses</th>
<th>Tier 1 IASIS Provider and UT: Primary Children's Hospital</th>
<th>Tier 2* Participating Providers - Services Not Available at IASIS</th>
<th>Tier 3* Participating Providers - Services Available at IASIS</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>TIER 1</td>
<td>TIER 2 &amp; TIER 3*</td>
<td>TIER 4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>--------</td>
<td>-----------------</td>
<td>--------</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IASIS PROVIDER</td>
<td>PARTICIPATING PROVIDERS</td>
<td>NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*UT: Tiers 2 & 3 include University of Utah only from a facility standpoint; all Altius contracted Physicians.

## NON-HOSPITAL AND FACILITY BASED BENEFITS AND PROFESSIONAL FEES

### CALENDAR YEAR DEDUCTIBLE
(combined with Hospital/facility based)

<table>
<thead>
<tr>
<th></th>
<th>TIER 1</th>
<th>TIER 2 &amp; TIER 3*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$1,000</td>
<td>$1,000</td>
</tr>
<tr>
<td>Family</td>
<td>$2,000</td>
<td>$2,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$3,000</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$6,000</td>
</tr>
</tbody>
</table>

### CALENDAR YEAR OUT-OF-POCKET MAXIMUM
(includes Deductibles, Copays, Coinsurance, precert penalties - combined with non-Hospital/facility based and Prescription Drug Card)

<table>
<thead>
<tr>
<th></th>
<th>TIER 1</th>
<th>TIER 2 &amp; TIER 3*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$6,850</td>
<td>$6,850</td>
</tr>
<tr>
<td>Family</td>
<td>$13,700</td>
<td>$13,700</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unlimited</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

### ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.

- **Allergy Serum, Injections & Testing**: 85% after Deductible, 75% after Deductible, 40% after Deductible
- **Ambulance Services**: 85% after Deductible, 75% after Deductible, 75% after Deductible
- **Cardiac Rehab (Outpatient)**: 85% after Deductible, 75% after Deductible, 40% after Deductible
  - Calendar Year Maximum Benefit: 30 visits
- **Chemotherapy (Outpatient)**
  - Office Visit: 85% after Deductible, 75% after Deductible, 40% after Deductible
  - All Other Outpatient Locations: 85% after Deductible, 75% after Deductible, 40% after Deductible
- **Chiropractic Care/Spinal Manipulation**: 85% after Deductible, 75% after Deductible, 40% after Deductible
  - Calendar Year Maximum Benefit: 20 visits
- **Diagnostic Testing, X-Ray and Lab Services (Outpatient – not performed in a Physician’s office)**: 85% after Deductible, 75% after Deductible, 40% after Deductible
  - MRI, CAT and PET Scans: 85% after Deductible, 75% after Deductible, 40% after Deductible
- **NOTE**: 3D mammograms are covered only when rendered at a Tier 1 facility.
- **Durable Medical Equipment (DME)**: 85% after Deductible, 75% after Deductible, 40% after Deductible
- **Emergency Services/Emergency Room Services**: 85% after Deductible, 75% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit
- **Hemodialysis (Outpatient)**: 85% after Deductible, 75% after Deductible, 40% after Deductible
- **Home Health Care**: 85% after Deductible, 75% after Deductible, 40% after Deductible
  - Calendar Year Maximum Benefit: 60 visits
- **Hospice Care**: 85% after Deductible, 75% after Deductible, 40% after Deductible
<table>
<thead>
<tr>
<th>Service Description</th>
<th>Tier 1 IASIS PROVIDER</th>
<th>Tier 2 &amp; Tier 3* PARTICIPATING PROVIDERS</th>
<th>Tier 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infertility (Testing Only)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Maternity (professional fees)*</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Prenatal and Breastfeeding Support (other than lactation consultations)</td>
<td>100%; Deductible waived</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Prenatal and Postnatal Care</td>
<td>100%; Deductible waived ($35 Copay to determine pregnancy)</td>
<td>40% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>* See Eligible Medical Expenses for limitations.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Mental Disorders and Substance Use Disorders (professional fees)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Outpatient</td>
<td>$35 Copay, then 100%; Deductible waived</td>
<td>$45 Copay, then 100%; Deductible waived</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Morbid Obesity (surgical)</td>
<td>IASIS Facility: $2,500 Copay per occurrence, then 100%; Deductible waived*</td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Any Other Facility: Not Covered</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>* Practitioner charges performed by an Aetna or IASIS provider will be considered at 100% as long as the Surgery is done at an IASIS facility.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: Complications covered only if original surgery was performed at IASIS facility and approved by the Plan. Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy (PT) (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Services</td>
<td>TIER 1 IASIS PROVIDER</td>
<td>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</td>
<td>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
</tr>
<tr>
<td>-----------------------------------------</td>
<td>-----------------------</td>
<td>------------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Physician’s Services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Services</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
<tr>
<td>Office Visits: Primary Care Physician</td>
<td>$35 Copay*, then</td>
<td>$45 Copay*, then</td>
<td></td>
</tr>
<tr>
<td></td>
<td>100%; Deductible</td>
<td>100%; Deductible</td>
<td></td>
</tr>
<tr>
<td></td>
<td>waived</td>
<td>waived</td>
<td></td>
</tr>
<tr>
<td></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>Specialist</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*Copay applies to the Physician office visit component only. All other services are paid subject to any Deductible and Coinsurance percentages. Office Surgery will be paid under the outpatient Surgery benefit.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Preventive Services and Routine Care**

<table>
<thead>
<tr>
<th>Services</th>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Preventive Services</td>
<td>100%; Deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Care</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>(includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>NOTE:</strong> 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Prosthetics**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Pulmonary Therapy (Outpatient)**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Radiation Therapy**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Skilled Nursing Facility and Rehabilitation Facility**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Speech Therapy (Outpatient)**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Surgery (Outpatient)**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td></td>
</tr>
<tr>
<td>40% after Deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Transportation and Lodging**

<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 &amp; TIER 3* PARTICIPATING PROVIDERS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transportation and Lodging Daily Maximum Benefit</td>
<td>$50 per day per person ($150 per day maximum) per transplant*</td>
<td></td>
</tr>
<tr>
<td>Transportation and Lodging Maximum Benefit</td>
<td>$10,000 per transplant*</td>
<td></td>
</tr>
</tbody>
</table>

*Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.
<table>
<thead>
<tr>
<th>Tier Type</th>
<th>Tier 1 IASIS Provider</th>
<th>Tier 2 &amp; Tier 3* Participating Providers</th>
<th>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Urgent Care Facility</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Located in Utah</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>75% after Deductible</td>
<td>75% after Deductible</td>
</tr>
<tr>
<td>All Other Locations</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
<td>$100 Copay*, then 100%; Deductible waived</td>
</tr>
<tr>
<td>*Copay applies per visit regardless of what services are rendered.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: Utah locations, Tier 1 benefits are available only at Medallus Urgent Care facilities.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>All Other Eligible Medical Expenses</strong></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>40% after Deductible</td>
</tr>
</tbody>
</table>
## PRESCRIPTION DRUG SCHEDULE OF BENEFITS – TIERED $1,000 PLAN

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong>&lt;br&gt;(includes Copays - combined with major medical)</td>
<td><strong>$6,850</strong>&lt;br&gt;<strong>$13,700</strong></td>
</tr>
<tr>
<td>Single</td>
<td>Family</td>
</tr>
<tr>
<td><strong>Retail Pharmacy: 30-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$10.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>$55.00 Copay, then 100%</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>$90.00 Copay, then 100%</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>$175.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
<tr>
<td><strong>Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply</strong></td>
<td></td>
</tr>
<tr>
<td>Generic Drug</td>
<td>$25.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>$137.50 Copay, then 100%</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>$225.00 Copay, then 100%</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100% ($0 Copay)</td>
</tr>
</tbody>
</table>

### Mandatory Generic Program

The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

### Mandatory Maintenance Drugs

All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:


For a paper copy, please contact the Plan Administrator.
HEALTH REIMBURSEMENT ACCOUNT - $2,000 PLAN ONLY
(Not Available in Arizona and Utah Locations)

The Employer provides a Health Reimbursement Account (HRA) to eligible Employees for reimbursement of certain Covered Expenses under the medical benefit component of the Plan. This HRA intends to meet the requirements of IRS Notice 2002-45. Notwithstanding anything in the Plan to the contrary, the HRA is not intended to be an Internal Revenue Code section 125 “cafeteria plan” and any reimbursements paid under the HRA are provided solely by the Employer and not pursuant to any salary reduction elections. Any provision of this Plan that would cause the HRA to fail to qualify as an employer-provided health reimbursement arrangement described in IRS Notice 2002-45 or that would cause the HRA to violate any applicable nondiscrimination requirements or other applicable legal requirement will be ineffective.

Eligibility
If you and your Dependents meet the general eligibility requirements of the Plan (see the section entitled “Eligibility for Participation”) you will also be eligible for benefits under the HRA once each of you have paid the first $1,500 of Out-of-Pocket expenses under the medical benefit component of the Plan (applies per person). Once this initial $1,500 has been paid, the HRA fund amount stated below will be available for reimbursement from the HRA.

HRA Fund Amount
- Single: $500
- Family: $1,000

Reimbursement Provisions
1. The HRA cannot be used to pay an Employee’s premium contributions under the Plan.
2. The HRA will be used to pay amounts that qualify as:
   a. Deductibles
   b. Coinsurance
3. The HRA may not be used to reimburse:
   a. Any amount paid as a penalty
4. Only those eligible expenses that are Incurred by you or your eligible Dependents can be reimbursed.

Any limitations or exclusions that apply under the Plan also apply under the HRA.

A medical expense is incurred at the time the medical care or service is furnished and not when the Covered Person is billed for, is charged for or pays for the medical care.

A medical expense that otherwise meets the requirements described in this section is eligible for HRA reimbursement provided that the expense was incurred while you and/or your Dependent were covered under the HRA during the applicable Calendar Year. Medical expenses can be reimbursed only to the extent that the person incurring the expense is not reimbursed (or eligible for reimbursement) for the expense through other insurance or any other accident or health plan and only if the expense is not taken as a deduction from income on such person’s federal income tax return in any tax year. If only a portion of a medical expense has been reimbursed elsewhere, the HRA can reimburse the remaining portion of such expense if it meets the HRA requirements.

5. The Employer funds the full amount of the HRA. There are no participant contributions for benefits under the HRA.
6. Your HRA account will be credited upon the first day of the Calendar Year. If you become eligible for benefits under the Plan after the beginning of the Calendar Year your entire HRA fund amount will be available once you have satisfied the eligibility requirements under this section.
(7) Rollover. If any balance remains in your HRA account after all reimbursements have been made for the Calendar Year, such balance shall rollover to reimburse the Employee for eligible expenses incurred during a subsequent Calendar Year as follows:

50% of the HRA balance will rollover up to a maximum of $2,000 single/$4,000 family.

(8) Only those medical expenses which are incurred during the same Calendar Year of the HRA will be debited from the account balance.

(9) Written notice of a claim and all information needed to process the claim must be given to the Third Party Administrator as soon as reasonably possible in accordance with the Claims Procedures section of the Plan and in no event, later than 12 months following the date services were Incurred.

Termination

(1) If you lose coverage during the Calendar Year due to termination of employment, any fund balance that is remaining at termination may be used for any claims that were incurred prior to the date of termination and would have been eligible for reimbursement while you were covered under the Plan. The HRA amount will not be pro-rated based on the termination date; however, any unused account balance that remains after eligible claims are paid will be forfeited, unless coverage under COBRA is elected.

(2) Upon termination Eligible Employees may spend down their HRA balance on eligible medical expenses (as limited in #2 above under Reimbursement Provisions) until the fund is depleted.

(3) If you choose coverage under COBRA, the fund balance will remain active until you are no longer eligible for coverage under COBRA.

(4) Should the Plan Sponsor choose to terminate this Plan, your rights are limited to reimbursement for any claims incurred prior to the date of termination.

COBRA and HRA Funds

When electing COBRA your HRA fund amounts will be determined based upon the COBRA continuation coverage election as indicated below.

(1) HRA Amount for Termination of Single Coverage and Election of Single COBRA Continuation. If an Employee terminated with single coverage and elected single COBRA continuation, the HRA fund amount will continue at the existing single HRA fund level amount at the time of termination, including any applicable annual rollover amounts, less any prior reimbursements for the current Calendar Year. Upon plan renewal, the HRA fund amount will continue at the single HRA fund level amount, including any applicable annual rollover amounts.

(2) HRA Amount for Termination of Family Coverage and Election of Single COBRA Continuation. If an Employee terminated with family coverage and elected single COBRA continuation, the HRA fund amount will continue at the existing family HRA fund level amount at the time of termination, including any applicable annual rollover amounts, less any prior reimbursements for the current Calendar Year. Upon plan renewal, the HRA fund amount will continue at the single HRA fund level amount, including any applicable annual rollover amounts.

(3) HRA Amount for Termination of Family Coverage and Election of Family COBRA Continuation. If an Employee terminated with family coverage and elected family COBRA continuation, the HRA fund amount will continue at same coverage level at the time of the COBRA qualifying event, including any applicable annual rollover amounts, less any prior reimbursements for the current Calendar Year. Upon plan renewal, the HRA fund amount will remain at the family HRA fund level amount, including any applicable annual rollover amounts.
# MEDICAL SCHEDULE OF BENEFITS – TIERED $2,000 PLAN

(Not Available in Arizona and Utah Locations)

<table>
<thead>
<tr>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>TIER 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>IASIS PROVIDER</td>
<td>PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</td>
<td>PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</td>
<td>NON-PARTICIPATING PROVIDERS</td>
</tr>
</tbody>
</table>

## LIFETIME MAXIMUM BENEFIT
- Unlimited
- Not Covered

## CALENDAR YEAR MAXIMUM BENEFIT
- Unlimited
- Not Covered

### HOSPITAL AND FACILITY BASED BENEFITS

#### CALENDAR YEAR DEDUCTIBLE
(combined with non-Hospital/facility based/professional fees)
- Single: $2,000
- Family: $4,000
- Not Covered
- Not Covered
- Not Covered

#### CALENDAR YEAR OUT-OF-POCKET MAXIMUM
(includes Deductibles, Coinsurance, precert penalties - combined with non-Hospital/facility based and Prescription Drug Card)
- Single: $6,850
- Family: $13,700
- Not Covered
- Not Covered
- Not Covered

### ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.

<table>
<thead>
<tr>
<th>Hospital Expenses or Long-Term Acute Care Facility/Hospital (facility charges)</th>
<th>TIER 1</th>
<th>TIER 2</th>
<th>TIER 3</th>
<th>TIER 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Room and Board Allowance</td>
<td>Semi-Private Room Rate*</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Intensive Care Unit</td>
<td>ICU/CCU Room Rate</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Miscellaneous Services &amp; Supplies</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Outpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

* A private room will be considered eligible when Medically Necessary. Charges made by a Hospital having only single or private rooms will be considered at the least expensive rate for a single or private room.
<table>
<thead>
<tr>
<th>TIER 1 IASIS PROVIDER</th>
<th>TIER 2 PARTICIPATING PROVIDERS - SERVICES NOT AVAILABLE AT IASIS</th>
<th>TIER 3 PARTICIPATING PROVIDERS - SERVICES ARE AVAILABLE AT IASIS</th>
<th>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehab (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Chemotherapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Diagnostic Testing, X-Ray and Lab Services (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
</tr>
</tbody>
</table>

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.

<table>
<thead>
<tr>
<th>Emergency Services/ Emergency Room Services</th>
<th>85% after Deductible</th>
<th>75% after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hemodialysis (outpatient Hospital)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
</tr>
<tr>
<td>Mental Disorders and Substance Use Disorders</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
</tr>
</tbody>
</table>

NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.

<table>
<thead>
<tr>
<th>Morbid Obesity (surgical)</th>
<th>IASIS Facility: 85% after Deductible</th>
<th>Any Other Facility: Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

* Practitioner charges performed by an Aetna or IASIS provider will be considered as long as the Surgery is done at an IASIS facility.

Complications covered only if original Surgery was performed at an IASIS facility and approved by the Plan.

Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.

<table>
<thead>
<tr>
<th>Occupational Therapy (outpatient)</th>
<th>85% after Deductible</th>
<th>75% after Deductible</th>
<th>Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Physical Therapy (outpatient)</th>
<th>85% after Deductible</th>
<th>75% after Deductible</th>
<th>Not Covered</th>
<th>Not Covered</th>
</tr>
</thead>
<tbody>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>Service</td>
<td>Tier 1 IASIS PROVIDER</td>
<td>Tier 2 Participating Providers - Services Not Available at IASIS</td>
<td>Tier 3 Participating Providers - Services Are Available at IASIS</td>
<td>Tier 4 Non-Participating Providers (Subject to Usual and Customary Charges)</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------------------</td>
<td>---------------------------------------------------------------</td>
<td>---------------------------------------------------------------</td>
<td>-------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Pulmonary Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Radiation Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive Services and Routine Care</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
<td>Not Covered</td>
</tr>
<tr>
<td>Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Speech Therapy (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>Surgery (outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Transplants</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>* Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Urgent Care Facility</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>All Other Eligible Hospital/Facility Based Medical Expenses</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td>Not Covered</td>
</tr>
<tr>
<td>Service Description</td>
<td>Tier 1 IASIS PROVIDER</td>
<td>Tier 2 &amp; Tier 3 Participating Providers</td>
<td>Tier 4 Non-Participating Providers</td>
<td></td>
</tr>
<tr>
<td>----------------------------------------------------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
<td>-----------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR DEDUCTIBLE</strong> (combined with Hospital/facility based)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$2,000</td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong> (includes Deductibles, Coinsurance, precert penalties - combined with non-Hospital/ facility based and Prescription Drug Card)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$6,850</td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
<tr>
<td>Family</td>
<td>$13,700</td>
<td></td>
<td>Not Covered</td>
<td></td>
</tr>
</tbody>
</table>

**ALL MAXIMUM AMOUNTS SPECIFIED BELOW ARE COMBINED BETWEEN HOSPITAL AND FACILITY BASED BENEFITS AND NON-HOSPITAL AND FACILITY BASED PROFESSIONAL FEES.**

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Payment after Deductible</th>
<th>Payment after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</th>
<th>Payment after Deductible</th>
<th>Payment after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</th>
<th>Payment after Deductible</th>
<th>Payment after Tier 2 Deductible, subject to Tier 2 Out-of-Pocket Limit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Serum, Injections &amp; Testing</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ambulance Services</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cardiac Rehab (Outpatient)</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chemotherapy (Outpatient)</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visit</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Outpatient Locations</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Chiropractic Care/Spinal Manipulation</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>20 visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic Testing, X-Ray and Lab Services (Outpatient – not performed in a Physician’s office)</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MRI, CAT and PET Scans</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.</td>
<td></td>
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<td></td>
</tr>
<tr>
<td>Durable Medical Equipment (DME)</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Services/Emergency Room Services</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hemodialysis (Outpatient)</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home Health Care</td>
<td>85%</td>
<td>75%</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>60 visits</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Service Description</td>
<td>TIER 1 IASIS PROVIDER</td>
<td>TIER 2 &amp; TIER 3 PARTICIPATING PROVIDERS</td>
<td>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
<td></td>
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<tr>
<td>-------------------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
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<td></td>
</tr>
<tr>
<td>Hospice Care</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Infertility (Testing Only)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Maternity (professional fees)*</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Prenatal and Breastfeeding Support (other than lactation consultations)</td>
<td>100%; Deductible waived</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lactation Consultations</td>
<td>100%; Deductible waived</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>All Other Prenatal and Postnatal Care</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Delivery</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* See Eligible Medical Expenses for limitations.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical Supplies</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mental Disorders and Substance Use Disorders (professional fees)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: Emergency care (ambulance and Emergency Services) will be paid the same as the benefits for ambulance services and Emergency Services listed above in the Medical Schedule of Benefits, however, the Tier 2 Participating Provider level of benefits will always apply regardless of the provider utilized.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Morbid Obesity (surgical)</td>
<td>IASIS Facility: 85% after Deductible*</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Lifetime Maximum Benefit</td>
<td>1 surgery (unless Medically Necessary)</td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>* Practitioner charges performed by an Aetna or IASIS provider will be considered as long as the Surgery is done at an IASIS facility.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NOTE: Complications covered only if original surgery was performed at IASIS facility and approved by the Plan. Eligibility: Employees: after 1 year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Occupational Therapy (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Therapy (PT) (Outpatient)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Calendar Year Maximum Benefit</td>
<td>30 visits</td>
<td></td>
<td>N/A</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physician’s Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient/Outpatient Services</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Office Visits:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Primary Care Physician Specialist</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services and Routine Care</td>
<td>TIER 1 IASIS PROVIDER</td>
<td>TIER 2 &amp; TIER 3 PARTICIPATING PROVIDERS</td>
<td>TIER 4 NON-PARTICIPATING PROVIDERS (Subject to Usual and Customary Charges)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------------------------------------</td>
<td>-----------------------</td>
<td>----------------------------------------</td>
<td>--------------------------------------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Preventive Services (includes the office visit and any other eligible item or service received at the same time, whether billed at the same time or separately)</td>
<td>100%; Deductible waived</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Routine Care (includes any routine care item or service not otherwise covered under the preventive services provision above)</td>
<td>85% after Deductible</td>
<td>75% after Deductible</td>
<td>Not Covered</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

NOTE: 3D mammograms are covered only when rendered at a Tier 1 facility.

| Prosthetics | 85% after Deductible | 75% after Deductible | Not Covered |
| Pulmonary Therapy (Outpatient) | 85% after Deductible | 75% after Deductible | Not Covered |

| Calendar Year Maximum Benefit | 30 visits | N/A |
| Radiation Therapy | 85% after Deductible | 75% after Deductible | Not Covered |
| Skilled Nursing Facility and Rehabilitation Facility | 85% after Deductible | 75% after Deductible | Not Covered |

| Combined Calendar Year Maximum Benefit | 60 days | N/A |
| Speech Therapy (Outpatient) | 85% after Deductible | 75% after Deductible | Not Covered |

| Calendar Year Maximum Benefit | 30 visits | N/A |
| Surgery (Outpatient) | Professional Services | 85% after Deductible | 75% after Deductible | Not Covered |
| Miscellaneous | 85% after Deductible | 75% after Deductible | Not Covered |
| Transplants | 85% after Deductible | 75% after Deductible* | Not Covered |

| Transportation and Lodging Daily Maximum Benefit | $50 per day per person ($150 per day maximum) per transplant* | N/A |
| Transportation and Lodging Maximum Benefit | $10,000 per transplant* | N/A |

* Transplant benefits will only be paid at the Participating Provider level if services are received at an Aetna IOE Facility. Please refer to the Aetna Institute of Excellence (IOE) section of this Plan for a more detailed description of this benefit.

| Urgent Care Facility | 85% after Deductible | 75% after Deductible | Not Covered |
| All Other Eligible Medical Expenses | 85% after Deductible | 75% after Deductible | Not Covered |
### PRESCRIPTION DRUG SCHEDULE OF BENEFITS – TIERED $2,000 PLAN
(Not Available in Arizona and Utah Locations)

<table>
<thead>
<tr>
<th>BENEFIT DESCRIPTION</th>
<th>BENEFIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CALENDAR YEAR DEDUCTIBLE</strong> (combined with major medical)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$2,000</td>
</tr>
<tr>
<td>Family</td>
<td>$4,000</td>
</tr>
<tr>
<td><strong>CALENDAR YEAR OUT-OF-POCKET MAXIMUM</strong> (includes Copays - combined with major medical)</td>
<td></td>
</tr>
<tr>
<td>Single</td>
<td>$6,850</td>
</tr>
<tr>
<td>Family</td>
<td>$13,700</td>
</tr>
</tbody>
</table>

### Retail Pharmacy: 30-day supply

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Specialty Drugs</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100%; Deductible waived</td>
</tr>
</tbody>
</table>

### Mail Order Pharmacy or 90 day Retail Pharmacy: 90-day supply

<table>
<thead>
<tr>
<th>Type</th>
<th>Benefit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Generic Drug</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Preferred Drug</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Non-Preferred Drug</td>
<td>85% after Deductible</td>
</tr>
<tr>
<td>Preventive Drug (Prescription Drugs classified as a Preventive Drug by HHS)</td>
<td>100%; Deductible waived</td>
</tr>
</tbody>
</table>

**Mandatory Maintenance Drugs**

All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
ELIGIBILITY AND PARTICIPATION

Employee Eligibility
An Employee of the Employer who regularly works 30 Hours of Service or more per week will be eligible to enroll for coverage under this Plan once he/she completes a waiting period of 30 days from the date he or she completes at least one Hour of Service with the Employer. Participation in the Plan will begin as of the first day of the month following completion of the waiting period provided all required election and enrollment forms are properly submitted to the Plan Administrator within 30 days.

You are not eligible to participate in the Plan if you are a PRN, temporary, leased or Seasonal Employee, an independent contractor or a person performing services pursuant to a contract under which you are designated an independent contractor (regardless of whether you might later be deemed a common law employee by a court or governmental agency) or a person covered by a collective bargaining agreement that does not provide for participation in this Plan.

Determining Full-Time Employee Status for Ongoing Employees
In determining whether an Ongoing Employee is classified as a Full-Time Employee the Employer has set forth a Standard Measurement Period of 12 months followed by a Standard Stability Period of 12 months. If during the Standard Measurement Period, the Ongoing Employee is determined to be a Full-Time Employee, the Plan will have a 90 day Administrative Period to notify the Employee of his or her eligibility (and the eligibility of the Employee’s eligible Dependents) to enroll in the Plan and to complete the enrollment process. An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period, and who is in an eligible job class, will be offered coverage that is effective as of the first day of the Employee’s Stability Period (and coverage will be added to such Full-Time Employee’s eligible Dependents).

Determining Full-Time Employee Status for New Variable Hour or Part-Time Employees
In determining whether a new Variable Hour or Part-Time Employee will be considered as a Full-Time Employee during the Initial Stability Period, the Employer has set forth an Initial Measurement Period of 11 months followed by an Initial Stability Period of 12 months. If during the Initial Measurement Period, the Employee is determined to be a Full-Time Employee, the Plan will have a 60 day Administrative Period to notify the Employee of his or her eligibility to enroll in the plan and to complete the enrollment process (and the eligibility of the Employee’s eligible Dependents).

An Employee who has been determined to be a Full-Time Employee during his or her Measurement Period will be offered coverage that is effective as of the first day of the Employee’s Stability Period (and coverage will be offered to such Full-Time Employee’s eligible Dependents). Notwithstanding any other provision to the contrary, the combined length of the Initial Measurement Period and the Administrative Period for a New Employee who is a Part-Time, Variable Hour may not extend beyond the last day of the first calendar month beginning on or after the first anniversary of the date the Employee completes at least one Hour of Service with the Employer.

Material Change in Position or Employment Status for New Variable Hour or Part-Time Employee
An Employee who, during his or her Initial Measurement Period, experiences a material change in position or employment status that results in the Employee becoming reasonably expected to work at least 30 Hours of Service per week for the Employer will be treated as a Full-Time Employee to whom coverage under the Plan will be offered to the Employee and his or her eligible Dependents. Coverage will begin according to IASIS policy as of the first day of the calendar month following 30 days from the date of the change in status.

Dependent Eligibility
Your Dependents are eligible for participation in this Plan provided he/she is:

1. Your Spouse.
2. Your Child until the end of the month he/she attains age 26.
3. Your Child age 26 or older, who is unable to be self supporting by reason of mental or physical handicap and is incapacitated, provided the child suffered such incapacity prior to the end of the month he/she attained age 26. Your Child must be unmarried, primarily dependent upon you for support, and incapable of self-sustaining employment. The Plan Sponsor may require subsequent proof of your Child’s disability and dependency, including a Physician’s statement certifying your Child’s physical or mental incapacity.
A child for whom you are required to provide health coverage due to a Qualified Medical Child Support Order (QMCSO). Procedures for determining a QMCSO may be obtained from the Plan Administrator at no cost.

The below terms have the following meanings:

“Child” means your natural born son, daughter, stepson, stepdaughter, legally adopted child (or a child placed with you in anticipation of adoption), Eligible Foster Child or a child for whom you are the Legal Guardian. Coverage for an Eligible Foster Child or a child for whom you are the Legal Guardian will remain in effect until such child no longer meets the age requirements of an eligible Dependent under the terms of the Plan, regardless of whether or not such child has attained age 18 (or any other applicable age of emancipation of minors).

"Child placed with you in anticipation of adoption" means a child that you intend to adopt, whether or not the adoption has become final, who has not attained the age of 18 as of the date of such placement for adoption. The term "placed" means the assumption and retention by you of a legal obligation for total or partial support of the child in anticipation of adoption of the child. The child must be available for adoption and the legal process must have commenced.

“Eligible Foster Child” shall mean an individual who is placed with you by an authorized placement agency.

“Legal Guardian” means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of an individual that is placed with such person by judgment, decree or other order of any court of competent jurisdiction.

“Spouse” means any person who is lawfully married to you under any state law, including persons of the same sex who were legally married in a state that recognizes such marriages, but who may reside in a state that does not recognize same sex marriages. The following are not eligible for coverage under the Plan: (a) your Spouse if you are legally separated; (b) your Spouse if you have been physically separated for 6 months or more; (c) your former Spouse if you are divorced, even if your divorce decree requires you to cover your former Spouse; or (d) your common law Spouse, civil union spouse partner, or domestic partner (same-sex or opposite-sex). The Plan Administrator may require documentation proving a legal marital relationship as defined herein.

The Plan Administrator, in its sole discretion, shall have the right to require documentation necessary to establish an individual's status as an eligible Dependent.

When you and your Spouse are both Covered Employees

When both you and your Spouse are covered Employees, each of you must choose coverage as either an Employee or as a Dependent. You may not be covered under this Plan as both an Employee and a Dependent. Eligible Dependent children of 2 covered Employees may not be enrolled as Dependents of both Employees, whether the Employees are married or unmarried.

Court Ordered Coverage for a Child

Federal law requires the Plan, under certain circumstances, to provide coverage for your children. The details of these requirements are summarized below.

The Plan Administrator shall enroll for immediate coverage under this Plan any Child, who is the subject of a “qualified medical child support order” ("QMCSO"). If you are ordered to provide such coverage for a Child and you are not enrolled in the Plan at the time the Plan Administrator receives a QMCSO, the Plan Administrator shall also enroll you for immediate coverage under this Plan. Coverage under the Plan will be effective as of the later of the date specified in the order or the date the Plan Administrator determines that the order is a QMCSO. Any required contribution for coverage pursuant to this section will be deducted from your pay in accordance with the Employer's payroll schedule and policies.

A QMCSO is defined as a child support decree or order issued by a court (or a state administrative agency that has the force and effect of law under applicable state law) that obligates you to support or provide health care coverage to your child and includes certain information concerning such coverage. The Plan Administrator will determine whether any child support order it receives constitutes a QMCSO. Except for QMCSO’s, no child is eligible for Plan coverage, even if you are required to provide coverage for that child under the terms of a separation agreement or court order, unless the child is an eligible Child under this Plan. Procedures for determining a QMCSO may be obtained, free of charge, by contacting the Plan Administrator.
**Timely Enrollment**

Once you are eligible to participate in the Plan, you must enroll for coverage by completing all election and enrollment forms and submitting them to the Plan Administrator within 30 days of employment. If you are required to contribute towards the cost of coverage you must complete and submit a payroll deduction authorization for the Plan Administrator to deduct the required contribution from your pay. In addition, as part of the enrollment requirements, you will be required to provide your social security number, as well as the social security numbers of your Dependents. The Plan Administrator may request this information at any time for continued eligibility under the Plan. Failure to provide the required social security numbers may result in loss of eligibility or loss of continued eligibility under the Plan.

If you fail to complete and submit the appropriate election and enrollment forms within the 30-day period described above, you will not be eligible to enroll in the Plan until the next open enrollment period or unless you experience a Special Enrollment Event or a Status Change Event.

**Open Enrollment Period**

You and your Dependents may enroll for coverage during the Plan’s open enrollment period, designated by the Plan Sponsor and communicated to you prior to such open enrollment period. During this time you will be permitted to make changes to any existing benefit elections. Benefit elections made during the open enrollment period will be effective as of January 1 and will remain in effect until the next open enrollment period unless you experience or your Dependent experiences a Special Enrollment Event or Status Change Event.

**Late Enrollment**

If you did not enroll during your original 30-day eligibility period you may do so by making written application to the Plan Administrator during the annual open enrollment period (refer to annual open enrollment period section above). In these circumstances, you and/or your eligible Dependents will be considered Late Enrollees.

**Special Enrollment Event**

A special enrollment event occurs when you or your Dependents suffer a loss of other health care coverage, when you become eligible for a state premium assistance subsidy or acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption. In these circumstances, you and/or your eligible Dependents will be considered Special Enrollees.

Each special enrollment event is more fully described below:

1. **Loss of Other Coverage (other than under Medicaid or SCHIP).** If you declined enrollment for yourself or your Dependents (including your Spouse) because you or your Dependents had other health coverage (including coverage under a group health plan sponsored by a governmental or educational institution, a medical care program of the Indian Health Service or of a tribal organization), you may enroll for coverage for yourself and/or your Dependents under this Plan if the other health coverage is lost as a result of one of the following provided, however, you submitted a written statement to the Plan Administrator when you and/or your Dependents were initially eligible stating that other health coverage was the reason for declining enrollment under this Plan:

   a. The other health coverage was under COBRA and the maximum continuation period available under COBRA has been exhausted;

   b. Loss of eligibility under the other health coverage for reasons other than non-payment of the required contribution or premium, making a fraudulent claim or intentional misrepresentation of a material fact in connection with the other plan; or

   c. Employer contributions cease for the other health coverage.

If you are already enrolled in a benefit option available under the Plan and your Dependent lost his or her other health coverage, you may enroll in a different benefit option available under the Plan due to the special enrollment event of your Dependent.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date the other health coverage was lost. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.
(2) **Loss of Coverage under Medicaid or SCHIP or Eligibility for a State Premium Assistance Subsidy.** If you or your Dependents did not enroll in the Plan when initially eligible because you were covered under Medicaid or a State sponsored Children's Health Insurance Program (SCHIP) and your coverage terminates because you or your Dependents are no longer eligible for Medicaid or SCHIP or you become eligible for a State premium assistance subsidy under Medicaid or SCHIP, you may enroll for coverage under this Plan after Medicaid or SCHIP coverage terminates or after your eligibility for a State assistance subsidy under Medicaid or SCHIP is determined.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 60 days after coverage under Medicaid or SCHIP terminates or within 60 days after eligibility for a State premium assistance subsidy under Medicaid or SCHIP is determined. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.

(3) **Acquisition of a New Dependent.** If you acquire a new Dependent as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll for coverage under this Plan for yourself and your Dependents. You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the date you acquire such Dependent.

   (a) Coverage becomes effective for a Dependent Child who is born after the date your coverage becomes effective as of such child’s date of birth provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after the child’s birth. Failure to enroll in the Plan within this 30-day period will result in no coverage under the Plan.

   (b) Coverage will be effective on the first day of the month following the date the Plan Sponsor receives the request for change. This must be received within 30 days after your date of marriage. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

   (c) Coverage for a newly acquired Dependent due to adoption (or placement with you in anticipation of adoption) will be effective as of the date of adoption (or placement in anticipation of adoption) provided you complete and submit the required election and enrollment forms (including a payroll deduction authorization, if applicable) within 30 days after adoption or placement in anticipation of adoption, as applicable. Failure to enroll in the Plan within the 30-day period described above will result in no coverage under the Plan.

**Status Change Event**
Generally your election under the Plan will remain in effect for the entire Plan Year unless you experience a Special Enrollment Event (described above) or a Status Change Event. If a Status Change Event occurs you may make a new election under the Plan provided your new election is consistent with the Status Change Event. A Status Change Event includes the following:

   (1) A change in your legal marital status, including divorce, legal separation or annulment;

   (2) The death of your Spouse or Dependent Child;

   (3) Termination or commencement of employment by you, your Spouse or your Dependent Child that results in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

   (4) A reduction or increase in your hours of employment or those of your Spouse or your Dependent Child, including a switch from part-time to full-time or commencement or return from an unpaid leave of absence, resulting in the gain or loss of eligibility under the Plan or another employer-sponsored employee benefit plan;

   (5) A change due to your Dependent Child satisfying or ceasing to satisfy the requirements for Dependents under the Plan;

   (6) A change in the place of residence or work of you, your Spouse or your Dependent Child;

   (7) Entitlement to or loss of entitlement to Medicare or Medicaid by you, your Spouse or your Dependent Child;
(8) Receipt of a Qualified Medical Child Support Order ("QMCSO") which requires that you provide the child named in the Order with health care coverage under the Plan. If the required coverage is different from your current coverage under the Plan, you may change your election accordingly;

(9) A change due to you, your Spouse or your Dependent Child gaining coverage under another employer’s plan;

(10) A significant increase in the cost of your coverage under the Plan during the Plan Year. If the cost of your coverage under the Plan significantly increases during the Plan Year, you may choose one of the following options: (a) maintain existing coverage and agree to pay the increased cost; (b) revoke your existing election and elect similar coverage under another Plan option (if any); or (c) drop coverage under the Plan, but only if there is no similar option available under the Plan;

(11) Addition or significant improvement of a Plan option. If the Plan adds a new option or significantly improves an existing option, you may revoke your existing election and elect coverage under the new option. Any eligible Employee, regardless of whether or not he/she elected coverage under the Plan previously, may elect coverage under any new option or significantly improved option for himself or herself and any eligible Dependents;

(12) Significant Curtailment of Coverage without Loss. If your coverage under the Plan is significantly curtailed without a loss of coverage (for example, a significant increase in the Out-of-Pocket maximum you are required to pay), you may revoke your existing election under the Plan and elect coverage under a similar Plan option, if any. If no similar option is available, then you must maintain your existing election until the end of the current Plan Year;

(13) Significant Curtailment of Coverage with Loss. If your coverage under the Plan is significantly curtailed with a loss of coverage (for example, elimination of a benefit option under the Plan), then you may either revoke your existing election under the Plan and elect coverage under a similar Plan option (if any) or drop your existing coverage provided there is no similar Plan option available; and

(14) Change in Election under another Employer Plan. You may make an election change that is on account of and corresponds with a change made under another employer-sponsored plan (including another plan maintained by the Employer or a plan maintained by the employer of your Spouse or Dependent Child) provided the election change satisfied the regulations under Code Section 125 regarding permitted election changes or the election is for a period of coverage under the plan maintained by the other employer which does not correspond to the Plan Year of this Plan.

You must submit the appropriate election and enrollment forms to the Plan Administrator within 30 days after the Status Change Event. Coverage under the Plan will become effective on the first day of the month following the date you submit the appropriate election and enrollment forms to the Plan Administrator.
TERMINATION OF COVERAGE

Termination of Employee Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) If you fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(3) The date you report to active military service, unless coverage is continued through the Uniformed Services Employment and Reemployment Rights Act (USERRA) as explained below;

(4) The end of the payroll period in which you cease to be eligible for coverage under the Plan;

(5) The end of the payroll period in which eligibility is lost you terminate employment or cease to be included in an eligible class of Employees;

(6) If an Employee becomes ineligible for coverage under the Plan due to a reduction in work-hours below the minimum number of hours an Employee is required to work per week to be eligible to enroll in coverage, the Employee’s coverage will terminate upon the start of the next Stability Period.

(7) The date you (or any person seeking coverage on your behalf) performs an act, practice or omission that constitutes fraud; and

(8) The date you (or any person seeking coverage on your behalf) makes an intentional misrepresentation of a material fact.

Termination of Dependent Coverage
Coverage under the Plan will terminate on the earliest of the following dates:

(1) The date the Plan terminates, in whole or in part;

(2) The date the Plan discontinues coverage for Dependents;

(3) The date your Dependent becomes covered as an Employee under the Plan;

(4) The date coverage terminates for the Employee;

(5) If you and/or your Dependents fail to make any contribution when it is due, the beginning of the period for which a required contribution has not been paid;

(6) The date the Dependent Spouse reports to active military service;

(7) The end of the payroll period in which a Dependent Spouse ceases to be a Dependent as defined by the Plan;

(8) The end of the month in which a Dependent Spouse ceases to be a Dependent as defined by the Plan;

(9) The date your Dependent (or any person seeking coverage on behalf of your Dependent) performs an act, practice or omission that constitutes fraud; and

(10) The date your Dependent (or any person seeking coverage on behalf of your Dependent) makes an intentional misrepresentation of a material fact.
Retroactive Termination of Coverage
Except in cases where you and/or your covered Dependents fail to pay any required contribution to the cost of coverage, the Plan will not retroactively terminate coverage under the Plan unless you and/or your covered Dependents (or a person seeking coverage on behalf of you and/or your covered Dependents) performs an act, practice or omission that constitutes fraud with respect to the Plan or unless the individual makes an intentional misrepresentation of material fact. In such cases, the Plan will provide at least 30 days advance written notice to you or your covered Dependent who is affected before coverage will be retroactively terminated. As provided above, coverage may be retroactively terminated in cases where required employee contributions have not been paid by the applicable deadline. In those cases, no advance written notice is required.

Rehire Provision
After you become covered under the Plan, if your employment ends and you are rehired by the Employer within 30 days after your termination date, your coverage will take effect on the date you complete at least one hour of service with the Employer. The waiting period will be waived. If you were not covered under the Plan on the date of your termination or you are rehired by the Employer more than 30 days after your termination date, you will be treated as a new Employee and will be required to satisfy the waiting period.

Continuation of Plan Coverage due to a Non-FMLA Approved Leave of Absence
Medical, dental, vision coverage will be continued by your Employer for you and your Dependents in the event of an non-FMLA approved leave of absence. Coverage will continue as follows:

(1) Non-FMLA Leave of Absence: For a period of 60 days provided all contributions are made to the cost of coverage.

Coverage under this provision will continue in accordance with the same terms and conditions of an active Employee. If a COBRA qualifying event occurs, any period of continued coverage under this section will not reduce the maximum time for which you may elect to continue coverage under COBRA. Please refer to the COBRA Continuation Coverage section of the Plan.

Continuation of Coverage under the Family and Medical Leave Act (FMLA)
The Plan shall at all times comply with the Family and Medical Leave Act of 1993 (FMLA), as amended and as promulgated in regulations issued by the Department of Labor.

During any leave taken under the FMLA, you may maintain coverage under the Plan on the same conditions as coverage would have been provided if you had been continuously employed during the leave period. Failure to make required payments within 30 days of the due date established by your Employer will result in the termination of coverage for you and/or your eligible Dependents.

If you fail to return to work after the FMLA leave, the Employer may have the right to recover its contributions toward the cost of coverage during the FMLA leave.

If coverage under the Plan terminates during the FMLA leave, coverage will be reinstated for you and your covered Dependents if you return to work at the end of the FMLA leave.

Continuation of Coverage under State Family and Medical Leave Laws
To the extent this Plan is required to comply with a State family and medical leave law that is more generous than the FMLA, continuation of coverage under this Plan will be provided in accordance with such State family and medical leave law, as well as under FMLA.

Continuation of Coverage under USERRA
You may elect to continue Plan coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA) if you are absent from work due to military service in the Uniformed Services (as defined under USERRA). You may elect to continue coverage for yourself and any of your Dependents that were covered under the Plan at the time of your leave. Your eligible Dependents do not have an independent right to elect coverage under USERRA; therefore unless you elect to continue coverage on their behalf, your eligible Dependents will not be permitted to continue coverage under USERRA separately.
To elect coverage under USERRA, you must submit your election to continue coverage under USERRA, on a form prescribed by the Plan Administrator to the Plan Administrator within 60 days after the date of your leave. Coverage under the Plan will become effective as of the date of your leave and will continue for the lesser of (a) 24 months (beginning on the date your absence begins); or (b) the period of time beginning on the date your absence begins and ending on the day after the date you return to employment with the Employer or fail to apply for or return to employment with the Employer within the time limit applicable under USERRA.

If your leave is 31 days or more, you will be required to pay up to 102% of the full contribution under the Plan. If your leave is 30 days or less, you will not be required to pay more than the amount (if any) you would have paid had you remained an active Employee of the Employer. Your Employer will notify you of the procedures for making payments under this Plan.

Continuation coverage provided under USERRA counts towards the maximum coverage period under COBRA continuation coverage.

An Employee returning from USERRA-covered military leave who participated in the Plan immediately before going on USERRA leave has the right to resume coverage under the Plan upon return from USERRA leave, as long as the Employee resumes employment within the time limit that applies under USERRA. No waiting period will apply to an Employee returning from USERRA leave (within the applicable time period) unless the waiting period or exclusionary period would have applied to the Employee if the Employee had remained continuously employed during the period of military leave.
ELIGIBLE MEDICAL EXPENSES

Eligible expenses shall be the charges actually made for services provided to the Covered Person and will be considered eligible only if the expenses are:

1. Routine care or preventive services provided such services are ordered and performed by a Physician and not otherwise excluded under the Plan; or

2. Due to Illness or Injury provided such services are ordered and performed by a Physician, Medically Necessary and not otherwise excluded under the Plan.

Reimbursement for eligible expenses will be made directly to the provider of the service, unless a receipt showing payment is submitted. All eligible expenses Incurred at a Participating Provider will be reimbursed to the provider.

1. **Allergy Services**: Allergy testing, serum and injections. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

2. **Ambulance Service**: Professional ground or air ambulance service to transport the Covered Person:
   (a) To the nearest Hospital equipped to treat the specific Illness or Injury in an emergency situation; or
   (b) To another Hospital in the area when the first Hospital did not have services required and/or facilities to treat the Covered Person; or
   (c) To and from a Hospital during a period of Hospital confinement to another facility for special services which are not available at the first Hospital; or
   (d) From the Hospital to the patient’s home or to a Skilled Nursing Facility, Rehabilitation Facility or any other type of convalescent facility nearest to the patient's home when there is documentation the patient required ambulance transportation.

   Professional ground or air ambulance charges for convenience are not covered. Air ambulance is covered only when terrain, distance or condition warrants.

   Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

3. **Ambulatory Surgery Center**: Services and supplies provided by an Ambulatory Surgery Center.

4. **Anesthetics**: Anesthetics and their professional administration.

5. **Blood and Blood Derivatives**: Blood, blood plasma or blood components not donated or replaced.

6. **Cardiac Rehabilitation**: Cardiac rehabilitation services which are rendered: (a) under the supervision of a Physician; and (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass Surgery or any other medical condition if medically appropriate; and (c) initiated within twelve (12) weeks after other treatment for the medical condition ends; and (d) in a medical care facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

   Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

7. **Chemotherapy**: Services and supplies related to chemotherapy. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

8. **Chiropractic Care/Spinal Manipulation**: Skeletal adjustments, manipulation or other treatment in connection with the correction by manual or mechanical means of structural imbalance or subluxation in the human body, including x-rays. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
(9) **Circumcision:** Services and supplies related to circumcision. Circumcision performed while Hospital confined following birth will be considered as part of the mother’s expenses, provided you complete and submit the required election and enrollment forms within 30 days after the child’s birth.

(10) **Contraceptives:** Contraceptive procedures and medications other than those considered preventive services, including, but not limited to: orals, patches, injections, diaphragms, intrauterine devices (IUD), implants and any related office visit. Some contraceptives may be available under the Prescription Drug Card Program. The Plan does not cover contraceptive supplies or devices available without a Physician’s prescription or contraceptives provided over-the-counter (unless the expense qualifies as a preventive service).

(11) **Cosmetic Procedures/Reconstructive Surgery:** Cosmetic procedures or Reconstructive Surgery will be considered eligible only under the following circumstances:

(a) For the correction of a Congenital Anomaly for a Dependent Child.

(b) Any other Medically Necessary Surgery related to an Illness or Injury.

(c) Charges for reconstructive breast Surgery following a mastectomy will be eligible as follows:

   (i) Reconstruction of the breast on which the mastectomy has been performed;

   (ii) Surgery and reconstruction of the other breast to produce symmetrical appearance; and

   (iii) Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas.

   The manner in which breast reconstruction is performed will be determined in consultation with the attending Physician and the Covered Person.

(12) **Dental Care:** Dental services and x-rays rendered by Dentist or dental surgeon for:

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

(b) Emergency repair due to Injury to sound natural teeth within one year of the Accident, including the replacement of sound natural teeth.

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

(d) Excision of benign bony growths of the jaw and hard palate.

(e) External incision and drainage of cellulitis.

(f) Incision of sensory sinuses, salivary glands or ducts.

(g) Surgery to correct congenital malformations that are outside of normal individual variation and have resulted in significant functional impairment.

General anesthesia and Hospital expenses for covered dental care that includes:

(h) Complex oral surgical procedures which have a high probability of complications due to the nature of the Surgery;

(i) Concomitant systemic disease for which the patient is under current medical management and which significantly increases the probability of complications;

(j) Mental Illness or behavioral condition that precludes dental Surgery in the office;

(k) Use of general anesthesia and the Covered Person’s medical condition requires that such procedure be performed in a Hospital;
(l) Dental surgery performed on a dependent child 8 years of age or younger, where such procedure cannot be provided safely in a dental office setting.

(13) **Diabetic Education:** The following diabetic education and self-management programs: diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered or licensed healthcare professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with diabetes.

(14) **Diabetic Supplies:** All Physician-prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes that are not covered under the Prescription Drug Card Program.

(15) **Diagnostic Testing, X-ray and Laboratory Services:** Diagnostic testing (including 3D mammography), x-ray and laboratory services, including services of a professional radiologist or pathologist. Dental x-rays are not eligible expenses, except as specified under Dental Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(16) **Durable Medical Equipment:** The rental of oxygen, wheelchairs, walkers, special Hospital beds, iron lungs and other Durable Medical Equipment subject to the following:

(a) The equipment must be prescribed by a Physician and Medically Necessary; and

(b) The equipment will be provided on a rental basis; however such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item (oxygen equipment is not limited to the purchase price); and

(c) Benefits will be limited to standard models as determined by the Plan; and

(d) The Plan will pay benefits for only one of the following unless Medically Necessary due to growth of the Covered Person or if changes to the Covered Person's medical condition requires a different product, as determined by the Plan: a manual wheelchair, motorized wheelchair or motorized scooter; and

(e) If the equipment is purchased, benefits will be payable for subsequent repairs, excluding batteries, necessary to restore the equipment to a serviceable condition. If such equipment cannot be restored to a serviceable condition, replacement will be considered eligible subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered; and

(f) Expenses for the rental or purchase of any type of air conditioner, air purifier or any other device or appliance will not be considered eligible.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(17) **Emergency Services:** The Plan will pay the greater of the following amounts for Emergency Services received from Non-Participating Providers (as required by law):

(a) The amount negotiated with Participating Providers for Emergency Services provided, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider. If there is more than one amount negotiated with Participating Providers for the Emergency Services provided the amount paid shall be the median of the negotiated amounts, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(b) The amount for the Emergency Services calculated using the same method the Plan generally uses to determine payments for services provided by a Non-Participating Provider (such as Usual and Customary Charge), excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider; or

(c) The amount that would be paid under Medicare (Part A or Part B of title XVIII of the Social Security Act, 42 U.S.C. 1395 et seq.) for the Emergency Services, excluding any Copay or Coinsurance that would be imposed if the service had been received from a Participating Provider.
(18) **Foot Care:** Treatment for the following foot conditions: (a) bunions, when an open cutting operation is performed; (b) non-routine treatment of corns or calluses; (c) toenails when at least part of the nail root is removed; (d) any Medically Necessary Surgical Procedure required for a foot condition. In addition, orthopedic shoes when an integral part of a leg brace will also be covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(19) **Genetic Testing:** Diagnostic testing of Genetic Information and counseling when Medically Necessary. Genetic testing is covered in addition to and to the extent it is not otherwise included for coverage under the preventive services section of the Plan.

(20) **Hemodialysis/Peritoneal Dialysis:** Treatment of a kidney disorder by hemodialysis or peritoneal dialysis as an Inpatient in a Hospital or other facility or for expenses in an outpatient facility or in the Covered Person's home, including the training of one attendant to perform kidney dialysis at home. The attendant may be a family member. When home care replaces Inpatient or outpatient dialysis treatments, the Plan will pay for rental of dialysis equipment and expendable medical supplies for use in the Covered Person's home as shown under the Durable Medical Equipment benefit. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(21) **Home Health Care:** Services provided by a Home Health Care Agency to a Covered Person in the home. The following are considered eligible home health care services:

(a) Home nursing care;

(b) Services of a home health aide or licensed practical nurse (L.P.N.), under the supervision of a registered nurse (R. N.);

(c) Visits provided by a medical social worker (MSW);

(d) Physical, occupational, speech, or respiratory therapy if provided by the Home Health Care Agency;

(e) Medical supplies, drugs and medications prescribed by a Physician;

(f) Laboratory services; and

(g) Nutritional counseling by a licensed dietician.

For the purpose of determining the benefits for home health care available to a Covered Person, each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and each 4 hours of home health aide services shall be considered as one home health care visit.

In no event will the services of a Close Relative, transportation services, housekeeping services and meals, etc., be considered an eligible expense.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(22) **Hospice Care:** Hospice care on either an inpatient or outpatient basis for a terminally ill person rendered under a Hospice treatment plan. The Hospice treatment plan must certify that the person is terminally ill with a life expectancy of 6 months or less.

Covered services include:

(a) Room and board charges by the Hospice.

(b) Other Medically Necessary services and supplies.

(c) Nursing care by or under the supervision of a registered nurse (R.N.).

(d) Home health care services furnished in the patient's home by a Home Health Care Agency for the following:
(i) health aide services consisting primarily of caring for the patient (excluding housekeeping, meals, etc.); and

(ii) physical and speech therapy.

(e) Counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family.

(f) Bereavement counseling services by a licensed social worker or a licensed pastoral counselor for the patient's immediate family within 6 months after the patient's death. For the purposes of bereavement counseling, the term "Patient's Immediate Family" means the patient's spouse, parents of a Dependent Child and/or Dependent children who are covered under the Plan.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(23) **Hospital Services or Long-Term Acute Care Facility/Hospital:**

(a) **Inpatient**

   Room and board, including all regular daily services in a Hospital or Long-Term Acute Care Facility/Hospital. Care provided in an Intensive Care Unit (including cardiac care (CCU) and burn units).

   Miscellaneous services and supplies, including any additional Medically Necessary nursing services furnished while being treated on an Inpatient basis.

(b) **Outpatient**

   Services and supplies furnished while being treated on an outpatient basis.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(24) **Infertility Testing:** Diagnosis and testing of infertility (the inability to conceive). However, treatment, drugs or procedures for the promotion of conception will not be considered eligible (e.g., invitro fertilization, GIFT, artificial insemination, etc.).

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(25) **Lenses:** Initial pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye or for aphakic patients. Soft lenses or sclera shells intended for use as corneal bandages.

(26) **Maternity:** Expenses Incurred by all Covered Persons for:

(a) Pregnancy.

(b) Preventive prenatal and breastfeeding support as identified under the preventive services section below.

(c) Services provided by a Birthing Center.

(d) One amniocentesis test per Pregnancy.

(e) Up to 2 ultrasounds per Pregnancy (more than 2 only when it is determined to be Medically Necessary).

Elective induced abortions when carrying the fetus to full term would seriously endanger the life of the mother. If complications arise after the performance of any abortion for any Covered Person, any expenses Incurred to treat those complications will be eligible, whether the abortion was eligible or not.
Hospital stays in connection with childbirth for either the mother or newborn may not be limited to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. These requirements can only be waived by the attending Physician in consultation with the mother. The Covered Person or provider is not required to precertify the maternity admission, unless the stay extends past the applicable 48 or 96 hour stay. A Hospital stay begins at the time of delivery or for deliveries outside the Hospital, the time the newborn or mother is admitted to a Hospital following birth, in connection with childbirth.

If a newborn remains hospitalized beyond the time frames specified above, the confinement must be precertified or a penalty may be applied.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(27) **Medical and Surgical Supplies:** Casts, splints, trusses, braces, crutches, orthotics (excluding foot orthotics), dressings and other Medically Necessary supplies ordered by a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(28) **Mental Disorders:** Covered charges for care, supplies and treatment of a Mental Disorder including, but not limited to treatment for autism, ADD and ADHD. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(29) **Morbid Obesity (IASIS Facility Only):**

Eligibility: Employees: after one year of being covered under the Plan. Spouses: after 2 years of being covered under the Plan. No coverage for dependent children for weight loss surgery or complications due to weight loss surgery.

Surgical treatment for Morbid Obesity will only be covered as shown in the Medical Schedule of Benefits if all the following conditions are met:

(a) The Covered Person has either (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

(b) The Covered Person has at least a 24-month history of Morbid Obesity as documented in such person's medical records.

(c) The Covered Person does not have an underlying diagnosed medical condition that would cause Morbid Obesity (e.g., an endocrine disorder) that can be corrected by means other than surgical treatment.

(d) The Covered Person has completed full growth (18 years old or supporting documentation of complete bone growth).

(e) The Covered Person has failed to achieve and maintain significant weight loss and such person has participated in a Physician-supervised nutrition and exercise program for at least 6 months (occurring within the 24-month period prior to the proposed surgical treatment) and such participation is documented in his or her medical records.

(f) The Covered Person must be evaluated by a licensed professional counselor, psychologist or psychiatrist within 12 months prior to the proposed surgical treatment. The evaluation should document the following:

   (i) that there is no significant psychological problem that would limit the ability of the Covered Person to understand the procedure and comply with any medical and/or surgical recommendations;

   (ii) any psychological co-morbidities that may be contributing to the Covered Person’s inability to lose weight or a diagnosed eating disorder; and

   (iii) the Covered Person’s willingness to comply with the preoperative and postoperative treatment plans.
The following surgery will not be eligible as treatment of Morbid Obesity under the Plan:

(a) Loop gastric bypass;

(b) Gastroplasty, more commonly known as "stomach stapling" (not to be confused with vertical band gastroplasty); and

(c) Mini gastric bypass.

(30) **Nutritional Supplements**: Physician-prescribed nutritional supplements or other enteral supplementation necessary to sustain life, including rental or purchase of equipment used to administer nutritional supplements or other enteral supplementation. Special dietary treatment for phenylketonuria (PKU) when prescribed by a Physician.

Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(31) **Off-Label Drug Use**: Expenses related to Off-Label Drug Use (the use of a drug for a purpose other than that for which it was approved by the FDA) will be eligible for coverage when all of the following criteria have been satisfied:

(a) The named drug is not specifically excluded under the General Exclusions and Limitations section of the Plan; and

(b) The named drug has been approved by the FDA; and

(c) The Off-Label Drug Use is appropriate and generally accepted by the medical community for the condition being treated; and

If the drug is used for the treatment of cancer, The American Hospital Formulary Service Drug Information or NCCN Drugs and Biologics Compendium recognize it as an appropriate treatment for that form of cancer.

(32) **Occupational Therapy**: Rehabilitative occupational therapy rendered by a qualified Physician or a licensed occupational therapist under the recommendation of a Physician. Expenses for Maintenance Therapy or therapy primarily for recreational or social interaction will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(33) **Outpatient Pre-Admission Testing**: Outpatient pre-admission testing performed within seven (5) days of a scheduled Inpatient hospitalization or Surgery.

(34) **Physical Therapy**: Physical therapy rendered by a qualified Physician or a licensed physical therapist under the recommendation of a Physician. Maintenance Therapy will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(35) **Physician Services**: Services of a Physician for medical care or Surgery.

(a) Services performed in a Physician's office on the same day for the same or related diagnosis. Services include, but are not limited to: examinations, x-ray and laboratory tests (including the reading or processing of the tests), supplies, injections, cast application and minor Surgery. If more than one Physician is seen in the same clinic on the same day, only one Copay will apply.

(b) Diagnostic x-ray and laboratory services which are ordered on the same day as the office visit, but performed or read at a later date and/or at another facility will be considered as part of the office visit.

(c) For multiple or bilateral surgeries performed during the same operative session which are not incidental or not part of some other procedure and which add significant time or complexity (all as determined by the Plan) to the complete procedure, the charge considered will be: (i) 100% for the primary procedure; (ii) 50% for the secondary procedure, including any bilateral procedure; and (iii) 50% for each additional covered procedure. This applies to all Surgical Procedures, except as determined by the Plan.
For surgical assistance by an Assistant Surgeon, the charge will be 25% of the Usual and Customary Charge for the corresponding Surgery.

Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(36) Preventive Services and Routine Care: The following preventive services and routine care are paid as shown in the Medical Schedule of Benefits:

(a) Preventive Services

(i) Evidence-Based Preventive Services

Evidence-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (the “Task Force”) with respect to the individual involved, except that with respect to breast cancer screening, mammography and prevention of breast cancer, the recommendations of the Task Force issued in 2002 will be considered the current recommendations until further guidance is issued by the Task Force or the Health Resources and Services Administration.

(ii) Routine Vaccines

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved.

(iii) Prevention for Children

With Respect to infants, children and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

(iv) Prevention for Women

With respect to women, such additional preventive care and screenings, not otherwise addressed by the Task Force, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration and published on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women’s preventive services). Those guidelines generally include the following:

(A) Well-woman visits. Well-woman preventive care visits annually for adult women to obtain the recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care. The inclusion of a well-woman visit is not meant to limit the coverage for any other preventive service described elsewhere in this Plan document that might be administered as part of the well-woman visit.

Coverage for prenatal care is limited to pregnancy-related Physician office visits including the initial and subsequent history and physical exams of the pregnant woman. In the event a provider bills a “maternity global rate”, the portion of the claim that will be considered for prenatal visits and therefore, preventive care, is 40% of the “maternity global rate”. As a result, 60% of the “maternity global rate” will be considered for delivery and postnatal care and the normal cost-sharing provisions would apply. Items not considered preventive (and therefore subject to normal cost-sharing provisions) include inpatient admissions, high risk specialist units, ultrasounds, amniocentesis, fetal stress tests, delivery including anesthesia and certain pregnancy diagnostic lab tests.

(B) Screening for gestational diabetes. A maximum of 5 screenings for gestational diabetes shall be covered in pregnant women.

(C) Human papillomavirus (HPV) testing. High-risk HPV DNA testing in women with normal cytology results. Screening is limited to women age 30 or older and is limited to one screening every 3 Calendar Years.
(D) Screening and counseling annually for human-immune-deficiency virus (HIV) for all sexually active women.

(E) Screening and counseling annually for interpersonal and domestic violence.

(F) Contraceptive methods and counseling, as prescribed by your Physician. All FDA approved contraceptive methods (see Preventive Drugs section below), sterilization procedures and patient education and counseling for women with reproductive capacity. Contraceptive counseling is limited to 2 visits per 12-month period.

For purposes of the above, the sterilization procedures to be considered preventive include sterilization implant (Essure) and surgical sterilization (Sterilization) either abdominally, vaginally or laparoscopically. Eligible charges for a sterilization procedure and all ancillary services will be covered when sterilization is the primary purpose of the services provided and/or if it is performed as a standalone procedure and billed as such. However, complications arising following a sterilization procedure are not covered as preventive services. Covered Expenses do not include charges for a sterilization procedure to the extent the procedure was not billed separately by the provider or because it was not the primary purpose of the procedure. To the extent sterilization is part of another procedure and/or is not a separate line on the bill, the sterilization procedure is not a Covered Expense.

(G) Breastfeeding support, supplies and counseling in conjunction with each birth, including the following:

(1) Comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postnatal period (60 days from baby’s date of birth).

(2) Breastfeeding equipment will be covered, subject to the following:

   (i) Rental of a Hospital grade electric pump while the baby is Hospital confined; and

   (ii) Purchase of a standard (non-Hospital grade) electric breast pump or manual breast pump if requested during pregnancy or during the duration of breastfeeding, provided the Covered Person has not received either a standard electric breast pump or a manual breast pump within the last 3 Calendar Years and provided the Covered Person remains continuously enrolled in the Plan.

(3) For women using a breast pump from a prior pregnancy, one new set of breast pump supplies will be covered at 100% with each subsequent pregnancy for initiation or continuation of breastfeeding.

For a detailed listing of women’s preventive services, please visit the U.S. Department of Health and Human Services website at: http://www.hrsa.gov/womensguidelines. For a paper copy, please contact the Plan Administrator. To the extent the above does not cover any preventive service required to be covered under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines or guidance requiring any additional women’s preventive services), the above shall be deemed to be amended to cover such preventive services to the extent required by such guidelines.

(v) Preventive Drugs means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

   https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
(b) Routine Care

Routine care including, but not limited to, the office visit, lab tests, x-rays, routine testing, vaccinations or inoculations, well child care, pap smears, mammograms (age 40 and over) (including 3D mammography), colorectal cancer screening (age 50 and over), and prostate cancer screening for men (age 50 and over). If a diagnosis is indicated after a routine exam, the exam will still be payable under the routine care benefit, however, all charges related to the diagnosis (except the initial exam) will be payable as any other Illness.

The above routine care items are covered in addition to and to the extent they are not otherwise included for coverage under the Preventive Services section of the Plan.

(37) Prosthetic Devices: Artificial limbs, eyes or other prosthetic devices when necessary due to an Illness or Injury. This benefit includes any necessary repairs to restore the prosthesis to a serviceable condition. If such prosthesis cannot be restored to a serviceable condition, replacement will be considered eligible, subject to prior approval by the Plan. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(38) Pulmonary Therapy: Pulmonary therapy under the recommendation of a Physician. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(39) Qualified Clinical Trial Expenses: Qualified Clinical Trial Expenses are, except as excluded below, healthcare items and services for the treatment of cancer or any other life threatening condition for a qualifying individual enrolled in a Qualified Clinical Trial that are otherwise consistent with the terms of the Plan and would be covered if the Covered Person did not participate in the Qualified Clinical Trial.

For purposes of this section, a “life threatening condition” means any condition or disease from which the likelihood of death is probable unless the course of the disease or condition is interrupted; and a “qualifying individual” means any Covered Person who is eligible to participate in a Qualified Clinical Trial according to the trial protocol for treatment of cancer of any other life threatening condition that makes his or her participation in the program appropriate, as determined based on either (i) a conclusion of a referring healthcare professional or (ii) medical and scientific information provided by the Covered Person.

Notwithstanding the above, Qualified Clinical Trial expenses do not include any of the following:

(a) Costs associated with managing the research associated with the Qualified Clinical Trial; or

(b) Costs that would not be covered for non-Experimental and/or Investigational treatments; or

(c) Any item or service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

(40) Radiation Therapy: Radium and radioactive isotope therapy treatment. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.


(42) Rehabilitation Facility: Inpatient care in a Rehabilitation Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Skilled Nursing Facility confinement; and (c) is not for Custodial Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

See the Skilled Nursing Facility benefit for services and supplies provided for confinements in a Skilled Nursing Facility.
(43) **Routine Newborn Care**: Routine newborn care including Hospital nursery expenses and routine pediatric care while confined following birth will be considered as part of the mother's expense, provided you complete and submit the required election and enrollment forms within 30 days after the child's birth.

If the newborn is ill, suffers an Injury or requires care other than routine care, benefits will be provided on the same basis as any other eligible expense.

(44) **Second Surgical Opinion**: Voluntary second surgical opinions for elective, non-emergency Surgery when recommended for a Covered Person.

Benefits for the second opinion will be payable only if the opinion is given by a specialist who: (a) is certified in the field related to the proposed Surgery; and (b) is not affiliated in any way with the Physician recommending the Surgery.

If the second opinion conflicts with the first opinion, the Covered Person may obtain a third opinion, although this is not required.

(45) **Skilled Nursing Facility**: Skilled nursing care in a Skilled Nursing Facility provided such confinement: (a) is under the recommendation and general supervision of a Physician; (b) is for the purpose of receiving medical care necessary for convalescence from the conditions causing or contributing to the precedent Hospital or Rehabilitation Facility confinement; and (c) is not for Custodial Care. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

See the Rehabilitation Facility benefit for services and supplies provided for confinements in a Rehabilitation Facility.

(46) **Sleep Apnea/Sleep Studies**: Oral appliances to treat obstructive sleep apnea if Medically Necessary. Sleep studies when precertified by the Plan. All other treatment for sleep disorders is not covered by the Plan. CPAP machines are covered when Medically Necessary for sleep disorders.

(47) **Speech Therapy**: Restorative or rehabilitative speech therapy rendered by a qualified Physician or a licensed speech therapist under the recommendation of a Physician, necessary because of loss or impairment due to an Illness, Injury or Surgery or therapy to correct a Congenital Anomaly. Speech therapy for developmental delay or to change voice sound will not be considered eligible. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(48) **Sterilization**: Elective sterilization procedures (this does not include reversal of sterilization). Elective sterilization procedures are covered in addition to and to the extent they are not otherwise included for coverage under the preventive services section of the Plan.

(49) **Substance Use Disorders**: Charges for care, supplies and treatment of a Substance Use Disorder. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

(50) **Transplants (other than those received through the Aetna IOE Program)**: Services and supplies in connection with Medically Necessary non-Experimental and/or non-Investigational transplant procedures.

(a) If both the donor and the recipient are covered under this Plan, eligible expenses Incurred by each person will be treated separately for each person.

(b) If the recipient is covered under this Plan, eligible expenses Incurred by the donor will be considered eligible if not covered by the donor's plan.

(c) If the donor is covered under this Plan and the recipient is not covered, eligible expenses Incurred by the donor will be considered eligible.

(d) The Usual and Customary fee of securing an organ from the designated live donor, a cadaver or tissue bank, including the surgeon's fees, anesthesiology, radiology and pathology fees for the removal of the organ and a Hospital's charge for storage or transportation of the organ.

See the Aetna Institute of Excellence (IOE) Program section of the Plan with respect to coverage for transplants received through the Aetna IOE Program.
Eligible expenses will be payable as shown in the Medical Schedule of Benefits.

Exclusions:

(a) Non-human and artificial organ transplants.

(b) The purchase price of any of bone marrow, organ, tissue or any similar items which are sold rather than donated.

(c) Transplants which are not medically recognized and are Experimental and/or Investigational in nature.

(d) Lodging expenses, including meals.

(e) Expenses related to the Covered Person’s transportation.

(51) **Urgent Care Facility:** Services and supplies provided by an Urgent Care Facility. Eligible expenses will be payable as shown in the Medical Schedule of Benefits.
AETNA INSTITUTE OF EXCELLENCE (IOE)

The Institute of Excellence (IOE) is a facility that contracted with Aetna to furnish particular services and supplies to you in connection with one or more highly specialized medical procedures. The maximum charge made by the IOE for such services and supplies will be the amount agreed to between Aetna and the IOE.

Transplant Expenses

Once it has been determined that you or one of your eligible Dependents may require an organ transplant, you or your Physician must call the Medical Management Program Administrator to discuss coordination of your transplant care. Aetna will coordinate all transplant services. In addition, you must follow any precertification requirements. Organ means solid organ; stem cell; bone marrow and tissue.

Benefits may vary if an IOE facility or a non-IOE facility is used. In addition, some expenses listed below are payable only within the IOE network. The IOE facility must be specifically approved and designated by Aetna to perform the procedure you require. A transplant will be covered at the highest level of benefits if performed at an IASIS facility (if the service is available). A transplant performed at a facility designated as an IOE facility for the type of transplant in question will be covered at the next highest level of benefits. Any treatment or service related to transplants that are provided by a facility that is not an IASIS facility or specified as an IOE network facility, even if the facility is considered a Participating Provider for other types of services, will be covered at the Non-Participating Provider level. Please read each section below carefully.

Covered Transplant Expenses

Covered transplant expenses include the following:

(1) Charges for activating the donor search process with national registries.

(2) Compatibility testing of prospective organ donors that are immediate family member. For purposes of this section an “immediate” family member is defined as a first-degree biological relative. These are your biological parent, sibling or child.

(3) Inpatient and outpatient expenses directly related to a transplant.

(4) Charges made by a Physician or a transplant team.

(5) Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.

(6) Related supplies and services provided by the IOE facility during the transplant process. These services and supplies may include: physical, speech and occupational therapy; bio-medicals and immunosuppressants; home health care expenses and home infusion services.

Covered transplant services are typically incurred during the 4 phases of transplant care described below. Expenses incurred for one transplant during these 4 phases of care will be considered one transplant occurrence.

A transplant occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date the patient is discharged from the Hospital or outpatient facility for the admission or visits related to the transplant, whichever is later.

The 4 phases of one transplant occurrence and a summary of covered transplant expense during each phase are as follows:

(1) Pre-transplant evaluation/screening. Pre-transplant evaluation screening includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility’s transplant program.

(2) Pre-transplant candidacy screening. Pre-transplant candidacy screening includes Human Leukocyte Antigen (HLA) typing/compatibility testing of prospective organ donors that are immediate family members.
(3) Transplant event. A transplant event includes Inpatient and outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or outpatient visits, including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or outpatient visits; cadaveric and live donor procurement.

(4) Follow-up care. Follow-up care includes all covered transplant expenses; home health care services; home infusion services and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

One Transplant Occurrence

The following are considered one transplant occurrence:

(1) Heart.
(2) Lung.
(3) Heart/Lung.
(4) Simultaneous Pancreas Kidney (SPK).
(5) Pancreas.
(6) Kidney.
(7) Liver.
(8) Intestine.
(9) Bone marrow/stem cell transplant.
(10) Multiple organs replaced during one transplant surgery.
(11) Tandem transplants (stem cell).
(12) Sequential transplants.
(13) Re-transplant of same organ type within 180 days of first transplant.
(14) Any other single organ transplant, unless otherwise excluded under the Plan.

More Than One Transplant Occurrence

The following are considered more than one transplant occurrence:

(1) Autologous blood/bone marrow transplant followed by allogenic blood/bone marrow transplant (when not part of a tandem transplant).
(2) Allogenic blood/bone marrow transplant followed by an autologous blood/bone marrow transplant (when not part of a tandem transplant).
(3) Re-transplant after 180 days of the first transplant.
(4) Pancreas transplant following a kidney transplant.
(5) A transplant necessitated by an additional organ failure during the original transplant surgery/process.
(6) More than one transplant when not performed as part of a planned tandem or sequential transplant (i.e. a liver transplant with subsequent heart transplant).
**Limitations**
Transplant coverage does not include charges for the following:

(1) Outpatient drugs, including bio-medicals and immunosuppressants not expressly related to an outpatient transplant occurrence.

(2) Services and supplies furnished to a donor when recipient is not a Covered Person.

(3) Home infusion therapy after the transplant occurrence.

(4) Harvesting or storage of organs without the expectation of immediate transplant for an existing Illness.

(5) Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing Illness.

(6) Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.

**Travel and Lodging Expenses**
Travel and lodging expenses will be covered under the Plan subject to the conditions described below.

(1) Distance requirement. The IOE facility must be more than 100 miles away from the patient's residence.

(2) Travel allowances. Travel is reimbursed between the patient's home and the facility for round trip (air, train or bus) transportation costs (coach class only). If traveling by auto to the facility, mileage, parking and toll cost will be reimbursed. Mileage reimbursement is $.23 per mile.

(3) Lodging allowances. Reimbursement of expenses Incurred by the patient and any companion for hotel lodging away from home is reimbursed at a rate of $50 per night per person, to a maximum of $150 per night.

(4) Overall maximum. Travel and lodging reimbursement is limited to $10,000 for any 1 transplant or procedure type, including tandem transplants. This is a combined maximum for the patient, companion and donor.

(5) Companions. One companion is permitted per adult and 2 parents or guardians are permitted per Child.
ALTERNATE BENEFITS

In addition to the benefits specified, the Plan may elect to offer benefits for services furnished by any provider pursuant to a Plan-approved alternative treatment plan, in which case those charges Incurred for services provided to a Covered Person under an alternate treatment plan to its end, will be more cost effective than those charges to be Incurred for services to be provided under the current treatment plan to its end.

The Plan shall provide such alternative benefits at its sole discretion and only when and for so long as it determines that alternative treatment plan is Medically Necessary and cost effective. If the Plan elects to provide alternative treatment plan benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for such Covered Person in any other instance or for other Covered Persons under this Plan in any other instance, nor shall it be construed as a waiver of the Plan Administrator's rights to administer this Plan thereafter in strict accordance with its express terms.
GENERAL EXCLUSIONS AND LIMITATIONS

No payment will be eligible under any portion of this Plan for expenses Incurred by a Covered Person for the expenses or circumstances listed below. If an expense is paid that is found to be excluded or limited as shown below, the Plan has the right to collect that amount from the payee, the Covered Person or from future benefits and any such payment does not waive the written exclusions, limitations or other terms of the Plan.

1. **Abortions**: Expenses related to elective abortions will not be considered eligible, except as specified under the Maternity benefit under Eligible Medical Expenses.

2. **Acupuncture**: Expenses for acupuncture will not be considered eligible.

3. **Adoption**: Expenses related to adoption will not be considered eligible. Expenses related to the care of the biological mother of an adopted child, if the biological mother is not a Covered Person, will not be considered eligible.

4. **Biofeedback**: Expenses related to biofeedback will not be considered eligible.

5. **Cardiac Rehabilitation**: Expenses in connection with Phase III cardiac rehabilitation, including, but not limited to occupational therapy or work hardening programs will not be considered eligible. Phase III is defined as the general maintenance level of treatment, with no further medical improvements being made and exercise therapy that no longer requires the supervision of medical professionals.

6. **Chelation Therapy**: Expenses for chelation therapy will not be considered eligible, unless due to heavy metal poisoning.

7. **Close Relative**: Expenses for services, care or supplies provided by a person who normally resides in the Covered Person’s home or by a Close Relative will not be considered eligible.

8. **Cognitive and Kinetic Therapy**: Expenses for cognitive therapy and kinetic therapy will not be considered eligible. Cognitive therapy is defined as therapy which embraces mental activities associated with thinking, learning and memory. Kinetic therapy is defined as therapy related to motion or movement (e.g., the study of motion, acceleration or rate of change). This exclusion will not apply to expenses related to a neurological brain impairment resulting from an acute major Illness or the diagnosis, testing and treatment of ADD, ADHD or autism.

9. **Complications**: Expenses for care, services or treatment required as a result of complications from a treatment or procedure not covered under the Plan will not be considered eligible, except complications from abortions, complications of pregnancy, or surgical procedures for Morbid Obesity as specified under Eligible Medical Expenses.

   Expenses for services or supplies related to treatment of complications that are a direct result or closely related result of a Covered Person’s refusal to accept treatment, medicines, or a course of treatment that a provider has recommended or has been determined to be Medically Necessary, including leaving an Inpatient medical facility against the advice of the treating Physician will not be considered eligible.

10. **Convenience Items**: Expenses for personal hygiene and convenience items will not be considered eligible.

11. **Cosmetic Procedures**: Expenses for Cosmetic and reconstructive procedures will not be considered eligible, except as specified under Eligible Medical Expenses.

   Expenses for: (a) removal of tattoos; (b) removal of moles; (c) facelifts; (d) blepharoplasty; (e) keloid removal; (f) dermabrasion; (g) chemical peels; (h) rhinoplasty; (i) breast augmentation; and (j) breast reduction.

12. **Counseling**: Expenses for religious, marital, family, or relationship counseling will not be considered eligible, except as specified under Eligible Medical Expenses.

13. **Court-Ordered**: Expenses for court-ordered examinations and treatment will not be considered eligible, unless Medically Necessary.
(14) **Custodial Care**: Expenses for Custodial Care will not be considered eligible, except as specified under the Home Health Care and Hospice Care benefits.

(15) **Dental Care**: Expenses Incurred in connection with dental care, treatment, x-rays, general anesthesia or Hospital expenses will not be considered eligible, except as specified under Eligible Medical Expenses. Removal of impacted teeth will not be considered eligible.

(16) **Developmental Delays**: Expenses in connection with the treatment of developmental delays, including, but not limited to speech therapy, occupational therapy, physical therapy and any related diagnostic testing will not be considered eligible. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD and to expenses covered as a preventive service under the Eligible Medical Expense section of the Plan.

(17) **Exercise Programs**: Exercise programs for treatment of any condition will not be considered eligible, except for Physician-supervised cardiac rehabilitation and occupational or physical therapy covered by the Plan.

(18) **Experimental and/or Investigational**: Expenses for treatment, procedures, devices, drugs or medicines which are determined to be Experimental and/or Investigational will not be considered eligible, except for Off-Label Drug Use or when such expenses are considered Qualified Clinical Trial Expenses.

(19) **Foot Care**: Expenses for routine foot care, treatment of weak, unstable or flat feet will not be considered eligible, unless Medically Necessary for diabetic patients.

(20) **Foot Orthotics**: Expenses for foot only orthotics, orthopedic shoes (except those that are an integral part of a leg brace), arch supports or for the exam, prescription or fitting thereof will not be considered eligible, unless Medically Necessary for diabetic patients.

(21) **Gambling Addiction**: Expenses for services related to gambling addiction will not be considered eligible.

(22) **Governmental Agency**: Expenses for services and supplies which are provided by any governmental agency for which the Covered Person is not liable for payment will not be considered eligible. In the case of a state-sponsored medical assistance program, benefits payable under this Plan will be primary. Benefits payable under this Plan will also be primary for any Covered Person eligible under TRICARE (the government sponsored program for military dependents).

(23) **Growth Hormone Replacement Therapy**: Expense for growth hormone replacement therapy will not be considered eligible, except for: (a) treatment of absolute growth hormone deficiency in children whose epiphyses have not closed and who at initiation of therapy had a height of more than 2 standard deviations below the mean for chronological age; (b) growth hormone replacement therapy prior to renal transplant in children whose epiphyses have not closed and who also have chronic renal insufficiency (glomerular filtration rate GFR less than 60ml/minute/1.73 meter squared); (c) persons diagnosed with Turners Syndrome; (d) persons diagnosed with Noonan Syndrome; (e) persons diagnosed with Prader-Willi Syndrome and confirmed by appropriate genetic testing; (f) persons with decreased hypothalamic function due to any of the following reasons: pituitary tumor, pituitary surgical damage; trauma or cranial irradiation; or (g) person under age 18 diagnosed with pituitary dwarfism.

(24) **Hair Loss**: Expenses for hair loss or hair transplants will not be considered eligible.

(25) **Hearing Exams/Aids**: Expenses for routine hearing examinations, hearing aids (including the fitting thereof) and supplies will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(26) **Home Births**: Expenses for planned maternity delivery in a home setting or location other than a licensed Hospital or Birthing Center will not be considered eligible.

(27) **Homeopathic Treatment**: Expenses for naturopathic and homeopathic treatments, services and supplies will not be considered eligible.

(28) **Hypnotherapy**: Expenses for hypnotherapy will not be considered eligible.
(29) **Illegal Occupation/Felony**: Expenses for or in connection with an Injury or Illness arising out of an illegal occupation or commission of a felony will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or due to an act of domestic violence.

(30) **Infertility**: Expenses for confinement, treatment or services related to infertility (the inability to conceive) or the promotion of conception will not be considered eligible, except diagnosis and testing of infertility as specified under Eligible Medical Expenses.

Nothing in this section is intended to exclude coverage for any infertility counseling or treatment required to be covered (if any) as a preventive service under the guidelines published by the Health Resources and Services Administration on August 1, 2011 (or any applicable subsequent guidelines).

(31) **Maintenance Therapy**: Expenses for Maintenance Therapy of any type when the individual has reached the maximum level of improvement will not be considered eligible.

(32) **Mandible Treatment**: Expenses for appliances, medical or surgical treatment for correction of a malocclusion or protrusion or recession of the mandible; maxillary or mandibular hyperplasia or maxillary or mandibular hypoplasia will not be considered eligible. (Malocclusion - teeth do not fit together properly, bite problem; mandible protrusion or recession: underbite, chin excessively large or overbite, chin abnormally small; maxillary/mandibular hyperplasia: overbite due to excess growth of upper/lower jaw; maxillary/mandibular hypoplasia: undergrowth of upper/lower jaw). This is considered dental Surgery, performed by dental surgeons. This is not considered a medical procedure.

(33) **Massage Therapy**: Expenses for massage therapy will not be considered eligible.

(34) **Medically Necessary**: Expenses which are determined not to be Medically Necessary will not be considered eligible.

(35) **Missed Appointments**: Expenses for completion of claim forms, missed appointments or telephone consultations will not be considered eligible.

(36) **Morbid Obesity**: Expenses for non-surgical treatment of Morbid Obesity will not be considered eligible.

(37) **No Legal Obligation**: Expenses for services provided for which the Covered Person has no legal obligation to pay will not be considered eligible. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires this Employer's plan to be primary.

(38) **Non-Covered Procedures**: Expenses for services related to a non-covered Surgery or procedure will not be considered eligible regardless of when the Surgery or procedure was performed.

(39) **Not Performed Under the Direction of a Physician**: Expenses for services and supplies which are not prescribed or performed by or under the direction of a Physician will not be considered eligible.

(40) **Not Recommended by a Physician**: Expenses by a Hospital or covered residential treatment center if hospitalization is not recommended or approved by a legally qualified Physician will not be considered eligible.

(41) **Nutritional Counseling**: Expenses related to nutritional counseling will not be considered eligible, except if received as part of the Home Health Care benefit and except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(42) **Nutritional Supplements**: Expenses for nutritional supplements or other enteral supplementation will not be considered eligible, except as specified under Eligible Medical Expenses. Over-the-counter nutritional supplements or infant formulas will not be considered eligible even if prescribed by a Physician.

(43) **Obesity**: Surgical and non-surgical care and treatment of obesity including weight loss or dietary control, whether or not it is in any case a part of a treatment plan for another Illness, will not be considered eligible, except as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan. This exclusion does not apply to surgical treatment of Morbid Obesity as shown under Eligible Medical Expenses.
(44) **Occupational Therapy:** Expenses for occupational therapy primarily for recreational or social interaction will not be considered eligible.

(45) **Operated by the Government:** Expenses for treatment at a facility owned or operated by the government will not be considered eligible, unless the Covered Person is legally obligated to pay. This does not apply to Covered Expenses rendered by a Hospital owned or operated by the United States Veteran’s Administration when services are provided to a Covered Person for a non-service related Illness or Injury.

(46) **Outside the United States (U.S.):** Expenses for services or supplies if the Covered Person leaves the U.S. or the U.S. Territories for the express purpose of receiving medical treatment will not be considered eligible.

Expenses for a patient who becomes sick or injured while out of the U.S. or the U.S. Territories will not be considered eligible after 120 consecutive days. This time limit will not be applied if the Covered Person is out of the country for business or as a student.

(47) **Over-the-Counter (OTC) Medication:** Expenses for any over-the-counter medication will not be considered eligible. Expenses for drugs and medicines not requiring a prescription by a licensed Physician and not dispensed by a licensed pharmacist will not be considered eligible, except as otherwise covered as a preventive services under the Eligible Medical Expenses section of the Plan.

(48) **Plan Maximums:** Charges in excess of Plan maximums will not be considered eligible.

(49) **Prior to Effective Date:** Expenses which are Incurred prior to the effective date of your coverage under the Plan will not be considered eligible.

(50) **Private Duty Nursing:** Expenses for private duty nursing will not be considered eligible, except those nursing services which are considered eligible under the Home Health Care and Hospice Care benefits.

(51) **Radioactive Contamination:** Expenses Incurred as the result of radioactive contamination or the hazardous properties of nuclear material will not be considered eligible.

(52) **Recreational and Educational Therapy:** Expenses for recreational and educational services; learning disabilities; behavior modification services; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies; will not be considered eligible. Diabetic education is considered eligible as specified under Eligible Medical Expenses. This exclusion will not apply to expenses related to the diagnosis, testing and treatment of autism, ADD or ADHD.

(53) **Refractive Errors:** Expenses for radial keratotomy, Lasik Surgery or any Surgical Procedure to correct refractive errors of the eye will not be considered eligible.

(54) **Required by Law:** In any case where an individual is required by law to maintain insurance coverage (or to maintain any other security or reserve amount in lieu of insurance coverage), expenses of a Covered Person that would be paid by such insurance coverage are not eligible expenses, regardless of whether the individual is in fact covered under such coverage. For purposes of any required automobile, motorcycle or other vehicle coverage, otherwise eligible expenses below the minimum required coverage or the actual coverage elected, whichever is higher, will be excluded from coverage under this Plan.

(55) **Riot/Revolt:** Expenses resulting from a Covered Person’s participation in a riot or revolt will not be considered eligible. This exclusion will not apply to Injuries and/or Illnesses sustained due to a medical condition (physical or mental) or domestic violence.

(56) **Routine Care:** Expenses for office visits and physical exams for school, camp, employment, travel, insurance, marriage or legal proceedings and related immunizations and tests are not considered eligible.

(57) **Sex Transformation:** Expenses in connection with sex transformation will not be considered eligible.

(58) **Sexual Dysfunction/Impotence:** Expenses for services, supplies or drugs related to sexual dysfunction/impotence not related to organic disease will not be considered eligible. Expenses for sex therapy will not be considered eligible.
(59) **Sleep Disorder:** Expenses for treatment, services and supplies for sleep disorders will not be considered eligible, except as specified under Eligible Medical Expenses.

(60) **Smoking Cessation:** Expenses for smoking cessation programs, including smoking deterrents will not be considered eligible, unless otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(61) **Sports:** Expenses for safety items, or item to affect performance primarily in sports-related activities will not be considered eligible.

(62) **Stand-by Physician:** Expenses for technical medical assistance or stand-by Physician services will not be considered eligible.

(63) **Sterilization:** Expenses for the reversal of elective sterilization will not be considered eligible.

(64) **Surrogate:** Expenses relating to a surrogate pregnancy of any person who is not covered under this Plan, including but not limited to pre-pregnancy, conception, pre-natal, childbirth and post-natal expenses, will not be considered eligible.

(65) **Temporomandibular Joint Dysfunction (TMJ):** Expenses for treatment or services due to Temporomandibular Joint Dysfunction (TMJ) will not be considered eligible.

(66) **Travel:** Expenses for travel will not be considered eligible, except as specified under Eligible Medical Expenses.

(67) **Usual and Customary Charge:** Expenses in excess of the Usual and Customary Charge will not be considered eligible.

(68) **Vision Care:** Expenses for vision care, including routine eye exams, professional services for the fitting and/or supply of lenses, frames, contact lenses and other fabricated optical devices; or vision exercise therapy will not be considered eligible. However, benefits will be provided for the necessary initial placement of a pair of eyeglasses, contact lenses or an intraocular lens following a Medically Necessary Surgical Procedure to the eye. This exclusion does not apply to aphakic patient and soft lenses or sclera shells intended for use as corneal bandages and as otherwise covered as a preventive service under the Eligible Medical Expenses section of the Plan.

(69) **Wage or Profit:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for wage or profit (including self-employment) will not be considered eligible.

(70) **War:** Expenses for the treatment of Illness or Injury resulting from a war or any act of war or terrorism, whether declared or undeclared, civil war, hostilities or invasion, or while in the armed forces of any country or international organization will not be considered eligible.

(71) **Weekend Admissions:** Expenses for care and treatment billed by a Hospital for non-Medical Emergency admissions on a Friday or Saturday will not be considered eligible, unless Surgery is scheduled within 24 hours.

(72) **Worker’s Compensation:** Expenses for or in connection with any Injury or Illness which arises out of or in the course of any occupation for which the Covered Person would be entitled to compensation under any Worker's Compensation Law or occupational disease law or similar legislation will not be considered eligible.

Expenses for Injuries or Illness which were eligible for payment under Worker's Compensation or similar law and have reached the maximum reimbursement paid under Worker's Compensation or similar law will not be eligible for payment under this Plan.
Eligible expenses include Prescription Drugs and medicines prescribed in writing by a Physician and dispensed by a licensed pharmacist, which are deemed necessary for treatment of an Illness or Injury including but not limited to: insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician, diabetic supplies and contraceptives (regardless of intended use). Please note Prescription Drugs are subject to the cost-sharing provisions described in the Prescription Drug Schedule of Benefits unless the Prescription Drug qualifies as a Preventive Drug (as described below).

When your prescription is filled at a retail pharmacy, the maximum amount or quantity of Prescription Drugs covered per Copay is a 30-day supply. Maintenance drugs of more than a 30-day supply may be purchased through the mail order program or through a retail pharmacy that participates in the 90-day retail network.

When using the mail order or 90-day retail programs, the maximum amount or quantity of Prescription Drugs covered per Copay is a 90-day supply.

Expenses for injectables that are not covered under the Prescription Drug Card Program and are Medically Necessary for the treatment of a covered Illness or Injury will be payable under this Plan subject to any applicable major medical Deductibles and Coinsurance as well as any coverage limitations and exclusions applicable to the major medical component of the Plan. Please refer to the Eligible Medical Expenses and the General Limitations and Exclusions section of the Plan.

NOTE: Coverage, limitations and exclusions for Prescription Drugs will be determined through the Prescription Drug Card Program elected by the Plan Sponsor and will not be subject to any limitations and exclusions under the major medical component of the Plan (except for injectables that are not covered under the Prescription Drug Card Program). For a complete listing of Prescription Drugs available under the Prescription Drug Card Program, as well as any exclusions or limitations that may apply, please contact the Prescription Drug Card Program Manager identified in the General Plan Information section of this Plan.

Mandatory Generic Program
The Plan requires that pharmacies dispense Generic Drugs when available. Should a Covered Person choose a Preferred or Non-Preferred Drug rather than the Generic equivalent, the Covered Person will be responsible for the cost difference between the Generic and Preferred or Non-Preferred Drug in addition to the Preferred or Non-Preferred Drug Copay, even if a DAW (Dispense As Written) is written by the prescribing Physician. The cost difference is not covered by the Plan and will not accumulate toward your Out-of-Pocket Maximum.

Mandatory Maintenance Drugs
All maintenance drugs must be filled at mail order or a participating 90-day retail pharmacy in order to be covered by the Plan.

Brand Name Drug: Means a trade name medication.

Generic Drug: A Prescription Drug which has the equivalency of the Brand Name Drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Non-Preferred Drug: Any Brand Name drugs that do not appear on the list of Preferred Drugs.

Preferred Drug: A list of Brand Name drugs that has been developed by a Pharmacy and Therapeutics Committee comprised of Physicians, Pharmacists and other health care professionals. The list of Brand Name drugs is subject to periodic review and modification based on a variety of factors such as, but not limited to, Generic Drug availability, Food and Drug Administration (FDA) changes, and clinical information. The Prescription Drug Card Program Manager will have a list of Preferred Drugs available.
**Prescription Drug**: Any of the following: (a) a Food and Drug Administration-approved drug or medicine, which, under federal law, is required to bear the legend, “Caution: federal law prohibits dispensing without prescription”; (b) injectable insulin; or (c) hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of an Illness or Injury.

**Preventive Drug** means items which have been identified by the U.S. Department of Health and Human Services (HHS) as a preventive service. You may view the guidelines established by HHS by visiting the following website:

https://www.healthcare.gov/what-are-my-preventive-care-benefits

For a paper copy, please contact the Plan Administrator.
COBRA CONTINUATION COVERAGE

The right to COBRA Continuation Coverage was created by a federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended (“COBRA”). COBRA Continuation Coverage can become available to you and/or your eligible Dependents when your coverage under the Plan ends because of a life event known as a “qualifying event”.

Qualified Beneficiary
In general, you, your Spouse and any Dependent Child covered under the Plan on the day before a qualifying event that causes you to lose coverage under the Plan is considered a “qualified beneficiary”.

In addition, any Dependent Child who is born to or placed for adoption with you during a period of COBRA continuation coverage is considered a “qualified beneficiary”.

Each qualified beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) is offered the opportunity to make an independent election to receive COBRA continuation coverage.

Qualifying Event
If you are a covered Employee, you, your Spouse and/or Dependent Child will become a qualified beneficiary if you lose your coverage under the Plan because of either one of the following qualifying events:

(1) Your hours of employment are reduced or

(2) Your employment ends for any reason other than your gross misconduct.

You, your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 18 months provided you elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage.

You, your Spouse and Dependent Child have an independent right to elect COBRA Continuation Coverage. You and/or your Spouse may elect coverage on behalf of either one of you and parents may elect coverage on behalf of their Dependent Child.

If you are the Spouse and/or Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose your coverage under the Plan because of any of the following qualifying events:

(1) Your spouse/parent-Employee dies;

(2) Your spouse/parent-Employee becomes entitled to Medicare benefits (under Part A, Part B or both); or

(3) You/your parents become divorced or legally separated.

Your Spouse and/or Dependent Child may elect to continue coverage under the Plan for up to a maximum period of 36 months provided such Spouse and/or Dependent Child provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date they are given notice of their rights to elect COBRA Continuation Coverage and their obligation to provide such notice. Please see the section below entitled “Notice Requirement” for the requirements of such notice.

If you are a Dependent Child of a covered Employee, you will also become a qualified beneficiary if you lose coverage under the Plan because you cease to be eligible for coverage under the Plan as a Dependent Child. You may elect to continue coverage under the Plan for up to a maximum period of 36 months provided you provide notice of the qualifying event to the Employer and elect to enroll in COBRA within 60 days following the later of: (a) the date coverage under the Plan would end due to the qualifying event; or (b) the date you are given notice of your rights to elect COBRA Continuation Coverage and your obligation to provide such notice. Please see the section below entitled “Notice Requirement” for the requirements of such notice.
Extension of 18-Month Continuation Coverage Period

If you, your Spouse or Dependent Child is determined to be disabled by the Social Security Act (SSA); you and all other qualified beneficiaries may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 61st day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of the date (a) of the SSA determination; (b) the date coverage under the Plan would end due to the qualifying event; or (c) the date you are given notice of your obligation to provide such notice. In any event, notice must be given to your Employer prior to the end of the initial 18-month period of coverage. If you are later determined not disabled by SSA, you must notify your Employer within 30 days following the later of (a) the date of the SSA determination; or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled “Notice Requirement” for the requirements of such notice.

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, your Spouse and any Dependent Child in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months. To qualify for this extension in coverage, notification must be given to your Employer within 60 days after the later of (a) the date coverage under the Plan would end due to the qualifying event or (b) the date you are given notice of your obligation to provide such notice. Please see the section below entitled “Notice Requirement” for the requirements of such notice.

Notice Requirement

The notice must be postmarked (if mailed) or received by the COBRA Administrator (if hand delivered), by the deadline set forth above. If the notice is late, the opportunity to elect or extend COBRA continuation coverage is lost and if you are electing COBRA continuation coverage, your coverage under the Plan will terminate on the last date for which you are eligible under the terms of the Plan or if you are eligible for an extension of COBRA continuation coverage, such coverage will end on the last day of the initial 18-month COBRA continuation coverage period.

For qualifying events such as divorce or legal separation of the Employee and Spouse or a Dependent Child's loss of eligibility under the Plan, the notice must contain the following information:

1. Name and address of the covered Employee or former employee;
2. Name and address of your Spouse, former Spouse and any Dependent Children;
3. Description of the qualifying event; and
4. Date of the qualifying event.

In addition to the information above, if you, your Spouse or any Dependent Child is determined by SSA to be disabled within 60 days after your COBRA continuation coverage begins, the notice must also contain the following information:

1. Name of person deemed disabled;
2. Date of disability determination; and
3. Copy of SSA determination letter.

If you cannot provide a copy of the decree of divorce or the SSA’s determination by the deadline for providing the notice, complete and provide the notice, as instructed, by the deadline and submit the copy of the decree of divorce or the SSA’s determination within 30 days after the deadline. The notice will be timely if you do so. However, no COBRA continuation coverage or extension of such coverage, will be available until the copy of the decree of divorce or the SSA’s determination is provided.

If the notice does not contain all of the required information, the COBRA Administrator may request additional information. If the individual fails to provide such information within the time period specified in the request, the notice may be rejected.
In addition to accepting a letter with the information described above, the Plan Administrator, in its discretion, may develop and make available a form, which may then be completed to provide the required notice. If such a form is available, a covered Employee or a covered Spouse may obtain a copy by requesting it from the Plan Administrator at the address provided in this notice.

Notice must be sent to the COBRA Administrator at:

Wageworks
P.O. Box 14055
Lexington, KY 40512-4055
877-502-6272

Termination of COBRA Continuation Coverage
COBRA continuation coverage automatically ends 18, 29 or 36 months (whichever is applicable) after the date of the qualifying event; however coverage may end before the end of the maximum period on the earliest of the following events:

(1) The date the Plan Sponsor ceases to provide any group health plan coverage;

(2) The date on which the qualified beneficiary fails to pay the required contribution;

(3) The date that the qualified beneficiary first becomes, after the date of election, covered under any other group health plan (as an Employee or otherwise) or entitled to either Medicare Part A or Part B (whichever comes first); or

(4) The first day of the month that begins more than 30 days after the date of the SSA’s determination that the qualified beneficiary is no longer disabled, but in no event before the end of the maximum coverage period that applied without taking into consideration the disability extension.

Payment for COBRA Continuation Coverage
Once COBRA continuation coverage is elected, you must pay for the cost of the initial period of coverage within 45 days. Payments then are due on the first day of each month to continue coverage for that month. If a payment is not received within 30 days of the due date, COBRA continuation coverage will be canceled and will not be reinstated. The amount you are required to pay for COBRA continuation coverage is 102% of the actual cost of coverage you elect, unless you qualify for the 11-month period of extended coverage due to disability (as specified above). In the event of disability, you will be required to pay 150% of the actual cost of coverage you elect for the 11-month extension period.

Additional Information
Additional information about the Plan and COBRA continuation coverage is available from the Plan Administrator, who is identified on the General Plan Information page of this Plan.

Current Addresses
In order to protect your family’s rights, you should keep the Plan Administrator informed of any changes in the addresses of family members.
CLAIM PROCEDURES

You will receive an Employee identification card which will contain important information, including claim filing directions and contact information. The Employee identification card will show your Participating Provider Network and the Medical Management Administrator.

At the time you receive treatment, show the Employee identification card to your provider of service. In most cases, your provider will file your claim for you. You may file the claim yourself by submitting the required information to:

Meritain Health, Inc.
P.O. Box 853921
Richardson, TX 75085-3921
(866) 209-2929

Most claims under the Plan will be “post service claims.” A “post service claim” is a claim for a benefit under the Plan after the services have been rendered. Post service claims must include the following information in order to be considered filed with the Plan:

1. The date of service;
2. The name, address, telephone number and tax identification number of the provider of the services or supplies;
3. The place where the services were rendered;
4. The diagnosis and procedure codes;
5. The amount of charges (including Network repricing information);
6. The name of the Plan;
7. The name of the covered Employee; and
8. The name of the patient.

A call from a provider who wants to know if an individual is covered under the Plan or if a certain procedure or treatment is a Covered Expense before the treatment is rendered, is not a “claim” since an actual written claim for benefits is not being filed with the Plan. Likewise, presentation of a prescription to a pharmacy does not constitute a claim.

Timely Filing
All claims must be filed with the Third Party Administrator within 12 months following the date services were Incurred. Claims filed after this time period will be denied. Claims for benefits from a Health Reimbursement Account must be filed no later than 12 months following the date services were Incurred. Claims filed after this time period will be denied.

Procedures for all Claims
The Plan's claim procedures are intended to reflect the Department of Labor's claims procedures regulations and should be interpreted accordingly. In the event of any conflict between this Plan and those Regulations, those Regulations will control. In addition, any changes in those Regulations shall be deemed to amend this Plan automatically, effective as of the date of those changes.

To receive benefits under the Plan, the claimant (i.e. you and your covered Dependents) must follow the procedures outlined in this section. There are 4 different types of claims: (1) Urgent Care Claims; (2) Concurrent Care Claims; (3) Pre-Service Claims; and (4) Post-Service Claims. The procedures for each type of claim are more fully described below:
(1) **Urgent Care Claims.** If your claim is considered an urgent care claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after the Plan receives the claim, unless you fail to provide sufficient information to determine whether or to what extent, benefits are covered or payable under the Plan. If you fail to provide sufficient information for the Plan to decide your claim, the Plan Administrator will notify you as soon as possible, but not later than 24 hours after the Plan receives the claim, of the specific information necessary to complete the claim. The notification may be oral unless written notification is requested by you. You will be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator will notify you of the Plan's determination as soon as possible, but in no case later than 48 hours after the earlier of (1) the Plan's receipt of the specified additional information or (2) the end of the period afforded the claimant to provide the specified additional information.

A claim for benefits is considered an urgent care claim if the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function or, in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that could not be adequately managed without the care or treatment which is the subject of the claim. In determining if the initial claim for benefits should be treated as an urgent care claim, the Plan will defer to a determination, if any, by an attending provider that the claim should be treated as an urgent care claim, if that determination is timely provided to the Plan.

(2) **Concurrent Care Claims.** If the Plan has approved an ongoing course of health care treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of the previously approved course of treatment (other than by Plan amendment or termination) before the approved time period or number of treatments constitutes an adverse determination. In such a case, the Plan Administrator will notify you of the adverse determination at a time sufficiently in advance of the reduction or termination to allow you, the claimant, to appeal and obtain a determination on review of that adverse determination before reduction or termination of the benefit.

Any request by you to extend a previously approved course of urgent care treatment beyond the approved period of time or number of treatments shall be decided as soon as possible, taking into account the medical exigencies and the Plan Administrator will notify you of the benefit determination, whether adverse or not, within 24 hours after the Plan receives the claim provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments.

(3) **Pre-Service Claims.** For a pre-service claim, the Plan Administrator will notify you of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after the Plan receives the claim. If, due to matters beyond the control of the Plan, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time to notify you of the Plan's benefit determination for up to 15 days provided that the Plan Administrator notifies you within 15 days after the Plan receives the claim, of those special circumstances and of when the Plan Administrator expects to make its decision. However, if such an extension is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension must specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.

A claim for benefits is considered a pre-service claim if the claim requires approval, in part or in whole, in advance of obtaining the health care in question.

(4) **Post-Service Claims.** For a post-service claim, the Plan Administrator will notify you of the Plan's adverse determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If, due to special circumstances, the Plan Administrator needs additional time to process a claim, the Plan Administrator may extend the time for notifying you of the Plan's benefit determination on a one-time basis for up to 15 days provided that the Plan Administrator notifies you within 30 days after the Plan receives the claim, of those special circumstances and of the date by which the reviewer expects to make a decision. However, if such a decision is necessary due to your failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information and you will be afforded at least 45 days from receipt of the notice within which to provide the specified information.
A claim for benefits is considered a post-service claim if it is a request for payment for services or other benefits that you have already received (or any other claim for health benefits that is not a pre-service claim or an urgent care claim).

**Manner and Content of Notice of Initial Adverse Determination**

If the Plan Administrator denies a claim, it must provide to you in writing or by electronic communication:

1. An explanation of the specific reasons for the denial;
2. A reference to the Plan provision or insurance contract provision upon which the denial is based;
3. A description of any additional information or material that you must provide in order to perfect the claim;
4. An explanation of why the additional material or information is necessary;
5. Notice that you have the right to request a review of the claim denial and information on the steps to be taken if you wish to request a review of the claim denial along with the time limits applicable to a request for review;
6. A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);
7. A copy of any rule, guideline, protocol or other similar criterion relied upon in making the adverse determination (or a statement that the same will be provided upon your request and without charge); and
8. If the adverse determination is based on the Plan's Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment applying the exclusion or limit to your medical circumstances or (b) a statement that the same will be provided upon your request and without charge.

Any notice of adverse determination also will include the following information:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan's standard, if any, that was used in denying the claim;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
5. A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).

For an adverse determination concerning an urgent care claim, the information described in this Section may be provided to you orally within the permitted time frame provided that a written or electronic notification in accordance with this section is furnished to you no later than 3 days after the oral notification.

**Internal Review of Initially Denied Claims**

If you submit a claim for Plan benefits and it is initially denied under the procedures described above, you may request a review of that denial under the procedures described below.

You have 180 days after you receive notice of an initial adverse determination within which to request a review of the adverse determination. For a request for a second level appeal, you have 60 days after you receive notice of an adverse determination at the first level of appeal to request a second level appeal of the adverse determination.
If you request a review of an adverse determination within the applicable time period, the review will meet the following requirements:

(1) The Plan will provide a review that does not afford deference to the adverse determination that is being appealed and that is conducted by an appropriate named fiduciary of the Plan who did not make the adverse determination that is the subject of the appeal and who is not a subordinate of the individual who made that adverse determination.

(2) The appropriate named fiduciary of the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment before making a decision on review of any adverse determination based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is Experimental and/or Investigational or not Medically Necessary or appropriate. The professional engaged for purposes of a consultation in the preceding sentence will be an individual who is neither an individual who was consulted in connection with the adverse determination that is the subject of the appeal, nor a subordinate of any such individual.

(3) The Plan will identify any medical or vocational experts whose advice is obtained on behalf of the Plan in connection with the Plan's review of an adverse determination, without regard to whether the advice is relied upon in making the adverse determination on review.

(4) For a requested review of an adverse determination involving an urgent care claim, the review process will meet the expedited deadlines described below. Your request for such an expedited review may be submitted orally or in writing and all necessary information, including the Plan's determination on review, will be transmitted between the Plan and you by telephone, facsimile or other available similarly expeditious method.

(5) The reviewer will afford you an opportunity to review and receive, without charge, all relevant documents, information and records relating to the claim and to submit issues and comments relating to the claim in writing to the Plan. The reviewer will take into account all comments, documents, records and other information submitted by the claimant relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination.

(6) You will be provided, free of charge, any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim. Such evidence or rationale will be provided as soon as possible and sufficiently in advance of the Plan's deadline for providing notice of its determination on review to give you a reasonable opportunity to respond prior to such determination.

(7) The Plan will ensure that all claims are adjudicated in a manner designed to ensure the independence and impartiality of the persons involved in making the decisions.

(8) The Plan will provide you with continued coverage pending the outcome of an internal appeal.

All requests for review of initially denied claims (including all relevant information) must be submitted to the following address:

Meritain Health, Inc.  
Appeals Department  
P. O. Box 41980  
Plymouth, MN 55441-0970

**Deadline for Internal Review of Initially Denied Claims**

(1) Urgent Care Claims. The Plan provides for two levels of appeal for urgent care claims. For each level of appeal, the reviewer will notify you of the Plan's determination on review as soon as possible, taking into account the medical exigencies, but not later than 36 hours after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

(2) Pre-Service Claims. The Plan provides for two levels of appeal for a pre-service claim. At each level of appeal, the reviewer will notify you of the Plan's determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 15 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).
Post-Service Claims. The Plan provides for two levels of appeal for a post-service claim. At each level of appeal, the reviewer will notify you of the Plan’s determination on review within a reasonable period of time appropriate to the medical circumstances, but in no event later than 30 days after the Plan receives your request for review of the initial adverse determination (or of the first-level appeal adverse determination).

Manner and Content of Notice of Decision on Internal Review of Initially Denied Claims

Upon completion of its review of an initial adverse determination (or a first-level appeal adverse determination), the reviewer will give you, in writing or by electronic notification, a notice of its benefit determination. For an adverse determination, the notice will include:

1. A description of the Plan’s decision;
2. The specific reasons for the decision;
3. The relevant Plan provisions or insurance contract provisions on which its decision is based;
4. A statement that you are entitled to receive, upon request and without charge, reasonable access to and copies of, all documents, records and other information in the Plan’s files which is relevant to your claim for benefits;
5. A statement describing your right to request an external review (or, if applicable, to request a second level appeal) or, if applicable, to bring an action under ERISA Section 502(a);
6. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination on review, a statement that a copy of the rule, guideline, protocol or other similar criterion will be provided without charge to you upon request;
7. If the adverse determination on review is based on a Medical Necessity, experimental treatment or similar exclusion or limit, either: (a) an explanation of the scientific or clinical judgment on which the determination was based, applying the terms of the Plan to the claimant’s medical circumstances or (b) a statement that such an explanation will be provided without charge upon request; and
8. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and, if your benefit is an insured benefit, your State insurance regulatory agency."

Any notice of adverse determination will include the following information:

1. Information sufficient to identify the claim involved, including the date of service, the health care provider and the claim amount (if applicable);
2. As part of the explanation of the determination, a discussion of the decision, as well as disclosure of any denial code used (and an explanation of its meaning) and a description of the Plan’s standard, if any, that was used in denying the claim;
3. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
4. Information (including contact information) about the availability of any applicable office of health insurance consumer assistance or ombudsmen established pursuant to the Patient Protection and Affordable Care Act (PPACA) to assist individuals with internal claims and appeals and external review processes; and
5. A statement describing the availability, upon request, of any applicable diagnosis code (and an explanation of its meaning) and any applicable treatment code (and an explanation of its meaning).
Calculation of Time Periods
For purposes of the time periods described in the Plan's claim procedures, the period of time during which a benefit determination is required to be made begins at the time a claim (or a request for review of a denied claim) is filed in accordance with the Plan procedures without regard to whether all the information necessary to make a decision accompanies the request. If a period of time is extended due to your failure to submit all information necessary for a claim for non-urgent care benefits, the period for making the determination is "frozen" from the date the notification requesting the additional information is sent to you until the date you respond or, if earlier, until 45 days from the date you receive (or were reasonably expected to receive) the notice requesting additional information.

Adverse Determination
For purposes of the Plan's claim procedures, an "adverse determination" is a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination or failure to provide or make payment that is based on a determination of an individual's eligibility to participate in the Plan and including a denial, reduction or termination of or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate. Adverse determination also includes any rescission of coverage, whether or not, in connection with the rescission, there is an adverse effect on any particular benefit at the time of rescission.

Plan's Failure to Follow Procedures
If the Plan fails to follow the claim procedures described above, you will be deemed to have exhausted the Plan internal claim procedures and you will be entitled to pursue any available remedy (including any available external review process) under State or Federal law on the basis that the Plan has failed to provide a reasonable claims procedure that would yield a decision on the merits of the claim.

However, the Plan will not be treated as failing to follow its claim procedures and you will not be deemed to have exhausted the Plan's administrative remedies merely because of a failure by the Plan that would be considered (based on applicable regulations) a "de minimis violation" that does not cause and is not likely to cause prejudice or harm to you as long as the Plan can demonstrate that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information between the Plan and you. You may request a written explanation of any violation by the Plan of these procedures. If you request such an explanation, the Plan will provide it within 10 days and, if applicable, the explanation will include a specific description of the Plan's reasons for asserting that the violation does not cause the Plan's internal claim procedures to be exhausted. If a court or external review rejects your request for an immediate review (based on a claim that you should be deemed to have exhausted the Plan's internal claim procedures), because the court or external reviewer determines that the "de minimis violation" exception applies, the Plan will provide to you a notice of your right to resubmit your internal appeal with a reasonable time (no longer than 10 days) after the court or external reviewer makes such a determination. Any applicable time limit for you to re-file your claim will begin to run when you receive that notice from the Plan.

External Review of Denied Claims
If you have exhausted the Plan's internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan's final adverse determination for certain health benefit claims.

The Plan will provide for an external review process in accordance with Federal law.

Note that the Federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, Federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, for any claim for which an external review request is not initiated before September 20, 2011, the Federal external review process is available only for:

1. An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan's determination that a treatment is experimental or investigational), as determined by the external reviewer; and
A rescission of coverage.

For any adverse determination for which external review is available, the Federal external review requirements are as follows:

1. You have 4 months following the date you receive notice of the Plan’s final internal adverse determination within which to request an external review. The request for an external review must be submitted to the following address:

   Meritain Health, Inc.
   Appeals Department
   P. O. Box 41980
   Plymouth, MN 55441-0970

2. Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

   a. If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

   b. If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.

3. Following the Plan’s preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within five business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

4. The assigned IRO will notify you in writing (within a reasonable period of time) of the request's eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within ten business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

5. Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO's notice is required to contain the following:

   a. A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

   b. The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

   c. References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

   d. A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

   e. A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;
(f) A statement that judicial review may be available to you; and

g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

**Expedited External Review**

You may request an expedited external review if you have received:

(1) An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan's internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(2) A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function or if the final internal adverse determination concerns an admission, availability of care, continued stay or health care item or service for which you received emergency services but have not been discharged from a facility.

The following requirements apply to an expedited external review:

(1) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

   (a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

   (b) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.

(2) Following the Plan's preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(3) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant's medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO's notice is required to contain the following information:

   (a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

   (b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

   (c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

   (d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

   (e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;
(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination
A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial decision that provides otherwise.

Statute of Limitations for Plan Claims
Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than 12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed rendered).

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

Physical Examinations
The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim. The Covered Person must comply with this requirement as a necessary condition to coverage.
COORDINATION OF BENEFITS

Benefits Subject to This Provision
This provision applies to all benefits provided under any section of this Plan.

Excess Insurance
If at the time of Injury, Illness, disease or disability there is available or potentially available, any coverage (including, but not limited to, coverage resulting from a judgment at law or settlements), the benefits under the Plan shall apply only as an excess over such other sources of coverage.

The Plan’s benefits will be excess to, whenever possible:

1. Any primary payer besides the Plan;
2. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
3. Any policy of insurance from any insurance company or guarantor of a third-party;
4. Worker’s Compensation or other liability insurance company; or
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Vehicle Limitation
When medical payments are available (or, under applicable law should be available) under any vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. If medical payments would have been available under a vehicle insurance policy if minimum legally required levels of coverage had been in effect, but the minimum level of coverage was not in effect, the Plan shall pay excess benefits only, determined as if the minimum legally required level of coverage had been in effect at the applicable time.

Allowable Expenses
“Allowable expenses” shall mean any Medically Necessary, Usual and Customary item of expense, at least a portion of which is covered under this Plan. When some Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered in the amount that would be payable in accordance with the terms of the Plan shall be deemed to be the benefit.

In the case of HMO (Health Maintenance Organization) plans, this Plan will not consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Further, when an HMO is primary and the Covered Person does not use an HMO provider, this Plan will not consider as allowable expenses any charge that would have been covered by the HMO had the Covered Person used the services of an HMO provider.

Other Plan
“Other Plan” means any of the following plans, other than this Plan, providing benefits or services for medical or dental care or treatment:

1. Group, blanket or franchise insurance coverage;
2. Any group Hospital service prepayment, group medical or dental service prepayment, group practice or other group prepayment coverage;
3. Any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, school insurance or employee benefit organization plans;
4. Coverage under Medicare and any other governmental program that the Covered Person is liable for payment, except state-sponsored medical assistance programs and TRICARE, in which case this Plan pays primary;
5. Coverage under any Health Maintenance Organization (HMO); or
Any mandatory automobile insurance (such as no-fault) providing benefits under a medical expense reimbursement provision for health care services because of Injuries arising out of a motor vehicle accident and any other medical and liability benefits received under any automobile policy.

Application to Benefit Determinations
The plan that pays first according to the rules in the section entitled “Order of Benefit Determination” will pay as if there were no other plan involved. When this Plan is secondary, this Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. When there is a conflict in the order of benefit determination, this Plan will never pay more than 50% of allowable expenses.

Order of Benefit Determination
For the purposes of the section entitled “Application to Benefit Determinations,” the rules establishing the order of benefit determination are listed below. The Plan will consider these rules in the order in which they are listed and will apply the first rule that satisfies the circumstances of the claim:

1. A plan without a coordinating provision will always be the primary plan;
2. The plan covering the person directly rather than as an employee’s dependent is primary and the other plans are secondary.
3. Active/laid-off or Retirees: The plan which covers a person as an active employee (or as that employee’s dependent) determines its benefits before the Plan which covers a person as a laid-off or retired employee (or as that employee’s dependent). If the Plan which covers that person has not adopted this rule and if, as a result, the Plans do not agree on the order of benefits, this rule will not apply.
4. Dependent children of parents not separated or divorced or unmarried parents living together: The plan covering the parent whose birthday falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If parents share the same birthday, the plan that covered one parent the longest is primary. However, if the other plan does not have this rule but instead has a rule based upon the gender of the parent and if as a result the plans do not agree on the order of benefits, the rule in the other plan will determine the order of benefits.
5. Dependent children of separated or divorced parents or unmarried parents not living together: When parents are separated or divorced or unmarried and not living together, neither the male/female nor the birthday rules apply. Instead:
   a. The plan of the parent with custody pays first;
   b. The plan of the spouse of the parent with custody (the step-parent) pays next;
   c. The plan of the parent without custody pays next; and
   d. The plan of the spouse of the non-custodial parent pays last.

Notwithstanding the above provisions, if there is a court decree that would otherwise establish financial responsibility for the child’s health care expenses, the benefits of the plan that covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan that covers the child as a dependent child.

6. If a person whose coverage is provided under a right of continuation pursuant to state or federal law (e.g., COBRA) is also covered under another plan, the plan covering the person as an employee, member, subscriber or retiree (or as that person’s dependent) is primary and the continuation coverage is secondary. If the other plan does not have this rule and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

When the rules above do not establish an order of benefit determination, the benefits of a plan which has covered the person on whose expenses claim is based for the longer period of time shall be determined before the benefits of a plan which has covered such person the shorter period of time.
**Right to Receive and Release Necessary Information**

For the purpose of determining the applicability of and implementing the terms of this coordination of benefits provision or any provision of similar purpose of any other plan, this Plan may, without notice to any person, release to or obtain from any insurance company or other organization or individual, any information with respect to any person, which the Plan deems to be necessary for such purposes. Any person claiming benefits under this Plan is deemed to consent to the release and receipt of such information and agrees to furnish to the Plan such information as may be necessary to implement this provision.

**Facility of Payment**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

**Right of Recovery**

Whenever payments have been made by this Plan with respect to allowable expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan shall have the right to recover such payments, to the extent of such excess, in accordance with the Recovery of Payments provision of this Plan.

**Recovery of Payments**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan’s terms, conditions, limitations or exclusions or should otherwise not have been paid by the Plan. This Plan may also inadvertently pay benefits that are later found to be greater than the maximum allowable charge. In this case, this Plan may recover the amount of the overpayment from the person or entity to which it was paid, primary payers or from the party on whose behalf the charge(s) were paid. Whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment.

A Covered Person, provider, another benefit plan, insurer or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have discretion in deciding whether to obtain payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Covered Person or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Covered Person and to deny or reduce future benefits payable (including payment of future benefits for any other Injury or Illness) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for any other Injury or Illness) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agree to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State’s health care practice acts, most recent edition of the ICD or CPT standards, Medicare guidelines, HCPCS standards or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Covered Person, provider or other person or entity to enforce the provisions of this section, then that Covered Person, provider or other person or entity agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.
Further, a Covered Person and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns ("Plan Participants") shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), provider error(s) or damages arising from another party’s act or omission for which the Plan has not already been reimbursed.

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

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

The deduction may be made against any claim for benefits under this Plan by a Covered Person if such payment is made with respect to the Covered Person.

If the Plan seeks to recoup funds from a provider, due to a claim being made in error, a claim being fraudulent on the part of the provider and/or the claim that is the result of the provider’s misstatement, said provider shall, as part of its assignment to benefits from the Plan, abstain from billing the Covered Person for any outstanding amount(s).

**Medicaid Coverage**

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

**Coordination of Benefits with Medicaid**

In all cases, benefits available through a state or federal Medicaid program will be secondary or subsequent to the benefits of this Plan.

**Coordination of Benefits with Medicare**

When Medicare is the primary payor, the Plan will base its payment upon benefits allowable by Medicare. If you did not elect coverage under Medicare Parts A and/or B when eligible, the Plan will be secondary and coordinate with benefits that would have been provided by Medicare.

When you, your Spouse or Dependents (as applicable) are eligible for or entitled to Medicare and covered by the Plan, the Plan at all times will be operated in accordance with any applicable Medicare secondary payer and non-discrimination rules. These rules include, where applicable, but are not necessarily limited to, rules concerning individuals with end stage renal disease, rules concerning active employees age 65 or over and rules concerning working disabled individuals (as discussed below).

When Medicare is the primary payor, the Plan will pay secondary to the extent the benefit is a Covered Expense under the Plan (meaning that the Plan will base its payment upon benefits allowable by Medicare).
In accordance with federal law, the following rules apply in determining whether Medicare or Plan coverage is primary health care coverage:

1) The Working Aged Rule: Medicare benefits are secondary to benefits payable under the Plan for individuals entitled to Medicare due to being age 65 or over and who have Plan coverage as a result of his or her current employment status (or the current employment status of a Spouse). When you or your Spouse become eligible for Medicare due to the attainment of age 65, you or your Spouse may still be eligible for benefits provided under the Plan based on your current employment status.

If, as a result, you have or your Spouse has primary coverage under the Plan, the Plan will pay the portion of your incurred expenses that are normally covered by the Plan. All or part of the remaining amount, if any, may be paid by Medicare if the expenses are covered expenses under Medicare and the portion of the expenses covered by Medicare exceeds the portion covered by the Plan. If the expenses are not covered by the Plan but are Medicare-covered expenses, then Medicare will process its payment of the expenses as if you do not have Plan coverage.

2) The Working Disabled Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals under age 65 entitled to Medicare on the basis of disability (other than end-stage renal disease) and who are covered under the Plan as a result of current employment status with an employer. That is, if you or your dependents are covered by the Plan based on your current employment status, Medicare benefits are secondary for you or your covered Dependents entitled to Medicare on the basis of disability (other than end-stage renal disease). In this case the Plan is primary.

3) End-Stage Renal Disease Rule: Medicare benefits are secondary to benefits payable under the Plan for covered individuals eligible for or entitled to Medicare benefits on the basis of end-stage renal disease ("ESRD"), for a period not to exceed 30 months generally beginning the first day of the month of eligibility or entitlement to Medicare due to ESRD. (Special rules apply if you were entitled to Medicare based on age or disability prior to becoming eligible for Medicare due to ESRD.) Because an ESRD patient can have up to a three-month wait to obtain Medicare coverage, the Plan's primary payment responsibility may vary up to three months. If the basis of your entitlement to Medicare changes from ESRD to age or disability, the Plan's primary payment responsibility may terminate on the month before the month in which the change is effective and the rules set forth above, if applicable, will apply. Your Employer can provide you with more detailed information on how this rule works.

Medicare and COBRA
For most COBRA beneficiaries (e.g., the working aged or disabled Medicare beneficiaries), Medicare rules state that Medicare will be primary to COBRA continuation coverage and this would apply to this Plan's Continuation of Benefits (COBRA) coverage. For an ESRD-related Medicare beneficiary, COBRA continuation coverage (if elected) is generally primary to Medicare during the 30-month coordination period.

Coordination of Benefits with TRICARE
The Plan at all times will be operated in accordance with any applicable TRICARE secondary payer and non-discrimination rules issued by the Department of Defense.
SUBROGATION, THIRD-PARTY RECOVERY AND REIMBURSEMENT

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by or results from the acts or omissions of you and/or your Dependents, plan beneficiaries and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative or assigns (collectively referred to hereinafter in this section as “Covered Person”) or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist and medical payment provisions (collectively “coverage”).

2. The Covered Person, his or her attorney and/or Legal Guardian of a minor or incapacitated individual agrees that acceptance of the Plan’s conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan’s conditional payment of benefits or the full extent of payment from anyone or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan’s assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan’s name as a co-payee on any and all settlement drafts.

3. In the event a Covered Person settles, recovers or is reimbursed by any coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan’s attempt to recover such money.

4. If there is more than one party responsible for charges paid by the Plan or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an “identifiable” fund from which the Plan may elect to seek reimbursement, at its discretion.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan’s discretion.

2. If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any coverage and/or party causing the Illness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person, commence a proceeding or pursue a claim against any party or coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

4. If the Covered Person fails to file a claim or pursue damages against:
   
   (a) The responsible party, its insurer or any other source on behalf of that party;
   
   (b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
   
   (c) Any policy of insurance from any insurance company or guarantor of a third party;
   
   (d) Workers’ Compensation or other liability insurance company; or,
   
   (e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.
The Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Persons and/or the Plan’s name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement
(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys’ fees and costs or application of the common fund doctrine, make whole doctrine or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan’s equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability or other expenses. If the Covered Persons’ recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

(2) No court costs, experts’ fees, attorneys’ fees, filing fees or other costs or expenses of litigation may be deducted from the Plan’s recovery without the prior, expressed written consent of the Plan.

(3) The Plan’s right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan’s recovery will not be applicable to the Plan and will not reduce the Plan’s reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness, injury, disease or disability.

Excess Insurance
If at the time of Injury, Illness, disease or disability, there is available or potentially available any coverage (including but not limited to coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of coverage, except as provided for under the Plan’s “Coordination of Benefits” section. The Plan’s benefits shall be excess to:

(1) The responsible party, its insurer or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Workers’ Compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments and school insurance coverage.

Separation of Funds
Benefits paid by the Plan, funds recovered by the Covered Person and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person or filing of bankruptcy by the Covered Person, will not affect the Plan’s equitable lien, the funds over which the Plan has a lien or the Plan’s right to subrogation and reimbursement.

Wrongful Death
In the event that the Covered Person dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any coverage, the Plan’s subrogation and reimbursement rights shall still apply.
Obligations

(1) It is the Covered Person’s obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan or any representatives of the Plan, in protecting its rights, including discovery, attending depositions and/or cooperating in trial to preserve the Plan’s rights;

(b) To provide the Plan with pertinent information regarding the Illness, disease, disability or Injury, including Accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan’s rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and

(f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Plan beneficiary may have against any responsible party or coverage.

(2) If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan’s attempt to recover such money from the Covered Person.

(3) The Plan’s rights to reimbursement and/or subrogation are in no way dependent upon the Covered Persons’ cooperation or adherence to these terms.

Offset

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan’s discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

Minor Status

(1) In the event the Covered Person is a minor as that term is defined by applicable law, the minor’s parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor’s parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor’s parents or court-appointed guardian.

Language Interpretation

The Plan Sponsor retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision and to administer the Plan’s subrogation and reimbursement rights. The Plan Sponsor may amend the Plan at any time without notice.

Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

Notwithstanding anything contained herein to the contrary, to the extent this Plan is not governed by ERISA, the Plan’s right to subrogation and reimbursement may be subject to applicable State subrogation laws.
DEFINITIONS

In this section you will find the definitions for the capitalized words found throughout this Plan. There may be additional words or terms that have a meaning that pertains to a specific section and those definitions will be found in that section provided, however, that any such capitalized word shall have such meaning when used in any other section. These definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan. Please refer to the appropriate sections of this Plan for that information.

**Accident** means a non-occupational sudden and unforeseen event, definite as to time and place or a deliberate act resulting in unforeseen consequences.

**Administrative Period** means the optional period, during which an Employer can determine which Employees are Full-Time Employees, notify and enroll eligible Employees in coverage, etc. (similar to an open enrollment period). This period cannot be longer than 90 days and cannot be used to reduce or lengthen the Measurement or Stability Periods. The Administrative Period includes all periods, other than the Initial Measurement Period, between the day he or she completes at least one Hour of Service with the Employer of a New Employee who is a Part-Time or Variable Hour Employee and the first day of the Employee’s Initial Stability Period.

**Ambulatory Surgical Center** means a free-standing surgical center, which is not part of a Hospital and which: (1) has an organized medical staff of Physicians; (2) has permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures; (3) has continuous Physician’s services and registered graduate nursing (R.N.) services whenever a patient is in the facility; (4) is licensed by the jurisdiction in which it is located; and (5) does not provide for overnight accommodations.

**Assistant Surgeon** means a Physician who actively assists the Physician in charge of a case in performing a Surgical Procedure. Depending on the type of Surgery to be performed, an operating surgeon may have one or 2 Assistant Surgeons. The technical aspects of the Surgery involved dictate the need for an Assistant Surgeon.

**Birthing Center** means a place licensed as such by an agency of the state. If the state does not have any licensing requirements, it must meet all of the following tests: (1) is primarily engaged in providing birthing services for low risk pregnancies; (2) is operated under the supervision of a Physician; (3) has at least one registered nurse (R.N.) certified as a nurse midwife in attendance at all times; (4) has a written agreement with a licensed ambulance for that service to provide immediate transportation of the Covered Person to a Hospital as defined herein if an emergency arises; and (5) has a written agreement with a Hospital located in the immediate geographical area of the Birthing Center to provide emergency admission of the Covered Person.

**Calendar Year** means January 1 – December 31.

**Close Relative** means a Covered Person's spouse, parent (including step-parents), sibling, child, grandparent or in-law.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as may be amended from time to time.

**Coinsurance** has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

**Concurrent Review** means the Medical Management Program Administrator will review all Inpatient admissions for a patient’s length of stay. The review is based on clinical information received by the Medical Management Program Administrator from the provider or facility.

**Congenital Anomaly** means a physical developmental defect that is present at birth.

**Copay** has the same meaning as set forth in the section of this Plan entitled “General Overview of the Plan”.

**Cosmetic** means any procedure which is primarily directed at improving an individual's appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease.
Covered Expense means:

(1) An item or service listed in the Plan as an eligible medical expense for which the Plan provides coverage.

(2) For prescription drug expenses, any prescription drugs or medicines eligible for coverage under the Prescription Drug Card Program.

Covered Person means, individually, a covered Employee and each of his or her Dependents who are covered under the Plan.

Custodial Care means care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dentist means an individual who is duly licensed to practice dentistry or to perform oral Surgery in the state where the service is performed and is operating within the scope of such license. A Physician will be considered a Dentist when performing any covered dental services allowed within such license.

Dependent is a Covered Person, other than the Employee, who is covered by the Plan pursuant to the terms and conditions set forth in the "Eligibility and Participation" section of the Plan.

Durable Medical Equipment means equipment that:

(1) Can withstand repeated use;

(2) Is primarily and customarily used to serve a medical purpose;

(3) Generally is not useful to a person in the absence of an Illness or Injury; and

(4) Is appropriate for use in the home.

Emergency Medical Condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

(1) Placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(2) Serious impairment to bodily functions; or

(3) Serious dysfunction of any bodily organ or part.

Emergency Services means, with respect to an Emergency Medical Condition:

(1) A medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a Hospital, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition; and

(2) Such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the Hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd(e)(3)) to Stabilize the individual.

Employee is defined in the "Eligibility and Participation" section of the Plan.

Employer means the IASIS Healthcare, LLC or any successor thereto.

ERISA means the Employee Retirement Income Security Act of 1974, as may be amended from time to time.
Experimental and/or Investigational means services, supplies, care and treatment which do not constitute accepted and appropriate medical practice considering the facts and circumstances of the case and by the generally accepted standards of a reasonably substantial, qualified, responsible, relevant segment of the appropriate medical community or government oversight agencies at the time services were rendered, as determined by the Plan Administrator as set forth below.

The Plan Administrator must make an independent evaluation of the Experimental or non-Experimental standings of specific technologies. The Plan Administrator shall be guided by a reasonable interpretation of Plan provisions. The decisions shall be made in good faith and rendered following a detailed factual background investigation of the claim and the proposed treatment. The decision of the Plan Administrator will be final and binding on the Plan. In addition to the above, the Plan Administrator will be guided by the following principles to determine whether a proposed treatment is deemed to be Experimental and/or Investigational:

(1) If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA) and approval for marketing has not been given at the time the drug or device is furnished, then it is deemed to be Experimental and/or Investigational; or

(2) If the drug, device, medical treatment or procedure or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function or if federal law requires such review or approval, then it is deemed to be Experimental and/or Investigational; or

(3) If Reliable Evidence shows that the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials or is the subject of the research, Experimental, study, Investigational or other arm of on-going Phase III clinical trials or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational; or

(4) If Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, then it is deemed to be Experimental and/or Investigational.

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

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

Expenses for drugs, devices, services, medical treatments or procedures related to an Experimental and/or Investigational treatment (related services) and complications from an Experimental and/or Investigational treatment and their related services are excluded from coverage, even if such complications and related services would be covered in the absence of the Experimental and/or Investigational treatment.

Final determination of Experimental and/or Investigational, Medical Necessity and/or whether a proposed drug, device, medical treatment or procedure is covered under the Plan will be made by and in the sole discretion of the Plan Administrator.

FMLA means the Family and Medical Leave Act of 1993, as may be amended from time to time.

Foster Child is defined in the "Eligibility and Participation" section of the Plan.

Full-Time Employee means for a New Employee, an Employee who upon hiring is reasonably expected to work, on average, at least 30 Hours of Service per week and who is not a Seasonal Employee. A Full-Time Employee (and his or her eligible Dependents) must be offered coverage no later than 90 days from the day he or she completes at least one Hour of Service with the Employer (or at the end of the waiting period). For an Ongoing Employee, it is defined to mean an Employee who has been determined during the Measurement Period to average at least 30 Hours of Service per week.
Genetic Information means information about genes, gene products and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories and direct analysis of genes or chromosomes. Genetic Information will not be taken into account for purposes of (1) determining eligibility for benefits under the Plan (including initial enrollment and continued eligibility); and (2) establishing contribution or premium accounts for coverage under the Plan.

HIPAA means the Health Insurance Portability and Accountability Act of 1996 (HIPAA), as may be amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all of the following conditions, it: (1) is duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services; (2) qualifies as a Home Health Care Agency under Medicare; (3) meets the standards of the area-wide healthcare planning agency; (4) provides skilled nursing services and other services on a visiting basis in the patient's home; (5) is responsible for administering a home health care program; and (6) supervises the delivery of a home health care program where the services are prescribed and approved in writing by the patient's attending Physician.

Hospice means an agency that provides counseling and incidental medical services and may provide room and board to terminally ill individuals and which meets all of the following requirements: (1) has obtained any required state or governmental Certificate of Need approval; (2) provides 24-hour-a-day, seven days-a-week service; (3) is under the direct supervision of a duly qualified Physician; (4) has a nurse coordinator who is a registered nurse (R.N.) with four years of full-time clinical experience, at least two of which involved caring for terminally ill patients; (5) has a social-service coordinator who is licensed in the jurisdiction in which it is located; (6) is an agency that has as its primary purpose the provision of hospice services; (7) has a full-time administrator; (8) maintains written records of services provided to the patient; (9) the employees are bonded and it provides malpractice and malplacement insurance; (10) is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having responsibility for licensing under the law; (11) provides nursing care by a registered nurse (R.N.), a licensed practical nurse (L.P.N.), a licensed physical therapist, certified occupational therapist, American Speech Language and Hearing Association certified speech therapist or a certified respiratory therapist; and (12) provides a home health aide acting under the direct supervision of one of the above persons while performing services specifically ordered by a Physician.

Hospital means a facility which: (1) is licensed as a Hospital where licensing is required; (2) is open at all times; (3) is operated mainly to diagnose and treat Illnesses or Injuries on an Inpatient basis; (4) has a staff of one or more Physicians on call at all times; (5) has 24-hour-a-day nursing services by registered nurses (R.N.'s); and (6) has organized facilities for major Surgery.

However, an institution specializing in the care and treatment of Mental Disorders or Substance Use Disorders which would qualify as a Hospital, except that it lacks organized facilities on its premises for major Surgery, shall be deemed a Hospital.

In no event shall "Hospital" include an institution which is primarily a rest home, a nursing home, a clinic, a Skilled Nursing Facility, a convalescent home or a similar institution.

Hour(s) of Service means each hour for which an Employee is paid, or entitled to payment, for the performance of duties for the Employer (or a related Employer) and each hour for which an Employee is paid, or entitled to payment by the Employer (or a related Employer) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence, but excluding Hours of Service to the extent that the compensation for those services constitutes income from sources outside the United States or performed as (1) a bona fide volunteer (as defined in Treas. Reg. Section 54.4980H-1(a)(7)) or (2) part of a Federal or State work study program. For purposes of this definition, a related Employer is any entity that must be treated as part of the same “applicable large employer” as the Employer for purposes of Code Section 4980H, as determined at the time that the applicable Hour of Service is performed or credited.
For Employees paid on an hourly basis, an Employer must calculate actual Hours of Service from records of hours worked and hours for which payment is made or due (the “actual method”). For Employees paid on a non-hourly basis, the Employer must calculate Hours of Service based on the actual method or, provided doing so does not substantially understate the Employee’s hours, using an equivalency method where the Employee is credited with either (1) 8 Hours of Service for each day for which the Employee would be required to be credited with one Hour of Service or (2) 40 Hours of Service for each week for which the Employee would be required to be credited with at least one Hour of Service.

**Illness** means a non-occupational bodily disorder, disease, physical sickness, Pregnancy (including childbirth and miscarriage), Mental Disorder or Substance Use Disorder.

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

**Initial Measurement Period** means the “look back period” during which an Employer measures the Hours of Service for its New Employees in order to determine their status as a Full-Time Employee or Part-Time Employee which may begin on the day the New Employee completes at least one Hour of Service with the Employer or any date up to and including the first day of the first calendar month (or, if later, the first day of the first payroll period) starting on or after the date the Employee completes at least one Hour of Service for the Employer. For purposes of this definition, an Employee who has been rehired by the Employer is treated as a New Employee for the Employer on his or her most recent reemployment date only if more than 13 consecutive weeks have passed since the Employee was last credited with an Hour of Service with the Employer (or with any affiliated company organization that is required to be treated as the same Employer for purposes of Code Section 4980H).

**Initial Stability Period** means the Stability Period New Employees must satisfy if a New Employee who is a Part-Time or Variable Hour Employee is determined to average less than 30 Hours of Service per week during his or her Initial Measurement Period. The Initial Stability Period must not be more than one month longer than the Initial Measurement Period and must not exceed the remainder of the first entire Standard Measurement Period (plus Administrative Period) for which the Employee has been employed. If a New Employee who is a Part-Time or Variable Hour Employee is determined to average at least 30 Hours of Service per week during the Initial Measurement Period, the Initial Stability Period must be a period of at least 6 consecutive calendar months and no shorter in duration than the Initial Measurement Period.

**Injury** means physical damage to the body, caused by an external force and which is due directly and independently of all other causes, to an Accident.

**Inpatient** means any person who, while confined to a Hospital, is assigned to a bed in any department of the Hospital other than its outpatient department and for whom a charge for room and board is made by the Hospital.

**Intensive Care Unit** means a separate, clearly designated service area, which is maintained within a Hospital solely for the care and treatment of patients who are critically ill. This also includes what is referred to as a “coronary care unit” or an “acute care unit.” It has: (1) facilities for special nursing care not available in regular rooms and wards of the Hospital; (2) special life saving equipment which is immediately available at all times; (3) at least 2 beds for the accommodation of the critically ill; and (4) at least one registered nurse (R.N.) in continuous and constant attendance twenty-four (24) hours a day.

**Late Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period. A Special Enrollee is not considered a Late Enrollee.

**Leave of Absence** means a Leave of Absence of an Employee that has been approved by the Employer, as provided for in the Employer’s rules, policies, procedures and practices.

**Legal Guardian** is defined in the "Eligibility and Participation" section of the Plan.
**Lifetime Maximum** means the maximum benefit payable during an individual's lifetime while covered under this Plan. Benefits are available only when an individual is eligible for coverage under this Plan. The Plan may provide for a Lifetime Maximum benefit for specific types of medical treatment. Any Lifetime Maximum will be shown in the applicable Schedule of Benefits or the applicable covered expenses section of the Plan.

**Long-Term Acute Care Facility/Hospital** (LTACH) means a facility that provides specialized acute care for medically complex patients who are critically ill; have multi-system complications and/or failures and require hospitalization in a facility offering specialized treatment programs and aggressive clinical and therapeutic intervention on a 24-hour-a-day, seven days a week basis. The severity of the LTACH patient's condition requires a Hospital stay that provides: (1) interactive Physician direction with daily on-site assessment; (2) significant ancillary services as dictated by complex, acute medical needs - such as full service and laboratory, radiology, respiratory care services, etc.; (3) a patient-centered outcome-focused, interdisciplinary approach requiring a Physician-directed professional team that includes intensive case management to move the patient efficiently through the continuum of care; (4) clinically competent care providers with advanced assessment and intervention skills; and (5) education for the patient and family to manage their present and future healthcare needs.

**Maintenance Therapy** means medical and non-medical health-related services that do not seek to cure or that are provided during periods when the medical condition of the patient is not changing or does not require continued administration by medical personnel.

**Measurement Period** means the “look back period” during which an Employer measures the Hours of Service for its Employees in order to determine their status as a Full-Time Employee or Part-Time Employee. This period can be between 3 and 12 consecutive calendar months.

For purposes of computing average Hours of Service for an Employee during any Measurement Period, any portion of that Measurement Period that qualifies as “special unpaid leave” will be disregarded. For purposes of this definition, “special unpaid leave” means unpaid leave for jury duty, unpaid leave that is subject to the Family and Medical Leave Act of 1993, or unpaid leave that is subject to the Uniformed Services Employment and Reemployment Rights Act of 1994.

For Employees paid on a biweekly, the determination of Hours of Service credited for a Measurement Period begins with the first day of the pay period that follows the first day of the Measurement Period and ends with the last day of the last pay period ending on or before the last day of the Measurement Period.

**Medically Necessary/Medical Necessity** means treatment is generally accepted by medical professionals in the United States as proven, effective and appropriate for the condition based on recognized standards of the health care specialty involved.

1. "Proven" means the care is not considered Experimental and/or Investigational, meets a particular standard of care accepted by the medical community and is approved by the Food and Drug Administration (FDA) for general use.

2. “Effective” means the treatments beneficial effects can be expected to outweigh any harmful effects. Effective care is treatment proven to have a positive effect on your health, while addressing particular problems caused by disease, Injury, Illness or a clinical condition.

3. "Appropriate" means the treatment's timing and setting are proper and cost effective.

Medical treatments which are not proven, effective and appropriate are not covered by the Plan.

All criteria must be satisfied. When a Physician recommends or approves certain care it does not mean that care is Medically Necessary.

**Medicare** means the program of health care for the aged established by Title XVIII of the Social Security Act of 1965, as amended.

**Mental Disorder** means any disease or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.
Morbid Obesity is defined as (1) a body mass index (BMI) of 40 or greater or (2) a BMI of 35 or greater in conjunction with a severe co-morbidity, such as obesity hypoventilation, sleep apnea, diabetes, hypertension, cardiomyopathy or musculoskeletal dysfunction.

New Employee means any Employee who has yet to be employed for a full Standard Measurement Period or who resumed employment with the Employer (or a related entity that would be considered the same Employer for purposes of Code Section 4980H) after at least 13 consecutive weeks during which the Employee was not credited with an Hour of Service for the Employer (or a related entity).

Non-Participating Provider means a health care practitioner or health care facility that has not contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Ongoing Employee is a current Employee who has worked at least one Standard Measurement Period, as defined by this Plan.

Part-Time Employee means for any New Employee, an Employee who the Employer reasonably expects to work, on average, less than 30 Hours of Service per week during the Initial Measurement Period. For an Ongoing Employee, an Employee who has been determined during the Standard Measurement Period to average less than 30 Hours of Service per week.

Participating Provider means a health care practitioner or health care facility that has contracted directly with the Plan or an entity contracting on behalf of the Plan to provide health care services to Plan enrollees.

Physician means a legally licensed Physician who is acting within the scope of their license and any other licensed practitioner required to be recognized for benefit payment purposes under the laws of the state in which they practice and who is acting within the scope of their license. The definition of Physician includes, but is not limited to: Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Chiropractor, Licensed Consulting Psychologist, Licensed Psychologist, Licensed Clinical Social Worker, Occupational Therapist, Optometrist, Ophthalmologist, Physical Therapist, Podiatrist, Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.), Speech Therapist, Speech Pathologist and Licensed Midwife. An employee of a Physician who provides services under the direction and supervision of such Physician will also be deemed to be an eligible provider under the Plan.

Plan means the IASIS Healthcare, LLC Welfare Benefit Plan.

Plan Administrator means the Plan Sponsor. The Plan Sponsor may delegate fiduciary and other responsibilities to the Plan Administrator. The Plan Administrator will handle benefit determinations and appeals in accordance with the stated Plan.

Plan Sponsor means IASIS Healthcare, LLC or any successor thereto.

Plan Year means the period from January 1 - December 31 each year.

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

Primary Care Physician means a licensed Physician practicing in one of the following fields: (1) family practice; (2) general practice; (3) internal medicine; (4) obstetrics and gynecology; or (5) pediatrics.

Qualified Clinical Trial is defined as a Phase I, Phase II, Phase III or Phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life threatening condition and is described in (1), (2) or (3) below:

1. The study or investigation is approved or funded (which may include funding though in-kind contributions) by one or more of the following:
   (a) The National Institutes of Health;
   (b) The Centers for Disease Control and Prevention;
(c) The Agency for Health Care Research and Quality;

(d) The Centers for Medicare & Medicaid Services;

(e) A cooperative group or center of one of the entities described in (a) through (d) above;

(f) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants; or

(g) The Department of Veteran Affairs; the Department of Defense or the Department of Energy, if (i) the study or investigation has been reviewed and approved through a system of peer review that the Secretary determines to be comparable to the system of peer review of studies and investigations used by the National Institutes of Health; and (ii) assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review.

(2) The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration.

(3) The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

Reconstructive Surgery means Surgery that is incidental to an Injury, Illness or Congenital Anomaly when the primary purpose is to improve physiological functioning of the involved part of the body. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify such Surgery as Cosmetic when a physical impairment exists and the Surgery restores or improves function. Additionally, the fact that a Covered Person may suffer psychological consequences or socially avoidant behavior as a result of an Injury, Illness or Congenital Anomaly does not classify Surgery to relieve such consequences or behavior as Reconstructive Surgery.

Rehabilitation Facility means a facility must meet all of the following requirements: (1) must be for the treatment of acute Injury or Illness; (2) is licensed as an acute Rehabilitation Facility; (3) the care is under the direct supervision of a Physician; (4) services are Medically Necessary; (5) services are specific to an active written treatment plan; (6) the patient's condition requires skilled nursing care and interventions which cannot be achieved or managed at a lower level of care; (7) twenty-four (24) hour nursing services are available; and (8) the confinement is not for Custodial Care or maintenance care.

Seasonal Employee is an Employee who is hired into a position that recurs annually at about the same time each year for which the customary annual employment is 6 months or less.

Security Standards mean the final rule implementing HIPAA's Security Standards for the Protection of Electronic PHI, as amended.

Semi-Private Room means a Hospital room shared by two or more patients.

Skilled Nursing Facility is a facility that meets all of the following requirements:

(1) It is licensed to provide professional nursing services on an inpatient basis to persons convalescing from Injury or Illness. The service must be rendered by a registered nurse (R.N.) or by a licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.

(2) Its services are provided for compensation and under the full-time supervision of a Physician.

(3) It provides 24 hour per day nursing services by licensed nurses, under the direction of a full-time registered nurse.

(4) It maintains a complete medical record on each patient.

(5) It has an effective utilization review plan.
(6) It is not, other than incidentally, a place for rest, the aged, drug addicts, alcoholics, developmentally disabled, Custodial or educational care or care of Mental Disorders.

(7) It is approved and licensed by Medicare.

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

**Special Enrollee** is an eligible Employee or eligible Dependent that does not elect coverage under this Plan during their original 30-day eligibility period and who later enrolls in the Plan due to a Special Enrollment Event.

**Specialist** means a licensed Physician that provides services to a Covered Person within the range of their specialty (e.g. cardiologist, neurologist, etc.).

**Spouse** is defined in the "Eligibility and Participation" section of the Plan.

**Stability Period** means the period during which Employees are considered Full-Time Employees or Part-Time Employees based on the Employee’s Hours of Service during the Measurement Period, regardless of how many hours the individual works during the Stability Period.

Stabilize means, with respect to an Emergency Medical Condition, to provide such medical treatment for the condition as may be necessary to assure, within reasonable medical probability that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility; or with respect to an Emergency Medical Condition of a pregnant woman who is having contractions and (1) there is inadequate time to effect a safe transfer to another Hospital before delivery or (2) transfer may pose a threat to the health or safety of the woman or her unborn child to deliver (including the placenta).

**Standard Measurement Period** means the "look back period" during which an Employer measures the Hours of Service for its Ongoing Employees in order to determine their status as a Full-Time Employee or Part-Time Employee.

**Standard Stability Period** for Ongoing Employees, must be at least 6 consecutive calendar months long, and must not be shorter than the Employer’s elected Standard Measurement Period. (For example, if the Employer chose a 12 month Standard Measurement Period, the Standard Stability Period would also have to be 12 months.)

**Substance Use Disorder** means any disease or condition that is classified as a Substance Use Disorder in the current edition of the International Classification of Diseases published by the U.S. Department of Health and Human Services.

**Surgery** or **Surgical Procedure** means any of the following:

(1) The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound;

(2) The manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction;

(3) The removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body;

(4) The induction of artificial pneumothorax and the injection of sclerosing solutions;

(5) Arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa;

(6) Obstetrical delivery and dilation and curettage; or

(7) Biopsy.

**Third Party Administrator** means Meritain Health, Inc., P.O. Box 27267, Minneapolis, MN 55427-0267.
**Urgent Care Facility** means a facility which is engaged primarily in providing minor emergency and episodic medical care to a Covered Person. A board-certified Physician, a registered nurse and a registered x-ray technician must be in attendance at all times that the facility is open. The facility must include x-ray and laboratory equipment and a life support system. For the purpose of this Plan, a facility meeting these requirements will be considered to be an Urgent Care Facility, by whatever actual name it may be called; however, an after-hours clinic shall be excluded from the terms of this definition.

**USERRA** means the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as may be amended from time to time.

**Usual and Customary Charge (U&C)** means, with respect to Non-Participating Providers, charges made for medical or dental services or supplies essential to the care of the individual will be subject to a Usual and Customary determination. Usual and Customary allowances are based on what is usually and customarily accepted as payment for the same service within a geographical area. In determining whether charges are Usual and Customary, consideration will be given to the nature and severity of the condition and any medical or dental complications or unusual circumstances which require additional time, skill or experience. Limitations for Usual and Customary Charges are not applicable to Participating Providers.

**Variable Hour Employee** is an Employee who, at the time of hire, the Employer cannot reasonably determine if he or she will average at least 30 Hours of Service per week.
PLAN ADMINISTRATION

Delegation of Responsibility
The Plan Sponsor is a named fiduciary of the Plan with full discretionary authority for the control and management of the operation and administration of the Plan. The Plan Sponsor may delegate fiduciary and other responsibilities to any individual or entity. Any person to whom any responsibility is delegated may serve in more than one fiduciary capacity with respect to the Plan and may be a participant in the Plan.

Authority to Make Decisions
The Plan is administered by the Plan Administrator in accordance with ERISA. The Plan Administrator has retained the services of the Third Party Administrator to provide certain claims processing and other ministerial services. An individual or entity may be appointed by the Plan Sponsor to be Plan Administrator and serve at the convenience of the Plan Sponsor. If the Plan Administrator resigns, dies, is otherwise unable to perform, is dissolved or is removed from the position, the Plan Sponsor will appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator will administer this Plan in accordance with its terms and establish its policies, interpretations, practices and procedures. It is the express intent of this Plan that the Plan Administrator will have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits (including the determination of what services, supplies, care and treatments are Experimental and/or Investigational), to decide disputes which may arise relative to you and/or your Dependent’s rights and to decide questions of Plan interpretation and those of fact and law relating to the Plan. The decisions of the Plan Administrator as to the facts related to any claim for benefits and the meaning and intent of any provision of the Plan or its application to any claim, shall receive the maximum deference provided by law and will be final and binding on all interested parties. Benefits under this Plan will be paid only if the Plan Administrator decides, in its discretion, that you and/or your Dependent (as applicable) are entitled to them.

The duties of the Plan Administrator include the following:

1. To administer the Plan in accordance with its terms;
2. To determine all questions of eligibility, status and coverage under the Plan;
3. To interpret the Plan, including the authority to construe possible ambiguities, inconsistencies, omissions and disputed terms;
4. To make factual findings;
5. To decide disputes which may arise relative to a Covered Person’s rights;
6. To prescribe procedures for filing a claim for benefits, to review claim denials and appeals relating to them and to uphold or reverse such denials; or, alternatively, to appoint a qualified administrator to carry out these functions on the Plan Administrator’s behalf;
7. To keep and maintain the Plan documents and all other records pertaining to the Plan;
8. To appoint and supervise a Third Party Administrator to pay claims;
9. To perform all necessary reporting as required by Federal or State law;
10. To establish and communicate procedures to determine whether a child support order or decree is a QMCSO;
11. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate; and
12. To perform each and every function necessary for or related to the Plan’s administration.
Amendment or Termination of Plan
The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part.

The Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate by operation of law, as a result of changes in law which are required to affect provisions in the Plan.

Any such amendment, suspension or termination shall be taken and enacted in accordance with applicable federal and state law and any applicable governing documents.

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

Assignment of Benefits
No benefit under the Plan shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance or charge and any attempt to do so shall be void. No benefit under the Plan shall in any manner be liable for or subject to the debts, contracts, liabilities, engagements or torts of any person.

Notwithstanding the foregoing, the Plan will honor any Qualified Medical Child Support Order ("QMCSO") which provides for coverage under the Plan for an alternate recipient, in the manner described in ERISA Section 609(a) and in the Plan's QMCSO procedures.

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

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

Cost of the Plan
The Plan Sponsor is responsible for funding the Plan and will do so as required by law. To the extent permitted by law, the Plan Sponsor is free to determine the manner and means of funding the Plan, including, but not limited to, payment of Plan expenses from the Employer's general assets. The amount of contribution (if any) for your coverage or coverage for your Dependents will be determined from time to time by the Plan Sponsor, in its sole discretion.

Interpretation of this Document
The use of masculine pronouns in this Plan shall apply to persons of both sexes unless the context clearly indicates otherwise. The headings used in this Plan are used for convenience of reference only. You and your Dependents are advised not to rely on any provision because of the heading.

The use of the words, “you” and “your” throughout this Plan applies to eligible or covered Employees and, where appropriate in context, their covered Dependents.

No Contract of Employment
This Plan and any amendments constitute the terms and provisions of coverage under this Plan. The Plan shall not be deemed to constitute a contract of any type between the Employer and any person or to be consideration for or an inducement or condition of, the employment of any Employee. Nothing in this Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

Release of Information
For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine the acceptability of any applicant or person covered for benefits under this Plan. In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action; however, the Plan Administrator at all times will comply with the applicable privacy standards. Any Covered Person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.
Worker’s Compensation
This Plan excludes coverage for any Injury or Illness that is eligible for coverage under any Workers’ Compensation policy or law regardless of the date of onset of such Injury or Illness. However, if benefits are paid by the Plan and it is later determined that you received or are eligible to receive Workers’ Compensation coverage for the same Injury or Illness, the Plan is entitled to full recovery for the benefits it has paid. This exclusion applies to past and future expenses for the Injury or Illness regardless of the amount or terms of any settlement you receive from Workers’ Compensation. The Plan will exercise its right to recover against you. The Plan reserves its right to exercise its rights under this section and the section entitled “Recovery of Payment” even though:

(1) The Workers’ Compensation benefits are in dispute or are made by means of settlement or compromise;

(2) No final determination is made that the Injury or Illness was sustained in the course of or resulted from your employment;

(3) The amount of Workers’ Compensation benefits due specifically to health care expense is not agreed upon or defined by you or the Workers’ Compensation carrier; or

(4) The health care expense is specifically excluded from the Workers’ Compensation settlement or compromise.

You are required to notify the Plan Administrator immediately when you file a claim for coverage under Workers’ Compensation if a claim for the same Injury or Illness is or has been filed with this Plan. Failure to do so or to reimburse the Plan for any expenses it has paid for which coverage is available through Workers’ Compensation, will be considered a fraudulent claim and you will be subject to any and all remedies available to the Plan for recovery and disciplinary action.

Minimum Essential Coverage
Refer to the Employer’s Summary of Benefits and Coverage (SBC) for determination as to whether the Plan provides “minimum essential coverage” within the meaning of Code Section 5000A(f) and any accompanying regulations or guidance and whether it provides “minimum value” within the meaning of Code Section 36B(2)(c)(ii) and any accompanying regulations or guidance (e.g. the Plan provides at least 60% actuarial value).
STATEMENT OF ERISA RIGHTS

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

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

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

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

Continue Group Health Plan Coverage
Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

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

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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 domestic relations order, a medical child support order or a national medical support notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a Federal court. The court will decide who would pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

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

The following is a description of certain rules that apply to the Plan Sponsor regarding uses and disclosures of your health information.

Disclosure of Summary Health Information to the Plan Sponsor
In accordance with HIPAA’s standards for privacy of individually identifiable health information (the “privacy standards”), the Plan may disclose summary health information to the Plan Sponsor, if the Plan Sponsor requests the summary health information for the purpose of:

(1) Obtaining premium bids from health plans for providing health insurance coverage under this Plan; or

(2) Modifying, amending or terminating the Plan.

“Summary health information” is information, which may include individually identifiable health information, that summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but that excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by 5-digit zip code.

Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes
Except as described under “Disclosure of Summary Health Information to the Plan Sponsor” above or under “Disclosure of Certain Enrollment Information to the Plan Sponsor” below or under the terms of an applicable individual authorization, the Plan may disclose PHI to the Plan Sponsor and may permit the disclosure of PHI by a health insurance issuer or HMO with respect to the Plan to the Plan Sponsor only if the Plan Sponsor requires the PHI to administer the Plan. The Plan Sponsor by formally adopting this Plan document certifies that it agrees to:

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

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

(3) Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

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

(5) Make available PHI in accordance with section 164.524 of the privacy standards;

(6) Make available PHI for amendment and incorporate any amendments to PHI in accordance with section 164.526 of the privacy standards;

(7) Make available the information required to provide an accounting of disclosures in accordance with section 164.528 of the privacy standards;

(8) Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Department of Health and Human Services (“HHS”), for purposes of determining compliance by the Plan with part 164, subpart E, of the privacy standards;

(9) If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible; and
Ensure that adequate separation between the Plan and the Plan Sponsor, as required in section 164.504(f)(2)(iii) of the privacy standards, is established as follows:

(a) The Plan Sponsor shall only allow certain named employees or classes of employees or other persons under control of the Plan Sponsor who have been designated to carry out plan administration functions, access to PHI. The Plan Sponsor will maintain a list of those persons and that list is incorporated into this document by this reference. The access to and use of PHI by any such individuals shall be restricted to plan administration functions that the Plan Sponsor performs for the Plan.

(b) In the event any of the individuals described in (a) above do not comply with the provisions of the Plan documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate and shall be imposed so that they are commensurate with the severity of the violation.

Plan administration activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend or terminate the Plan or solicit bids from prospective issuers. “Plan administration” functions include quality assurance, claims processing, auditing, monitoring and management of carve-out plans, such as vision and dental. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that:

(1) The Plan documents have been amended to incorporate the above provisions; and

(2) The Plan Sponsor agrees to comply with such provisions.

Disclosure of Enrollment Information to the Plan Sponsor
Pursuant to section 164.504(f)(1)(iii) of the privacy standards, the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered under the Plan.

Disclosure of PHI to Obtain Stop-loss or Excess Loss Coverage; Disclosures of Genetic Information
Except as otherwise provided below, the Plan Sponsor hereby authorizes and directs the Plan, through the Plan Administrator or the Third Party Administrator, to disclose PHI to stop-loss carriers, excess loss carriers or managing general underwriters (“MGUs”) for underwriting and other purposes in order to obtain and maintain stop-loss or excess loss coverage related to benefit claims under the Plan. Such disclosures shall be made in accordance with the privacy standards.

The Plan will not use or disclose genetic information, including information about genetic testing and family medical history, for underwriting purposes. The Plan may use or disclose PHI for underwriting purposes, assuming the use or disclosure is otherwise permitted under the privacy standards and other applicable law, but any PHI that is used or disclosed for underwriting purposes will not include genetic information.

“Underwriting purposes” is defined for this purpose under federal law and generally includes any Plan rules relating to (1) eligibility for benefits under the Plan (including changes in deductibles or other cost-sharing requirements in return for activities such as completing a health risk assessment or participating in a wellness program); (2) the computation of premium or contribution amounts under the Plan (including discounts or payments or differences in premiums based on activities such as completing a health risk assessment or participating in a wellness program); and (3) other activities related to the creation, renewal, or replacement of a contract for health insurance or health benefits. However, “underwriting purposes” does not include rules relating to the determination of whether a particular expense or claim is medically appropriate.
HIPAA SECURITY PRACTICES

Disclosure of Electronic Protected Health Information ("Electronic PHI") to the Plan Sponsor for Plan Administration Functions
In accordance with HIPAA’s standards for security (the “security standards”), to enable the Plan Sponsor to receive and use Electronic PHI for Plan administration functions (as defined in 45 CFR § 164.504(a)), the Plan Sponsor agrees to:

(1) Implement and maintain administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains or transmits on behalf of the Plan.

(2) Ensure that adequate separation between the Plan and the Plan Sponsor, as required in 45 CFR § 164.504(f)(2)(iii), is supported by reasonable and appropriate Security Measures.

(3) Ensure that any agent, including any business associate or subcontractor, to whom the Plan Sponsor provides Electronic PHI created, received, maintained or transmitted on behalf of the Plan, agrees to implement reasonable and appropriate Security Measures to protect the Electronic PHI.

(4) Report to the Plan any Security Incident of which it becomes aware.

(5) The Plan Sponsor will promptly report to the Plan any breach of unsecured Protected Health Information of which it becomes aware in a manner that will facilitate the Plan’s compliance with the breach reporting requirements of the HITECH Act, based on regulations or other applicable guidance issued by the Department of Health and Human Services.

Any terms not otherwise defined in this section shall have the meanings set forth in the Security Standards.
GENERAL PLAN INFORMATION

Name of Plan: IASIS Healthcare, LLC Welfare Benefit Plan

Plan Sponsor: IASIS Healthcare, LLC
(Named Fiduciary)
117 Seaboard Lane, Bldg. E
Franklin, TN 37067
615-844-2747

Plan Administrator: IASIS Healthcare, LLC
117 Seaboard Lane, Bldg. E
Franklin, TN 37067
615-844-2747

Plan Sponsor EIN: 20-1150104

Plan Year: January 1 - December 31

Plan Number: 501

Plan Type: Welfare benefit plan providing medical and prescription drug benefits.

Plan Funding: All benefits are paid from the general assets of the Employer.

Contributions: The cost of coverage under the Plan is funded in part by Employer contributions and in part by Employee contributions.

Third Party Administrator: Meritain Health, Inc.
P.O. Box 27267
Minneapolis, MN 55427-0267
(866) 209-2929

COBRA Administrator: Wageworks
P.O. Box 14055
Lexington, KY 40512-4055
877-502-6272

Medical Management Program Administrator: Meritain Health Medical Management
7400 West Campus Road, F-510
New Albany, OH 43054-8725
(888) 578-1799

Prescription Drug Program Card Administrator: Envision/Rx Options, Inc.
2181 East Aurora Road, Suite 201
Twinsburg, OH 44087
(800) 361-4542

Agent for Service of Legal Process: IASIS Healthcare, LLC
117 Seaboard Lane, Bldg. E
Franklin, TN 37067
615-844-2747

The Plan is a legal entity. Legal notice may be filed with and legal process served upon, the Plan Administrator.
Prescription Drugs
Introduction

This Evidence of Health Coverage (this "EOC") is included in the Summary Plan Description document (SPD) created by IASIS Healthcare, LLC as part of its employee welfare benefit plan (the "Plan"), and is subject to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA). References in this EOC to “administrator,” “We,” “Us,” “Our,” or “EnvisionRx” mean Envision Pharmaceutical Services, LLC.

Employer has entered into an Administrative Services Agreement (ASA) with EnvisionRx for it to administer the claims Payments under the terms of the SPD, and to provide other services. EnvisionRx does not assume any financial risk or obligation with respect to Plan claims. EnvisionRx is not the Plan Sponsor, the Plan Administrator or the Plan Fiduciary, as those terms are defined in ERISA. The Employer is the Plan Fiduciary, the Plan Sponsor and the Plan Administrator. Other federal laws may also affect your Coverage. To the extent applicable, the Plan complies with federal requirements.

This EOC provides information about prescription drug and device coverage. Prescription drug and device coverage is provided to Employees who elect to participate in one of the medical programs. A separate election is not made for prescription drug coverage; rather, coverage is integrated with the medical program. This EOC is separated from the medical EOC because different rules may apply and because there is a different claims administrator.

This EOC describes the terms and conditions of your Coverage through the Plan. It replaces and supersedes any EOC or other description of benefits you have previously received from the Plan.

Please read this EOC carefully. It describes the rights and duties of members. It is important to read the entire EOC. Certain items are not covered by the plan. Other covered items are limited. The plan will not pay for any item not specifically listed as a covered item, even if a health care provider recommends or orders that non-covered item.

While the Employer has delegated discretionary authority to make any benefit or eligibility determinations to the administrator, the Employer also has the authority to make any final Plan determination. The Employer, as the Plan Administrator, and EnvisionRx also have the authority to construe the terms of your Coverage. The Plan and EnvisionRx shall be deemed to have properly exercised that authority unless it abuses its discretion when making such determinations, whether or not the Employer’s benefit plan is subject to ERISA.

Any grievance related to your coverage under this EOC shall be resolved in accordance with the "grievance procedure" section of this EOC.

Please contact one of the administrator’s customer service representatives, at the number listed on the Subscriber’s membership ID card, if you have any questions when reading this EOC. The customer service representatives are also available to discuss any other matters related to your Coverage from the Plan.

Benefit Administration Error

If the administrator makes an error in administering the benefits under this EOC, the Plan may provide additional benefits or recover any overpayments from any person, insurance company, or plan. No such error may be used to demand more benefits than those otherwise due under this EOC.
Relationship with Network Providers

Independent Contractors

Network Providers contract with the administrator, which has agreed to pay them for dispensing prescription drugs and devices to you. Network Providers are solely responsible for dispensing prescribed medications and devices as directed by prescribers legally licensed to practice medicine and prescribe drugs and devices. The Employer and the administrator do not make medical treatment decisions under any circumstances.

While the administrator has the authority to make benefit and eligibility determinations and interpret the terms of your Coverage, the Employer, as the Plan Administrator as that term is defined in ERISA, has the discretionary authority to make the final determination regarding the terms of your Coverage (“Coverage Decisions.”) Both the administrator and the Employer make Coverage Decisions based on the terms of this EOC, the Administrative Services Agreement, the administrator’s participation agreements with Network Providers, the administrator’s internal guidelines, policies, procedures, and applicable State or Federal laws.

Termination of Providers’ Participation

The administrator or a Network Provider may end their relationship with each other at any time. The administrator does not promise that any specific Network Provider will be available to fill prescription drugs or devices while you are covered.

Provider Directory

You may check to see if a Provider is in your Plan’s Network by going online to www.EnvisionRx.com.

Subrogation and Right of Reimbursement

Subrogation Rights

The Plan assumes and is subrogated to your legal rights to recover any payments the Plan makes for Covered Prescription Drugs or Devices, when your illness or injury resulted from the action or fault of a third party. The Plan’s subrogation rights include the right to recover the reasonable value of prepaid Prescription Drugs or Devices rendered by Network Providers.

The Plan has the right to recover any and all amounts equal to the Plan’s payments from:

- the insurance of the injured party;
- the person, company (or combination thereof) that caused the illness or injury, or their insurance company; or
- any other source, including uninsured motorist coverage, medical payment coverage, or similar medical reimbursement policies.

This right of recovery under this provision will apply whether recovery was obtained by suit, settlement, mediation, arbitration, or otherwise. The Plan’s recovery will not be reduced by your negligence, nor by attorney fees and costs you incur.

Priority Right of Reimbursement

Separate and apart from the Plan’s right of subrogation, the Plan shall have first lien and right to reimbursement. The Plan’s first lien supersedes any right that you may have to be “made whole.” In other words, the Plan is entitled to the right of first reimbursement out of any recovery you might procure regardless of whether you have received compensation for any of your damages or expenses, including your attorney’s fees or costs. This priority right of reimbursement supersedes your right to be made whole from any recovery, whether full or partial. In addition, you agree to do nothing to prejudice or oppose the Plan’s right to subrogation and reimbursement and
you acknowledge that the Plan precludes operation of the “made-whole”, “attorney fund”, and “common fund” doctrines. You agree to reimburse the Plan 100% first for any and all benefits provided through the Plan, and for any costs of recovering such amounts from those third parties from any and all amounts recovered through:

- Any settlement, mediation, arbitration, judgment, suit, or otherwise, or settlement from your own insurance and/or from the third party (or their insurance);
- Any auto or recreational vehicle insurance coverage or benefits including, but not limited to, uninsured motorist coverage;
- Business and homeowner medical liability insurance coverage or payments.

The Plan may notify those parties of its lien and right to reimbursement without notice to or consent from those Members.

This priority right of reimbursement applies regardless of whether such payments are designated as payment for (but not limited to) pain and suffering, medical benefits, and/or other specified damages. It also applies regardless of whether the Member is a minor.

This priority right of reimbursement will not be reduced by attorney fees and costs you incur.

The Plan may enforce its rights of subrogation and recovery against, without limitation, any tortfeasors, and other responsible third parties or against available insurance coverages, including underinsured or uninsured motorist coverages. Such actions may be based in tort, contract or other cause of action to the fullest extent permitted by law.

**Notice and Cooperation**

Members are required to notify the administrator promptly if they are involved in an incident that gives rise to such subrogation rights and/or priority right of reimbursement, to enable the administrator to protect the Plan’s rights under this section. Members are also required to cooperate with the administrator and to execute any documents that the administrator, acting on behalf of the Employer, deems necessary to protect the Plan’s rights under this section.

The Member shall not do anything to hinder, delay, impede or jeopardize the Plan’s subrogation rights and/or priority right of reimbursement. Failure to cooperate or to comply with this provision shall entitle the Plan to withhold any and all benefits due the Member under the Plan. This is in addition to any and all other rights that the Plan has pursuant to the provisions of the Plan’s subrogation rights and/or priority right of reimbursement. If the Plan has to file suit, or otherwise litigate to enforce its subrogation rights and/or priority right of reimbursement, you are responsible for paying any and all costs, including attorneys’ fees, the Plan incurs in addition to the amounts recovered through the subrogation rights and/or priority right of reimbursement.

**Legal Action and Costs**

If you settle any claim or action against any third party, you shall be deemed to have been made whole by the settlement and the Plan shall be entitled to collect the present value of its rights as the first priority claim from the settlement fund immediately. You shall hold any such proceeds of settlement or judgment in trust for the benefit of the Plan. The Plan shall also be entitled to recover reasonable attorneys’ fees incurred in collecting proceeds held by you in such circumstances.

Additionally, the Plan has the right to sue on your behalf, against any person or entity considered responsible for any condition resulting in medical expenses, to recover benefits paid or to be paid by the Plan.

**Settlement or Other Compromise**

You must notify the administrator prior to settlement, resolution, court approval, or anything that may hinder, delay, impede or jeopardize the Plan’s rights so that the Plan may be present and protect its subrogation rights and/or priority right of reimbursement.
The Plan’s subrogation rights and priority right of reimbursement attach to any funds held, and do not create personal liability against you.

The right of subrogation and the right of reimbursement are based on the Plan language in effect at the time of judgment, payment or settlement.
The Plan, or its representative, may enforce the subrogation and priority right of reimbursement.

CLAIMS AND PAYMENT

When you receive Covered Items, either you or the Provider must submit a claim form to Us. We will review the claim, and let you or the Provider know if We need more information before We pay or deny the claim. We follow our internal administration procedures when We adjudicate claims. If these procedures differ from those required by the ERISA claims regulations, the ERISA claims regulations shall control.

Claims

Due to federal regulations, there are several terms to describe a claim: pre-service claim; post-service claim; and a claim for Urgent Care.

A pre-service claim is any claim that requires approval of a Covered Item in advance of obtaining prescription drugs or devices as a condition of receipt of a Covered Item, in whole or in part.

A post-service claim is a claim for a Covered Item that is not a pre-service claim – the prescription drug or device has already been provided to the Member. Only post-service claims can be billed to the Plan, or you.

Urgent Care is medical care or treatment that, if delayed or denied, could seriously jeopardize: (1) the life or health of the claimant; or (2) the claimant’s ability to regain maximum function. Urgent Care is also medical care or treatment that, if delayed or denied, in the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the medical care or treatment. A claim for denied Urgent Care is always a pre-service claim.

Claims Billing

You should not be billed or charged for Covered Items provided by Network Providers, except for required Member payments. The Network Provider will submit the claim directly to Us.

You may be charged or billed by an Out-of-Network Provider for Covered Items dispensed by that Provider. If you use an Out-of-Network Provider, you are responsible for the difference between Billed Charges and the Maximum Allowable Charge for a Covered Item. You are also responsible for complying with any of the Plan’s medical management policies or procedures (including, obtaining Prior Authorization of such Services, when necessary).

If you are charged, or receive a bill, you must submit a claim to Us.

To be reimbursed, you must submit the claim within 1 year from the date a Covered Item was dispensed. If you do not submit a claim, within the 1 year time period, it will not be paid. If it is not reasonably possible to submit the claim within the 1 year time period, the claim will not be invalidated or reduced.

You may request a claim form from our customer service department. We will send you a claim form within 15 days. You must submit proof of payment acceptable to Us with the claim form. We may also request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.

A Network Provider or an Out-of-Network Provider may refuse to provide a prescription drug or device or require you to pay for what you believe should be a Covered Item. If this occurs:
you may submit a claim to Us to obtain a Coverage decision concerning whether the Plan will Cover that item.
You may request a claim form from our customer service department. We will send you a claim form within 15 days. We may request additional information or documentation if it is reasonably necessary to make a Coverage decision concerning a claim.
**Payment**
If you received Covered Items from a Network Provider, the Plan will pay the Network Provider directly. These payments are made according to our agreement with that Network Provider. You authorize assignment of benefits to that Network Provider. Covered Items will be paid at the In-Network Benefit level.

If you received Covered Items from an Out-of-Network Provider, you must submit, in a timely manner, a completed claim form for Covered Prescription Drugs or Devices. If the claim does not require further investigation, the Plan will reimburse you. The Plan may make payment for Covered Items either to the Provider or to you, at its discretion. The Plan’s payment fully discharges its obligation related to that claim.

Non-Contracted Providers may or may not file your claims for you. Either way, the In-Network Benefit level shown in Attachment B: Schedule of Benefits will apply to claims for Covered Prescription Drugs or Devices received from Non-Contracted Providers. However, you are responsible for the difference in the Billed Charge and the Maximum Allowable Charge for that Prescription Drug or Device. The Plan’s payment fully discharges its obligation related to that claim.

If the ASA is terminated, all claims for Covered Prescription Drugs or Devices rendered prior to the termination date, must be submitted to the Plan within 1 year from the date the Covered Prescription Drugs or Devices were received.

Benefits will be paid according to the Plan within 30 days after we receive a claim form that is complete. Claims are processed in accordance with current industry standards, and based on our information at the time we receive the claim form. Neither the Plan nor We are responsible for over or under payment of claims if our information is not complete or is inaccurate. We will make reasonable efforts to obtain and verify relevant facts when claim forms are submitted.

You are responsible for paying any applicable Copayments, Coinsurance, or Deductible amounts to the Provider.

**Prior Authorization, Medical Policy And Patient Safety**

EnvisionRx provides services to help manage your care including performing Prior Authorization of certain prescription drugs to ensure they are Medically Necessary and/or appropriately dispensed.

EnvisionRx does not make medical treatment decisions under any circumstances. You may always elect to receive prescription items that do not comply with EnvisionRx's Care Management requirements or medical policy, but doing so may affect the Coverage of such Covered Prescription Drugs or Devices.

**Prior Authorization**

EnvisionRx must authorize some Covered Items in advance in order for those Covered Items to be paid without Penalty. Obtaining Prior Authorization is not a guarantee of Coverage. All provisions of the EOC must be satisfied before Coverage for Items will be provided.

Covered Prescription Drugs or Devices that require Prior Authorization include, but are not limited to:

- Specialty Pharmacy Products
- Compound Prescriptions
- All Other Prescription Products on the EnvisionRx's standard Prior Authorization List.

Other items not listed at the time of printing may be added to the list of items that require Prior Authorization. You may call the EnvisionRx customer service department at the phone number on your ID card to find out which Prescription Drugs or Devices require Prior Authorization.

EnvisionRx may authorize some items for a limited quantity or amount. EnvisionRx must review any request for additional quantities or amounts.
Grievance Procedure

Introduction

Our Grievance procedure (the “Procedure”) is intended to provide a fair, quick and inexpensive method of resolving any and all Disputes with the Plan. Such Disputes include: any matters that cause you to be dissatisfied with any aspect of your relationship with the Plan; any Adverse Benefit Determination concerning a Claim; or any other claim, controversy, or potential cause of action you may have against the Plan.

This Procedure is the exclusive method of resolving any Dispute. Exemplary or punitive damages are not available in any Grievance or litigation, pursuant to the terms of this EOC. Any decision to award damages must be based upon the terms of this EOC.

- The Procedure can only resolve Disputes that are subject to our control.
- You cannot use this Procedure to resolve a claim that a Provider was negligent. Network Providers are independent contractors. They are solely responsible for making treatment decisions in consultation with their patients. You may contact the Plan, however, to complain about any matter related to the quality or availability of services, or any other aspect of your relationship with Providers.
- This Procedure incorporates the definitions of: (1) Adverse Benefit Determination; (2) urgent care; and (3) pre-service and post-service claims (“Claims”), which are in the Employee Retirement Income Security Act of 1974 (“ERISA”); Rules and Regulations for Administration and Enforcement; Claims Procedure (the “Claims Regulation”).
- An Adverse Benefit Determination is any denial, reduction, termination or failure to provide or make payment for what you believe should be a Covered Item.

Next Levels Grievance Procedure

If you are not satisfied, and the Employer’s ASA is governed by ERISA, you also have the right to bring a civil action against the Plan to obtain the remedies available pursuant to Sec. 502(a) of ERISA (“ERISA Actions”) after completing the mandatory first level Grievance process.

The Plan may require you to exhaust each step of this Procedure in any Dispute that is not an ERISA Action. If you disagree with the decision of the first level Grievance committee, EnvisionRx will handle the second level Grievance.

External Review of Denied Claims

If you have exhausted the Plan’s internal appeal process (or if you are eligible to request an external review for any other reason under the above procedures), you may request an external review of the Plan’s final adverse determination for certain health benefit claims. The Plan will provide for an external review process in accordance with Federal law.

Note that the Federal external review process (including the expedited external review process described later in these procedures) is not available for review of all internal adverse determinations. Specifically, Federal external review is not available for review of an internal adverse determination that is based on a determination that a claimant fails to meet the eligibility requirements under the terms of the Plan. Also, for any claim for which an external review request is not initiated before September 20, 2011, the Federal external review process is available only for:

- An adverse determination that involves medical judgment (including, but not limited to determinations based on the Plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness of a covered benefit; or the Plan’s determination that a treatment is experimental or investigational), as determined by the external reviewer; and
- A rescission of coverage.

For any adverse determination for which external review is available, the Federal external review requirements are as follows:
You have 4 months following the date you receive notice of the Plan’s final internal adverse determination within which to request an external review. Call the customer service number on the back of the subscriber’s ID card to receive instructions for filing a request for external review.

Within 5 business days following the date the Plan receives your external review request the Plan will complete a preliminary review. The Plan will notify you in writing within one business day after it completes the preliminary review whether the claim is eligible for the external review process:

(a) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will provide contact information for the U.S. Department of Health and Human Services Health Insurance Assistance Team (HIAT).

(b) If the request is not complete, the notice will describe information or materials needed to make the request complete. If the request is not complete and additional information or materials are needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.

Following the Plan’s preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) (as soon as administratively feasible) to make a determination on the request for external review. Within five business days following assignment of the IRO, the Plan will forward to the IRO all information and materials relevant to the final internal adverse determination.

The assigned IRO will notify you in writing (within a reasonable period of time) of the request’s eligibility and acceptance for external review. The notice will include a statement regarding your right to submit any additional information, within ten business days from the date of receipt of the notice, for the IRO to consider as part of the external review process. Any such additional information received by the IRO will be forwarded on and shared with the Plan. The Plan, based upon any new information received, may reconsider its final internal adverse determination. Reconsideration by the Plan will not delay the external review process. If the Plan does not reconsider its final internal adverse benefits determination, the IRO will continue to proceed with the external review process.

Within 45 days after the IRO receives the external review request from the Plan, the IRO must provide written notice of its external review determination to you and the Plan. The IRO’s notice is required to contain the following:

(a) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(b) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(c) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(d) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(e) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(f) A statement that judicial review may be available to you; and

(g) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Expeditied External Review

You may request an expedited external review if you have received:

- An initial internal adverse determination if the adverse determination involves a medical condition for which the time frame for completion of an expedited internal appeal under the Plan’s internal claim procedures would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or
A final internal adverse determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function.

The following requirements apply to an expedited external review:

(a) Immediately following the date the Plan receives the external review request the Plan will complete a preliminary review. The Plan will notify you in writing immediately after completion of the preliminary review whether the request is eligible for the external review process.

(b) If the request is complete, but the claim is not eligible for external review, the notice will describe the reasons it is not eligible and will include contact information for the Employee Benefits Security Administration.

(c) If the request is not complete, the notice will describe any information or materials needed to make the request complete. If the request is not complete and additional information or materials is needed to complete the preliminary review, you will have until the later of (i) 48 hours following the date of receipt of the notification or (ii) the end of the four-month deadline described in (1) above to provide the necessary additional information or materials.

(d) Following the Plan’s preliminary review, if the request is eligible for external review, the Plan will assign an independent review organization (IRO) to make a determination on the request for external review. The Plan will promptly forward to the IRO, by any available expeditious method (e.g. telephone, facsimile, etc.), all information and materials relevant to the final internal adverse determination.

(e) The IRO must provide notice to the claimant and the Plan (either in writing or orally) as expeditiously as the claimant’s medical condition or circumstance require and no later than 72 hours after it receives the expedited external review request from the Plan. If notice is not provided in writing, the IRO must provide written notice to you and the Plan as confirmation of the decision within 48 hours after the date of the notice. The IRO’s notice is required to contain the following information:

(f) A general description of the reason for the request for external review, including information sufficient to identify the claim, the diagnosis code and treatment code and the corresponding meaning for each and the reason for the previous denial;

(g) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

(h) References to the evidence or documentation, including the specific coverage provisions and evidence based standards, considered in reaching its decision;

(i) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

(j) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the group health plan or to you;

(k) A statement that judicial review may be available to you; and

(l) Current contact information, including telephone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Public Health Service Act Section 2793.

Effect of External Review Determination

A determination on external review is binding on the Plan and the claimant, except to the extent that other remedies are available under applicable State or Federal law. However, a decision by the external reviewer does not preclude the Plan from making payment or providing benefits on a claim at any time, including after a decision that denies the claim. When an external review decision requires the Plan to provide benefits or payment on a claim, the Plan will provide benefits or payment pursuant to the decision without unreasonable delay.
regardless of whether the Plan intends to seek judicial review of the decision, unless and until there is a judicial
decision that provides otherwise.

Statute of Limitations for Plan Claims

Please note that no legal action may be commenced or maintained to recover benefits under the Plan more than
12 months after the final review/appeal decision by the Plan Administrator has been rendered (or deemed
rendered).

Appointment of Authorized Representative

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

Physical Examinations

The Plan reserves the right to have a Physician of its own choosing examine any Covered Person whose Illness or
Injury is the basis of a claim. All such examinations will be at the expense of the Plan. This right may be
exercised when and as often as the Plan Administrator may reasonably require during the pendency of a claim.
The Covered Person must comply with this requirement as a necessary condition to coverage.
Attachment A
Prescription Drug Program
Covered Items, Benefit Payment, Limitations, and Exclusions

DEFINITIONS

1. **Average Wholesale Price** – A published suggested wholesale price of the drug by the manufacturer.
2. **Brand Name Drug** - a Prescription Drug identified by its registered trademark or product name given by its manufacturer, labeler or distributor.
3. **Compound Drug** – An outpatient Prescription Drug, which is not commercially prepared by a licensed pharmaceutical manufacturer in a dosage form approved by the Food and Drug Administration (FDA) and which contains at least one ingredient classified as an outpatient Prescription Drug.
4. **Covered Drug Expenses** – Covered Drug Expenses will be the lesser of: (a) the Maximum Allowable Charge (MAC) plus any dispensing fees and applicable sales tax; (b) the Average Wholesale Price less any negotiated discounts plus any applicable dispensing fees and applicable sales tax; or (c) the applicable copayment.
5. **Experimental and/or Investigational Drugs** – Drugs or medicines, which are labeled: Caution – limited by federal law to Investigational use.
6. **Generic Drug** - a Prescription Drug which can be legally substituted for a trade or Brand Name Drug prescribed under applicable law. Generic Drugs must be AB rated by the FDA.
7. **Legend Drugs** – A drug that, by law, can be obtained only by Prescription and bears the label, "Caution: Federal law prohibits dispensing without a Prescription."
8. **Maintenance Drug** – Prescription Drugs most commonly used for selected disease states that are considered long term, chronic, and stable. EnvisionRx maintains a list of Maintenance Drugs, which is reviewed periodically by our Pharmacy and Therapeutics Committee. In keeping with accepted standards of medical practice, not all-therapeutic classes are included on the Maintenance Drug Prescription list.
9. **Managed Dosage Limitation** – Quantity limitations applied to certain Prescription Drug products as determined by the Pharmacy and Therapeutics Committee.
10. **Maximum Allowable Charge** – the amount that the Plan, at its sole discretion, has determined to be the maximum amount payable for a Covered Prescription Drug or Device. That determination will be based upon the Plan’s contract with a Participating Provider or the amount payable based on the Plan’s fee schedule for the Covered Prescription Drugs or Devices provided by Out-of-Network Providers.
11. **Network Pharmacy** - a Pharmacy which has entered into a Network Pharmacy Agreement with EnvisionRx to provide Prescription Drug benefits to Members, either in person or through home delivery.
12. **Out-of-Network Pharmacy** - a Pharmacy which has not entered into a service agreement with EnvisionRx to provide benefits at specified rates to Members.
13. **Pharmacy** - a state or federally licensed establishment which is physically separate and apart from the office of a physician or authorized Practitioner, and where Legend Drugs are dispensed by Prescription to the general public by a pharmacist licensed to dispense such drugs and products under the laws of the state in which he or she practices.
14. **Pharmacy and Therapeutics Committee or P&T Committee** – A panel of EnvisionRx participating pharmacists, medical directors and pharmacy directors which reviews medications for safety, efficacy and cost effectiveness. The P&T Committee evaluates medications for addition and deletion from the: (1) Drug Formulary; (2) Preferred Brand Drug list; (3) Maintenance Drug list; (4) Prior Authorization Drugs list; and (5) Managed Dosage Limitation list. The P&T Committee may also set dispensing limits on medications.
15. **Preferred Brand Drug** – Brand Name Drugs that the plan has reviewed for clinical appropriateness, safety, therapeutic efficacy, and cost effectiveness.
16. **Prescription Drug** - a medication containing at least one Legend Drug which may not be dispensed under applicable state or federal law without a Prescription, and/or insulin.
17. **Prescription** - a written or verbal order issued by a physician or duly licensed Practitioner practicing within the scope of his or her licensure to a pharmacist for a drug, or drug product to be dispensed.
18. **Preventive drug** – a category of drugs named by the U.S. Task Force on preventive care that are subject to coverage in full by the Affordable Care Act.
19. **Prior Authorization Drugs** - Prescription Drugs which are only eligible for reimbursement after prior approval from EnvisionRx.
20. **Specialty Pharmacy Products** – Injectable, infusion and select oral medications that require complex care, including special handling, patient education and continuous monitoring. Specialty Pharmacy Products
are listed on the administrator’s Specialty Pharmacy Products list. Specialty Pharmacy Products are
categorized as provider-administered or self-administered.

21. **Step Therapy Limitations** – A form of Prior Authorization that begins drug therapy for a medical condition
with the most cost-effective and safest drug therapy and progresses to alternate drugs only if necessary.
Prescription drugs subject to Step Therapy guidelines are: (1) used only for patients with certain conditions;
and (2) Covered only for patients who have failed to respond to, or have demonstrated an intolerance to,
alternate Prescription Drugs, as supported by appropriate medical documentation.

I. COVERED PRESCRIPTION DRUGS AND DEVICES

- Prescription Drugs and Devices prescribed to a Member who is not confined in a hospital or other facility.
  - Prescription Drugs and Devices must be:
    - prescribed on or after the Member's coverage begins;
    - approved for use by the Food and Drug Administration (FDA);
    - dispensed by a licensed pharmacist;
    - listed on the Drug Formulary; and
    - not available for purchase without a Prescription.
  - Treatment of phenylketonuria (PKU), including special dietary formulas while under the supervision of a
    Practitioner.
  - Injectable insulin, and insulin needles/syringes, lancets, alcohol swabs and test strips for glucose monitoring
    upon Prescription.

II. BENEFIT PAYMENT

Benefit payment for Covered Services will be determined as follows:
- Generic Drug. We will determine the lesser of the billed charge or Maximum Allowable Charge, subtract
  the Generic Drug Copayment, and pay the difference up to the Maximum Allowable Charge.
- Preferred Brand Drug. We will determine the lesser of the billed charge or Maximum Allowable Charge,
  subtract the Drug Copayment and pay the difference up to the Maximum Allowable Charge.
- Non-preferred Brand Name Drug. We will determine the lesser of the billed charge or Maximum Allowable
  Charge, subtract the Drug Copayment, and pay the difference up to the Maximum Allowable Charge.

If the Member or the prescribing physician insists on a Brand Name Drug and a Generic Drug equivalent is
available, the Member will be financially responsible for the amount by which the cost of the Brand Name Drug
exceeds the Generic Drug cost plus the required Brand Drug copayment.

If a Member has a Prescription filled at a Non-Participating Pharmacy, the Member must pay all expenses and file
a claim for reimbursement with EnvisionRx. The Member will be reimbursed based on the Maximum Allowable
Charge, less any applicable Drug Deductible and/or Drug Copayment amount.

III. LIMITATIONS

- Refills must be dispensed pursuant to a Prescription. If the number of refills is not specified in the
  Prescription, benefits for refills will not be provided beyond one year from the date of the original
  Prescription.
  - Any Prescription and non-Prescription medical supplies, devices and appliances, other than syringes used in
    conjunction with injectable medications or other supplies used in the treatment of diabetes and/or asthma;
  - Immunizations or immunological agents, including but limited to:
    a. Biological sera;
    b. Blood;
    c. Blood plasma; or
    d. Other blood products except as required by hemophiliacs; and
    e. Injectable drugs, except when:
      i. Intended for self-administration, or
      ii. Defined by the Plan.
IV. EXCLUSIONS

In addition to the limitations and exclusions specified in the EOC, benefits are not available for the following:

- drugs which are prescribed, dispensed or intended for use while the Member is confined in a hospital, skilled nursing facility or similar facility;
- any drugs, medications, prescription devices, supplies or vitamins that are available over-the-counter and that do not require a Prescription by Federal or State law except as otherwise covered in this EOC;
- Nexium, omeprazole, Prilosec, Prevacid and other over-the-counter protein pump inhibitors;
- prescription nutrients and dietary supplements;
- immunizations and vaccinations;
- any quantity of Prescription Drugs which exceeds that specified by EnvisionRx;
- all aspirin, vitamin D, folic acid and iron supplements not meeting the criteria for a Preventive Drug;
- any Prescription drug purchased outside the United States, except those authorized by EnvisionRx;
- non-medical supplies or substances, including support garments, regardless of their intended use;
- artificial appliances and miscellaneous medical supplies;
- any drugs, supplies or devices dispensed more than one year following the date of the Prescription;
- Prescription drugs, supplies or devices a Member is entitled to receive without charge in accordance with any workers’ compensation laws or any municipal, state or federal program;
- replacement prescriptions resulting from lost, spilled, stolen or misplaced medications (except as required by applicable law);
- administration or injection of any drugs;
- prescription drugs used for the treatment of infertility;
- prescription drugs dispensed by a provider other than a pharmacy;
- all drugs newly approved by the FDA prior to review and acceptance of the EnvisionRx Pharmacy & Therapeutics Committee;
- Compound drugs not containing at least one ingredient requiring a Prescription, not identified with a valid National Drug Code (NDC) number, and all bulk powders and chemicals. All compound drugs are subject to the Plan’s prior authorization requirements.
- any Prescription Drugs or medications used for the treatment of sexual dysfunction, including but not limited to erectile dysfunction (e.g. Viagra), delayed ejaculation, anorgasmia and decreased libido;
- prescription Drugs used for cosmetic purposes including, but not limited to:
  a. drugs used to reduce wrinkles;
  b. drugs to promote hair-growth;
  c. drugs used to control perspiration;
  d. drugs to remove hair; and
  e. fade cream products.
- drugs for treatment of benign prostatic hyperplasia;
- anorectics (any drug or device for the purpose of weight loss or appetite suppression;
- drugs used to enhance athletic performance;
- prescription drugs or refills dispensed:
  a. in quantities in excess of amounts specified in the Benefit Payment section;
  b. without Prior Authorization as required; or
  c. which exceed any applicable Annual Maximum Benefit, or any other maximum benefit amounts stated in the EOC, and
- experimental and/or investigational Drugs, including drugs used for off-label treatments.
### EVIDENCE OF COVERAGE
#### ATTACHMENT B: PRESCRIPTION DRUG SCHEDULE OF BENEFITS
**Effective Date: January 1, 2016**

<table>
<thead>
<tr>
<th>Plan Level</th>
<th>Any Network Pharmacy – Up to 30 Day Supply</th>
<th>Mail Service or Network Pharmacy – Up to 90 Day Supply</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>$500 PPO and Preferred</strong></td>
<td>Preventive Drugs (as classified by HHS)</td>
<td>100% ($0 copay)</td>
</tr>
<tr>
<td></td>
<td>Generic Drugs</td>
<td>$10.00</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs</td>
<td>$55.00</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand Drugs</td>
<td>$90.00</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs</td>
<td>$175.00</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket maximum</td>
<td>Single: $5,750 / Family: $11,500</td>
</tr>
<tr>
<td><strong>$750 PPO and Preferred</strong></td>
<td>Preventive Drugs (as classified by HHS)</td>
<td>100% ($0 copay)</td>
</tr>
<tr>
<td></td>
<td>Generic Drugs</td>
<td>$10.00</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs</td>
<td>$55.00</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand Drugs</td>
<td>$90.00</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs</td>
<td>$175.00</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket maximum</td>
<td>Single: $6,250 / Family: $12,500</td>
</tr>
<tr>
<td><strong>$1000 PPO and Preferred</strong></td>
<td>Preventive Drugs (as classified by HHS)</td>
<td>100% ($0 copay)</td>
</tr>
<tr>
<td></td>
<td>Generic Drugs</td>
<td>$10.00</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs</td>
<td>$55.00</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand Drugs</td>
<td>$90.00</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs</td>
<td>$175.00</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket maximum</td>
<td>Single: $6,850 / Family: $13,700</td>
</tr>
<tr>
<td><strong>$2000 PPO and Preferred</strong></td>
<td>Preventive Drugs (as classified by HHS)</td>
<td>100% ($0 copay)</td>
</tr>
<tr>
<td></td>
<td>Generic Drugs</td>
<td>You pay 15% after deductible</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand Drugs</td>
<td>You pay 15% after deductible</td>
</tr>
<tr>
<td></td>
<td>Non-preferred Brand Drugs</td>
<td>You pay 15% after deductible</td>
</tr>
<tr>
<td></td>
<td>Specialty Drugs</td>
<td>You pay 15% after deductible</td>
</tr>
<tr>
<td></td>
<td>Out-of-pocket maximum</td>
<td>Single: $6,850 / Family: $13,700</td>
</tr>
</tbody>
</table>
Dental and Vision
YOUR GROUP INSURANCE
PLAN BENEFITS

IASIS HEALTHCARE, LLC
CLASS 0002
DENTAL, VISION
The enclosed certificate is intended to explain the benefits provided by the Plan. It does not constitute the Policy Contract. Your rights and benefits are determined in accordance with the provisions of the Policy, and your insurance is effective only if you are eligible for insurance and remain insured in accordance with its terms.
This Booklet Includes All Benefits For Which You Are Eligible.

You are covered for any benefits provided to you by the policyholder at no cost.

But if you are required to pay all or part of the cost of insurance you will only be covered for those benefits you elected in a manner and mode acceptable to Guardian such as an enrollment form and for which premium has been received by Guardian.

"Please Read This Document Carefully".
CERTIFICATE OF COVERAGE

The Guardian
7 Hanover Square
New York, New York 10004

We, The Guardian, certify that the employee named below is entitled to the insurance benefits provided by The Guardian described in this certificate, provided the eligibility and effective date requirements of the plan are satisfied.

<table>
<thead>
<tr>
<th>Group Policy No.</th>
<th>Certificate No.</th>
<th>Effective Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Issued To

This CERTIFICATE OF COVERAGE replaces any CERTIFICATE OF COVERAGE previously issued under the above Plan or under any other Plan providing similar or identical benefits issued to the Planholder by The Guardian.

The Guardian Life Insurance Company of America

Stuart Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-3-R-STK-90-3

B110.0023
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IMPORTANT NOTICE FOR EMPLOYEES OF AN ARIZONA WORK LOCATION

For employees who work at your employer’s Arizona location, your certificate of insurance may not provide all benefits and protections provided by law in Arizona. Please read your certificate carefully.

B120.0082
GENERAL PROVISIONS

As used in this booklet:

"Accident and health" means any dental, dismemberment, hospital, long term disability, major medical, out-of-network point-of-service, prescription drug, surgical, vision care or weekly loss-of-time insurance provided by this plan.

"Covered person" means an employee or a dependent insured by this plan.

"Employer" means the employer who purchased this plan.


"Plan" means the Guardian plan of group insurance purchased by your employer.

"You" and "your" mean an employee insured by this plan.

CGP-3-R-GENPRO-90

Limitation of Authority

No person, except by a writing signed by the President, a Vice President or a Secretary of The Guardian, has the authority to act for us to: (a) determine whether any contract, plan or certificate of insurance is to be issued; (b) waive or alter any provisions of any insurance contract or plan, or any requirements of The Guardian; (c) bind us by any statement or promise relating to any insurance contract issued or to be issued; or (d) accept any information or representation which is not in a signed application.

CGP-3-R-LOA-90

Incontestability

This plan is incontestable after two years from its date of issue, except for non-payment of premiums.

No statement in any application, except a fraudulent statement, made by a person insured under this plan shall be used in contesting the validity of his insurance or in denying a claim for a loss incurred, or for a disability which starts, after such insurance has been in force for two years during his lifetime.

If this plan replaces a plan your employer had with another insurer, we may rescind the employer’s plan based on misrepresentations made by the employer or an employee in a signed application for up to two years from the effective date of this plan.

CGP-3-R-incy-90
All Options

Accident and Health Claims Provisions

Your right to make a claim for any accident and health benefits provided by this plan, is governed as follows:

**Notice**
You must send us written notice of an injury or sickness for which a claim is being made within 20 days of the date the injury occurs or the sickness starts. This notice should include your name and plan number. If the claim is being made for one of your covered dependents, his or her name should also be noted.

**Proof of Loss**
We’ll furnish you with forms for filing proof of loss within 15 days of receipt of notice. But if we don’t furnish the forms on time, we’ll accept a written description and adequate documentation of the injury or sickness that is the basis of the claim as proof of loss. You must detail the nature and extent of the loss for which the claim is being made. You must send us written proof within 90 days of the loss.

If this plan provides weekly loss-of-time insurance, you must send us written proof of loss within 90 days of the end of each period for which we’re liable. If this plan provides long term disability income insurance, you must send us written proof of loss within 90 days of the date we request it. For any other loss, you must send us written proof within 90 days of the loss.

**Late Notice of Proof**
We won’t void or reduce your claim if you can’t send us notice and proof of loss within the required time. But you must send us notice and proof as soon as reasonably possible.

**Payment of Benefits**
We’ll pay benefits for loss of income once every 30 days for as long as we’re liable, provided you submit periodic written proof of loss as stated above. We’ll pay all other accident and health benefits to which you’re entitled as soon as we receive written proof of loss.

We pay all accident and health benefits to you, if you’re living. If you’re not living, we have the right to pay all accident and health benefits, except dismemberment benefits, to one of the following: (a) your estate; (b) your spouse; (c) your parents; (d) your children; (e) your brothers and sisters; and (f) any unpaid provider of health care services. See “Your Accidental Death and Dismemberment Benefits” for how dismemberment benefits are paid.

When you file proof of loss, you may direct us, in writing, to pay health care benefits to the recognized provider of health care who provided the covered service for which benefits became payable. We may honor such direction at our option. But we can’t tell you that a particular provider must provide such care. And you may not assign your right to take legal action under this plan to such provider.

**Limitations of Actions**
You can’t bring a legal action against this plan until 60 days from the date you file proof of loss. And you can’t bring legal action against this plan after three years from the date you file proof of loss.

**Workers’ Compensation**
The accident and health benefits provided by this plan are not in place of, and do not affect requirements for coverage by Workers’ Compensation.
An Important Notice About Continuation Rights

The following "Federal Continuation Rights" section may not apply to the employer's plan. The employee must contact his employer to find out if: (a) the employer is subject to the "Federal Continuation Rights" section, and therefore; (b) the section applies to the employee.

CGP-3-R-NCC-87
All Options

YOUR CONTINUATION RIGHTS

Federal Continuation Rights

Important Notice
This notice contains important information about the right to continue group dental coverage. In addition to the continuation rights described below, other health coverage alternatives may be available through states’ Health Insurance Marketplaces. Please read the information contained in this notice very carefully.

This section applies only to any dental, out-of-network point-of-service medical, major medical, prescription drug or vision coverages which are part of this plan. In this section, these coverages are referred to as “group health benefits.”

This section does not apply to any coverages which apply to loss of life, or to loss of income due to disability. These coverages can not be continued under this section.

Under this section, “qualified continuee” means any person who, on the day before any event which would qualify him or her for continuation under this section, is covered for group health benefits under this plan as: (a) an active, covered employee; (b) the spouse of an active covered employee; or (c) the dependent child of an active, covered employee. A child born to, or adopted by, the covered employee during a continuation period is also a qualified continuee. Any other person who becomes covered under this plan during a continuation provided by this section is not a qualified continuee.

Conversion
Continuing the group health benefits does not stop a qualified continuee from converting some of these benefits when continuation ends. But, conversion will be based on any applicable conversion privilege provisions of this plan in force at the time the continuation ends.

If Your Group Health Benefits End
If your group health benefits end due to your termination of employment or reduction of work hours, you may elect to continue such benefits for up to 18 months, if you were not terminated due to gross misconduct.

The continuation: (a) may cover you or any other qualified continuee; and (b) is subject to "When Continuation Ends”.

Extra Continuation for Disabled Qualified Continuees
If a qualified continuee is determined to be disabled under Title II or Title XVI of the Social Security Act on or during the first 60 days after the date his or her group health benefits would otherwise end due to your termination of employment or reduction of work hours, and such disability lasts at least until the end of the 18 month period of continuation coverage, he or she or any member of that person’s family who is a qualified continuee may elect to extend his or her 18 month continuation period explained above for up to an extra 11 months.
To elect the extra 11 months of continuation, a qualified continuee must give your employer written proof of Social Security’s determination of the disabled qualified continuee’s disability as described in "The Qualified Continuee’s Responsibilities". If, during this extra 11 month continuation period, the qualified continuee is determined to be no longer disabled under the Social Security Act, he or she must notify your employer within 30 days of such determination, and continuation will end, as explained in "When Continuation Ends."

This extra 11 month continuation is subject to "When Continuation Ends".

An additional 50% of the total premium charge also may be required from all qualified continuees who are members of the disabled qualified continuee’s family by your employer during this extra 11 month continuation period, provided the disabled qualified continuee has extended coverage.

All Options

If You Die While Insured

If you die while insured, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If Your Marriage Ends

If your marriage ends due to legal divorce or legal separation, any qualified continuee whose group health benefits would otherwise end may elect to continue such benefits. The continuation can last for up to 36 months, subject to "When Continuation Ends".

If a Dependent Child Loses Eligibility

If a dependent child’s group health benefits end due to his or her loss of dependent eligibility as defined in this plan, other than your coverage ending, he or she may elect to continue such benefits. However, such dependent child must be a qualified continuee. The continuation can last for up to 36 months, subject to "When Continuation Ends".

Concurrent Continuations

If a dependent elects to continue his or her group health benefits due to your termination of employment or reduction of work hours, the dependent may elect to extend his or her 18 month or 29 month continuation period to up to 36 months, if during the 18 month or 29 month continuation period, the dependent becomes eligible for 36 months of continuation due to any of the reasons stated above.

The 36 month continuation period starts on the date the 18 month continuation period started, and the two continuation periods will be deemed to have run concurrently.
Special Medicare Rule
If you become entitled to Medicare before a termination of employment or reduction of work hours, a special rule applies for a dependent. The continuation period for a dependent, after your later termination of employment or reduction of work hours, will be the longer of: (a) 18 months (29 months if there is a disability extension) from your termination of employment or reduction of work hours; or (b) 36 months from the date of your earlier entitlement to Medicare. If Medicare entitlement occurs more than 18 months before termination of employment or reduction of work hours, this special Medicare rule does not apply.

The Qualified Continuee's Responsibilities
A person eligible for continuation under this section must notify your employer, in writing, of: (a) your legal divorce or legal separation from your spouse; (b) the loss of dependent eligibility, as defined in this plan, of an insured dependent child; (c) a second event that would qualify a person for continuation coverage after a qualified continuee has become entitled to continuation with a maximum of 18 or 29 months; (d) a determination by the Social Security Administration that a qualified continuee entitled to receive continuation with a maximum of 18 months has become disabled during the first 60 days of such continuation; and (e) a determination by the Social Security Administration that a qualified continuee is no longer disabled.

Notice of an event that would qualify a person for continuation under this section must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date on which an event that would qualify a person for continuation under this section occurs; (b) the date on which the qualified continuee loses (or would lose) coverage under this plan as a result of the event; or (c) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice.

Notice of a disability determination must be given to your employer by a qualified continuee within 60 days of the latest of: (a) the date of the Social Security Administration determination; (b) the date of the event that would qualify a person for continuation; (c) the date the qualified continuee loses or would lose coverage; or (d) the date the qualified continuee is informed of the responsibility to provide notice to your employer and this plan's procedures for providing such notice. But such notice must be given before the end of the first 18 months of continuation coverage.

CGP-3-R-COBRA-96-3 B235.0178
Your Employer's Responsibilities

A qualified continuee must be notified, in writing, of: (a) his or her right to continue this plan’s group health benefits; (b) the premium he or she must pay to continue such benefits; and (c) the times and manner in which such payments must be made.

Your employer must give notice of the following qualifying events to the plan administrator within 30 days of the event: (a) your death; (b) termination of employment (other than for gross misconduct) or reduction in hours of employment; (c) Medicare entitlement; or (d) if you are a retired employee, a bankruptcy proceeding under Title 11 of the United States Code with respect to the employer. Upon receipt of notice of a qualifying event from your employer or from a qualified continuee, the plan administrator must notify a qualified continuee of the right to continue this plan’s group health benefits no later than 14 days after receipt of notice.

If your employer is also the plan administrator, in the case of a qualifying event for which an employer must give notice to a plan administrator, your employer must provide notice to a qualified continuee of the right to continue this plan’s group health benefits within 44 days of the qualifying event.

If your employer determines that an individual is not eligible for continued group health benefits under this plan, they must notify the individual with an explanation of why such coverage is not available. This notice must be provided within the time frame described above.

If a qualified continuee’s continued group health benefits under this plan are cancelled prior to the maximum continuation period, your employer must notify the qualified continuee as soon as practical following determination that the continued group health benefits shall terminate.

Your Employer's Liability

Your employer will be liable for the qualified continuee’s continued group health benefits to the same extent as, and in place of, us, if: (a) he or she fails to remit a qualified continuee’s timely premium payment to us on time, thereby causing the qualified continuee’s continued group health benefits to end; or (b) he or she fails to notify the qualified continuee of his or her continuation rights, as described above.

Election of Continuation

To continue his or her group health benefits, the qualified continuee must give your employer written notice that he or she elects to continue. This must be done by the later of: (a) 60 days from the date a qualified continuee receives notice of his or her continuation rights from your employer as described above; or (b) the date coverage would otherwise end. And the qualified continuee must pay his or her first premium in a timely manner.

The subsequent premiums must be paid to your employer, by the qualified continuee, in advance, at the times and in the manner specified by your employer. No further notice of when premiums are due will be given.

The premium will be the total rate which would have been charged for the group health benefits had the qualified continuee stayed insured under the group plan on a regular basis. It includes any amount that would have been paid by your employer. Except as explained in "Extra Continuation for Disabled Qualified Continuees", an additional charge of two percent of the total premium charge may also be required by your employer.
If the qualified continuee fails to give your employer notice of his or her intent to continue, or fails to pay any required premiums in a timely manner, he or she waives his or her continuation rights.

**Grace in Payment of Premiums**

A qualified continuee’s premium payment is timely if, with respect to the first payment after the qualified continuee elects to continue, such payment is made no later than 45 days after such election. In all other cases, such premium payment is timely if it is made within 31 days of the specified due date. 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 the period of coverage, then the amount paid is deemed to satisfy the requirement for the premium that must be paid; unless your employer notifies the qualified continuee of the amount of the deficiency and grants an additional 30 days for payment of the deficiency to be made. Payment is calculated to be made on the date on which it is sent to your employer.

**When Continuation Ends**

A qualified continuee’s continued group health benefits end on the first of the following:

1. with respect to continuation upon your termination of employment or reduction of work hours, the end of the 18 month period which starts on the date the group health benefits would otherwise end;

2. with respect to a qualified continuee who has an additional 11 months of continuation due to disability, the earlier of: (a) the end of the 29 month period which starts on the date the group health benefits would otherwise end; or (b) the first day of the month which coincides with or next follows the date which is 30 days after the date on which a final determination is made that the disabled qualified continuee is no longer disabled under Title II or Title XVI of the Social Security Act;

3. with respect to continuation upon your death, your legal divorce, or legal separation, or the end of an insured dependent’s eligibility, the end of the 36 month period which starts on the date the group health benefits would otherwise end;

4. the date the employer ceases to provide any group health plan to any employee;

5. the end of the period for which the last premium payment is made;

6. the date, after the date of election, he or she becomes covered under any other group health plan which does not contain any pre-existing condition exclusion or limitation affecting him or her; or

7. the date, after the date of election, he or she becomes entitled to Medicare.

CGP-3-R-COBRA-96-4 B235.0198
Uniformed Services Continuation Rights

If you enter or return from military service, you may have special rights under this plan as a result of the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA").

If your group health benefits under this plan would otherwise end because you enter into active military service, this plan will allow you, or your dependents, to continue such coverage in accord with the provisions of USERRA. As used here, "group health benefits" means any dental, out-of-network point-of service medical, major medical, prescription drug or vision coverages which are part of this plan.

Coverage under this plan may be continued while you are in the military for up to a maximum period of 24 months beginning on the date of absence from work. Continued coverage will end if you fail to return to work in a timely manner after military service ends as provided under USERRA. You should contact your employer for details about this continuation provision including required premium payments.
ELIGIBILITY FOR DENTAL COVERAGE

All Options

Employee Coverage

Eligible Employees
To be eligible for employee coverage you must be an active full-time employee or an active part-time employee. And you must belong to a class of employees covered by this plan.

Other Conditions
If you must pay all or part of the cost of employee coverage, we won’t insure you until you enroll and agree to make the required payments. If you do this: (a) more than 31 days after you first become eligible; or (b) after you previously had coverage which ended because you failed to make a required payment, we consider you to be a late entrant.

If you initially waived dental coverage under this plan because you were covered under another group plan, and you now elect to enroll in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to you with regard to dental coverage provided your coverage under the other plan ends due to one of the following events: (a) termination of your spouse’s employment; (b) loss of eligibility under your spouse’s plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

When Your Coverage Starts
Employee benefits are scheduled to start on your effective date. But you must be actively at work, and working your regular number of hours, on the scheduled effective date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on the date your insurance is scheduled to start, we will postpone your coverage until the date you return to active work.

Sometimes, your effective date is not a regularly scheduled work day. But coverage will still start on that date if you were actively at work on your last regularly scheduled work day.

When Your Coverage Ends
Your coverage ends on the last day of the pay period in which your active service ends for any reason, other than disability. Such reasons include retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.
Employee Coverage (Cont.)

It also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all employees. And it ends when this plan is changed so that benefits for the class of employees to which you belong ends.

If you are required to pay all or part of the cost of this coverage and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue certain group benefits for a limited time.

CGP-3-EC-90-3.0 B489.0090-R

All Options

Your Right To Continue Group Coverage During A Family Leave Of Absence

Important Notice
This section may not apply. You must contact your employer to find out if your employer must allow for a leave of absence under federal law. In that case the section applies.

If Your Group Coverage Would End
Group coverage may normally end for an employee because he or she ceases work due to an approved leave of absence. But, the employee may continue his or her group coverage if the leave of absence has been granted: (a) to allow the employee to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the employee’s own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the employee is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The employee will be required to pay the same share of the premium as he or she paid before the leave of absence.

When Continuation Ends
Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an employee who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the employee under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other employee; or (b) any later 12 month period in the case of an employee who cares for a covered servicemember.
- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.
Definitions

As used in this section, the terms listed below have the meanings shown below:

- **Active Duty**: This term means duty under a call or order to active duty in the Armed Forces of the United States.

- **Contingency Operation**: This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

- **Covered Servicemember**: This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin**: This term means the nearest blood relative of the employee.

- **Outpatient Status**: This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness**: This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

Dependent Coverage

Your eligible dependents are: (a) your legal spouse; (b) your dependent children who are under age 26.
Dependent Coverage (Cont.)

All Options

**Adopted Children And Step-Children**

Your "dependent children" include your legally adopted children and, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

**Dependents Not Eligible**

We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

CGP-3-DEP-90-3.0

B489.0463

All Options

**Handicapped Children**

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself or herself. Subject to all of the terms of this coverage and the plan, such a child may stay eligible for dependent benefits past this coverage's age limit.

The child will stay eligible as long as he or she stays unmarried and unable to support himself or herself, if: (a) his or her conditions started before he or she reached this coverage’s age limit; (b) he or she became insured by this coverage before he or she reached the age limit, and stayed continuously insured until he or she reached such limit; and (c) he or she depends on you for most of his or her support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his or her support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

CGP-3-DEP-90-4.0

B449.0042
All Options

Waiver Of Dental Late Entrants Penalty

If you initially waived dental coverage for your spouse or eligible dependent children under this plan because they were covered under another group plan, and you now elect to enroll them in the dental coverage under this plan, the Penalty for Late Entrants provision will not apply to them with regard to dental coverage provided their coverage under the other plan ends due to one of the following events: (a) termination of your spouse’s employment; (b) loss of eligibility under your spouse’s plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan.

But you must enroll your spouse or eligible dependent children in the dental coverage under this plan within 30 days of the date that any of the events described above occur.

In addition, the Penalty for Late Entrants provision for dental coverage will not apply to your spouse or eligible dependent children if: (a) you are under legal obligation to provide dental coverage due to a court-order; and (b) you enroll them in the dental coverage under this plan within 30 days of the issuance of the court-order.

All Options

When Dependent Coverage Starts

In order for your dependent coverage to begin you must already be insured for employee coverage or enroll for employee and dependent coverage at the same time. Subject to the “Exception” stated below and to all of the terms of this plan, the date your dependent coverage starts depends on when you elect to enroll your initial dependents and agree to make any required payments.

If you do this on or before your eligibility date, the dependent’s coverage is scheduled to start on the later of the first of the month which coincides with or next follows your eligibility date and the date you become insured for employee coverage.

If you do this within the enrollment period, the coverage is scheduled to start on the date you become insured for employee coverage.

If you do this after the enrollment period ends, each of your initial dependents is a late entrant and is subject to any applicable late entrant penalties. The dependent’s coverage is scheduled to start on the first of the month which coincides with or next follows the date you sign the enrollment form.

Once you have dependent coverage for your initial dependents, you must notify us when you acquire any new dependents and agree to make any additional payments required for their coverage.

If you do this within 31 days of the date the newly acquired dependent becomes eligible, the dependent’s coverage will start on the date the dependent first becomes eligible. If you fail to notify us on time, the newly acquired dependent, when enrolled, is a late entrant and is subject to any applicable late entrant penalties. The late entrant’s coverage is scheduled to start on the date you sign the enrollment form.
Dependent Coverage (Cont.)

All Options

Exception
If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

CGP-3-DEP-90-7.0

All Options

Newborn Children
We cover your newborn child for dependent benefits, from the moment of birth if you are already covered for dependent child coverage when the child is born. If you do not have dependent coverage when the child is born, we cover the child for the first 31 days from the moment of birth. To continue the child’s coverage past the 31 days, you must enroll the child and agree to make any required premium payments within 31 days of the date the child is born. If you fail to do this, the child’s coverage will end at the end of the 31 days, and once the child is enrolled, the child is a late entrant, is subject to any applicable late entrant penalties, and will be covered as of the date you sign the enrollment form.

CGP-3-DEP-90-8.0

All Options

When Dependent Coverage Ends
Dependent coverage ends for all of your dependents when your coverage ends. But if you die while insured, we'll automatically continue dependent benefits for those of your dependents who were insured when you died. We'll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his or her dependent benefits under this plan’s "Federal Continuation Rights" provision, or under any other continuation provision of this plan, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee’s class.
If you are required to pay all or part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent’s coverage ends when he or she stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this coverage’s age limit. It happens to a spouse on the last day of the pay period in which a marriage ends in legal divorce or annulment.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue certain group benefits for a limited time.
CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee's domestic partner will be eligible for dental coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be of the same gender;
- be unmarried, constitute each other's sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee's state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner's dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee's dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a “Statement of Termination” must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee’s death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of dental coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart J Shaw

CGP-3-A-DMST-96

B210.0016-R
Options G, H

DENTAL HIGHLIGHTS

This page provides a quick guide to some of the Dental Expense Insurance plan features which people most often want to know about. But it’s not a complete description of your Dental Expense Insurance plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- Benefit Year Cash Deductible for Non-Orthodontic Services
  
  For Group I Services ......................................................... None
  
  For Group II and III Services .......................................... $25.00
  
  for each covered person
This page provides a quick guide to some of the Dental Expense Insurance plan features which people most often want to know about. But it's not a complete description of your Dental Expense Insurance plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

- **Benefit Year Cash Deductible for Preventive Services**  
  None

- **Payment Rates:**
  - For Group I Services 100%
  - For Group II Services 80%
  - For Group III Services 50%
  - For Group IV Services 50%

- **Benefit Year Payment Limit for Preventive Services**  
  Unlimited

- **Benefit Year Payment Limit for Non-Orthodontic Services**
  - For Group I, II and III Services Up to $1,500.00

- **Lifetime Payment Limit for Orthodontic Treatment**
  - For Group IV Services Up to $1,500.00

*Note:* A covered person may be eligible for a rollover of a portion of his or her unused Benefit Year Payment Limit for Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Non-Orthodontic Services" for details.
All Options

Once each year, during the group enrollment period, you may elect to enroll in one of the dental expense plan options offered by your employer. The group enrollment period is a time period agreed to by your employer and us. Coverage starts on the first day of the month that next follows the date of enrollment. You and your eligible dependents are not subject to late entrant penalties if they enroll during the group enrollment period.

Once each year, during a special election period you may select to transfer to another dental expense plan option offered by your employer. The special election period is a time period agreed to by your employer and us. Coverage under the new plan option starts of the first day of the month that follows election. Coverage under the former plan option ends on that date.

The group enrollment period and the special election periods are time periods agreed to by your employer and us. Such open enrollment period and special election period may occur during the same time period.
Options E, F

DENTAL EXPENSE INSURANCE

This insurance will pay many of a covered person’s preventive dental expenses. We pay benefits for covered charges incurred by a covered person. What we pay and terms for payment are explained below.

CGP-3-DG2000

B498.0006
DENTAL EXPENSE INSURANCE

This insurance will pay many of a covered person’s dental expenses. We pay benefits for covered charges incurred by a covered person. What we pay and terms for payment are explained below.

Options G, H

Covered Charges

Covered charges are reasonable and customary charges for the dental services named in this plan’s List of Covered Dental Services. To be covered by this plan, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, we mean the charge is the dentist’s usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn’t more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a covered person while he or she is insured by this plan. All covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, we’ll only pay benefits for services which are completed within 31 days of the date his or her coverage under this plan ends.
Covered charges are reasonable and customary charges for the dental services named in this plan’s List of Covered Dental Services. To be covered by this plan, a service must be: (a) necessary; (b) appropriate for a given condition; and (c) included in the List of Covered Dental Services.

We may use the professional review of a dentist to determine the appropriate benefit for a dental procedure or course of treatment.

By reasonable, we mean the charge is the dentist’s usual charge for the service furnished. By customary, we mean the charge made for the given dental condition isn’t more than the usual charge made by most other dentists. But, in no event will the covered charge be greater than the 90th percentile of the prevailing fee data for a particular service in a geographic area.

When certain comprehensive dental procedures are performed, other less extensive procedures may be performed prior to, at the same time or at a later date. For benefit purposes under this plan, these less extensive procedures are considered to be part of the more comprehensive procedure. Even if the dentist submits separate bills, the total benefit payable for all related charges will be limited to the maximum benefit payable for the more comprehensive procedure. For example, osseous surgery includes the procedure scaling and root planing. If the scaling and root planing is performed one or two weeks prior to the osseous surgery, we may only pay benefits for the osseous surgery.

We only pay benefits for covered charges incurred by a covered person while he or she is insured by this plan. A covered charge for a crown, bridge or cast restoration is incurred on the date the tooth is initially prepared. A covered charge for any other dental prosthesis is incurred on the date the first master impression is made. A covered charge for root canal treatment is incurred on the date the pulp chamber is opened. A covered charge for orthodontic treatment is incurred on the date the active orthodontic appliance is first placed. All other covered charges are incurred on the date the services are furnished. If a service is started while a covered person is insured, we’ll only pay benefits for services which are completed within 31 days of the date his or her coverage under this plan ends.
Options E, F

**Alternate Treatment**

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding amalgam filling benefit.

**Proof Of Claim**

So that we may pay benefits accurately, the covered person or his or her dentist must provide us with information that is acceptable to us. This information may, at our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document proof of claim and support the necessity of the proposed treatment. If we don't receive the necessary information, we may pay no benefits, or minimum benefits. However, if we receive the necessary information within 15 months of the date of service, we will redetermine the covered person’s benefits based on the new information.

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Options G, H

**Alternate Treatment**

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent teeth, or multiple missing teeth in both quadrants of an arch, the benefit will be based on a removable partial denture.

**Proof Of Claim**

So that we may pay benefits accurately, the covered person or his or her dentist must provide us with information that is acceptable to us. This information may, at our discretion, consist of radiographs, study models, periodontal charting, narratives or other diagnostic materials that document proof of claim and support the necessity of the proposed treatment. If we don't receive the necessary information, we may pay no benefits, or minimum benefits. However, if we receive the necessary information within 15 months of the date of service, we will redetermine the covered person’s benefits based on the new information.

CGP-3-DGY2K-AT  B498.1141
Options G, H

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the covered person’s dentist should send us a treatment plan before he or she starts. This must be done on a form acceptable to Guardian. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to us.

A treatment plan should always be sent to us before orthodontic treatment starts.

We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person’s dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person’s condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won’t deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

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Options E, F

Pre-Treatment Review

When the expected cost of a proposed course of treatment is $300.00 or more, the covered person’s dentist should send us a treatment plan before he or she starts. This must be done on a form acceptable to Guardian. The treatment plan must include: (a) a list of the services to be done, using the American Dental Association Nomenclature and codes; (b) the itemized cost of each service; and (c) the estimated length of treatment. In order to evaluate the treatment plan, dental radiographs, study models and whatever else will document the necessity of the proposed course of treatment, must be sent to us.
We review the treatment plan and estimate what we will pay. We will send the estimate to the covered person and/or the covered person’s dentist. If the treatment plan is not consistent with accepted standards of dental practice, or if one is not sent to us, we have the right to base our benefit payments on treatment appropriate to the covered person’s condition using accepted standards of dental practice.

The covered person and his or her dentist have the opportunity to have services or a treatment plan reviewed before treatment begins. Pre-treatment review is not a guarantee of what we will pay. It tells the covered person, and his or her dentist, in advance, what we would pay for the covered dental services listed in the treatment plan. But, payment is conditioned on: (a) the services being performed as proposed and while the covered person is insured; and (b) the deductible, payment rate and payment limits provisions, and all of the other terms of this plan.

Emergency treatment, oral examinations, evaluations, dental radiographs and teeth cleaning are part of a course of treatment, but may be done before the pre-treatment review is made.

We won’t deny or reduce benefits if pre-treatment review is not done. But what we pay will be based on the availability and submission of proof of claim.

Benefits From Other Sources

Other plans may furnish benefits similar to the benefits provided by this plan. For instance, you may be covered by this plan and a similar plan through your spouse’s employer. You may also be covered by this plan and a medical plan. In such instances, we coordinate our benefits with the benefits from that other plan. We do this so that no one gets more in benefits than the charges he or she incurs. Read "Coordination of Benefits" to see how this works.

The Benefit Provision - Qualifying For Benefits

During the first 6 months that a late entrant is covered by this plan, we won’t pay for the following services:

- All Group II Services.

During the first 12 months a late entrant is covered by this plan, we won’t pay for the following services:
The Benefit Provision - Qualifying For Benefits (Cont.)

- All Group III Services.

During the first 24 months a late entrant is covered by this plan, we won’t pay for the following services:

- All Group IV Services.

Charges for the services we don’t cover under this provision are not considered to be covered charges under this plan, and therefore can’t be used to meet this plan’s deductibles.

*We* don’t apply a late entrant penalty to covered charges incurred for services needed solely due to an injury suffered by a covered person while insured by this plan.

A late entrant is a person who: (a) becomes covered by this dental plan more than 31 days after he or she is eligible; or (b) becomes covered again, after his or her coverage lapsed because he or she did not make required payments.

Options E, F

**How We Pay Benefits For Group I Services**

*We* pay for Group I covered charges at the applicable payment rate.

These charges must be incurred while the covered person is insured.

Options G, H

**How We Pay Benefits For Group I, II And III Non-Orthodontic Services**

There is no deductible for Group I services. *We* pay for Group I covered charges at the applicable payment rate.

A benefit year deductible of $25.00 applies to Group II and III services. Each covered person must have covered charges from these service groups which exceed the deductible before we pay him or her any benefits for such charges. These charges must be incurred while the covered person is insured.

Once a covered person meets the deductible, we pay for his or her Group II and III covered charges above that amount at the applicable payment rate for the rest of that benefit year.

Options E, F

All covered charges must be incurred while insured.

Options G, H

All covered charges must be incurred while insured. And we limit what we pay each benefit year to $1,500.00.
The Benefit Provision - Qualifying For Benefits

A covered person may be eligible for a rollover of a portion of his or her unused benefit year payment limit for Group I, II and III Non-Orthodontic Services. See "Rollover of Benefit Year Payment Limit for Group I, II and III Services" for details.

Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services

A covered person may be eligible for a rollover of a portion of his or her unused benefit year payment limit for Group I, II and III Non-Orthodontic Services, as follows:

If a covered person submits at least one claim for covered charges during a benefit year and, in that benefit year, receives benefits that are in excess of any deductible or co-pay fees, and that, in total, do not exceed the Rollover Threshold, he or she may be entitled to a Reward.

Note: If all of the benefits that a covered person receives in a benefit year are for services provided by a preferred provider, he or she may be entitled to a greater Reward than if any of the benefits are for services of a non-preferred provider.

Rewards can accrue and are stored in the covered person's Bank. If a covered person reaches his or her benefit year payment limit for Group I, II and III Non-Orthodontic Services, we pay benefits up to the amount stored in the covered person's Bank. The amount of Reward stored in the Bank may not be greater than the Bank Maximum.

A covered person's Bank may be eliminated, and the accrued Reward lost, if he or she has a break in coverage of any length of time, for any reason.

The amounts of this plan's Rollover Threshold, Reward, and Bank Maximum are:

- **Rollover Threshold** .......................... $700.00
- **Reward (if all benefits are for services provided by a preferred provider)** .......................... $500.00
- **Reward (if any benefits are for services provided by a non-preferred provider)** .......................... $350.00
- **Bank Maximum** .......................... $1,250.00

If this plan's dental coverage first becomes effective in October, November or December, this rollover provision will not apply until January 1 of the first full benefit year. And, if the effective date of a covered person's dental coverage is in October, November or December, this rollover provision will not apply to the covered person until January 1 of the next full benefit year. In either case:
Rollover of Benefit Year Payment Limit for Group I, II and III Non-Orthodontic Services (Cont.)

- only claims incurred on or after January 1 will count toward the Rollover Threshold; and
- Rewards will not be applied to a covered person’s Bank until the benefit year that starts one year from the date the rollover provision first applies.

If charges for any dental services are not payable for a covered person for a period set forth in the provision of this plan called Penalty for Late Entrants and Waiting Periods for Certain Services, this rollover provision will not apply to the covered person until the end of such period. And, if such period ends within the three months prior to the start of this plan’s next benefit year, this rollover provision will not apply to the covered person until the next benefit year, and:

- only claims incurred on or after the start of the next benefit year will count toward the Rollover Threshold; and
- Rewards will not be applied to a covered person’s Bank until the benefit year that starts one year from the date the rollover provision first applies.

Definitions of terms used in this provision:

"Bank" means the amount of a covered person’s accrued Reward.

"Bank Maximum" means the maximum amount of Reward that a covered person can store in his or her Bank.

"Reward" means the dollar amount which may be added to a covered person’s Bank when he or she receives benefits in a benefit year that do not exceed the Rollover Threshold.

"Rollover Threshold" means the maximum amount of benefits that a covered person can receive during a benefit year and still be entitled to receive a Reward.

Options G, H

How We Pay Benefits For Group IV Orthodontic Services

This plan provides benefits for Group IV orthodontic services only for covered dependent children who are less than 26 years old when the active orthodontic appliance is first placed.

We pay for Group IV covered charges at the applicable payment rate.

Using the covered person’s original treatment plan, we calculate the total benefit we will pay. We divide the benefit into equal payments, which we will spread out over the shorter of: (a) the proposed length of treatment; or (b) two years.
The Benefit Provision - Qualifying For Benefits (Cont.)

We make the initial payment when the active orthodontic appliance is first placed. We make further payments at the end of each subsequent three month period, upon receipt of verification of ongoing treatment. But, treatment must continue and the covered person must remain covered by this plan. We limit what we pay for orthodontic services to the lifetime payment of $1,500.00. What we pay is based on all of the terms of this plan.

We don’t pay for orthodontic charges incurred by a covered person prior to being covered by this plan. We limit what we pay for orthodontic treatment started prior to a covered person being covered by this plan to charges determined to be incurred by the covered person while covered by this plan. Based on the original treatment plan, we determine the portion of charges incurred by the covered person prior to being covered by this plan, and deduct them from the total charges. What we pay is based on the remaining charges. We limit what we consider of the proposed treatment plan to the shorter of the proposed length of treatment, or two years from the date the orthodontic treatment started.

The benefits we pay for orthodontic treatment won’t be charged against a covered person’s benefit year payment limits that apply to all other services.

Options G, H

Non-Orthodontic Family Deductible Limit

A covered family must meet no more than three individual benefit year deductibles in any benefit year. Once this happens, we pay benefits for covered charges incurred by any covered person in that covered family, at the applicable payment rate for the rest of that benefit year. The charges must be incurred while the person is insured. What we pay is based on this plan’s payment limits and to all of the terms of this plan.

Options E, F

Payment Rates

Benefits for covered charges are paid at the following payment rates:

- Benefits for Group I Services ............................. 100%

Options G, H

Payment Rates

Benefits for covered charges are paid at the following payment rates:

- Benefits for Group I Services ............................. 100%
- Benefits for Group II Services ............................. 80%
- Benefits for Group III Services ............................. 50%
- Benefits for Group IV Services ............................. 50%
Options G, H

**After This Insurance Ends**

*We* don’t pay for charges incurred after a covered person’s insurance ends. But, subject to all of the other terms of this plan, we’ll pay for the following if the procedure is finished in the 31 days after a covered person’s insurance under this plan ends: (a) a bridge or cast restoration, if the tooth or teeth are prepared before the covered person’s insurance ends; (b) any other dental prosthesis, if the master impression is made before the covered person’s insurance ends; and (c) root canal treatment, if the pulp chamber is opened before the covered person’s insurance ends.

We pay benefits for orthodontic treatment to the end of the month in which the covered person’s insurance ends.

CGP-3-DGY2K-END

Options E, F

**After This Insurance Ends**

*We* don’t pay for charges incurred after a covered person’s insurance ends.

CGP-3-DGY2K-END

All Options

**Special Limitations**

CGP-3-DGY2K-LMT

Options G, H

**Teeth Lost, Extracted Or Missing Before A Covered Person Becomes Covered By This Plan**

*A covered person* may have had one or more teeth lost or extracted before he or she became covered by this plan. We won’t pay for a dental prosthesis which replaces such teeth unless the dental prosthesis also replaces one or more eligible natural teeth lost or extracted after the covered person became covered by this plan.

CGP-3-DGY2K-TL
Options E, F

If This Plan Replaces The Prior Plan

This plan may be replacing the prior plan you had with another insurer. If a covered person was insured by the prior plan and is covered by this plan on its effective date, the following provisions apply to such covered person.

- **Deductible Credit** - In the first benefit year of this plan, we reduce a covered person’s deductibles required under this plan, by the amount of covered charges applied against the prior plan’s deductible. The covered person must give us proof of the amount of the prior plan’s deductible which he or she has satisfied.

- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first benefit year of this plan, we reduce a covered person’s benefit year payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan’s payment limits.

Options G, H

If This Plan Replaces The Prior Plan

This plan may be replacing the prior plan you had with another insurer. If a covered person was insured by the prior plan and is covered by this plan on its effective date, the following provisions apply to such covered person.

- **Teeth Extracted While Insured By The Prior Plan** - The “Teeth Lost, Extracted or Missing Before A Covered Person Becomes Covered By This Plan” provision above, does not apply to a covered person’s dental prosthesis which replaces teeth: (a) that were extracted while the covered person was insured by the prior plan; and (b) for which extraction benefits were paid by the prior plan.

- **Deductible Credit** - In the first benefit year of this plan, we reduce a covered person’s deductibles required under this plan, by the amount of covered charges applied against the prior plan’s deductible. The covered person must give us proof of the amount of the prior plan’s deductible which he or she has satisfied.

- **Benefit Year Non-Orthodontic Payment Limit Credit** - In the first benefit year of this plan, we reduce a covered person’s benefit year payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan’s payment limits.

- **Orthodontic Payment Limit Credit** - We reduce a covered person’s orthodontic payment limits by the amounts paid or payable under the prior plan. The covered person must give us proof of the amounts applied toward the prior plan’s payment limits.

Options E, F

Exclusions

We will not pay for:

- Any service or supply which is not specifically listed in this plan’s List of Covered Dental Services.
• Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan.

• Educational services, including, but not limited to, oral hygiene instruction, plaque control, tobacco counseling or diet instruction.

• Precision attachments and the replacement of part of a precision attachment, magnetic retention or overdenture attachments.

• Overdentures and related services, including root canal therapy on teeth supporting an overdenture.

• Any restoration, procedure, appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.

• The use of general anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including but not limited to nitrous oxide, except when administered in conjunction with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations and services listed under the "Other Oral Surgical Procedures" section of this plan.

• The use of local anesthetic.

• Cephalometric radiographs, oral/facial images, including traditional photographs and images obtained by intraoral camera, except when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment.

• Replacement of a lost, missing or stolen appliance or dental prosthesis or the fabrication of a spare appliance or dental prosthesis.

• Prescription medication.

• Desensitizing medicaments and desensitizing resins for cervical and/or root surface.

• Duplication of radiographs, the completion of claim forms, OSHA or other infection control charges.

• Caries susceptibility tests.

• Bite registration or bite analysis.

• Gingival curettage.

• The localized delivery of chemotherapeutic agents.

• Tooth transplants.

• Maxillofacial prosthetics that repair or replace facial and skeletal anomalies, maxillofacial surgery, orthognathic surgery or any oral surgery requiring the setting of a fracture or dislocation.

• Temporary or provisional dental prosthesis or appliances except interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan.
● Any service or procedure associated with the placement, prosthodontic restoration or maintenance of a dental implant and any incremental charges to other covered services as a result of the presence of a dental implant.

● Any service furnished solely for cosmetic reasons. This includes, but is not limited to: (1) characterization and personalization of a dental prosthesis; (2) facings on a dental prosthesis for any teeth posterior to the second bicuspid; (3) bleaching of discolored teeth; and (4) odontoplasty.

● Replacing an existing appliance or dental prosthesis with a like or un-like appliance or dental prosthesis; unless (1) it is at least 10 years old and is no longer usable; or (2) it is damaged while in the covered person’s mouth in an injury suffered while insured, and can’t be made serviceable.

● A fixed bridge replacing the extracted portion of a hemisected tooth or the placement of more than one unit of crown and/or bridge per tooth.

● The replacement of extracted or missing third molars/wisdom teeth.

● Treatment of congenital or developmental malformations, or the replacement of congenitally missing teeth.

● Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

● Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

● Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).

● Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Worker’s Compensation or similar laws.

● Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person’s employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.

● Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.

● Orthodontic treatment, unless the benefit provision provides specific benefits for orthodontic treatment.
We will not pay for:

- Any service or supply which is not specifically listed in this plan’s List of Covered Dental Services.
- Any procedure performed in conjunction with, as part of, or related to a procedure which is not covered by this plan.
- Educational services. This includes, but is not limited to: oral hygiene instruction; plaque control; tobacco counseling; or diet instruction.
- Precision attachments and the replacement of part of a precision attachment; magnetic retention; or overdenture attachments.
- Overdentures and related services. This includes root canal therapy on teeth that support an overdenture.
- Any restoration, procedure, or appliance or prosthetic device used solely to: (1) alter vertical dimension; (2) restore or maintain occlusion, except to the extent that this plan covers orthodontic treatment; (3) treat a condition necessitated by attrition or abrasion; or (4) splint or stabilize teeth for periodontal reasons.
- The use of: general anesthesia; intramuscular sedation; intravenous sedation; non-intravenous sedation; or inhalation sedation, which includes but is not limited to nitrous oxide. But, this does not apply when administered in conjunction with: covered periodontal surgery; surgical extractions; the surgical removal of impacted teeth; apicoectomies; root amputations; and services listed under the "Other Oral Surgical Procedures" section of this plan.
- The use of local anesthetic.
- Cephalometric radiographs; oral/facial images. This includes traditional photographs and images obtained by intraoral camera. But, these services are covered when performed as part of the orthodontic treatment plan and records for a covered course of orthodontic treatment.
- Replacement of a lost, missing or stolen appliance or dental prosthesis; or the fabrication of a spare appliance or dental prosthesis.
- Prescription medication.
- Duplication of radiographs; the completion of claim forms; OSHA or other infection control charges.
- Caries susceptibility tests.
- Bite registration; or bite analysis.
- Gingival curettage.
- Tooth transplants.
- Maxillofacial prosthetics that repair or replace facial and skeletal anomalies; maxillofacial surgery; orthognathic surgery; or any oral surgery requiring the setting of a fracture or dislocation.
Temporary or provisional dental prosthesis or appliances. But, this does not include interim partial dentures/stayplates to replace anterior teeth extracted while insured under this plan.

Any service furnished solely for cosmetic reasons, unless the "List of Covered Dental Services" provides benefits for specific cosmetic services. Excluded cosmetic services include, but are not limited to: (1) characterization and personalization of a dental prosthesis; and (2) odontoplasty.

Replacing an existing appliance or dental prosthesis, denture, bridge and implants denture with any appliance or prosthesis, unless it is: (1) at least 10 years old and is no longer usable; or (2) damaged while in the covered person's mouth in an injury suffered while insured, and can not be made serviceable.

Replacing an existing crown, inlay, onlay, labial veneer, post & core, implant crown with a like or un-like appliance or dental prosthesis; unless (1) it is at least 5 years old and is no longer usable; or (2) it is damaged while in the covered person's mouth in an injury suffered while insured, and can't be made serviceable.

A fixed bridge replacing the extracted portion of a hemisected tooth; or the placement of more than one unit of crown and/or bridge per tooth.

The replacement of extracted or missing third molars/wisdom teeth.

Treatment of congenital or developmental malformations.

Any endodontic, periodontal, crown or bridge abutment procedure or appliance performed for a tooth or teeth with a guarded, questionable or poor prognosis.

Any procedure or treatment method which does not meet professionally recognized standards of dental practice or which is considered to be experimental in nature.

Any procedure, appliance, dental prosthesis, modality or surgical procedure intended to treat or diagnose disturbances of the temporomandibular joint (TMJ).

Treatment needed due to: (1) an on-the-job or job-related injury; or (2) a condition for which benefits are payable by Workers' Compensation or similar laws.

Treatment for which no charge is made. This usually means treatment furnished by: (1) the covered person's employer, labor union or similar group, in its dental or medical department or clinic; (2) a facility owned or run by any governmental body; and (3) any public program, except Medicaid, paid for or sponsored by any governmental body.

Evaluations and consultations for non-covered services; detailed and extensive oral evaluations.

The repair of an orthodontic appliance.

The replacement of a lost or broken orthodontic retainer.
List of Covered Dental Services

The services covered by this plan are named in this list. Each service on this list has been placed in one of four groups. A separate payment rate applies to each group. Group I is made up of preventive services. Group II is made up of basic services. Group III is made up of major services. Group IV is made up of orthodontic services.

All covered dental services must be furnished by or under the direct supervision of a dentist. And they must be usual and necessary treatment for a dental condition.

CGP-3-DNTL-90-13

Options G, H

List of Covered Dental Services

The services covered by this plan are named in this list. Group I is made up of preventive services.

All covered dental services must be furnished by or under the direct supervision of a dentist. And they must be usual and necessary treatment for a dental condition.

CGP-3-DNTL-90-13

Options E, F

All Options

Group I - Preventive Dental Services

(Non-Orthodontic)

Prophylaxis And Fluorides

Prophylaxis - limited to two prophylaxis procedures in a calendar year. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

Periodontal maintenance procedure - limited to a total of 4 prophylaxis or periodontal maintenance procedures in a calendar year. Allowance includes periodontal pocket charting, scaling and polishing. Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

- Adult prophylaxis covered age 12 and older.

Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient’s medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.

Fluoride treatment, topical application - limited to covered persons under age 19 and limited to one treatment in any calendar year.
**Group I Preventive Dental Services (Cont.)**

*(Non-Orthodontic)*

### Office Visits, Evaluations And Examination

Office visits, examinations or limited problem focused re-evaluations - limited to a total of 2 in any calendar year.

- Emergency palliative treatment and other non-routine, unscheduled visits.
- After hours office visit and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed during the same visit.

### Diagnostic Services

Pulp vitality tests

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.

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**Group I - Preventive Dental Services**

*(Non-Orthodontic)*

### Prophylaxis And Fluorides

Prophylaxis - limited to two prophylaxis procedures in a calendar year. Allowance includes scaling and polishing procedures to remove coronal plaque, calculus, and stains.

- Adult prophylaxis covered age 12 and older.
- Additional prophylaxis when needed as a result of a medical (i.e., a non-dental) condition - covered once in 12 months, and only when the additional prophylaxis is recommended by the dentist and is a result of a medical condition as verified in writing by the patient's medical physician. This does not include a condition which could be resolved by proper oral hygiene or that is the result of patient neglect.
- Fluoride treatment, topical application - limited to covered persons under age 19 and limited to one treatment in any calendar year.

### Office Visits, Evaluations And Examination

Office visits, examinations or limited problem focused re-evaluations - limited to a total of 2 in any calendar year.

- Emergency palliative treatment and other non-routine, unscheduled visits.
- After hours office visit and other non-routine, unscheduled visits. Limited to a total of 1 in a 6 consecutive month period. Covered if no other treatment, other than radiographs, is performed during the same visit.

### Diagnostic Services

Pulp vitality tests

Diagnostic casts - when needed to prepare a treatment plan for three or more of the following performed at the same time in more than one arch: dentures, crowns, bridges, inlays or onlays.
All Options

**Space Maintainers**
Space Maintainers - limited to *covered persons* under age 19 and limited to initial appliance only. Covered only when necessary to replace prematurely lost or extracted deciduous teeth. Allowance includes all adjustments in the first six months after insertion, limited to a maximum of one bilateral per arch or one unilateral per quadrant, per lifetime.

- Fixed - unilateral
- Fixed - bilateral
- Removable - bilateral
- Removable - unilateral

Recementation of space maintainer performed more than 12 months after the initial insertion

CGP-3-DNTL-90-14 B498.0164-R

All Options

**Radiographs**
Allowance includes evaluation and diagnosis.

- Full mouth, complete series or panoramic radiograph - Either, but not both, of the following procedures, limited to one in any 60 consecutive month period.
  - Full mouth series, of at least 14 films including bitewings
  - Panoramic film, maxilla and mandible, with or without bitewing radiographs.

Other diagnostic radiographs:

- Bitewing films - limited to either a maximum of 4 bitewing films or a set (7-8 films) of vertical bitewings, in one visit, two per calendar year.
- Intraoral periapical or occlusal films - single films

CGP-3-DNTL-90-14 B498.8740-R

All Options

**Dental Sealants**
Dental Sealants - permanent molar teeth only - Topical application of sealants is limited to the unrestored, permanent molar teeth of *covered persons* under age 19 and limited to one treatment, per tooth, in any 60 consecutive month period.

**Periodontal Services**
Full mouth debridement - limited to once per lifetime.

CGP-3-DNTL-90-14 B498.0166-R

Options G, H

**Group II - Basic Dental Services**
(Non-Orthodontic)

**Diagnostic Services**
Allowance includes examination and diagnosis.
Consultations - Diagnostic consultations with a dentist other than the one providing treatment, limited to two consultations in a calendar year. Covered only when no other treatment, other than radiographs, is performed during the visit.

Diagnostic Services: Allowance includes examination and diagnosis.

Histopathologic examinations when performed in conjunction with a tooth related biopsy.

**Restorative Services**

Multiple restorations on one surface will be considered one restoration. Also see the "Major Restorative Services" section.

Amalgam restorations - Allowance includes bonding agents, liners, bases, polishing and local anesthetic.

Resin restorations - Allowance includes light curing, acid etching, adhesives, including resin bonding agents and local anesthetic.

Silicate cement, per restoration
Composite resin
Pin retention, per tooth, covered only in conjunction with a permanent amalgam or composite restoration, exclusive of restorative material.

**Options G, H**

**Crown And Prosthodontic Restorative Services**

Also see the "Major Restorative Services" section.

Crown and bridge repairs - allowance based on the extent and nature of damage and the type of material involved.

Recementation, limited to recementations performed more than 12 months after the initial insertion.

Inlay or onlay
Crown
Bridge

Adding teeth to partial dentures to replace extracted natural teeth

Denture repairs - Allowance based on the extent and nature of damage and on the type of materials involved.

Denture repairs, metal
Denture repairs, acrylic
Denture repair, no teeth damaged
Denture repair, replace one or more broken teeth
Replacing one or more broken teeth, no other damage

Denture rebase, full or partial denture - limited to once per denture in any 36 consecutive month period. Denture rebases done within 6 months are considered to be part of the denture placement when the rebase is done by the dentist who furnished the denture. Limited to rebase done more than 6 consecutive months after the insertion of the denture.
Group II - Basic Dental Services (Cont.)
(Non-Orthodontic)

Denture reline, full or partial denture - limited to once per denture in any 36 consecutive month period. Denture relines done within 6 months are considered to be part of the denture placement when the reline is done by the dentist who furnished the denture. Limited to reline done more than 6 consecutive months after a denture rebase or the insertion of the denture.

Denture adjustments - Denture adjustments done within 6 months are considered to be part of the denture placement when the adjustment is done by the dentist who furnished the denture. Limited to adjustments that are done more than 6 consecutive months after a denture rebase, denture reline or the initial insertion of the denture.

Tissue conditioning - Tissue conditioning done within 12 months is considered to be part of the denture placement when the tissue conditioning is done by the dentist who furnished the denture. Limited to a maximum of 1 treatment, per arch, in any 12 consecutive month period.

Options G, H

Endodontic Services

Allowance includes diagnostic, treatment and final radiographs, cultures and tests, local anesthetic and routine follow-up care, but excludes final restoration.

- Pulp capping, limited to permanent teeth and limited to one pulp cap per tooth, per lifetime.
  - Pulp capping, direct
  - Pulp capping, indirect - includes sedative filling.

- Vital pulpotomy, only when root canal therapy is not the definitive treatment

- Gross pulpal debridement

- Pulpal therapy, limited to primary teeth only

Root Canal Treatment

- Root canal therapy
- Root canal retreatment, limited to once per tooth, per lifetime
- Treatment of root canal obstruction, no-surgical access
- Incomplete endodontic therapy, inoperable or fractured tooth
- Internal root repair of perforation defects

Other Endodontic Services

- Apexification, limited to a maximum of three visits
- Apicoectomy, limited to once per root, per lifetime
- Root amputation, limited to once per root, per lifetime
- Retrograde filling, limited to once per root, per lifetime
- Hemisection, including any root removal, once per tooth
Periodontal Services

Allowance includes the treatment plan, local anesthetic and post-treatment care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

Periodontal maintenance procedure - limited to a total of four periodontal maintenance procedures (including prophylaxis) in any calendar year. Allowance includes periodontal pocket charting, scaling and polishing. (Also see Prophylaxis under "Preventive Services") Coverage for periodontal maintenance is considered upon evidence of completed active periodontal therapy (periodontal scaling and root planing or periodontal surgery).

Scaling and root planing, per quadrant - limited to once per quadrant in any 24 consecutive month period. Covered when there is radiographic and pocket charting evidence of bone loss.

Full mouth debridement - limited to once per lifetime.

Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth by report.

Periodontal Surgery

Allowance includes the treatment plan, local anesthetic and post-surgical care. Requires documentation of periodontal disease confirmed by both radiographs and pocket depth probings of each tooth involved.

The following treatment is limited to a total of one of the following, once per tooth in any 12 consecutive months.

Gingivectomy, per tooth (less than 3 teeth)
Crown lengthening - hard tissue

The following treatment is limited to a total of one of the following once per quadrant, in any 36 consecutive months.

Gingivectomy or gingivoplasty, per quadrant
Osseous surgery, including scaling and root planing, flap entry and closure, per quadrant
Gingival flap procedure, including scaling and root planing, per quadrant
Distal or proximal wedge, not in conjunction with osseous surgery
Surgical revision procedure, per tooth

The following treatment is limited to a total of one of the following, once per quadrant in any 36 consecutive months.
Pedicle or free soft tissue grafts, including donor site, or subepithelial connective tissue graft procedure, when the tooth is present, or when dentally necessary as part of a covered surgical placement of an implant.

The following treatment is limited to a total of one of the following, once per area or tooth, per lifetime.

Guided tissue regeneration, resorbable barrier or nonresorbable barrier
Bone replacement grafts, when the tooth is present

Periodontal surgery related
Limited occlusal adjustment - limited to a total of two visits, covered only when done within a 6 consecutive month period after covered scaling and root planing or osseous surgery. Must have radiographic evidence of vertical defect or widened periodontal ligament space.
Options G, H

Non-Surgical Extractions  Allowance includes the treatment plan, local anesthetic and post-treatment care.

Uncomplicated extraction, one or more teeth
Root removal non-surgical extraction of exposed roots

Surgical Extractions  Allowance includes the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Surgical removal of erupted teeth, involving tissue flap and bone removal
Surgical removal of residual tooth roots
Surgical removal of impacted teeth

Other Oral Surgical Procedures  Allowance includes diagnostic and treatment radiographs, the treatment plan, local anesthetic and post-surgical care. Services listed in this category and related services, may be covered by your medical plan.

Alveoloplasty, per quadrant
Removal of exostosis, per site
Incision and drainage of abscess
Frenulectomy, Frenectomy, Frenotomy
Biopsy and examination of tooth related oral tissue
Surgical exposure of impacted or unerupted tooth to aid eruption
Excision of tooth related tumors, cysts and neoplasms
Excision or destruction of tooth related lesion(s)
Excision of hyperplastic tissue
Excision of pericoronal gingiva, per tooth
Oroantral fistula closure
Sialolithotomy
Sialodochoplasty
Closure of salivary fistula
Excision of salivary gland
Maxillary sinusotomy for removal of tooth fragment or foreign body
Vestibuloplasty

Options G, H

Other Services  General anesthesia, intramuscular sedation, intravenous sedation, non-intravenous sedation or inhalation sedation, including nitrous oxide, when administered in connection with covered periodontal surgery, surgical extractions, the surgical removal of impacted teeth, apicoectomies, root amputations, surgical placement of an implant and services listed under the "Other Oral Surgical Procedures" section of this plan.

Injectable antibiotics needed solely for treatment of a dental condition.

Application of desensitizing medicaments.
Options G, H

Group III - Major Dental Services
(Non-Orthodontic)

**Major Restorative Services**

Crowns, inlays, onlays, labial veneers, and crown buildups are covered only when needed because of decay or injury, and only when the tooth cannot be restored with amalgam or composite filling material. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Post and cores are covered only when needed due to decay or injury. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement. Limited to permanent teeth only. Also see the "Basic Restorative Services" section.

**Single Crowns**
- Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal (other than stainless steel)
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Stainless steel crown, prefabricated resin crown, and resin based composite crown - limited to once per tooth in any 24 consecutive month period. Stainless steel crowns, prefabricated resin crowns and resin based composite crowns are considered to be a temporary or provisional procedure when done within 24 months of a permanent crown. Temporary and provisional crowns are considered to be part of the permanent restoration.

**Inlays**
- Onlays, including inlay
- Labial veneers

Posts and buildups - only when done in conjunction with a covered unit of crown or bridge and only when necessitated by substantial loss of natural tooth structure.

- Cast post and core in addition to a unit of crown or bridge, per tooth
- Prefabricated post and composite or amalgam core in addition to a unit of crown or bridge, per tooth
- Crown or core buildup, including pins
Implant supported prosthetics - Allowance includes the treatment plan and local anesthetic, when done in conjunction with a covered surgical placement of an implant, on the same tooth.
   Abutment supported crown
   Implant supported crown
   Abutment supported retainer for fixed partial denture
   Implant supported retainer for fixed partial denture
   Implant/abutment supported removable denture for completely edentulous arch
   Implant/abutment supported removable denture for partially edentulous arch
   Implant/abutment supported fixed denture for completely edentulous arch
   Implant/abutment supported fixed denture for partially edentulous arch
   Dental implant supported connecting bar
   Prefabricated abutment
   Custom abutment

Implant services - Allowance includes the treatment plan, local anesthetic and post-surgical care. Limited to the replacement of permanent teeth only. The number of implants we cover is limited to the number of teeth extracted while insured under this plan.
   Surgical placement of implant body, endosteal implant
   Surgical placement, eposteal implant
   Surgical placement, transosteal implant

Other Implant Services
   Bone replacement graft for ridge preservation, per site, when done in conjunction with a covered surgical placement of an implant in the same site, limited to once per tooth, per lifetime
   Radiographic/surgical implant index - limited to once per arch in any 24 month period
   Repair implant supported prosthesis
   Repair implant abutment
   Implant removal
Options G, H

Prosthodontic Services
Specialized techniques and characterizations are not covered. Facings on dental prostheses for teeth posterior to the second bicuspid are not covered. Allowance includes insulating bases, temporary or provisional restorations and associated gingival involvement.

Fixed bridges - Each abutment and each pontic makes up a unit in a bridge

Bridge abutments - See inlays, onlays and crowns under "Major Restorative Services"

Bridge Pontics
Resin with metal
- Porcelain
- Porcelain with metal
- Full cast metal
- 3/4 cast metal crowns
- 3/4 porcelain crowns

Dentures - Allowance includes all adjustments and repairs done by the dentist furnishing the denture in the first 6 consecutive months after installation and all temporary or provisional dentures. Temporary or provisional dentures, stayplates and interim dentures older than one year are considered to be a permanent appliance.

Complete or Immediate dentures, upper or lower
Partial dentures - Allowance includes base, clasps, rests and teeth
- Upper, resin base, including any conventional clasps, rests and teeth
- Upper, cast metal framework with resin denture base, including any conventional clasps, rests and teeth
- Lower, resin base, including any conventional clasps, rests and teeth
- Lower, cast metal framework with resin denture base, including any conventional clasps, rests and teeth
- Interim partial denture (stayplate), upper or lower, covered on anterior teeth only
- Removable unilateral partial, one piece cast metal, including clasps and teeth

Simple stress breakers, per unit

Fixed And Removable Appliances
Fixed and Removable Appliances To Inhibit Thumbsucking - limited to covered persons under age 14 and limited to initial appliance only. Allowance includes all adjustments in the first 6 months after insertion.

Other Implant Services
Sinus augmentation.

Other Services
Occlusal guards are limited to once every 36 months.

Diagnostic Services
Cone beam imaging limited to once every 5 years.
Options G, H

**Group IV - Orthodontic Services**

**Orthodontic Services** Any covered Group I, II or III service in connection with *orthodontic treatment*.

Transseptal fiberotomy

Surgical exposure of impacted or unerupted teeth in connection with *orthodontic treatment* - Allowance includes treatment and final radiographs, local anesthetics and post-surgical care.

Treatment *plan* and records, including initial, interim and final records.

Limited *orthodontic treatment*, Interceptive *orthodontic treatment* or Comprehensive *orthodontic treatment*, including fabrication and insertion of any and all fixed *appliances* and periodic visits.

Orthodontic retention, including any and all necessary fixed and removable *appliances* and related visits - limited to initial *appliance(s)* only.

CGP-3-DNTL-90-8 B498.0071
ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE

Eligible Employees
To be eligible for employee coverage under this plan, you must be an active full-time employee or an active part-time employee. And you must belong to a class of employees covered by this plan.

Other Conditions
You must enroll and agree to make required payments within 31 days of your eligibility date. If you fail to do so, you can’t enroll until this plan’s next vision open enrollment period.

This plan’s vision open enrollment period occurs from November 1st to November 14th of each year.

Once you enroll in this plan, you can’t drop your vision coverage until this plan’s next vision open enrollment period. And if you drop your vision coverage, you can’t enroll again until the next vision open enrollment period.

If you initially waived vision coverage under this plan because you were covered for vision care benefits under another group plan, and you wish to enroll in this plan because your coverage under the other plan ends, you may do so without waiting until the next vision open enrollment period. However, your coverage under the other plan must have ended due to one of the following events: (a) termination of your spouse’s employment; (b) loss of eligibility under your spouse’s plan; (c) divorce; (d) death of your spouse; or (e) termination of the other plan. But you must enroll in this plan within 30 days of the date that any of these events occur.

When Your Coverage Starts
Your coverage under this plan is scheduled to start on the effective date shown on the sticker attached to the inside front cover of this booklet. But you must be actively at work on that date. And you must have met all of the applicable conditions explained above, and any applicable waiting period. If you are not actively at work on that date, we will postpone your coverage until the date you return to active work.

Sometimes, the effective date shown on the sticker is not a regularly scheduled work day. But your coverage will still start on that date if you were actively at work on your last regularly scheduled work day.
All Options

When Your Coverage Ends

Your coverage under this **plan** ends on the last day of the pay period in which your active service ends for any reason. Such reasons include disability, retirement, layoff, leave of absence and the end of employment.

Your coverage ends on the date you die.

It also ends on the date you stop being a member of a class of employees eligible for insurance under this plan, or when this plan ends for all **employees**. And it ends when this **plan** is changed so that benefits for the class of **employees** to which you belong ends.

If you are required to pay part of the cost of this **plan** and you fail to do so, your coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

Read this booklet carefully if your coverage ends. You may have the right to continue vision care benefits for a limited time.

CGP-3-EC-90-3.0

All Options

Your Right To Continue Group Coverage During A Family Leave Of Absence

**Important Notice**

This section may not apply. You must contact your **employer** to find out if your **employer** must allow for a leave of absence under federal law. In that case the section applies.

**If Your Group Coverage Would End**

Group coverage may normally end for an **employee** because he or she ceases work due to an approved leave of absence. But, the **employee** may continue his or her group coverage if the leave of absence has been granted: (a) to allow the **employee** to care for a seriously injured or ill spouse, child, or parent; (b) after the birth or adoption of a child; (c) due to the **employee**’s own serious health condition; or (d) because of any serious injury or illness arising out of the fact that a spouse, child, parent, or next of kin, who is a covered servicemember, of the **employee** is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation. The **employee** will be required to pay the same share of the premium as he or she paid before the leave of absence.

**When Continuation Ends**

Coverage may continue until the earliest of the following:

- The date you return to active work.
- The end of a total leave period of 26 weeks in one 12 month period, in the case of an **employee** who cares for a covered servicemember. This 26 week total leave period applies to all leaves granted to the **employee** under this section for all reasons.
- The end of a total leave period of 12 weeks in: (a) any 12 month period, in the case of any other **employee**; or (b) any later 12 month period in the case of an **employee** who cares for a covered servicemember.
Your Right To Continue Group Coverage During A Family Leave Of Absence (Cont.)

- The date on which your coverage would have ended had you not been on leave.
- The end of the period for which the premium has been paid.

Definitions

As used in this section, the terms listed below have the meanings shown below:

- **Active Duty**: This term means duty under a call or order to active duty in the Armed Forces of the United States.

- **Contingency Operation**: This term means a military operation that: (a) is designated by the Secretary of Defense as an operation in which members of the armed forces are or may become involved in military actions, operations, or hostilities against an enemy of the United States or against an opposing military force; or (b) results in the call or order to, or retention on, active duty of members of the uniformed services under any provision of law during a war or during a national emergency declared by the President or Congress.

- **Covered Servicemember**: This term means a member of the Armed Forces, including a member of the National Guard or Reserves, who for a serious injury or illness: (a) is undergoing medical treatment, recuperation, or therapy; (b) is otherwise in outpatient status; or (c) is otherwise on the temporary disability retired list.

- **Next Of Kin**: This term means the nearest blood relative of the employee.

- **Outpatient Status**: This term means, with respect to a covered servicemember, that he or she is assigned to: (a) a military medical treatment facility as an outpatient; or (b) a unit established for the purpose of providing command and control of members of the Armed Forces receiving medical care as outpatients.

- **Serious Injury Or Illness**: This term means, in the case of a covered servicemember, an injury or illness incurred by him or her in line of duty on active duty in the Armed Forces that may render him or her medically unfit to perform the duties of his or her office, grade, rank, or rating.

Dependent Vision Care Expense Coverage

Eligible Dependents

Your eligible dependents are: (a) your legal spouse; (b) your dependent children who are under age 26.
All Options

Adopted Children And Step-Children

Your "unmarried dependent children" include your legally adopted children and, if they depend on you for most of their support and maintenance, your step-children. We treat a child as legally adopted from the time the child is placed in your home for the purpose of adoption. We treat such a child this way whether or not a final adoption order is ever issued.

We exclude any dependent who is insured by this plan as an employee. And we exclude any dependent who is on active duty in any armed force.

All Options

Handicapped Children

You may have an unmarried child with a mental or physical handicap, or developmental disability, who can't support himself. Subject to all of the terms of this section and the plan, such a child may stay eligible for dependent vision care benefits past this plan's age limit.

The child will stay eligible as long as he stays unmarried and unable to support himself, if: (a) his conditions started before he reached this plan's age limit; (b) he became insured by this plan before he reached the age limit, and stayed continuously insured until he reached such limit; and (c) he depends on you for most of his support and maintenance.

But, for the child to stay eligible, you must send us written proof that the child is handicapped and depends on you for most of his support and maintenance. You have 31 days from the date the child reaches the age limit to do this. We can ask for periodic proof that the child's condition continues. But, after two years, we can't ask for this proof more than once a year.

The child's coverage ends when yours does.

All Options

When Dependent Coverage Starts

In order for your dependent coverage to begin, you must already be insured for employee coverage, or enroll for employee and dependent coverage at the same time. Subject to the "Exception" stated below and to all of the terms of this plan, the date your dependent coverage starts depends on when you elect to enroll all of your initial dependents and agree to make any required payments.

If you do this on or before your eligibility date, date, your dependent coverage is scheduled to start on the later of the date you sign the enrollment form and the date you become covered for employee coverage.

If you do this within 31 days of your eligibility date, date, your dependent coverage is scheduled to start on the date you become covered for employee coverage.
If you do this after the enrollment period ends, you can’t enroll your initial dependents until the next vision open enrollment period.

Once you have coverage for your initial dependents, you must notify us when you acquire any new dependents, and agree to make any additional payments required for the coverage. If you do this within 31 days of the date the newly acquired dependent becomes eligible, the dependent’s coverage will start on the date the dependent becomes eligible. If you fail to notify us on time, you can’t enroll the newly acquired dependent until the next vision open enrollment period.

Once a dependent is enrolled for vision care expense insurance, the coverage can’t be dropped until the next vision open enrollment period. And once coverage is dropped for a dependent, the dependent can’t be enrolled again until the next vision open enrollment period.

**All Options**

**Exception**

If a dependent, other than a newborn child, is confined to a hospital or other health care facility; or is home-confined; or is unable to carry out the normal activities of someone of like age and sex on the date his dependent benefits would otherwise start, we will postpone the effective date of such benefits until the day after his discharge from such facility; until home confinement ends; or until he resumes the normal activities of someone of like age and sex.

**Newborn Children**

We cover your newborn child from the moment of birth if you’re already insured for dependent vision coverage, and you notify us within 31 days of the child’s birth. If you fail to notify us on time, you can’t enroll the child until the next vision open enrollment period.

If the newborn child is your first eligible dependent, we cover the child from the moment of birth if you enroll for dependent coverage and agree to make any required payments within 31 days of the child’s birth. If you fail to enroll on time, you can’t enroll the child until the next vision open enrollment period.

If the newborn child is not your first eligible dependent, but you did not previously enroll your other eligible dependents for vision care expense coverage, you can enroll the child during the next vision open enrollment period, if you also enroll all of your other eligible dependents at this time.
Dependent coverage ends for all of your dependents when your employee coverage ends. But if you die while insured, we’ll automatically continue dependent vision care benefits for those of your dependents who are insured when you die. We’ll do this for six months at no cost, provided: (a) the group plan remains in force; (b) the dependents remain eligible dependents; and (c) in the case of a spouse, the spouse does not remarry.

If a surviving dependent elects to continue his dependent vision care benefits under this plan’s "Federal Continuation Rights" provision, or under any other continuation provision of this plan, if any, this free continuation period will be provided as the first six months of such continuation. Premiums required to be paid by, or on behalf of a surviving dependent will be waived for the first six months of continuation, subject to restrictions (a), (b) and (c) above. After the first six months of continuation, the remainder of the continuation period, if any, will be subject to the premium requirements, and all of the terms of the "Federal Continuation Rights" or other continuation provisions.

Dependent coverage also ends for all of your dependents when you stop being a member of a class of employees eligible for such coverage. And it ends when this plan ends, or when dependent coverage is dropped from this plan for all employees or for an employee’s class.

If you are required to pay part of the cost of dependent coverage, and you fail to do so, your dependent coverage ends. It ends on the last day of the period for which you made the required payments, unless coverage ends earlier for other reasons.

An individual dependent’s coverage ends when he stops being an eligible dependent. This happens to a child on the last day of the month in which the child attains this plan’s age limit, when he marries, or when a step-child is no longer dependent on the employee for support and maintenance. It happens to a spouse on the last day of the pay period in which a marriage ends in legal divorce or annulment.

Read this plan carefully if dependent coverage ends for any reason. Dependents may have the right to continue vision care benefits for a limited time.
CERTIFICATE AMENDMENT

This rider amends the "Dependent Coverage" provisions as follows:

An employee’s domestic partner will be eligible for vision care coverage under this plan. Coverage will be provided subject to all the terms of this plan and to the following limitations:

To qualify for such coverage, both the employee and his or her domestic partner must:

- be 18 years of age or older;
- be of the same gender;
- be unmarried, constitute each other’s sole domestic partner and not have had another domestic partner in the last 12 months;
- share the same permanent address for at least 12 consecutive months and intend to do so indefinitely;
- share joint financial responsibility for basic living expenses including food, shelter and medical expenses;
- not be related by blood to a degree that would prohibit marriage in the employee’s state of residence; and
- be financially interdependent which must be demonstrated by at least four of the following:
  a. ownership of a joint bank account;
  b. ownership of a joint credit account;
  c. evidence of a joint mortgage or lease;
  d. evidence of joint obligation on a loan;
  e. joint ownership of a residence;
  f. evidence of common household expenses such as utilities or telephone;
  g. execution of wills naming each other as executor and/or beneficiary;
  h. granting each other durable powers of attorney;
  i. granting each other health care powers of attorney;
  j. designation of each other as beneficiary under a retirement benefit account; or
  k. evidence of other joint financial responsibility.

The employee must complete a "Declaration of Domestic Partnership" attesting to the relationship.

The domestic partner’s dependent children will be eligible for coverage under this plan on the same basis as if the children were the employee’s dependent children.
Coverage for the domestic partner and his or her dependent children ends when the domestic partner no longer meets the qualifications of a domestic partner as indicated above. Upon termination of a domestic partnership, a "Statement of Termination" must be completed and filed with the employer. Once the employee submits a "Statement of Termination," he or she may not enroll another domestic partner for a period of 12 months from the date of the previous termination.

And, the domestic partner and his or her children will be not eligible for:

a. survivor benefits upon the employee's death as explained under the "When Dependent Coverage Ends" section; or

b. continuation of vision care coverage as explained under the "Federal Continuation Rights" section and under any other continuation rights section of this plan, unless the employee is also eligible for and elects continuation.

This rider is a part of this plan. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this plan.

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary
**VISION CARE HIGHLIGHTS**

This page provides a quick guide to some of the Vision Care Expense Insurance plan features which people most often want to know about. But it’s not a complete description of your Vision Care Expense Insurance plan. Read the following pages carefully for a complete explanation of what we pay, limit and exclude.

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<td>For Covered Charges</td>
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### VISION CARE HIGHLIGHTS

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If a member receives elective contact lenses from a preferred provider that is not part of the formulary, we waive the plan’s materials copay. We also waive the copay for elective contact lenses received from a non-preferred provider.
Options E, G

VISION CARE EXPENSE INSURANCE

This insurance will pay many of your and your covered dependent’s vision care expenses. What we pay and the terms for payment are explained below.

CGP-3-VSN-96-VIS B505.0007

Options E, G

Vision Service Plan - This Plan’s Vision Care Preferred Provider Organization

Vision Service Plan

This plan is designed to provide high quality vision care while controlling the cost of such care. To do this, the plan encourages a covered person to seek vision care from doctors and vision care facilities that belong to Vision Service Plan (VSP), a vision care preferred provider organization (PPO).

This vision care PPO is made up of preferred providers in a covered person’s geographic area. A vision care preferred provider is a vision care practitioner or a vision care facility that: (a) is a current provider of VSP; and (b) has a participatory agreement in force with VSP.

Use of the vision care PPO is voluntary. A covered person may receive vision care from any vision care provider. And, he or she is free to change providers at any time. But, this plan usually pays more in benefits for covered services furnished by a vision care preferred provider. Conversely, it usually pays less for covered services not furnished by a vision care preferred provider.

When an employee and his or her dependents enroll in this plan, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care preferred providers.

What we pay is based on all the terms of this plan. The covered person should read this material with care, and have it available when seeking vision care. Read this plan carefully for specific benefit levels, copayments, deductibles, payment rates and payment limits.

The covered person can call VSP if he or she has any questions after reading this material.

Choice Of Preferred Providers

When a person becomes enrolled in this plan, he or she will receive a list of VSP preferred providers in his or her area. A covered person may receive vision services from any VSP preferred provider.

Replacement Of Preferred Provider

If a preferred provider terminates his or her relationship with VSP for any reason, VSP shall be responsible for furnishing vision services to covered persons either through that provider or through another VSP preferred provider.
Pre-Authorization Of Preferred Provider Services

When a covered person desires to receive treatment from a preferred provider, the covered person must contact the preferred provider BEFORE receiving treatment. The preferred provider will contact VSP to verify the covered person’s eligibility and VSP will notify the preferred provider of the 60 day time period during which the covered person may schedule an appointment. If the covered person cancels an appointment and reschedules it, it must be done within those 60 days. If the appointment is not rescheduled during the previously approved time period, the covered person must contact the preferred provider again to receive authorization.

What we pay is subject to all the terms of this plan.

CGP-3-VSN-96-PPOA B505.0009

Options E, G

Pre-Treatment Review For Necessary Contact Lenses

Subject to prior approval by VSP consultants, we will pay benefits for Necessary Contact Lenses provided to a covered person. A covered person’s doctor must request approval for Necessary Contact Lenses from VSP.

No benefits will be paid for Necessary Contact Lenses if prior approval is not received from VSP.

What we pay for Necessary Contact Lenses is subject to all of the terms of this plan.

CGP-3-VSN-96-PTR2 B505.0014

Options E, G

Claim Appeals

If, under the provisions of this plan, a claim for benefits is denied in whole or in part, a request, in writing, may be submitted to VSP for a full review of the denial.

The written request must be made to the Plan Administrator within 60 days following the denial of benefits. The request should contain sufficient information to identify the covered person whose benefits were denied. This includes the name of the covered person, the employee’s social security number and the employee’s date of birth. The covered person may state the reasons he or she believes that the denial of the claim was in error and may provide any pertinent documents which he or she wishes to be reviewed. The Plan Administrator will review the claim and give the covered person the opportunity to review pertinent documents, submit any statements, documents or written arguments in support of the claim, and appear personally to present materials or arguments. The determination of the Plan Administrator, including specific reasons for the decision, shall be provided and communicated to the covered person in writing within one hundred twenty (120) days after receipt of a request to review.

Any dispute or question arising between VSP and any covered person involving the application, interpretation or performance under this plan shall be settled, if possible, by amicable and informal negotiations, allowing such opportunity as may be appropriate under the circumstances for fact finding and mediation.
Preferred Provider Grievance Procedures

Grievances are handled by VSP’s Professional Relations Vice President for action. The grievance process is designed to address covered persons’ concerns quickly and satisfactorily. The following grievance procedures have been established:

1. The patient’s written complaint will be referred to VSP’s Professional Relations Vice President for action.
2. The complaint will be evaluated and, if deemed appropriate, the original examining doctor will be contacted.
3. If the complaint can be resolved within fifteen (15) days, the disposition of the complaint will be forwarded to the covered person. Otherwise, a notice of receipt of the complaint will be forwarded to the covered person advising the time for resolution.
4. Grievance procedures and complaint forms will be maintained in each preferred provider’s office.
5. All complaints will be retained in the Professional Relations Department.

Complaints and grievances may be sent to the Professional Relations Vice President at:

Vision Service Plan, Inc.
3333 Quality Drive
Rancho Cordova, California 95670
(877) 814-8970 or (800) 877-7195

CGP-3-VSN-96-APP-TN B505.0407

Options E, G

How This Plan Works

We pay benefits for the covered charges a covered person incurs as follows. The services and supplies covered under this plan are explained in the "Covered Services and Supplies" section of this plan. What we pay is subject to all of the terms of this plan. Read the entire plan to find out what we limit or exclude.

Services or Supplies From a Preferred Provider

If a covered person uses the services of a preferred provider, the preferred provider must receive approval from VSP prior to providing the covered person with any service or supply. See the "Pre-Authorization of Preferred Provider Services" section of this plan for specific requirements.

Copayments

The covered person must pay a copayment when he or she receives services from a preferred provider. We pay benefits for the covered charges a covered person incurs in excess of the copayment. This plan’s copayments are as follows:

For each vision examination from a preferred provider ............... $20.00
Services or Supplies From a Preferred Provider (Cont.)

For each pair of standard frames and/or standard lenses from a preferred provider $20.00

For Necessary Contact Lenses from a preferred provider $20.00

Payment Limits
Payment limits, durational or monetary, are shown in the "Covered Services and Supplies" section of this plan. When a monetary payment limit is set for a pair of materials, the limit is automatically halved if only one item is purchased.

Payment Rates
Once a covered person has paid any applicable copayment, we pay benefits for covered charges under this plan as follows. What we pay is subject to all of the terms of this plan.

For covered charges 100%

Discounts
If a covered person receives a vision examination, and lenses or frames from a preferred provider, he or she will receive a discount on the cost of purchasing an unlimited number of prescription glasses and non-prescription sunglasses from the any preferred provider. The covered person may also receive a discount on the costs of evaluation and fitting of contact lenses. No discount applies to contact lenses or materials. The discount is available for 12 months after the initial examination.

The discounts are:

For Prescription Glasses 20% off of the preferred provider's usual and customary fee

For Non-Prescription Sunglasses 20% off of the preferred provider's usual and customary fee

For Contact Lens Evaluation and Fitting Costs 15% off of the preferred provider's usual and customary fee

If a covered person receives a vision examination, and lenses or frames from a preferred provider, he or she will receive a discount on the cost of purchasing an unlimited number of additional prescription glasses and non-prescription sunglasses from the same preferred provider on the same day.

The discounts are:

For Prescription Glasses 30% off of the preferred provider's usual and customary fee

For Non-Prescription Sunglasses 30% off of the preferred provider's usual and customary fee
Options E, G

**Services or Supplies From a Non-Preferred Provider**

If a *covered person* uses the services of a *non-preferred provider*, the *covered person* must submit the itemized bill to VSP for claims payment. All claims must be sent to VSP within 180 days of the date services are completed or supplies are received. The benefits we pay are subject to all of the terms of this *plan.*

<table>
<thead>
<tr>
<th>Cash Deductible For Services Of A Non-Preferred Provider</th>
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<td>There are separate cash <em>deductibles</em> for each <em>covered service</em> provided by a <em>non-preferred provider</em>. These cash <em>deductibles</em> are shown below. The <em>covered person</em> must have covered charges in excess of the cash <em>deductible</em> before we pay him or her any benefits for the service or supply.</td>
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<td>Once a <em>covered person</em> has met any applicable <em>deductible</em>, we pay benefits for covered charges under this <em>plan</em> as follows. What we pay is subject to all of the terms of this <em>plan</em>.</td>
</tr>
<tr>
<td>For covered charges ................................................................. 100%</td>
</tr>
</tbody>
</table>

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Options E, G

**Covered Charges**

Covered charges are the *usual* and *customary* charges for the services and supplies described below. We pay benefits only for covered charges incurred by a *covered person* while he or she is insured by this *plan*. Charges in excess of any payment limits shown in this *plan* are not covered charges.

**Covered Services and Supplies**

This section lists the types of charges we cover. But what we pay is subject to all of the terms of this *plan*. Read the entire *plan* to find out what we limit or exclude.

All covered vision services must be furnished by or under the direct supervision of an optometrist, ophthalmologist or other licensed or qualified vision care provider. The services or supplies must be the *usual* and *customary* treatment for a vision condition.
Vision Examinations

We cover charges for comprehensive vision care examinations. Such examinations include a complete analysis of the eyes and related structures to determine the presence of vision problems or other abnormalities. When a vision examination indicates that new lenses or frames or both are **visually necessary and appropriate** for the proper visual health of a **covered person**, professional services covered by this plan include:

- prescribing and ordering of proper lenses;
- assisting in the selection of frames;
- verifying the accuracy of finished lenses;
- proper fitting and adjustment of frames;
- subsequent adjustments to frames to maintain comfort and efficiency; and
- progress or follow-up work as necessary.

We don't cover more than one vision examination in any calendar year period.

And if a **covered person** uses a **non-preferred provider**, we limit what we pay for each vision examination to $50.00.

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Options E, G

**Standard Lenses**

We cover charges for single vision, bifocal, trifocal or **lenticular lenses**. We cover glass, plastic or for dependent children to age 26, polycarbonate lenses.

If a **covered person** uses a **non-preferred provider**, we limit what we pay to

- $50.00 for each pair of single vision lenses
- $75.00 for each pair of bifocal lenses
- $100.00 for each pair of trifocal lenses and
- $125.00 for each pair of **lenticular lenses**.

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Options E, G

We cover charges for one pair of **standard lenses** in any calendar year **benefit period**.

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Options E, G

**Standard Frames**

We cover charges for standard frames.

If a covered person uses a preferred provider, we cover charges up to a retail frame allowance of $130.00, plus 20% of any amount over the allowance.
If a covered person uses a non-preferred provider, we limit what we pay for each set of standard frames to $70.00.

If the covered person chooses elective contact lenses, we do not cover standard frames until the beginning of the calendar year following the next calendar year after the date the elective contacts are purchased.

We cover charges for one set of standard frames in any period of 2 calendar years.

Options E, G

Necessary Contact Lenses We cover charges for Necessary Contact Lenses upon prior approval by VSP. We cover charges, and charges for related professional services, only if the lenses are needed:

(a) following cataract surgery;
(b) to correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
(c) for certain conditions of anisometropia; or
(d) for keratoconus.

We don't cover charges for more than one pair of Necessary Contact Lenses in any calendar year period.

If a covered person receives Necessary Contact Lenses from a preferred provider, we pay 100% of covered charges. If he or she receives Necessary Contact Lenses from a non-preferred provider, we limit what we pay to $210.00 in any calendar year period.

Options E, G

Elective Contact Lenses We cover charges for elective contact lenses, but only in lieu of standard lenses and standard frames. We cover charges for hard, rigid gas permeable, soft, disposable, 30-day extended wear, daily-wear and planned replacement elective lenses.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses until the next calendar year and standard frames for a period of 2 calendar years.

If a covered person uses a preferred provider, we limit what we pay for elective contact lenses to $130.00.
If a covered person uses a non-preferred provider, we limit what we pay for elective contact lenses to $105.00.

We cover charges for one set of elective contact lenses in any calendar year period.

**Diabetic Eye Care Program**

We pay benefits for covered charges for diabetic eye care from a Preferred Provider. The Covered Person must pay a $20.00 Copayment for each office visit. In order to be covered, the services for diabetic eye care must be within the scope of the Preferred Provider’s optometric license. We cover charges for the treatment of non-surgical medical eye conditions for Covered Persons with type 1 or type 2 diabetes. We cover charges for: Medical follow up exams, specialized screening and tests and medically necessary retinal imaging.

**Options E, G**

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**Special Limitations**

If, prior to being covered under this plan, a covered person was covered by another vision care plan with VSP under which he or she received a covered service within 6 months prior to the effective date of this plan, the date he or she received such a covered service will be used as the last date of service when applying the benefit period limitations under this plan. We apply this provision only if the covered person was enrolled in another VSP plan immediately before enrolling in this plan.

**Options E, G**

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**Exclusions**

- We won’t pay for orthoptics or vision training and any associated supplemental testing.
- We won’t pay for medical or surgical treatment of the eyes.
- We won’t pay for any eye examination or corrective eyewear required by an employer as a condition of employment.

**Options E, G**

- We will not pay for plano lenses (lenses with less than a +/- .38 diopter power).
- We will not pay for two sets of glasses in lieu of bifocals.
- We will not pay for replacement of lenses and frames furnished under this plan which are lost or broken, except at normal intervals when services are otherwise available.
Exclusions (Cont.)

- We will not pay for cosmetic lenses or any cosmetic process, unless specifically shown as covered in the "Covered Services and Supplies" section.

- We will not pay for a frame that costs more than the plan allowance.

- We will not pay for refitting of contact lenses after the initial 90 day fitting period.

- We will not pay for routine maintenance of contact lenses such as polishing or cleaning.

- We will not pay for Corneal Refractive Therapy (CRT) or Orthokeratology (procedure using contact lenses to change the shape of the cornea in order to reduce myopia).

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Options E, G

- We will not pay for photochromic lenses and tinted lenses, except for pink #1 and pink #2.

B505.1015

Options E, G

- We will not pay for UV (ultraviolet) protected lenses.

B505.1016

Options E, G

- We will not pay for the scratch resistant coating of the lens or lenses.

B505.1017

Options E, G

- We will not pay for blended lenses.

B505.1018

Options E, G

- We will not pay for high index lenses.

B505.1019

Options E, G

- We will not pay for the mirror/ski coating of the lens or lenses.

B505.1020

Options E, G

- We will not pay for oversized lenses.

B505.1021
Options E, G
- We will not pay for laminating of the lens or lenses.

Options E, G
- We will not pay for edge treatment.

Options E, G
- We will not pay for progressive lenses.
- We will not pay for progressive multifocal lenses.

Options E, G
- We will not pay for the anti-reflective coating of the lens or lenses.

Options E, G
- We will not pay for polycarbonate lenses.

Options E, G
Charges not covered due to this provision are not considered covered vision services and cannot be used to satisfy this plan’s copayments or deductibles, if any.
VISION CARE BENEFITS

This insurance will pay many of an employee's and his or her covered dependent's vision care expenses. What we pay and the terms for payment are explained below.

This Plan's Vision Care Preferred Provider Organization

Davis Vision: This plan is designed to provide a high quality vision care benefit while controlling the cost of such care. To do this, the plan encourages a covered person to seek vision care from doctors and vision care facilities that belong to Davis Vision's Preferred Provider Network.

This vision care preferred provider organization (PPO) is made up of preferred providers in a covered person's geographic area. A vision care preferred provider is a vision care practitioner or a vision care facility that: (a) is a credentialed provider in Davis Vision's network; and (b) has a current participatory agreement in force with Davis Vision.

Use of the vision care PPO is voluntary. A covered person may receive vision care from either a preferred provider or a non-preferred provider. And, he or she is free to change providers at any time. But, this plan usually pays more in benefits for covered services furnished by a vision care preferred provider. Conversely, it usually pays less for covered services not furnished by a vision care preferred provider.

When an employee and his or her dependents enroll in this plan, they will get an enrollment packet which will tell them how to obtain benefits and information about current vision care preferred providers.

What we pay is based on all of the terms of this plan. The covered person should read this material with care and have it available when seeking vision care. Read this plan carefully for specific benefit levels, frequencies, copayments and payment limits.

The covered person can call Davis Vision if he or she has any questions after reading this material.

Choice of Preferred Providers

When a person becomes enrolled in this plan, he or she will receive information about Davis Vision preferred providers in his or her area. A covered person may receive vision services from any current Davis Vision preferred provider.

When a covered person wants to receive services from a preferred provider, he or she must contact the preferred provider before receiving treatment. The preferred provider will contact Davis Vision to verify the covered person’s eligibility before any treatment takes place.

It is not necessary to submit a claim for services or supplies from a preferred provider.
This Plan’s Vision Care Preferred Provider Organization (Cont.)

Non-Preferred Providers

If a covered person receives services or supplies from a non-preferred provider, he or she must submit a claim form along with the itemized bill to Davis for claims payment. All claims must be sent to Davis within 90 days of the date services are completed or supplies are received.

Claims for services or supplies from a non-preferred provider must be sent to:

Davis Vision - Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

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Options F, H

Appeals Process

In the event that a claim is denied, Davis Vision will consult with the provider involved with the covered person’s vision care treatment. If the issue cannot be resolved, the provider or patient has the right to request a review of the adverse determination. The provider, covered person or patient may appeal denied authorizations or claim decisions. Should a covered person request a review of an authorization or claim decision, Davis Vision must notify the covered person, or his or her designee, within five (5) business days of receipt of the request and the review must be conducted by a clinical peer who was not involved in the original vision care determination. Pre-service review decisions are to be completed within fifteen (15) days and post-service review decisions are to be completed within thirty (30) days, or as required by state statute, from the date that Davis Vision receives notification from the covered person or his or her designee and be mailed within five (5) days of the date of decision. Denials can be appealed through Davis Vision’s Grievance Resolution Process or as per plan contract. A covered person has the right to appeal through an external review organization at any time during the grievance process. A covered person has the right to designate a representative, including his or her provider, to act on his or her behalf with regard to review of a vision care claim determination. Use of the Appeals Process does not waive the covered person’s legal rights.

Grievance Process

Registering a Complaint or Grievance

A covered person has the right to file a grievance or make an appeal to any claim decision at any time. The covered person has the right to designate a representative to file complaints and appeals on his or her behalf.

A covered person is entitled to a copy of the Grievance Resolution process upon request and a copy will be provided to a covered person should the determination be made that vision care benefits are not available.

Davis Vision defines a "grievance" as a complaint that may or may not require specific corrective action and is made:
1. via the telephone;
2. in writing to Davis Vision;
3. via the Davis Vision website.

A grievance or complaint can arise from and includes but is not limited to the following:

1. benefit denials.
2. an adverse determination as to whether a service is covered pursuant to the terms of the contract.
3. difficulty accessing or utilizing a benefit, and issues regarding the quality of vision care services.
4. challenges with vision care services or products received.
5. dissatisfaction with the resolution of a complaint/grievance or appeal.

Verbal Grievances and Telephone Communication

A covered person may file a verbal grievance by contacting Davis Vision. Registering a grievance by telephone will be considered filing a "formal grievance". A Davis Vision associate will acknowledge receipt of all complaints in writing within five (5) business days from the date the grievance or appeal is received.

A covered person has access to the Davis Vision toll free number twenty-four (24) hours a day seven (7) days a week to voice any concern or grievance and also has the right to contact their Human Resources Department or Benefits Administration Department. The Davis Vision Toll Free number is: 1 (800) 584-1487.

Written Grievances

Written notice of grievances received via e-mail, U.S. Mail or other written correspondence will be acknowledged within five (5) business days. All written correspondence should be addressed to:

Davis Vision
159 Express Street
Plainview, New York 11803
Attention: Quality Assurance/Patient Advocate Department

A covered person can register any concern or grievance by logging on to Davis’ website: www.davisvision.com and entering the "Contact Davis Vision" area.
Internal Grievance Procedure

**Appeal Level 1**

Upon receipt of a concern or grievance by a Davis Vision associate, the *covered person* is contacted by telephone, or in writing, within five (5) business days to confirm that the concern or grievance was received and is being investigated. Every attempt is made to contact the *covered person* or his or her designated representative. Contact may include but is not limited to telephone contact, e-mail or U.S. Mail. A designated Davis Vision associate reviews the appeal with the *covered person* and may request additional information. Details of the complaint are documented in the *covered person’s* file. The *covered person* is given the Associate’s name, phone number, department and the estimated time needed to perform the research. The *covered person* is informed of their right to have a representative, including their provider, present during the review of the concern and final outcome of the investigation. The *covered person* is informed of their right to appeal to an external review organization at any time during the grievance procedure or as required by state statute.

The review committee will include a licensed (peer) health care professional when grievances pertain to clinical decisions. All decisions are reviewed and approved by the Vice President of Professional Affairs, a licensed optometrist.

The investigation may involve contacting the provider or the point of service location to determine the cause of the concern. If necessary, the Regional Quality Assurance Representative (RQAR) or Professional Field Consultant (PFC) will be contacted and a site visit may be scheduled. Davis Vision will contact the *covered person* when further information is required and inform them of the status of the investigation or the need for more information.

**Options F , H**

The determination will be communicated to the *covered person* within fifteen (15) days for pre-service review decisions and within thirty (30) days for post-service review decisions, or as required by state statute. An additional ten (10) days may be requested in order to complete further research. The written decision will be mailed to the *covered person* within five (5) days of the decision. The appeal determination will include the following:

- the decision, and will include a summary of the facts related to the issue,
- the criteria that was used, summary of the evidence, including the documentation supporting the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing to the Quality Assurance/Patient Advocate Department within fifteen (15) business days of the date of the notice of the decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of the person(s) responsible for the decision.

The decision of the Quality Assurance/Patient Advocate Department shall be final and binding unless appealed by the *covered person* to Davis Vision within fifteen (15) business days of the date of notice of the decision.
Internal Grievance Procedure (Cont.)

**Appeal Level 2** Should Davis Vision uphold a denial, as the result of a Level 1 review, the *covered person* has the right to request a Level 2 appeal.

A Level 2 appeal will not include associate(s) or licensed (peer) health care professional(s) that were involved in the Level 1 review.

A Level 2 appeal requires the *covered person* to contact Davis Vision in writing or by telephone within fifteen (15) days following receipt of the Level 1 summary statement. The *covered person* requesting a Level 2 appeal must indicate the reason they believe the denial of coverage was incorrect. Davis Vision reserves the right to request further information from the *covered person* or provider.

Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 pre-service review. Davis Vision has thirty (30) days, or as required by state statute, from the date the requested information is received, to respond to the Level 2 post-service review. The Vice President of Professional Affairs will review all clinical appeals. A Davis Vision Associate(s) and a Regional Quality Assurance Representative(s) (RQAR), a licensed optometrist, not involved in the initial determination will review the Level 1 decision. If the Level 2 appeal upholds the Level 1 determination the *covered person* will be notified in writing of this decision. Notification will include, but not be limited to:

- the decision, and contain a summary stating the nature of the concern and the facts related to the issue,
- the criteria that was used, summary of the evidence, including documentation that was used to support the decision,
- a statement indicating that the decision will be final and binding unless the *covered person* appeals in writing or by telephone to the Quality Assurance/Patient Advocacy Department within forty-five (45) days of the date of the notice of the Level 2 decision,
- a copy of the appeals process, if applicable, and
- the name, position, phone number, and department of person(s) responsible for the decision.

**External Review** A *covered person*, as required by state statute, has the right to request an impartial review of concerns that resulted in a denial of coverage. A *covered person* who has exhausted the internal appeals process may appeal the final decision if the denial for services was not deemed medically necessary or the requested service was deemed Investigational or Experimental.

An external review organization will refer the case for review by a neutral, independent practitioner experienced in vision care. Davis Vision will provide all requested documentation to the external review organization. The external review organizations will have up to thirty (30) days, or as required by state statute, to make their determination.
External Review Process

A covered person has the right to an external review of a denial of coverage. A covered person has the right to an external review of a final adverse decision under the following circumstances:

- the covered person has been denied a vision care service, which should have been covered under the terms of the contract.
- services were denied on the basis that requested services were not medically necessary.
- a treatment or service that will have a significant positive impact on the covered person has been denied and any alternative service or treatment will not affect the Covered person’s ocular health and/or produce a negative outcome.
- services denied are related to a current illness or injury.
- the cost of the requested services will not exceed that of any equally effective treatment.
- the denied service, procedure or treatment is a covered benefit under the Covered person’s policy.
- the covered person has exhausted all internal appeal processes with an adverse determination upheld at each level.

Investigational or Experimental Treatment means an approved ocular diagnostic procedure warranted by the ocular health of the covered person and the subsequent diagnostic findings could alter the covered person’s treatment plan. The risk of a negative outcome utilizing the approved treatment would be no greater than utilizing an alternative treatment.

The vision care provider may contact the appropriate State Agency to determine if other documentation may be required for the appeal process.

Once the determination is made, notification is made, in writing, within two (2) business days. This notification will include an explanation and the clinical criteria used in the decision.

Options F, H

How This Plan Works

We pay benefits for the covered charges a covered person incurs as follows. What we pay is subject to all of the terms of this plan. Read the entire plan to find out what we limit or exclude.

Covered charges are the usual charges for the services and supplies described below. We pay benefits only for covered charges incurred by a covered person while he or she is insured by this plan. Charges in excess of any payment limits shown in this plan are not covered charges.

When a payment limit is for a pair of materials (such as lenses), the limit is halved if only one item is purchased.
Options F, H

Copays

A covered person must pay a copay each time he or she receives a vision examination. A covered person must pay a copay each time he or she receives any vision materials covered by this plan.

How We Cover Vision Examinations

A covered person must pay a $20.00 copay each time he or she receives a vision examination. If the vision examination is performed by a preferred provider, we pay benefits in full for the exam in excess of the copay. If the vision examination is performed by a non-preferred provider, we pay benefits in excess of the copay up to $50.00.

We pay benefits for one vision examination in any calendar year.

A vision examination includes:

- case history - chief complaint, eye and vision history, medical history;
- entrance distance acuities;
- external ocular evaluation including slit lamp examination;
- internal ocular examination;
- tonometry;
- distance refraction - objective and subjective;
- binocular coordination and ocular motility evaluation;
- evaluation of papillary function;
- biomicroscopy;
- gross visual fields;
- assessment and plan;
- advice to a Covered Person on matters pertaining to vision care;
- form completion - school, motor vehicle, etc.

If the doctor recommends vision correction, we cover the fitting of eyeglasses and follow-up adjustments.

How We Cover Vision Materials

We pay benefits for either glass or plastic prescription single vision, bifocal, trifocal or lenticular lenses. We pay benefits for frames. We pay benefits for prescription contact lenses.

In any calendar year period, we pay benefits for either one pair of standard lenses or one pair of contact lenses, but not both.

In any period of 2 calendar years, we pay benefits for one set of frames.
Options F, H

How We Cover
Standard Lenses

A covered person must pay a $20.00 copay each time he or she purchases standard lenses. If the lenses are received from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the lenses are received from a non-preferred provider, we pay benefits in excess of the copay up to:

- $50.00 for single vision lenses;
- $75.00 for bifocal lenses;
- $100.00 for trifocal lenses; and
- $125.00 for lenticular lenses.

We cover one pair of standard lenses in any calendar year.

We cover charges for glass or plastic lenses in single vision, bifocal or trifocal prescriptions, including charges for the following cosmetic extras:

- oversized lenses;
- fashion and gradient tinting of plastic lenses;
- polycarbonate lenses (for children up to age 20 and monocular individuals and Covered Persons with prescriptions of greater than +/-6.00 diopters);
- glass-grey #3 prescription sunglasses.

The following cosmetic lens extras are not covered. But if a covered person purchases his or her lenses from a preferred provider, the price will be discounted as follows:

- standard progressive addition lenses - $50
- premium progressives (Varilux, Kodak, Seiko, Rodenstock) - $90
- photochromatic lenses - single vision or multifocal - $20
- scratch resistant coating - single vision or multifocal - $20
- ultra violet coating - $12
- blended invisible bifocal lenses - $20
- intermediate Lenses - $30
- plastic photosensitive lenses - $65
- polarized lenses - $75
- hi-Index lenses - $55
- supershield (scratchguard) coating - $20
- glare resistant treatment (multi layer hydrophobic) - $35
- premium glare resistant treatment - $48
Options F, H

How We Cover Elective Contact Lenses

We cover charges for standard, soft, daily-wear, disposable or planned replacement contact lenses, but only in lieu of standard lenses and frames.

If we cover charges for elective contact lenses, we will not cover charges for standard lenses and frames until the next following calendar year.

A covered person must pay a $20.00 copay each time he or she purchases elective contact lenses.

If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $105.00.

If the contact lenses are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis’ elective contact lenses collection (the formulary), we cover any elective contact lenses selected from the formulary in full in excess of a $20.00 copay.
- We cover non-formulary elective contact lenses in full to the retail elective contact lenses allowance of $130.00. The copay is waived.
- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of a pair of non-formulary elective contact lenses, including evaluation and fitting, from the same preferred provider*.

The discount is an amount equal to 15% of the preferred provider’s usual and customary fee in excess of the copay and retail elective contact lenses allowance.

*At Wal-Mart locations, covered persons will receive Wal-Mart’s every day low price on purchases of elective contact lenses.

We cover one pair of elective contact lenses in any calendar year.

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Options F, H

How We Cover Necessary Contact Lenses

We cover charges for necessary contact lenses, including charges for related professional services:

- only if the lenses are needed for the correction of keratoconus; and
How This Plan Works (Cont.)

- the covered person complies with the following requirements regarding prior notification.

The covered person or the provider must send a completed request to Davis Vision for necessary contact lenses for the correction of keratoconus before the lenses are dispensed. If the required notification is not obtained, no benefits will be paid for such lenses.

A covered person must pay a $20.00 copay each time he or she purchases necessary contact lenses. If the contact lenses are purchased from a preferred provider, we pay benefits in full for the lenses in excess of the copay. If the contact lenses are purchased from a non-preferred provider, we pay benefits in excess of the copay up to a maximum of $210.00.

CGP-3-DAVIS-05-NCL  B505.0489

Options F, H

How We Cover Frames

A covered person must pay a copay each time he or she purchases a set of frames.

If the frames are purchased from a non-preferred provider, we pay benefits in excess of a $20.00 copay up to $70.00.

If the frames are purchased from a preferred provider, we pay benefits in excess of the copay as follows:

- If a preferred provider offers Davis’ Tower designer frame collection (the Tower), we cover any Fashion or Designer Collection frame selected from the Tower in excess of a $20.00 copay. We cover any Premier Collection frame selected from the Tower in full in excess of a $45.00 copay.

- We cover a non-Tower frame in excess of a $20.00 copay up to the retail frame allowance of $130.00.

- If a covered person receives a vision examination from a preferred provider, he or she will receive a discount on the cost of purchasing a pair of non-Tower frames from the same preferred provider*.

  The discount is an amount equal to 20% of the preferred provider’s usual and customary fee in excess of the copay and retail frame allowance.

  *At Wal-Mart locations, covered persons will receive Wal-Mart’s every day low price on frame purchases.

We cover one set of frames in any period of 2 calendar years.

CGP-3-DAVIS-05-FRM  B505.0853

Options F, H

Exclusions

- We won’t pay for orthoptics or vision training and any associated supplemental training.
• We won’t pay for medical or surgical treatment of the eyes.
• We won’t pay for any eye examination or corrective eyewear required by an employer as a condition of employment.
• We won’t pay for plano lenses (lenses with less than a +/- 0.38 diopter power).
• We won’t pay for two sets of glasses in lieu of bifocals.
• We won’t pay for replacement of lenses and frames furnished under this Plan which are lost or broken, except at normal intervals when services are otherwise available.
• We won’t pay for necessary contact lenses prescribed for a covered person affected with keratoconus for which prior notification was not sent to Davis Vision.
• We won’t pay for lens cosmetic extras that are not specifically listed in this Plan as covered.

CGP-3-DAVIS-05-EXC  B505.0492
CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of the any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Major Restorative Services are modified to provide that titanium or high noble metal (gold) is covered when used in a dental prosthesis.

This rider is part of the Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

The Guardian Life Insurance Company of America

[Signature]

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DGOPT-10

B531.0025
Options E, F

CERTIFICATE AMENDMENT

Effective on the latter of (i) the original effective date of the Policy; or (ii) the effective date of any applicable amendment requested by the Policyholder and approved by the Insurance Company, this rider amends the Dental Expense Insurance provisions of the Group Policy as follows:

The Alternate Treatment provision is changed to read as follow when titanium or high noble metal (gold) is used in a dental prosthesis.

If more than one type of service can be used to treat a dental condition, we have the right to base benefits on the least expensive service which is within the range of professionally accepted standards of dental practice as determined by us. For example, in the case of bilateral multiple adjacent missing teeth, or multiple missing teeth in both quadrants of an arch the benefit will be based on a removable partial denture. In the case of titanium or high noble metal (gold) used in a dental prosthesis, the benefit will be based on the noble metal benefit. In the case of a composite filling on a posterior tooth, the benefit will be based on the corresponding covered amalgam filling benefit.

This rider is part of the Policy. Except as stated in this rider, nothing contained in this rider changes or affects any other terms of this Policy.

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

CGP-3-A-DGOPT-10

B531.0029
CERTIFICATE AMENDMENT

The certificate is amended as follows:

The Vision Insurance eligibility provisions applicable to dependent coverage are modified to provide that:

(a) your dependent child is a child under age 26;

(b) marital status, residency and financial dependency requirements do not apply to your dependent child; except as stated in item (c);

(c) your handicapped child can stay eligible for dependent coverage past age 26 if your child is unmarried and is unable to support himself or herself; and

(d) reference to an individual dependent’s coverage ending when he or she marries or is no longer dependent on you for support and maintenance, except as stated for a handicapped child past the age limit, is deleted.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Stuart J. Shaw
Vice President, Risk Mgt. & Chief Actuary
CERTIFICATE AMENDMENT

Amendment Effective: On the later of January 1, 2012 and the effective date of your certificate.

This rider amends the ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE provisions of VSP’s vision coverage, by adding the following:

Vision Care Plan Election procedures: Your employer offers a Davis Vision care plan as an alternative to VSP’s vision coverage under this plan. You can enroll for either Davis Vision’s vision coverage or for the VSP’s vision coverage, but not both at the same time.

If you are enrolled for VSP’s vision coverage under this plan, you may change your election and enroll in Davis Vision’s vision care plan during any open enrollment period, except you may not change your election until the end of any 2 calendar year frequency benefit period.

If you change your election, your covered dependents will automatically be switched to Davis Vision’s vision care plan at the same time as you.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Vice President, Risk Mgt. & Chief Actuary

Stuart J. Shaw
CERTIFICATE AMENDMENT

Amendment Effective: On the later of January 1, 2012 and the effective date of your certificate.

This rider amends the ELIGIBILITY FOR VISION CARE EXPENSE COVERAGE provisions of VSP’s vision coverage, by adding the following:

Vision Care Plan Election procedures: Your employer offers a VSP vision care plan as an alternative to Davis Vision’s vision coverage under this plan. You can enroll for either the VSP vision coverage or for Davis Vision’s vision coverage, but not both at the same time.

If you are enrolled for Davis Vision’s vision coverage under this plan, you may change your election and enroll in the VSP vision care plan during any open enrollment period, except you may not change your election until the end of any 2 calendar year frequency benefit period.

If you change your election, your covered dependents will automatically be switched to the VSP vision care plan at the same time as you.

All terms and conditions of your certificate not specifically changed herein remain in full force and effect.

The Guardian Life Insurance Company of America

Stuart J Shaw
Vice President, Risk Mgt. & Chief Actuary

CGP-A-1

All Options
COORDINATION OF BENEFITS

Important Notice  This section applies to all group dental benefits under this plan. It does not apply to any death, dismemberment, or loss of income benefits that may be provided under this plan.

Purpose  When a covered person has dental coverage under more than one plan, this section allows this plan to coordinate what it pays with what other plans pay. This is done so that the covered person does not collect more in benefits than he or she incurs in charges.

Definitions

Allowable Expense  This term means a dental care or expense that is covered, at least in part, by any of the plans which cover the person. This includes: (a) deductibles; (b) coinsurance; and (c) copayments. When a plan provides benefits in the form of services, the reasonable cash value of each service will be considered an allowable expense and a benefit paid.

An expense or service that is not covered by any of the plans is not an allowable expense. Examples of other expenses or services that are not allowable expenses are:

(1) If a person is covered by two or more plans that compute their benefit payments on the basis of reasonable and customary charges, any amount in excess of the primary plan’s reasonable and customary charges for a specific benefit is not an allowable expense.

(2) If a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the primary plan’s negotiated fees for a specific benefit is not an allowable expense.

If a person is covered by one plan that computes its benefits or services on the basis of reasonable and customary charges and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan’s payment arrangements will be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan’s payment arrangement and if the provider’s contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefit.

Claim  This term means a request that benefits of a plan be provided or paid.

Claim Determination Period  This term means a calendar year. It does not include any part of a year during which a person has no coverage under this plan, or before the date this section takes effect.

Coordination Of Benefits  This term means a provision which determines an order in which plans pay their benefits, and which permits secondary plans to reduce their benefits so that the combined benefits of all plans do not exceed total allowable expenses.
**Custodial Parent**
This term means a parent awarded custody by a court decree. In the absence of a court decree, it is the parent with whom the child resides more than one half of the calendar year without regard to any temporary visitation.

**Group-Type Contracts**
This term means contracts: (a) which are not available to the general public; and (b) can be obtained and maintained only because of membership in or connection with a particular organization or group. This includes, but is not limited to, franchise and blanket coverage.

**Hospital Indemnity Benefits**
This term means benefits that are not related to expenses incurred. This term does not include reimbursement-type benefits even if they are designed or administered to give the insured the right to elect indemnity-type benefits at the time of claim.

**Plan**
This term means any of the following that provides benefits or services for dental care or treatment: (1) group insurance and group subscriber contracts; (2) uninsured arrangements of group or group-type coverage; (3) group or group-type coverage through health maintenance organizations (HMOs) and other prepayment, group practice and individual practice plans; (4) group-type contracts; (5) amounts of group or group-type hospital indemnity benefits in excess of $100.00 per day; (6) medical benefits under group, group-type, and individual automobile contracts; and (7) governmental benefits, except Medicare, as permitted by law.

This term does not include individual or family: (a) insurance contracts; (b) subscriber contracts; (c) coverage through HMOs; or (d) coverage under other prepayment, group practice and individual practice plans. This term also does not include: (i) amounts of group or group-type hospital indemnity benefits of $100.00 or less per day; (ii) school accident type coverage; or (iii) Medicare, Medicaid, and coverage under other governmental plans, unless permitted by law.

This term also does not include any plan that this plan supplements. Plans that this plan supplements are named in the benefit description.

Each type of coverage listed above is treated separately. If a plan has two parts and coordination of benefits applies only to one of the two, each of the parts is treated separately.

**Primary Plan**
This term means a plan that pays first without regard that another plan may cover some expenses. A plan is a primary plan if either of the following is true: (1) the plan either has no order of benefit determination rules, or its rules differ from those explained in this section; or (2) all plans that cover the person use the order of benefit determination rules explained in this section, and under those rules the plan pays its benefits first.

**Secondary Plan**
This term means a plan that is not a primary plan.

**This Plan**
This term means the group dental benefits provided under this group plan.
Order Of Benefit Determination

The primary plan pays or provides its benefits as if the secondary plan or plans did not exist.

A plan may consider the benefits paid or provided by another plan to determine its benefits only when it is secondary to that other plan. If a person is covered by more than one secondary plan, the rules explained below decide the order in which secondary plan benefits are determined in relation to each other.

A plan that does not contain a coordination of benefits provision is always primary.

When all plans have coordination of benefits provisions, the rules to determine the order of payment are listed below. The first of the following rules that applies is the rule to use.

### Non-Dependent Or Dependent
The plan that covers the person other than as a dependent (for example, as an employee, member, subscriber, or retiree) is primary. The plan that covers the person as a dependent is secondary.

### Child Covered Under More Than One Plan
The order of benefit determination when a child is covered by more than one plan is:

1. If the parents are married, or are not separated (whether or not they ever have been married), or a court decree awards joint custody without specifying that one party must provide coverage, the plan of the parent whose birthday is earlier in the year is primary. If both parents have the same birthday, the plan that covered either of the parents longer is primary. If a plan does not have this birthday rule, then that plan's coordination of benefits provision will determine which plan is primary.

2. If the specific terms of a court decree state that one of the parents must provide coverage and the plan of the parent has actual knowledge of those terms, that plan is primary. This rule applies to claim determination periods that start after the plan is given notice of the court decree.

3. In the absence of a court decree, if the parents are not married, or are Separated (whether or not they ever have been married), or are divorced, the order of benefit determination is: (a) the plan of the custodial parent; (b) the plan of the spouse of the custodial parent; and (c) the plan of the noncustodial parent.

### Active Or Inactive Employee
The plan that covers a person as an active employee, or as that person’s dependent, is primary. An active employee is one who is neither laid off nor retired. The plan that covers a person as a laid off or retired employee, or as that person’s dependent, is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.
Continuation Coverage
The plan that covers a person as an active employee, member, subscriber, or retired employee, or as that person’s dependent, is primary. The plan that covers a person under a right of continuation provided by federal or state law is secondary. If a plan does not have this rule and as a result the plans do not agree on the order of benefit determination, this rule is ignored.

Length Of Coverage
The plan that covered the person longer is primary.

Other
If the above rules do not determine the primary plan, the allowable expenses will be shared equally between the plans that meet the definition of plan under this section. But, this plan will not pay more than it would have had it been the primary plan.

Effect On The Benefits Of This Plan

When This Plan Is Primary
When this plan is primary, its benefits are determined before those of any other plan and without considering any other plan’s benefits.

When This Plan Is Secondary
When this plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a claim determination period are not more than 100% of total allowable expenses. When the benefits of this plan are reduced, each benefit is reduced in proportion. It is then charged against the applicable benefit limit of this plan.

Right To Receive And Release Needed Information
Certain facts about dental care coverage and services are needed to apply these rules and to determine benefits payable under this plan and other plans. This plan may get the facts it needs from, or give them to, other organizations or persons to apply these rules and determine benefits payable under this plan and other plans which cover the person claiming benefits. This plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under this plan must provide any facts it needs to apply these rules and determine benefits payable.

Facility Of Payment
A payment made under another plan may include an amount that should have been paid by this plan. If it does, this plan may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid by this plan. This plan will not have to pay that amount again.

As used here, the term "payment made" includes the reasonable cash value of any benefits provided in the form of services.
Right Of Recovery

If the amount of the payments made by this plan is more than it should have paid under this section, it may recover the excess: (a) from one or more of the persons it has paid or for whom it has paid; or (b) from any other person or organization that may be responsible for benefits or services provided for the covered person.

As used here, the term "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

CGP-3-R-COB-05

B555.0370
GLOSSARY

This Glossary defines the italicized terms appearing in your booklet.

Options E, G

**Anisometropia**

means a condition of unequal refractive state for the two eyes, one eye requiring different lens correction than the other.

CGP-3-GLOSS-90

Options G, H

**Active Orthodontic**

means an *appliance*, like a fixed or removable appliance, braces or a functional orthotic used for orthodontic treatment to move teeth or reposition the jaw.

CGP-3-GLOSS-90

All Options

**Anterior Teeth**

means the incisor and cuspid teeth. The teeth are located in front of the bicusps (pre-molars).

CGP-3-GLOSS-90

All Options

**Appliance**

means any dental device other than a *dental prosthesis*.

CGP-3-GLOSS-90

Options E, G

**Benefit Period**

with respect to Vision Care Insurance, means the time period beginning when a covered service is received and extending to the date on which, according to the time limitations contained in this *plan*, the covered service is again available to a *covered person*.

CGP-3-VSN-96-DEF3

All Options

**Benefit Year**

means a 12 month period which starts on January 1st and ends on December 31st of each year.

CGP-3-GLOSS-90

Options E, G

**Blended Lenses**

means bifocals which do not have a visible dividing line.

CGP-3-VSN-96-DEF3
Options F, H

Blended Lenses means bifocals which do not have a visible dividing line.

CGP-3-GLOSS-90 B750.0781

Options E, G

Coated Lenses means substance added to a finished lens on one or both surfaces.

CGP-3-VSN-96-DEF3 B750.0460

Options F, H

Coated Lenses means substance added to a finished lens on one or both surfaces.

CGP-3-GLOSS-90 B750.0782

Options E, G

Copayment with respect to Vision Care Insurance, means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a covered person to a preferred provider at the time covered vision services are received.

CGP-3-VSN-96-DEF3 B750.0461

Options F, H

Copay means a charge, expressed as a fixed dollar amount, required to be paid by or on behalf of a covered person before any benefits are paid by this plan.

CGP-3-GLOSS-90 B750.0783

All Options

Covered Dental Specialty means any group of procedures which falls under one of the following categories, whether performed by a specialist dentist or a general dentist: restorative/prosthodontic services; endodontic services, periodontic services, oral surgery and pedodontics.

CGP-3-GLOSS-90 B750.0667

All Options

Covered Family means an employee and those of his or her dependents who are covered by this plan.

CGP-3-GLOSS-90 B750.0668

All Options

Covered Person means an employee or any of his or her covered dependents.

CGP-3-GLOSS-90 B750.0669
Options E, G

**Covered Person** with respect to Vision Care Insurance, means an employee or eligible dependent who meets this plan’s eligibility criteria and who is covered under this plan.

CGP-3-VSN-96-DEF3 B750.0462

Options F, H

**Covered Person** with respect to vision care insurance means an employee or eligible dependent who meets this plan’s eligibility criteria and who is covered under this plan.

CGP-3-GLOSS-90 B750.0784

Options E, G

**Customary** with respect to Vision Care Insurance, means, when referring to a covered charge, that the charge for the covered vision condition isn’t more than the usual charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-VSN-96-DEF3 B750.0484

Options F, H

**Customary** means, when referring to a covered charge, that the charge for the covered vision condition is not more than the usual charge made by most other doctors with similar training and experience in the same geographic area.

CGP-3-GLOSS-90 B750.0785

Options E, G

**Deductible** with respect to Vision Care Insurance, means any amount which a covered person must pay before he or she is reimbursed for covered services provided by a non-preferred provider.

CGP-3-VSN-96-DEF3 B750.0483

All Options

**Dental Prosthesis** means a restorative service which is used to replace one or more missing or lost teeth and associated tooth structures. It includes all types of abutment crowns, inlays and onlays, bridge pontics, complete and immediate dentures, partial dentures and unilateral partials. It also includes all types of crowns, veneers, inlays, onlays, implants and posts and cores.

CGP-3-GLOSS-90 B750.0670
Dentist means any dental or medical practitioner we are required by law to recognize who: (a) is properly licensed or certified under the laws of the state where he or she practices; and (b) provides services which are within the scope of his or her license or certificate and covered by this plan.

Eligibility Date for dependent coverage is the earliest date on which: (a) you have initial dependents; and (b) are eligible for dependent coverage.

Eligible Dependent is defined in the provision entitled "Dependent Coverage."

Emergency Treatment means bona fide emergency services which: (a) are reasonably necessary to relieve the sudden onset of severe pain, fever, swelling, serious bleeding, severe discomfort, or to prevent the imminent loss of teeth; and (b) are covered by this plan.

Employee means a person who works for the employer at the employer’s place of business, and whose income is reported for tax purposes using a W-2 form.

Employer means IASIS HEALTHCARE, LLC.

Enrollment Period with respect to dependent coverage, means the 31 day period which starts on the date that you first become eligible for dependent coverage.

Full-time means the employee regularly works at least the number of hours in the normal work week set by the employer (but not less than 30 hours per week), at his employer’s place of business.
Options E, G

Incurred, Or Incurred Date with respect to Vision Care Insurance, means the placing of an order for lenses, frames or contact lenses, or the date on which such an order was placed.

CGP-3-VSN-96-DEF3 B750.0466

All Options

Initial Dependents means those eligible dependents you have at the time you first become eligible for employee coverage. If at this time you do not have any eligible dependents, but you later acquire them, the first eligible dependents you acquire are your initial dependents.

CGP-3-GLOSS-90 B900.0006

All Options

Injury means all damage to a covered person’s mouth due to an accident which occurred while he or she is covered by this plan, and all complications arising from that damage. But the term injury does not include damage to teeth, appliances or dental prostheses which results solely from chewing or biting food or other substances.

CGP-3-GLOSS-90 B750.0673

Options E, G

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes coneshaped due to a thinning and stretching of the tissue in its central area.

CGP-3-VSN-96-DEF11 B750.0467

Options F, H

Keratoconus means a development or dystrophic deformity of the cornea in which it becomes cone shaped due to a thinning and stretching of the tissue in its central area.

CGP-3-GLOSS-90 B750.0786

Options E, G

Lenticular Lenses mean high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

CGP-3-VSN-96-DEF11 B750.0485

Options F, H

Lenticular Lenses means high-powered lenses with the desired prescription power found only in the central portion. The outer carrier portion has a front surface with a changing radius of curvature.

CGP-3-GLOSS-90 B750.0787
All Options

**Newly Acquired Dependent** means an eligible dependent you acquire after you already have coverage in force for initial dependents.

CGP-3-GLOSS-90 B900.0008

**Options E, G**

**Non-Preferred Provider** with respect to Vision Care Insurance, means any optometrist, optician, ophthalmologist, or other licensed and qualified vision care provider who has not contracted with the plan to provide vision care services and/or vision care materials to covered persons of the plan.

CGP-3-VSN-96-DEF14 B750.0487

**Options F, H**

**Non-Preferred Provider** with respect to vision care insurance, means any optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has not entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of the covered persons of the plan.

CGP-3-GLOSS-90 B750.0788

**Options G, H**

**Orthodontic Treatment** means the movement of one or more teeth by the use of active appliances. It includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits.

CGP-3-GLOSS-90 B750.0675

**Options E, F**

**Orthodontic Treatment** means the movement of one or more teeth by the use of active appliances. It includes: (a) treatment plan and records, including initial, interim and final records; (b) periodic visits, limited orthodontic treatment, interceptive orthodontic treatment and comprehensive orthodontic treatment, including fabrication and insertion of any and all fixed appliances; (c) orthodontic retention, including any and all necessary fixed and removable appliances and related visits. This plan does not pay benefits for orthodontic treatment.

CGP-3-GLOSS-90 B750.0685

**Options E, G**

**Orthoptics** means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

CGP-3-VSN-96-DEF16 B750.0472
Orthoptics means the teaching and training process for the improvement of visual perception and coordination of two eyes for efficient and comfortable binocular vision.

CGP-3-GLOSS-90 B750.0789

Oversize lenses mean larger than a standard lens blank, to accommodate prescriptions.

CGP-3-VSN-96-DEF17 B750.0489

Oversize Lenses means larger than a standard lens blank to accommodate prescriptions.

CGP-3-GLOSS-90 B750.0790

Part-time means the employee regularly works at least half the number of hours that a full-time employee works (but not less than 30 hours per week), at your employer’s place of business.

CGP-3-GLOSS-90 B750.0011-R

Payment Limit means the maximum amount this plan pays for covered services during either a benefit year or a covered person’s lifetime, as applicable.

CGP-3-GLOSS-90 B750.0676

Payment Rate means the percentage rate that this plan pays for covered services.

CGP-3-GLOSS-90 B750.0677

Photochromic Lenses mean lenses which change color with the intensity of sunlight.

CGP-3-VSN-96-DEF17 B750.0490

Photochromic Lenses means lenses which change color with the intensity of sunlight.

CGP-3-GLOSS-90 B750.0791

Posterior Teeth means the bicuspid (pre-molars) and molar teeth. These are the teeth located behind the cuspids.

CGP-3-GLOSS-90 B750.0679
All Options

**Plan** means the Guardian group dental plan purchased by the planholder.

CGP-3-GLOSS-90 B750.0678

Options E, G

**Plan Benefits** with respect to Vision Care Insurance, mean the vision care services and vision care materials which a *covered person* is entitled to receive by virtue of coverage under this *plan*.

CGP-3-VSN-96-DEF17 B750.0492

Options F, H

**Plan** means the Davis Vision plan of vision care services described herein.

CGP-3-GLOSS-90 B750.0792

Options E, G

**Plano Lenses** mean lenses which have no refractive power (lenses with less than a +/- .38 diopter power).

CGP-3-VSN-96-DEF17 B750.0491

Options F, H

**Plano Lenses** means lenses which have no refractive power (lenses with less than a +/- .38 diopter power).

CGP-3-GLOSS-90 B750.0793

Options E, G

**Preferred Provider** with respect to Vision Care Insurance, means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has contracted with the *plan* to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan*.

CGP-3-VSN-96-DEF14 B750.0488

Options F, H

**Preferred Provider** with respect to vision care insurance means an optometrist, ophthalmologist or optician or other licensed and qualified vision care provider who has entered into a contract with Davis Vision to provide vision care services and/or vision care materials on behalf of *covered persons* of the *plan*.

CGP-3-GLOSS-90 B750.0794

All Options

**Prior Plan** means the planholder’s plan or policy of group dental insurance which was in force immediately prior to this *plan*. To be considered a prior plan, this *plan* must start immediately after the prior coverage ends.

CGP-3-GLOSS-90 B750.0681
All Options

Proof Of Claim means dental radiographs, study models, periodontal charting, written narrative or any documentation that may validate the necessity of the proposed treatment.

Options E, G

Standard Frames mean frames valued up to the limit published by VSP which is given to preferred providers.

Options F, H

Standard Lenses means regular glass or plastic lenses. See "Exclusions" for what we limit or exclude.

Options E, G

Standard Lenses mean regular glass or plastic lenses. See the "Special Limitations" section for what we limit or exclude.

Options E, G

Tinted Lenses mean lenses which have an additional substance added to produce constant tint.

Options F, H

Tinted Lenses means lenses which have an additional substance added to produce constant tint.

Options E, G

Usual means, when referring to a covered charge, that the charge is the doctor's standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, "usual" refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.
Options F, H

Usual means when referring to a covered charge that the charge is the doctor’s standard charge for the service furnished. If more than one type of service can be used to treat a vision condition, “usual” refers to the charge for the least expensive type of service which meets the accepted standards of vision care practice.

CGP-3-GLOSS-90 B750.0797

Options E, G

Visually Necessary Or Appropriate means medically or visually necessary for the restoration or maintenance of a covered person’s visual acuity and health and for which there is no less expensive professionally acceptable alternatives.

CGP-3-VSN-96-DEF17 B750.0482

All Options

We, Us, Our And Guardian mean The Guardian Life Insurance Company of America.

CGP-3-GLOSS-90 B750.0683
You participate in a single employer insured Welfare Plan. This supplement and your certificate of insurance constitute the Summary Plan Description as required by the Employee Retirement Income Security Act of 1974 (ERISA). This supplement should be retained with your certificate.

- **Name of Plan:**
  IASIS HEALTHCARE, LLC GROUP INSURANCE PLAN

- **Employer's Name:** (Plan Sponsor)
  IASIS HEALTHCARE, LLC

  **Address:** 117 SEABOARD LANE
  FRANKLIN TN 37067

  **Phone Number:** 615-467-1231

- **IRS Employer Identification Number (EIN):** 201150104

- **Plan Number:** 501

- **Plan Administrator:** (if other than Plan Sponsor)
  IASIS HEALTHCARE, LLC

  **Address:** 117 SEABOARD LANE
  FRANKLIN TN 37067

  **Phone Number:** 615-467-1231

- **Agent for The Service of Legal Process:**
  IASIS HEALTHCARE, LLC

  **Address:** 117 SEABOARD LANE
  FRANKLIN TN 37067

  (Legal process may also be served on the Plan Administrator.)

- **Date of End of Plan Year:** One day prior to January 1st.

- Contributions to the plan are provided by the Employer and the Employee.

- The following class or classes of full-time and part-time employees are eligible to apply for insurance:

**Class 0002**

ALL ELIGIBLE EMPLOYEES LOCATED IN LOUISIANA & COLORADO

provided they have completed the service waiting period established by the employer, if any. Qualified dependents of these employees may also be eligible for insurance. (Your certificate provides details.)
STATEMENT OF ERISA RIGHTS

As a participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

(a) Examine, without charge, at the plan administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, 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.

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

(c) Receive a summary of the plan’s annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. You should review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

**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 the employee benefit plan. The people who operate the plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of plan participants and beneficiaries. No one, including your employer, your union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforcement Of Your Rights**

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a state or Federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110.00 a day until you receive the material, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a 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 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 that your claim is frivolous.

Assistance with Questions

If you have questions about the plan, you should contact the plan administrator. If you have questions about this statement or about your rights under ERISA, 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 your telephone directory or the 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.

Qualified Medical Child Support Order

Federal law requires that group health plans provide medical care coverage of a dependent child pursuant to a qualified medical child support order (QMCSO). A "qualified medical child support order" is a judgment or decree issued by a state court that requires a group medical plan to provide coverage to the named dependent child(ren) of an employee pursuant to a state domestic relations order. For the order to be qualified it must include:

- The name of the group health plan to which it applies.
- The name and last known address of the employee and the child(ren).
- A reasonable description of the type of coverage or benefits to be provided by the plan to the child(ren).
- The time period to which the order applies.

A dependent enrolled due to a QMCSO will not be considered a late enrollee in the plan.

Note: A QMCSO cannot require a group health plan to provide any type or form of benefit or option not otherwise available under the plan except to the extent necessary to meet medical child support laws described in Section 90 of the Social Security Act.

If you have questions about this statement, see the plan administrator.
The Guardian’s Responsibilities

All Options

The dental expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

All Options

The vision care expense benefits provided by this plan are guaranteed by a policy of insurance issued by The Guardian. The Guardian also supplies administrative services, such as claims services, including the payment of claims, preparation of employee certificates of insurance, and changes to such certificates.

All Options

The Guardian is located at 7 Hanover Square, New York, New York 10004.
**Group Health Benefits Claims Procedure**

If you seek benefits under the plan you should complete, execute and submit a claim form. Claim forms and instructions for filing claims may be obtained from the Plan Administrator.

Guardian is the Claims Fiduciary with discretionary authority to determine eligibility for benefits and to construe the terms of the plan with respect to claims. Guardian has the right to secure independent professional healthcare advice and to require such other evidence as needed to decide your claim.

In addition to the basic claim procedure explained in your certificate, Guardian will also observe the procedures listed below. These procedures are the minimum requirements for benefit claims procedures of employee benefit plans covered by Title 1 of the Employee Retirement Income Security Act of 1974 ("ERISA").

**Definitions**

"Adverse determination" means any denial, reduction or termination of a benefit or failure to provide or make payment (in whole or in part) for a benefit. A failure to cover an item or service: (a) due to the application of any utilization review; or (b) because the item or service is determined to be experimental or investigational, or not medically necessary or appropriate, is also considered an adverse determination.

"Group Health Benefits" means any dental, out-of-network point-of-service medical, major medical, vision care or prescription drug coverages which are a part of this plan.

"Pre-service claim" means a claim for a medical care benefit with respect to which the plan conditions receipt of the benefit, in whole or in part, on approval of the benefit in advance of receipt of care.

"Post-service claim" means a claim for payment for medical care that already has been provided.

"Urgent care claim" means a claim for medical care or treatment where making a non-urgent care decision: (a) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, as determined by an individual acting on behalf of the plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; or (b) in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care.

Note: Any claim that a physician with knowledge of the claimant's medical condition determines is a claim involving urgent care will be treated as an urgent care claim for purposes of this section.

**Timing For Initial Benefit Determination**

The benefit determination period begins when a claim is received. Guardian will make a benefit determination and notify a claimant within a reasonable period of time, but not later than the maximum time period shown below. A written or electronic notification of any adverse benefit determination must be provided.

**Urgent Care Claims.** Guardian will make a benefit determination within 72 hours after receipt of an urgent care claim.
If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 24 hours after receipt of the claim. The claimant will be given not less than 48 hours to provide the specified information.

Guardian will notify the claimant of the benefit determination as soon as possible but not later than the earlier of:

- the date the requested information is received; or
- the end of the period given to the claimant to provide the specified additional information.

The required notice may be provided to the claimant orally within the required time frame provided that a written or electronic notification is furnished to the claimant not later than 3 days after the oral notification.

**Pre-Service Claims.** Guardian will provide a benefit determination not later than 15 days after receipt of a pre-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 5 days after receipt of the claim. A notification of a failure to follow proper procedures for pre-service claims may be oral, unless a written notification is requested by the claimant.

The time period for providing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 15-day period.

If Guardian extends the time period for making a benefit determination due to a claimant’s failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.

**Post-Service Claims.** Guardian will provide a benefit determination not later than 30 days after receipt of a post-service claim. If a claimant fails to provide all information needed to make a benefit determination, Guardian will notify the claimant of the specific information that is needed as soon as possible but no later than 30 days after receipt of the claim.

The time period for completing a benefit determination may be extended by up to 15 days if Guardian determines that an extension is necessary due to matters beyond the control of the plan, and so notifies the claimant before the end of the initial 30-day period.

If Guardian extends the time period for making a benefit determination due to a claimant’s failure to submit information necessary to decide the claim, the claimant will be given at least 45 days to provide the requested information. The extension period will begin on the date on which the claimant responds to the request for additional information.
Concurrent Care Decisions. A reduction or termination of an approved ongoing course of treatment (other than by plan amendment or termination) will be regarded as an adverse benefit determination. This is true whether the treatment is to be provided (a) over a period of time; (b) for a certain number of treatments; or (c) without a finite end date. Guardian will notify a claimant at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal.

In the case of a request by a claimant to extend an ongoing course of treatment involving urgent care, Guardian will make a benefit determination as soon as possible but no later than 24 hours after receipt of the claim.

Adverse Benefit Determination

If a claim is denied, Guardian will provide a notice that will set forth:

- the specific reason(s) for the adverse determination;
- reference to the specific plan provision(s) on which the determination is based;
- a description of any additional material or information necessary to make the claim valid and an explanation of why such material or information is needed;
- a description of the plan’s claim review procedures and the time limits applicable to such procedures, including a statement indicating that the claimant has the right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination;
- identification and description of any specific internal rule, guideline or protocol that was relied upon in making an adverse benefit determination, or a statement that a copy of such information will be provided to the claimant free of charge upon request;
- in the case of an adverse benefit determination based on medical necessity or experimental treatment, notice will either include an explanation of the scientific or clinical basis for the determination, or a statement that such explanation will be provided free of charge upon request; and
- in the case of an urgent care adverse determination, a description of the expedited review process.

Appeal of Adverse Benefit Determinations

If a claim is wholly or partially denied, the claimant will have up to 180 days to make an appeal.

A request for an appeal of an adverse benefit determination involving an urgent care claim may be submitted orally or in writing. Necessary information and communication regarding an urgent care claim may be sent to Guardian by telephone, facsimile or similar expeditious manner.

Guardian will conduct a full and fair review of an appeal which includes providing to claimants the following:

- the opportunity to submit written comments, documents, records and other information relating to the claim;
- the opportunity, upon request and free of charge, for reasonable access to, and copies of, all documents, records and other information relating to the claim; and
a review that takes into account all comments, documents, records and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

In reviewing an appeal, Guardian will:

- provide for a review conducted by a named fiduciary who is neither the person who made the initial adverse determination nor that person’s subordinate;
- in deciding an appeal based upon a medical judgment, consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- identify medical or vocational experts whose advice was obtained in connection with an adverse benefit determination; and
- ensure that a health care professional engaged for consultation regarding an appeal based upon a medical judgment shall be neither the person who was consulted in connection with the adverse benefit determination, nor that person’s subordinate.

Guardian will notify the claimant of its decision regarding review of an appeal as follows:

**Urgent Care Claims.** Guardian will notify the claimant of its decision as soon as possible but not later than 72 hours after receipt of the request for review of the adverse determination.

**Pre-Service Claims.** Guardian will notify the claimant of its decision not later than 30 days after receipt of the request for review of the adverse determination.

**Post-Service Claims.** Guardian will notify the claimant of its decision not later than 60 days after receipt of the request for review of the adverse determination.

**Alternative Dispute Options**

The claimant and the plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact the local U.S Department of Labor Office and the State insurance regulatory agency.
Termination of This Group Plan

Your employer may terminate this group plan at any time by giving us 31 days advance written notice. This plan will also end if your employer fails to pay a premium due by the end of this grace period.

We may have the option to terminate this plan if the number of people insured falls below a certain level.

When this plan ends, you may be eligible to continue your insurance coverage. Your rights upon termination of the plan are explained in this booklet.
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Effective: 9/23/2013

This Notice of Privacy Practices describes how Guardian and its subsidiaries may use and disclose your Protected Health Information (PHI) in order to carry out treatment, payment and health care operations and for other purposes permitted or required by law.

Guardian is required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices concerning PHI. We are required to abide by the terms of this Notice so long as it remains in effect. We reserve the right to change the terms of this Notice of Privacy Practices as necessary and to make the new Notice effective for all PHI maintained by us. If we make material changes to our privacy practices, copies of revised notices will be made available on request and circulated as required by law. Copies of our current Notice may be obtained by contacting Guardian (using the information supplied below), or on our Web site at: www.GuardianLife.com/PrivacyPolicy

What is Protected Health Information (PHI):

PHI is individually identifiable information (including demographic information) relating to your health, to the health care provided to you or to payment for health care. PHI refers particularly to information acquired or maintained by us as a result of your having health coverage (including medical, dental, vision and LTC coverage).

In What Ways may Guardian Use and Disclose your Protected Health Information (PHI):

Guardian has the right to use or disclose your PHI without your written authorization to assist in your treatment, to facilitate payment and for health care operations purposes. There are certain circumstances where we are required by law to use or disclose your PHI. And there are other purposes, listed below, where we are permitted to use or disclose your PHI without further authorization from you. Please note that examples are provided for illustrative purposes only and are not intended to indicate every use or disclosure that may be made for a particular purpose.

Guardian has the right to use or disclose your PHI for the following purposes:

Treatment. Guardian may use and disclose your PHI to assist your health care providers in your diagnosis and treatment. For example, we may disclose your PHI to providers to supply information about alternative treatments.

Payment. Guardian may use and disclose your PHI in order to pay for the services and resources you may receive. For example, we may disclose your PHI for payment purposes to a health care provider or a health plan. Such purposes may include: ascertaining your range of benefits; certifying that you received treatment; requesting details regarding your treatment to determine if your benefits will cover, or pay for, your treatment.

Health Care Operations. Guardian may use and disclose your PHI to perform health care operations. For example, we may use your PHI for underwriting and premium rating purposes.

Appointment Reminders. Guardian may use and disclose your PHI to contact you and remind you of appointments.

Health Related Benefits and Services. Guardian may use and disclose PHI to inform you of health related benefits or services that may be of interest to you.
Plan Sponsors. Guardian may use or disclose PHI to the plan sponsor of your group health plan to permit the plan sponsor to perform plan administration functions. For example, a plan may contact us regarding benefits, service or coverage issues. We may also disclose summary health information about the enrollees in your group health plan to the plan sponsor so that the sponsor can obtain premium bids for health insurance coverage, or to decide whether to modify, amend or terminate your group health plan.

All Options

Guardian is required to use or disclose your PHI:

- To you or your personal representative (someone with the legal right to act for you);
- To the Secretary of the Department of Health and Human Services, when conducting a compliance investigation, review or enforcement action; and
- Where otherwise required by law.

Guardian is Required to Notify You of any Breaches of Your PHI.

Although Guardian takes reasonable, industry-standard measures to protect your PHI, should a breach occur, Guardian is required by law to notify affected individuals. A breach means the acquisition, access, use, or disclosure of PHI in a manner not permitted by law that compromises the security or privacy of the PHI.

Other Uses and Disclosures.

Guardian may also use and disclose your PHI for the following purposes without your authorization:

- We may disclose your PHI to persons involved in your care, such as a family member or close personal friend, when you are incapacitated, during an emergency or when permitted by law.
- We may disclose your PHI for public health activities, such as reporting of disease, injury, birth and death, and for public health investigations.
- We may disclose your PHI to the proper authorities if we suspect child abuse or neglect; we may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- We may disclose your PHI to a government oversight agency authorized by law to conducting audits, investigations, or civil or criminal proceedings.
- We may disclose your PHI in the course of a judicial or administrative proceeding(e.g., to respond to a subpoena or discovery request).
- We may disclose your PHI to the proper authorities for law enforcement purposes.
- We may disclose your PHI to coroners, medical examiners, and/or funeral directors consistent with law.
- We may use or disclose your PHI for organ or tissue donation.
- We may use or disclose your PHI for research purposes, but only as permitted by law.
- We may use or disclose PHI to avert a serious threat to health or safety.
- We may use or disclose your PHI if you are a member of the military as required by armed forces services, and we may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- We may disclose your PHI to comply with workers’ compensation and other similar programs.
- We may disclose your PHI to third party business associates that perform services for us, or on our behalf (e.g. vendors).
- Guardian may use and disclose your PHI to federal officials for intelligence and national security activities authorized by law. We also may disclose your PHI to authorized federal
officials in order to protect the President, other officials or foreign heads of state, or to conduct investigations authorized by law.

- We may disclose your PHI to correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official (e.g., for the institution to provide you with health care services, for the safety and security of the institution, and/or to protect your health and safety or the health and safety of other individuals).
- We may disclose your PHI to your employer under limited circumstances related primarily to workplace injury or illness or medical surveillance.

All Options

Your Rights with Regard to Your Protected Health Information (PHI): Your Authorization for Other Uses and Disclosures. Other than for the purposes described above, or as otherwise permitted by law, Guardian must obtain your written authorization to use or disclose your PHI. You have the right to revoke that authorization in writing except to the extent that: (i) we have taken action in reliance upon the authorization prior to your written revocation, (ii) you were required to give us your authorization as a condition of obtaining coverage, or (iii) and we have the right, under other law, to contest a claim under the coverage or the coverage itself.

Under federal and state law, certain kinds of PHI will require enhanced privacy protections. These forms of PHI include information pertaining to:

- HIV/AIDS testing, diagnosis or treatment
- Venereal and/or communicable Disease(s)
- Genetic Testing
- Alcohol and drug abuse prevention, treatment and referral
- Psychotherapy notes

We will only disclose these types of delineated information when permitted or required by law or upon your prior written authorization.

Your Right to an Accounting of Disclosures. An ‘accounting of disclosures’ is a list of the disclosures we have made, if any, of your PHI. You have the right to receive an accounting of certain disclosures of your PHI that were made by us. This right applies to disclosures for purposes other than those made to carry out treatment, payment and health care operations as described in this notice. It excludes disclosures made to you, or those made for notification purposes.

We ask that you submit your request in writing. Your request must state a requested time period not more than six years prior to the date when you make your request. Your request should indicate in what form you want the list(e.g., paper, electronically).

Your Right to Obtain a Paper Copy of This Notice. You have a right to request a paper copy of this notice even if you have previously agreed to accept this notice electronically.

Your Right to File a Complaint. If you believe your privacy rights have been violated, you may file a complaint with the U.S. Secretary of Health and Human Services. If you wish to file a complaint with Guardian, you may do so using the contact information below. You will not be penalized for filing a complaint.

Any exercise of the Rights designated below must be submitted to the Guardian in writing. Guardian may charge for reasonable costs associated with complying with your requests; in such a case, we will notify you of the cost involved and provide you the opportunity to modify your request before any costs are incurred.
Your Right to Request Restrictions. You have the right to request a restriction on the PHI we use or disclose about you for treatment, payment or health care operations as described in this notice. You also have the right to request a restriction on the medical information we disclose about you to someone who is involved in your care or the payment for your care.

Guardian is not required to agree to your request; however, if we do agree, we will comply with your request until we receive notice from you that you no longer want the restriction to apply (except as required by law or in emergency situations). Your request must describe in a clear and concise manner: (a) the information you wish restricted; (b) whether you are requesting to limit Guardian’s use, disclosure or both; and (c) to whom you want the limits to apply.

Your Right to Request Confidential Communications. You have the right to request that Guardian communicate with you about your PHI be in a particular manner or at a certain location. For example, you may ask that we contact you at work rather than at home. We are required to accommodate all reasonable requests made in writing, when such requests clearly state that your life could be endangered by the disclosure of all or part of your PHI.

All Options

Your Right to Amend Your PHI. If you feel that any PHI about you, which is maintained by Guardian, is inaccurate or incomplete, you have the right to request that such PHI be amended or corrected. Within your written request, you must provide a reason in support of your request. Guardian reserves the right to deny your request if: (i) the PHI was not created by Guardian, unless the person or entity that created the information is no longer available to amend it(ii) if we do not maintain the PHI at issue(iii) if you would not be permitted to inspect and copy the PHI at issue or (iv) if the PHI we maintain about you is accurate and complete. If we deny your request, you may submit a written statement of your disagreement to us, and we will record it with your health information.

Your Right to Access to Your PHI. You have the right to inspect and obtain a copy of your PHI that we maintain in designated record sets. Under certain circumstances, we may deny your request to inspect and copy your PHI. In an instance where you are denied access and have a right to have that determination reviewed, a licensed health care professional chosen by Guardian will review your request and the denial. The person conducting the review will not be the person who denied your request. Guardian promises to comply with the outcome of the review.

How to Contact Us:

If you have any questions about this Notice or need further information about matters covered in this Notice, please call the toll-free number on the back of your Guardian ID card. If you are a broker please call 800-627-4200. All others please contact us at 800-541-7846. You can also write to us with your questions, or to exercise any of your rights, at the address below:

Attention:
Guardian Corporate Privacy Officer
National Operations

Address:
The Guardian Life Insurance Company of America
Group Quality Assurance - Northeast
P.O. Box 2457
Spokane, WA 99210-2457
Flexible Spending Accounts
SUMMARY PLAN DESCRIPTION

for the

IASIS Healthcare Flexible Benefits Plan

a part of the IASIS Healthcare Welfare Benefit Plan

Effective January 1, 2015
INTRODUCTION

IASIS Healthcare LLC (the “Employer”) has established the IASIS Healthcare Flexible Benefits Plan (the “Plan”) for you and other eligible employees. This Plan is intended to constitute a “cafeteria plan” within the meaning of Section 125 of the Internal Revenue Code of 1986, as amended (the “Code”). The Plan is a part of the IASIS Healthcare Welfare Benefit Plan (“Welfare Benefit Plan”), effective January 1, 2015.

Under this Plan, you are able to choose between cash compensation (i.e., your normal paycheck without elective salary reductions) and certain benefits that your Employer makes available. This Plan has two main components:

1. The pre-tax salary reduction component. Under this aspect of the Plan, your payments for certain benefits will be paid by payroll deduction before federal income or Social Security taxes are withheld.
2. The flexible spending account (“FSA”) component. The FSAs contained in the Plan are designed to provide you with a means of paying for certain expenses with pre-tax dollars. You may be able to participate in a Health Care FSA and/or a Dependent Care FSA.

The benefits that you may choose and other basic features of the Plan are outlined in this Summary Plan Description (“SPD”). Read this SPD carefully so that you understand the provisions of the Plan and the benefits you will receive. The SPD is only a summary of the key parts of the Plan and the FSAs, and a brief description of your rights as a Participant. It is not a part of the official Plan or Welfare Benefit Plan documents. If there is a conflict between the Plan document or Welfare Benefit Plan document and this SPD, the Plan and/or Welfare Benefit Plan document will control.

The information in this SPD is provided in question and answer format. We encourage you to read the entire SPD, but if you have specific questions about your rights and obligations under the Plan, please refer to the question that most resembles your question. If this SPD does not answer all of your questions, you should contact your Employer or the Claims Administrator, both of whom are identified in the Administrative Information Attachment. Many of the capitalized words in this SPD have special meanings that are either defined in this SPD, the Plan document itself, or the Welfare Benefit Plan and/or its SPD, as applicable.

GENERAL INFORMATION

1. What “Benefit Options” are offered through the Plan?

The Plan offers several Benefit Options that you may elect to receive in lieu of cash compensation. As noted above, those Benefit Options currently are: (a) payment of the employee’s share of the premium for medical, dental, prescription, and vision coverage under the Welfare Benefit Plan for you and your eligible dependents (as permitted by the Code); (b) reimbursement of eligible medical care expenses incurred by you and your eligible dependents (as permitted by the Code) under the Health Care FSA Plan (see Appendix A for details); and (c) work-related dependent care expense reimbursement under the Dependent Care FSA Plan (see Appendix B for details).

2. Who can participate in the Plan?

Current employees who were participating in a Benefit Option as of January 1, 2015, are eligible to participate in the Plan immediately. New employees hired on or after that date are eligible to participate in this Plan as of the date coinciding with their eligibility for a Benefit Option. Current employees who were not participating in a Benefit Option as of January 1, 2015, but were otherwise eligible to participate in a Benefit Option may begin participation in this Plan as of the next election period.
3. **How do I become a Participant?**

You become a Participant by completing an enrollment form on which you elect one or more of the Benefit Options available under the Plan, and agree to a salary reduction to pay for those benefits. By completing enrollment, you therefore authorize the Employer to place some of your earnings into special funds or accounts which must be set up for you in order to pay for the benefits you have chosen.

You will be provided an enrollment form during certain enrollment periods, beginning with an initial enrollment period when you first become eligible to participate. After that, you will have the opportunity to complete a new enrollment form during the annual enrollment period each year to be held before January 1 of each year, for elections effective January 1. You will be notified each year of the beginning and end dates of the annual enrollment period.

The elections that you make under this Plan during your initial enrollment period are effective for the remainder of that Plan Year, and the elections that you make during any subsequent annual enrollment period are effective the first day of the following Plan Year. In either event, the elections that you make for a Plan Year generally cannot be revoked or changed during the Plan Year unless you experience an eligible event that will allow a mid-year election change (see Question 5 below for details on mid-year election changes).

4. **When does my participation in the Plan end?**

Once you become a Participant, you continue to participate until the earliest of the date that (i) the Plan terminates; (ii) your benefit election for all Benefit Options is terminated; (iii) you elect, during an enrollment period, not to participate in the Plan; (iv) you no longer satisfy the eligibility requirements (for example, because you terminate employment); or (v) you fail to make the required contribution for all Benefit Options by the due date (when in an arrearage situation).

5. **Can I change my election during the Plan Year?**

Generally, you cannot change the elections you have made after the beginning of the Plan Year, including, for example, the amount that you elect to contribute to a FSA. However, your election to participate in the Plan will automatically terminate in the event you cease to satisfy the applicable eligibility requirements. Otherwise, you may change your elections during the Plan Year only if one of the following situations applies, and only to the extent permitted under the applicable Benefit Option:

1. **Change in Status.** If one or more of the “Changes in Status” as defined in the Plan occur, you may, within 31 days of such Change in Status, revoke your old election and make a new election, provided that both the revocation and new election are on account of and correspond with the Change in Status (as described below). Those occurrences that qualify as Changes in Status include such things as changes: (i) to your legal marital status; (ii) in the number of your dependents; (iii) to your employment status or that of your Spouse or dependent; or (iv) that cause your dependent to satisfy or cease to satisfy eligibility requirement(s) for a particular Benefit Option. Note that for all purposes in this SPD and throughout the Plan, the term “Spouse” refers to your “spouse” within the meaning of federal tax law.

   With the exception of an election change to a Benefit Option that is a group health plan resulting from the birth, placement for adoption, or adoption, all election changes under the Plan must be prospective. Further, the election change must be on account of and correspond with the Change in Status event as determined by the Plan Administrator. As a general rule, a desired election change will be considered consistent with a Change in Status event if the event affects eligibility for coverage under the applicable Benefit Option. A Change in Status affects eligibility for coverage if it results in an increase or decrease in
the number of dependents who may benefit under the Plan. In addition, there is a special rule for Changes in Status in which you, your Spouse, or your dependent gain eligibility for coverage under another employer’s plan as a result of a change in your marital status or a change in your, your Spouse’s, or your dependent’s employment status. In that case, your election to cease or decrease coverage for that individual under the Plan would correspond with that Change in Status only if coverage for that individual becomes effective or is increased under the other employer’s plan. You may be required to provide proof that coverage will become effective.

If you do not make a change to your election within 31 days of the event that makes the change necessary, you cannot make a coverage change before the next annual enrollment period unless you or your eligible family member has another qualifying change in status.

In addition, a Participant in the Dependent Care FSA Plan may change his or her election when there is a change in providers, a change in care costs, or such other events that the Plan Administrator may determine will permit a change or revocation of an election in accordance with IRS regulations (and other guidance).

2. Special Enrollment Rights (applies to coverage under the Health Care Plans (as defined in the Plan) only). If you, your Spouse and/or a dependent are entitled to any of the following special enrollment rights, you may change your election to correspond with the special enrollment right prospectively, unless the special enrollment is attributable to the birth, adoption, or placement for adoption of a child, in which case the change may be retroactive up to 31 days.

• **Other Coverage.** If you declined enrollment in medical coverage for yourself or your eligible dependents because of outside medical coverage and eligibility for such coverage is subsequently lost due to certain reasons (i.e., due to legal separation, divorce, death, termination of employment, reduction in hours, or exhaustion of COBRA period), you may be able to elect coverage for yourself and your eligible dependents who lost such coverage, provided that you request enrollment within the 31-day election change period.

• **New Dependent.** If you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may also be able to enroll yourself, your Spouse, and your newly acquired dependents, provided that you request enrollment within the 31-day election change period. Note that the establishment of a domestic partnership during the year is not a special enrollment event unless your domestic partner qualifies as your “dependent” for this purpose under the Code.

• **Medicaid- and CHIP-Related Events.** If you (or your dependent) are eligible for but not enrolled in medical coverage, you may be eligible to elect coverage for yourself and/or your dependent if (i) your (or your dependent’s) coverage under a Medicaid plan or state children’s health insurance program (commonly referred to as a “CHIP” plan) is terminated as a result of the loss of eligibility for such coverage or (ii) you (or your dependent) become eligible for a premium assistance subsidy from a Medicaid or CHIP plan with respect to medical coverage under the Plan. You must request enrollment within 60 days of the occurrence of either of these Medicaid- or CHIP-related events.

3. **Certain Judgments, Decrees and Orders.** If a judgment, decree or order from a divorce, separation, annulment or custody change requires your child to be covered under a health care plan, you may change your election to provide the applicable coverage for the child identified in the order. If the order requires that another individual (such as your former spouse) cover the child, and such coverage is actually provided, you may change your election to revoke coverage for the child.
4. Entitlement to Medicare or Medicaid. If you, your Spouse, or a dependent becomes entitled to Medicare or Medicaid, you may revoke or change a benefit election with respect to such person under the Health Care Plans (as defined in the Plan) or the Health Care FSA Plan for the balance of a period of coverage if the revocation is on account of and corresponds with you, your Spouse, or your dependent becoming entitled to Medicare or Medicaid. Similarly, if you, your Spouse, or a dependent that has been entitled to Medicare or Medicaid loses eligibility for such coverage, you may, subject to the terms of the underlying plan, elect to begin or increase that person’s coverage under the Health Care Plans and/or the Health Care FSA Plan, as applicable.

5. Cost Changes (does not apply to Health Care FSA Plan elections). If the cost of a Benefit Option under the Plan increases or decreases by an insignificant amount during a Plan Year, the Employer will automatically increase or decrease, as the case may be, your salary reduction for that Benefit Option. If the cost significantly increases, you may choose to make an increase in your contributions, revoke your election and choose other coverage, or drop coverage. If the cost significantly decreases, you may revoke your election and make a new election to correspond with the decrease in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

6. Coverage Changes (does not apply to Health Care FSA Plan elections). If the coverage under a Benefit Option is significantly curtailed or ceases during a Plan Year, then you may revoke your elections and elect to receive (on a prospective basis) coverage under another Benefit Option with similar coverage, or you may drop coverage if no similar coverage is available. In addition, if the Employer adds a new coverage option or eliminates an existing option, you may elect the newly-added option (or elect another option if an option has been eliminated) and make corresponding election changes to other options providing similar coverage. If you are not a Participant when such a coverage change is made, you may elect to join the Plan. Also, you may make an election change on account of and corresponding with a change under another employer plan (including a plan of the Employer’s or another employer), so long as: (i) the other employer plan permits its participants to make an election change permitted under the IRS regulations; or (ii) the Plan Year for this Plan is different from the plan year of the other employer plan.

7. Approved Leave of Absence. If you take leave an approved leave of absence, your elections are subject to the following terms, depending, in part, on the type of leave you take, and the Employer’s applicable leave policies:

- If you go on a qualifying paid leave under the Family and Medical Leave Act of 1993 (“FMLA”), to the extent required by the FMLA, the Employer will continue to maintain your coverage under the Health Care Plans and/or the Health Care FSA Plan on the same terms and conditions as though you were still an active employee.

- To the extent that your coverage is continued while on a paid FMLA leave, you will pay your share of the contributions on the same basis as existed prior to your leave: that is, with pre-tax contributions withheld from pay received while on leave.

- If you go on a qualifying unpaid leave under FMLA (or paid leave where coverage is not required to be continued), you may revoke coverage under any of the Health Care Plans and/or the Health Care FSA Plan while on FMLA leave and discontinue payment of the required premiums or pre-tax contributions during the period of unpaid FMLA leave and the Employer may recover your share of the unpaid premiums when you return to work.

- If you continue your coverage under the Health Care Plans and/or the Health Care FSA Plan during your unpaid leave, you may pre-pay for the coverage, pay for your coverage during your leave or you and the Employer may arrange a schedule for you to “catch up” your payments.
when you return. The payment options provided by the Employer will be established in accordance with Section 125 of the Code, FMLA, and the Employer’s policies and procedures regarding leaves of absences.

- If your coverage under the Health Care Plans and/or the Health Care FSA Plan terminates while you are on FMLA leave, due to your revocation of the benefit while on leave or due to your non-payment of required contributions, you will be permitted to reinstate coverage for the remaining part of the Plan Year upon your return, on the same basis as you were participating in such coverage prior to the leave, or as otherwise required by the FMLA. Your coverage under the Health Care Plans and/or the Health Care FSA Plan may be automatically reinstated provided that coverage for employees on non-FMLA leave is automatically reinstated upon return from leave.

- The Employer may, on a uniform and consistent basis, continue your coverage under the Health Care Plans and/or the Health Care FSA Plan for the duration of the leave following your failure to pay the required contribution. In that case, upon return from leave, you will be required to repay the contribution in a manner agreed upon by you and the Employer.

- The expenses you incur during the time you revoke your coverage under the Plan are not reimbursable.

- The above provisions do not apply to the Dependent Care FSA Plan. Your entitlement to continue coverage under the Dependent Care FSA Plan during a period of FMLA leave will be determined by the Employer’s established policy for providing such benefits when an employee is on other forms of leave (paid or unpaid, as appropriate).

8. Reduction in Hours of Service (does not apply to Health Care FSA Plan elections). If you have been in an employment status under which you were reasonably expected to average at least 30 hours of service per week and there is a change in your status so that you will reasonably be expected to average fewer than 30 hours of service per week after the change, even if that reduction does not result in a loss of eligibility under the Health Care Plans, you may revoke your election under the Plan for coverage under the Health Care Plans on a prospective basis, provided, however, that (i) the revocation of your election of coverage under the Health Care Plans corresponds to your intended enrollment, and the enrollment of any related individuals who cease coverage due to the revocation, in another plan that provides minimum essential coverage, and (ii) the new coverage is effective no later than the first day of the second month following the month that includes the date the original coverage is revoked.

9. Enrollment in a Qualified Health Plan (does not apply to Health Care FSA Plan elections). If you are eligible for a Special Enrollment Period to enroll in a Qualified Health Plan through an Exchange, or you seek to enroll in a Qualified Health Plan through an Exchange during the Exchange’s annual open enrollment, you may revoke your election under the Plan for coverage under the Health Care Plans on a prospective basis, provided, however, that (i) the revocation of such election of coverage under the Health Care Plans corresponds to your intended enrollment, and the enrollment of any related individuals who cease coverage due to the revocation, in a Qualified Health Plan through an Exchange, and (ii) the new coverage is effective no later than the day immediately following the last day of coverage under the Health Care Plan.

6. What happens if I do not submit an enrollment form?

Except as is otherwise described in the enrollment materials, if you fail to return a completed enrollment form to the Plan Administrator on or before the due date after you first become eligible under the Plan, the
Plan Administrator will deem that you have elected not to participate and to receive your full compensation in cash.

If you had previously submitted an enrollment form electing to participate in the Plan, and you fail to submit another form during a subsequent annual enrollment period, you will be considered to have made the same election as was in effect as to such benefits and coverage under the Benefit Options for the preceding Plan Year; provided, however, you will be deemed not to have elected any benefits under the FSAs.

7. How do I receive my benefits under the Plan?

Premiums representing your share of the cost for the health, dental, and vision insurance premiums under the Employer’s group plans, as well as the amount that you elected (if any) to be credited to your Health Care FSA and/or Dependent Care FSA, will automatically be deducted each week from your paycheck on a pre-tax basis.

If you have elected to participate in the Health Care FSA Plan and/or the Dependent Care FSA Plan, you will have to take certain steps to be reimbursed for your eligible expenses. When you want to be reimbursed for an expense that is eligible for payment from one of these FSAs, you submit a claim to the Plan Administrator. See Appendix A for a description of the reimbursement procedures that apply to the Health Care FSA Plan and Appendix B for an explanation of the requirements for reimbursement under the Dependent Care FSA Plan. You may not be reimbursed for any expense that arose before your enrollment became effective or with respect to any Plan Year for any expense incurred after the close of the Plan Year.

8. How do I submit a claim under the Plan?

You should submit all requests for reimbursement from the FSAs (each, a “claim”) to the Plan Administrator or its designee during the Plan Year, but in no event later than the earlier of (i) March 31 following the close of the Plan Year (or, if March 31 falls on a Saturday, Sunday, or a holiday, the next following business day) or (ii) three (3) months after you ceased to be a Participant. Any claims submitted after that time will not be considered.

The applicable claims and appeals procedures for each FSA are described in Appendices A and B of this SPD, as applicable. For expenses paid for with a debit card, no manual submission of the claim is required; however, you may be asked to submit additional information in some instances.

Claims for benefits under plans other than the FSAs will be reviewed in accordance with procedures contained in the policies for those plans. All other requests related to the Plan, including requests related to your eligibility under the Plan, should be directed to the Plan Administrator. Note that claims for benefits under the medical prescription, dental and vision coverages should be submitted as described in the Welfare Benefit Plan SPD.

9. What if the payment I received for an approved claim was more than my actual expense? For example, what if the Claims Administrator made a mistake or I paid a certain amount at the doctor’s office, but once the claim was processed, I owed a lesser amount?

If it is later determined that you and/or your Spouse or dependent(s) received an overpayment or a payment was made in error, you will be required to refund the overpayment or erroneous reimbursement to the appropriate FSA. If you do not refund the overpayment or erroneous payment, the FSA Plan and the Employer reserve the right to offset future reimbursement equal to the overpayment or erroneous payment or, if that is not feasible, to withhold such funds from your pay. In no event will an error by the Plan Administrator or the Claims Administrator entitle you to more benefits than are otherwise due under this Plan.
If failure to repay an overpayment is your fault, you must indemnify the Employer and Claims Administrator for any penalties or losses they incur as a result of the failure. If you have a debit card and fail to repay an overpayment, your debit card will be deactivated.

10. Will I receive any statements of my FSAs in the Plan?

You will be provided with an Explanation of Benefits (EOB) for each payment that is made from your FSA by manual submission. Claims paid with a debit card issued under the Plan will not result in an EOB. You may also monitor the balance of your FSAs online at www.wageworks.com. It is important to read your EOBs carefully and monitor your account activity so you understand the balance remaining to pay for a benefit. Remember, you want to spend all the money you have designated for a particular benefit by the end of the Plan Year.

11. What rights do I have under the Uniformed Services Employment and Reemployment Rights Act of 1994 (“USERRA”)?

If you are going into or returning from military service, you may have special rights to health care coverage under the Health Care FSA Plan under USERRA. These rights can include extended health care coverage. If you think you may be affected by this law, ask the Plan Administrator for further details.

12. What if I terminate my employment during the Plan Year?

If your employment with the Employer is terminated during the Plan Year, your active participation in the Plan will cease, and you will not be able to make any more contributions to the Plan, other than as may be permitted under COBRA (see Question 16 below for a description of your rights and obligations under COBRA).

If you participate in the Health Care FSA Plan, you will be able to submit claims for health care expenses incurred prior to your date of termination up to the amount of the balance remaining in your Health Care FSA, provided that you submit the claims no more than three (3) months after your termination.

If you participate in the Dependent Care FSA Plan, you will still be able to request reimbursement for qualifying dependent care expenses for the remainder of the Plan Year from the balance remaining in your Dependent Care FSA at the time of termination of employment.

13. How long will the Plan remain in effect?

The Plan is intended to be in effect indefinitely, but since future conditions affecting your Employer cannot be anticipated or foreseen, the Employer reserves the right to amend, modify or terminate the Plan in any manner, at any time, which may result in the termination or modification of your coverage. If the Plan is terminated, any plan assets will be used to pay for eligible expenses incurred prior to the Plan’s termination, and such expenses will be paid as provided under the terms of the Plan prior to its termination.

14. Are my benefits taxable?

Since the Plan is intended to meet certain requirements of the federal tax laws, the benefits you receive under the Plan are not currently taxable to you under present law. However, neither the Employer nor the Plan Administrator makes any commitment or guarantee that any reimbursements or salary reductions under the Plan will be excluded from your income for tax purposes. In addition, the requirements for the desired tax benefits are complex, subject to change, and depend to some degree on the manner in which the Plan is operated. In case of doubt, you should consult your own tax advisor.
15. What happens if my claim for benefits is denied?

The Plan Administrator has established procedures for the filing of claims for benefits. If a claim under the Plan or the Dependent Care FSA Plan is denied, the Plan Administrator will furnish you with written notice of the denial within 90 days of its receipt of the claim, except in special circumstances that may require an extension of up to another 90 days. This notice will include: (a) the specific reason(s) for the decision; (b) reference to the pertinent Plan or Dependent Care FSA Plan provisions on which the decision was based; (c) a description of any additional material or information necessary for you to complete your claim, including an explanation of why such information is necessary; and (d) an explanation of the Plan’s or Dependent Care FSA Plan’s claim review procedures. Upon receipt of this notice, you may appeal a denial of your claim by written notice to the Plan Administrator within 60 days for a full and fair review. You will be provided written notice of a decision on such review within 60 days except in special circumstances that may require an extension of up to another 60 days. This notice will include the decision itself, the specific reason(s) for the decision and specific references to the pertinent Plan or Dependent Care FSA Plan provisions on which the decision is based.

If your claim for benefits under the Health Care FSA Plan is denied, the Plan Administrator will furnish you with written notice of the denial within 30 days of its receipt of the claim, except in special circumstances that may require an extension of up to another 15 days. If the extension is necessary due to your failure to provide information necessary to decide the claim, then you will be given 45 days to provide the missing information. The benefit determination period will be delayed until the earlier of the date you provide the missing information or 45 days.

In any event, the notification of any claim denial under the Health Care FSA Plan will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the pertinent Health Care FSA Plan provision(s) on which the denial was based;

(c) 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;

(d) A description of the Health Care FSA Plan’s claim review procedures, including the applicable time limits and your right to bring a civil action under Section 502 of ERISA following a denial on review;

(e) Any internal rule, guidelines, protocol or other similar criterion (collectively, the “Protocols”) that were relied upon in making the determination or a statement that says the Protocols were used and that a copy of the Protocols will be available to you free of charge upon request; and

(f) If the decision was based on a medical necessity, experimental treatment or similar exclusion or limit, the notice will also contain either (A) an explanation of the scientific or clinical judgment for the decision, applying the terms of the Health Care FSA Plan, as applicable, to your medical circumstances or (B) a statement that such an explanation will be provided to you free of charge upon request.

If you receive a denial notice, you will have 180 days following receipt of the notice in which to appeal the decision. You may submit written comments, documents, records and other information relating to the claim. Also, 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 (i.e., that were relied upon in making the
benefit determination, or submitted, considered, or generated in the course of making the benefit determination).

The period of time within which a denial on review is required to be made will begin at the time an appeal is filed in accordance with the procedures of the Health Care FSA Plan. This timing is without regard to whether all the necessary information accompanies the filing.

The review will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial claim determination. The review will not afford deference to the initial denial and will be conducted by a fiduciary of the Health Care FSA Plan who is neither the individual who made the initial adverse determination nor a subordinate of that individual.

The decision on review shall be made within a reasonable period of time, but not later than sixty (60) days, following receipt of the request for review. The decision on review shall be made in writing, and will state:

(a) The specific reason or reasons for the denial;

(b) Reference to the specific Health Care FSA Plan provisions on which the denial was based;

(c) A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all materials and required information relevant to the claim;

(d) A statement of your right to bring an action under ERISA;

(e) If Protocols were used to make the decision regarding the claim, either a copy of the Protocols used or a statement that provides that such Protocols were used and that a copy of the Protocols will be available to you free of charge upon request; and

(f) If scientific or clinical judgments were used, either (A) an explanation of the scientific or clinical judgment used for the denial or (B) a statement that an explanation of the clinical judgment used in making the decision will be available to you free of charge upon request.

16. Do I have any continuation coverage rights under the Plan?

Under a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (“COBRA”), you and your family may have the opportunity to elect a temporary extension of health coverage (called “COBRA continuation coverage”), at your own expense, where coverage under the Health Care Plans or Health Care FSA Plan would otherwise end because of a life event known as a “qualifying event.” Any rights you may have under COBRA are described below.

Specific qualifying events are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a “qualified beneficiary.” You, your Spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. However, for purposes of the Health Care FSA Plan, COBRA continuation coverage will only be offered to qualified beneficiaries who have a positive Health Care FSA balance at the time of a COBRA qualifying event, taking into account all claims submitted before the date of the qualifying event; that is, COBRA continuation coverage would not be offered to Participants in the Health Care FSA Plan who have “overspent” their Health Care FSAs.
If you are a Participant in the Plan, you will become a “qualified beneficiary” if you lose your coverage under the Health Care Plans or Health Care FSA Plan because of one of the following “qualifying events” happens:

(a) your employment ends for reason any reason other than your gross misconduct; or
(b) your hours of employment are reduced.

If you are the Spouse or dependent child of a Participant in the Plan, you will become a qualified beneficiary if you lose your coverage under the Health Care Plans or Health Care FSA Plan because any of the following qualifying events happens:

(a) the Participant dies;
(b) the Participant’s employment ends for any reason other than his or her gross misconduct;
(c) the Participant’s hours of employment are reduced;
(d) the Participant becomes entitled to Medicare benefits (under Part A, Part B, or both);
(e) the Participant and his or her Spouse divorce or legally separate; or
(f) in the case of a dependent child, the child ceases to be a “dependent child” under the terms of the Plan.

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Participant, or the Participant’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the Plan Administrator or Third Party Administrator, as appropriate, of the qualifying event.

Important—You must give timely notice of some qualifying events

For the other qualifying events (divorce or legal separation of the Participant and Spouse or a dependent child’s losing eligibility for coverage as a dependent child), COBRA continuation coverage will be available to you only if you notify the Plan in writing within 60 days after the qualifying event occurs. You must provide this notice to the Plan Administrator (whose contact information appears in the Administrative Information Attachment) in writing and with any required documentation attached.

How is COBRA continuation coverage provided?

Once the Plan receives 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 on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their children.

How long does COBRA continuation coverage last?
COBRA continuation coverage is a temporary continuation of coverage. COBRA continuation coverage under the Health Care FSA Plan will extend only through the end of the Plan Year in which the qualifying event occurred, to the extent permitted by law. Such COBRA continuation coverage for the Health Care FSA Plan will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

However, COBRA continuation coverage under the Health Care Plans lasts for up to 18 months if the qualifying event is a Participant’s termination of employment or reduction in hours. For a Spouse or dependent child, the COBRA continuation coverage period under the Health Care Plans is up to 36 months for any qualifying event other than a Participant’s termination of employment or reduction in hours. These coverage periods may be extended or shortened under the following circumstances:

(a) If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled, and you timely notify the Plan in writing, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage, and must last at least until the end of the 18-month period of continuation coverage. A copy of the social security disability award must be sent to the Plan Administrator before the end of the initial 18-month period of continuation coverage and within 60 days of the latest of:

- The date of the disability determination by the SSA;
- The date on which the qualifying event occurs; or
- The date on which the qualified beneficiary loses (or would lose) coverage under the terms of the Plan because of the qualifying event.

This disability extension only applies when the qualifying event is the Participant’s termination of employment or reduction of hours.

(b) If your family experiences another qualifying event while receiving 18 months of continuation coverage, your Spouse and dependent children can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any dependent receiving COBRA continuation coverage if the Participant or former Participant dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the dependent child stops being eligible under the Plan as a dependent child, but only if the event would have caused the dependent to lose coverage under the Plan had the first qualifying event not occurred. This extension due to a second qualifying event is available only if you notify the Plan in writing within 60 days of the second qualifying event. A termination of employment that follows a reduction in hours that was a qualifying event is never a second qualifying event for purposes of extending the maximum coverage period.

For more information

If you have any questions concerning the information in this section, your rights to COBRA continuation coverage, or if you need a copy of the COBRA notice or the SPD for the Plan, you should contact the Plan Administrator (contact information appears in Administrative Information Attachment).

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”).
in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website.)

*Keep your Plan informed of address changes*

In order to protect your and your family’s rights, you should keep the Plan Administrator informed of any changes in your address and the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan.

**17. Do I have any ERISA rights under the Plan?**

*This notice is required by federal law and regulation, and applies only to the Health Care FSA portion of this Plan.*

As a Participant in the Health Care FSA Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 ("ERISA"). ERISA provides that all Plan Participants shall be entitled to:

**Receive Information about Your Plan and Benefits**

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites, all Plan documents 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan’s annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

**Continue Group Health Plan Coverage**

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

**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 the Plan. The people who operate your Plan, called “fiduciaries” of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including the Employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

**Enforce Your Rights**

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

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the
court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits 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. 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.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this part of the summary plan description or about your rights under ERISA, 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 your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.
Plan Name and Number: The name of the Plan is the IASIS Healthcare Flexible Benefits Plan, which includes the IASIS Healthcare Health Care FSA Plan and the IASIS Healthcare Dependent Care FSA Plan (collectively, the “Plan”). The Plan is a part of the IASIS Healthcare Welfare Benefit Plan, which was assigned ERISA plan number 501.

Type of Plan and Plan Benefits: The Plan is a cafeteria plan providing employees the opportunity to receive their full wages or salary for the Plan Year in cash or to have the Employer apply a part of their earnings on a pretax basis to certain welfare benefits. While you may choose to have the Employer apply a portion of your earnings to your share of the cost of the Benefit Options described above, this Plan does not provide actual benefits. Consult the separate summary plan description for the Welfare Benefit Plan to determine the benefits and choices available to you under that plan. This Summary Plan Description includes a discussion of the basic features of the Flexible Benefits Plan, the Health Care FSA, and the Dependent Care FSA.

Plan Year: The Plan Year is the twelve-month period beginning January 1 and ending on December 31.

Effective Date: The effective date of this Summary Plan Description is January 1, 2015. The Plan document was also effective as of that date.

Employer/Plan Sponsor: The name, address, and Employer Identification Number of the plan sponsor are:

IASIS Healthcare LLC
117 Seaboard Lane, Building E
Franklin, TN 37067
20-1150104

Plan Administrator: The name, business address, and business telephone number of the Plan Administrator are:

IASIS Healthcare LLC
117 Seaboard Lane, Building E
Franklin, TN 37067
(615) 844-2747

The Plan Administrator administers the Plan and has the discretionary authority to interpret all Plan provisions and to determine all issues arising under the Plan, including issues of eligibility, coverage, and benefits. The Plan Administrator's failure to enforce any provision of the Plan shall not affect its right to later enforce that provision or any other provision of the Plan. The Plan Administrator may delegate some of its administrative duties to agents.

Claims Administrator: The Plan Administrator has engaged a Claims Administrator to manage claims under the Health Care Flexible Spending Account Plan and the Dependent Care Flexible Spending Account Plan. The Claims Administrator is Wageworks, its website is www.wageworks.com and its business telephone number is 1 (877) 942-3967.

Type of Administration: The Plan Administrator pays applicable benefits from the general assets of the Employer.

Funding: The Plan is paid for by the Employer out of the Employer's general assets. There is no trust or other fund from which benefits are paid.
Agent for Service of Legal Process: The name and address of the Plan’s agent for service of legal process are:

CT Corporation
1201 Peachtree Street, N.E.
Team 3
Atlanta, GA 30361

Service of legal process may also be made upon the Plan Administrator.
Appendix A
HEALTH CARE FSA

The Health Care Flexible Spending Account Plan (“Health Care FSA Plan”) is the portion of the Plan that enables you to pay for expenses which are not covered by the medical plan and save taxes at the same time. If you elect benefits under this portion of the Plan, a non-interest-bearing bookkeeping account (the “Health Care FSA”) will be set up to keep a record of the pre-tax contributions you allocate to the account. The account allows you to be reimbursed for out-of-pocket medical, dental and vision expenses incurred by you and your dependents during the Plan Year.

A-1. What is the maximum amount I can contribute each year?

You may choose to contribute any amount you desire, subject to a maximum of $2,550 (the Code limit for 2015), which may be increased by the IRS in future years. Any amounts you rollover from one Plan Year into the next (see Question A-6) will not count against the current Code maximum. That is, in your Health Care FSA, you could choose a reimbursement amount of $2,550 for 2015, and rollover up to the maximum $500 in unused funds (if such funds were available) from the prior year, for a total reimbursement amount of $3,050 in 2015.

A-2. What amounts will be available for reimbursement of Eligible Medical Expenses at any particular time during the Plan Year?

The full annual amount of reimbursement you have elected under the Health Care FSA for the Plan Year (reduced by prior reimbursements made during the Plan Year) will be available for reimbursement of Eligible Medical Expenses at any time during the Plan Year, without regard to how much you have contributed to the Health Care FSA at that time, so long as you continue to make the contributions.

A-3. How do I receive reimbursements under the Health Care FSA?

After you incur an Eligible Medical Expense, you file a claim with the Claims Administrator (whose contact information appears in the Administrative Information Attachment) by completing and submitting a request for reimbursement form prescribed by the Claims Administrator.

You must include with your request for reimbursement a written statement from the service provider (for example, a receipt or invoice) associated with each expense that indicates the following:

- The individual(s) on whose behalf eligible medical expenses have been incurred;
- The nature (i.e., what type of service or treatment was provided) and date of the eligible medical expenses so incurred;
- The amount of the requested reimbursement;
- A statement that such eligible medical expenses have not otherwise been reimbursed and are not reimbursable through any other source; and
- All other required or requested information or documentation.

Alternatively, you may provide a written statement from an independent third party (such as an explanation of benefits or “EOB”) indicating the date the medical care was received and your share of the responsibility for payment for that medical care (e.g., the deductible), along with your certification that you have not been reimbursed, and will not seek reimbursement, for your share of the expense from any other plan. You may be required to provide additional substantiation to the extent determined necessary to support your claim. The Claims Administrator will process the claim once it receives the
request for reimbursement form (and all supporting documentation) from you. Reimbursement for expenses that are determined to be Eligible Medical Expenses will be made as soon as possible after receiving the claim and processing it. If the expense is determined to not be an “Eligible Medical Expense,” you will receive notification of this determination. You must submit all claims for reimbursement of Eligible Medical Expenses no later than the earlier of (i) the March 31st immediately following the close of the Plan Year (or, if March 31 falls on a Saturday, Sunday, or holiday, the next following business day) or (ii) three (3) months after your ceased to be a Participant. This extended opportunity to submit claims for reimbursement is called the “run-out period.”

You may also be able to use a debit card to pay expenses at the time they are incurred. Your debit card can be used at qualified providers (e.g., a doctor’s office) for eligible health care services and products, but cannot be used at non-qualified providers (e.g., a restaurant). For expenses paid for with a debit card, no manual submission of the claim is required; however, your debit card transactions still must be substantiated by the Claims Administrator as having been appropriate. You will be contacted for that purpose and may be required to provide receipts and/or other documentation to verify that purchases made with your debit card were appropriate. The terms and limitations of the debit card, if available, are set forth in the information provided to you (along with your debit card) by the Claims Administrator.

A-4. What is an “Eligible Medical Expense”?

An “Eligible Medical Expense” is an expense that has been incurred by you and/or your Eligible Dependents that satisfies both of the following conditions:

- The expense is for “medical care” as defined by Section 213(d) of the Code. Whether an expense is for “medical care” is determined in the sole discretion of the Plan Administrator.
- The expense has not been reimbursed by any other source and your will not seek reimbursement for the expense from any other source.

An “Eligible Dependent” for these purposes is your Spouse and any other individual who is your “dependent” as defined in Section 105(b) of the Code (i.e., a dependent who is eligible to receive tax-free health coverage under the Code). This includes your child, step-child, or foster child who, as of the end of the Plan Year, has not attained age 27. This may include your domestic partner, to the extent your domestic partner otherwise qualifies as your “dependent” for this purpose under the Code. Coverage for the expenses incurred by an Eligible Dependent under the Health Care FSA ends on the date that the individual ceases to be an Eligible Dependent.

The Code generally defines “medical care” as any amounts incurred to diagnose, treat, or prevent a specific medical condition or for purposes of affecting any function or structure of the body. This includes over-the-counter medicine or drugs if a prescription is obtained for the over-the-counter medicine or drugs, insulin, and over-the-counter devices.

Not every health-related expense you or your Eligible Dependents incur constitutes an expense for “medical care.” For example, an expense is not for “medical care,” as that term is defined by the Code, if it is merely for the beneficial health of you and/or your eligible dependents (e.g., vitamins or nutritional supplements that are not taken to treat a specific medical condition) or for cosmetic purposes, unless necessary to correct a deformity arising from illness, injury, or birth defect. You may, in the discretion of the Plan Administrator, be required to provide additional documentation from a healthcare provider showing that you have a medical condition and/or the particular item is necessary to treat a medical condition.

In addition, certain expenses that might otherwise constitute “medical care” as defined by the Code are
not reimbursable under the Health Care FSA (per IRS regulations);

- Health insurance premiums;
- Medicare Part B premiums;
- Marriage or family counseling;
- Custodial care in an institution;
- Expenses incurred for qualified long-term care services; and
- Health club dues.

A-5. When must the expenses be incurred in order to receive reimbursement?

Eligible expenses must be incurred during the Plan Year and while you are a Participant. An expense is incurred when the service or treatment giving rise to the expense has been performed and not in advance of the services or when you pay for the services.

You may not be reimbursed for any expenses arising before your benefit election becomes effective, after your separation from service during the Plan Year (except for expenses incurred during an applicable COBRA continuation period described in Question 18) or for any expenses incurred after the close of the Plan Year.

A-6. What happens if I don’t spend all of my Health Care FSA contributions?

If the Eligible Medical Expenses you incur during the Plan Year are less than the annual amount you have allocated to your Health Care FSA, you will be able to “carryover,” to the subsequent Plan Year, up to a maximum of $500 in unused funds (the difference between the amount you elected and the amount you were reimbursed) to be used to reduce Eligible Medical Expenses you incur in the subsequent Plan Year. You will not be entitled to receive any direct or indirect payment of any amount of unused funds in excess of $500.

However, note that the Health Care FSA Plan still is subject to the “use-it-or-lose-it” rule. That is, if you do not timely submit claims for reimbursement for the total annual benefit that you have elected, you will lose any unused funds in excess of $500. Any amounts so forfeited will be applied by the Employer to offset administrative expenses and future costs of the Welfare Benefit Plan, and/or applied in a manner that is consistent with the Plan and applicable IRS rules and regulations. Therefore, it is important that you carefully decide how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

A-7. Will my health information be kept confidential?

Under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), group health plans such as the Health Care FSA Plan and the third party service providers are required to take steps to ensure that certain “protected health information” is kept confidential. You will receive a separate Notice of Privacy Practices that outlines the health information privacy policies of the affected plans under the Plan.

A-8. What else do I need to know about the Health Care FSA Plan?

Qualified Medical Child Support Order ("QMCSO")
A medical child support order is a judgment, decree or other order (including approval of a property settlement) made under state law that provides for child support or health coverage for the child of a Participant. The child becomes an “alternate recipient” and can receive benefits under the health plans of the Employer, if the order is determined to be “qualified.” You may obtain, without charge, a copy of the procedures governing the determination of QMCSOs from the Plan Administrator.

*Newborns’ and Mothers’ Health Protection Act*

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

*Women’s Health and Cancer Rights Act*

The Health Care FSA Plan, as required by the Women’s Health and Cancer Rights Act of 1998, will reimburse up to plan limits for benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complication resulting from a mastectomy (including lymphedema). Contact the Plan Administrator for more information.

*Qualified Reservist Distribution*

You may be entitled to take a distribution (a “QRD”) of all or a portion of the balance in your Health Care FSA (reduced by prior reimbursements made during the Plan Year) if you are a member of a reserve component ordered or called to active duty for a period of 180 days or more or for an indefinite period, and you make the request for such QRD during the period beginning on the date of the order or call to active duty and ending on the last day of the Plan Year that includes the date of the order or call. You may not make a QRD request with respect to a Plan Year ending before the order or call to active duty. In order to make a QRD, you must provide the Plan Administrator (or its delegate) with a copy of the order or call to active duty. You will not be permitted to submit claims for reimbursement of Eligible Medical Expenses incurred after the date the QRD is requested. The Plan Administrator (or Claims Administrator, as applicable) will pay the QRD to you within a reasonable amount of time, but not more than 60 days after the request for the QRD has been made.
Appendix B

DEPENDENT CARE FSA

The purpose of the Dependent Care Flexible Spending Account (“Dependent Care FSA”) portion of the Plan is to provide a tax-savings program to help eligible individuals pay for work-related dependent care expenses. Expenses for a day care center or in-home child care providers may be reimbursed on a pre-tax basis through a Dependent Care FSA. If you elect benefits under this portion of the Plan, a non-interest-bearing bookkeeping account will be set up to keep a record of the pre-tax contributions you allocate to the account.

B-1. What is the maximum amount I can contribute each year?

You may elect any Dependent Care FSA reimbursement amount, subject to the maximum annual Dependent Care FSA limits under the Code. Currently, your reimbursements may not exceed the lesser of:

- $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns);
- Your taxable compensation; or
- Your spouse’s actual or deemed earned income (a spouse who is a full-time student or incapable of caring for himself/herself has a deemed monthly earned income of $250 for one dependent or $500 for two or more dependents).

B-2. What are “Eligible Dependent Care Expenses”?

You may be reimbursed for employment-related dependent care expenses (“Eligible Dependent Care Expenses”) as a Participant in the Dependent Care FSA. Generally, an expense must meet all of the following conditions for it to be an Eligible Dependent Care Expense:

- The expense must be incurred for the care of your Dependent or for incidental household services;
- The expense must be incurred to enable you to be gainfully employed (or in active search of employment) for any period for which you have one or more Dependents as defined below;
- The expense must not be reimbursed through insurance or any other dependent care assistance program;
- If the expense is incurred for services outside your household and such expenses are incurred for the care of a Dependent who is age 13 or older, such Dependent must regularly spend at least 8 hours per day in your home;
- If the expense is incurred for services provided by a dependent day care center (i.e., a facility that provides care for more than 6 individuals not residing at the facility), the center must comply with all applicable state and local laws and regulations; and
- The expense must not be paid or payable to a “child” (as defined in Section 152(f)(1) of the Code) of yours who is under age 19 the entire year in which the expense is incurred.

For purposes of the Dependent Care FSA, a “Dependent” means any individual who is:

- A dependent of the Participant who is under age 13 and who (i) has the same principal place of abode as the Participant; (ii) does not provide over half of his/her own support; and (iii) is the Participant’s “child” (i.e., son, daughter, grandchild, stepchild, brother, sister, niece, or nephew); or
• The Spouse or other tax dependent (as defined in Section 152 of the Code, without regard to subsection (b)(1), (b)(2), and (d)(1)(b) thereof) of the Participant, who is physically or mentally incapable of caring for himself/herself and who has the same principal place of abode as the Participant for more than half of the year.

**Note:** There is a special rule for children of divorced parents. If you are divorced, the child is only a Dependent of the “custodial” parent (as defined in Section 152(e) of the Code).

You are encouraged to consult your personal tax advisor for guidance as to what constitutes an Eligible Dependent Care Expense in your particular situation.

**B-3. When must the expenses be incurred in order to receive reimbursement?**

Eligible Dependent Care Expenses must be incurred on or after the date you become a Participant for the Plan Year and during the remainder of the Plan Year. An expense is “incurred” when the service or care giving rise to the expense has been performed and not in advance of the services or when you pay for the services.

You may not be reimbursed for any expenses arising before your benefit election becomes effective or for any expenses incurred after the close of the Plan Year. You may be reimbursed for Eligible Dependent Care Expenses incurred for the remainder of the Plan Year in which your employment terminates, but only up to the amount of funds in your Dependent Care FSA at the time or your termination; no further salary reduction contributions will be made on your behalf after you terminate.

**B-4. How do I receive reimbursement under the Dependent Care FSA?**

When you incur an eligible expense, you should file a written claim with the Claims Administrator by completing and submitting a reimbursement form. Reimbursement forms may be obtained from the Claims Administrator (contact information appears in the **Administrative Information Attachment**). You must submit all claims for reimbursement for expenses during the Plan Year in which they were incurred.

When you submit a claim for reimbursement, along with the reimbursement form, you must include a written statement from the service provider (e.g., an invoice) associated with each expense that indicates the following:

- The name, Social Security number or federal tax ID number of the care provider;
- The dependent’s name, relationship to you, age;
- Dates of service; and
- The nature and amount of the expense.

The Claims Administrator will process the claim once it receives the request form from you. Expenses are considered “incurred” when the service is performed, not necessarily when it is paid. If the request qualifies as a benefit or expense that the Plan has agreed to pay (this is an “Approved Claim”), you will receive a reimbursement payment soon after you submit the request. If the expense is determined not to be an “Eligible Dependent Care Expense” you will receive notification of this determination.

Dependent Care FSA reimbursements are limited to your account balance at the time the request for reimbursement is processed, which is equal to your year-to-date contributions. The claims administration system assumes 26 pay periods during a 12-month period. Contributions are determined

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FSA SPD
by taking your annual Dependent Care FSA pledge and dividing by 26 pay periods. If your Employer’s payroll system is different you may need to check your account balance before filing a claim, because there may be a delay between the date of your contribution and the date it is credited to your account. If there are not funds available when a claim is submitted, the Claims Administrator will enter the claim into its claims processing system and as soon as additional funds are deposited, a reimbursement will be issued. If the amount of the expense was more than the account balance, the excess part of the claim will be carried over to the next pay period to be paid out as the account balance becomes adequate.

**B-6. What happens if I don’t spend all of my Dependent Care FSA contributions?**

You will not be entitled to receive any direct or indirect payment of any amount that represents the difference between the actual Eligible Dependent Care Expenses you have incurred and the annual benefit you have elected and paid for. The Dependent Care FSA is subject to the “use-it-or-lose-it” rule. That is, if you do not timely submit claims for reimbursement for the total annual benefit that you have elected, you will lose the difference between the amount you elected and the amount you were reimbursed. Any amounts so forfeited will be applied by the Employer to offset administrative expenses and future costs of the Welfare Benefit Plan, and/or applied in a manner that is consistent with the Plan and applicable IRS rules and regulations. Therefore, it is important that you carefully decide how much to place in each account. Remember, you must decide which benefits you want to contribute to and how much to place in each account before the Plan Year begins. You want to be as certain as you can that the amount you decide to place in each account will be used up entirely.

**B-7. Will I be taxed on the Dependent Care FSA reimbursements I receive?**

You will not normally be taxed on your Dependent Care FSA reimbursements, provided that your family’s aggregate dependent day care expense reimbursement (under this Dependent Care FSA and/or another employer’s dependent day care assistance program) does not exceed the applicable statutory limit (described in Question B-1). However, to qualify for tax-free treatment, you will be required to list the names and taxpayer identification numbers on your annual tax return of any persons who provided you with dependent day care services during the calendar year for which you have claimed a tax-free reimbursement.

**B-8. If I participate in the Dependent Care FSA Plan, will I still be able to claim the household and dependent day care credit on my federal income tax return?**

You may not claim any other tax benefit for the tax-free amounts received by you under this Dependent Care FSA Plan, although the balance of your Eligible Dependent Care Expenses not reimbursed under this Dependent Care FSA Plan may be eligible for the dependent day care credit.

You may save more money if you take advantage of the tax credit rather than using this Dependent Care FSA Plan. You should consult your tax advisor regarding your particular circumstances to determine whether participation in this Dependent Care FSA Plan is advantageous to you.

For more information about the federal tax credit, you can call the IRS at (800) 829-3676 and ask for Publication 503, Child and Dependent Care Expenses, and for Publication 596, Earned Income Credit. You may also find these publications online at [http://www.irs.gov/formspubs/index.html](http://www.irs.gov/formspubs/index.html).
Life and AD&D
We certify that you (provided you belong to a class described on the Schedule of Benefits and your completed enrollment card is attached) are insured, for the benefits which apply to your class, under Group Policy No. GL 668964 issued to IASIS Healthcare, LLC, the Policyholder.

When loss of life covered under the Policy occurs, we will pay the amount stated on the Schedule of Benefits to the named beneficiary, subject to provisions entitled Beneficiary and Facility of Payment.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

Secretary

President

GROUP LIFE INSURANCE CERTIFICATE

This Group Life Certificate replaces any previous Group Life Certificates and is dated October 2, 2014.
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SCHEDULE OF BENEFITS

EFFECTIVE DATE: June 1, 2014

ELIGIBLE CLASSES: Each active, Full-time Employee, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month coinciding with or next following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 30 days

AMOUNT OF INSURANCE:

Basic Life and Accidental Death and Dismemberment: One (1) times Earnings, rounded to the next higher $1,000, subject to a maximum Amount of Insurance of $500,000.

Supplemental Life (Applicable only to you if you elected Supplemental coverage and are paying the applicable premium): Choice of: One (1), Two (2), Three (3), Four (4) or Five (5) times Earnings, rounded to the next higher $1,000, subject to a maximum Amount of Insurance of $1,000,000.

All amounts of supplemental insurance over the lesser of: (1) five (5) times Earnings; or (2) $500,000 (guarantee issue amount) are subject to our approval of your proof of good health. However, any proof of good health required due to late application for this insurance (See EFFECTIVE DATE OF INDIVIDUAL INSURANCE) will be at no expense to us.
For Insureds age 65 and over, the Amount of Basic Life and Accidental Death and Dismemberment Insurance and Supplemental Life Insurance is subject to automatic reduction. Upon the Insured’s attainment of the specified age below, the Amount of Basic Life and Accidental Death and Dismemberment Insurance and Supplemental Life Insurance will be reduced to the applicable percentage, rounded to the next higher $1,000. This reduction also applies to Insureds who are age 65 or over on their Individual Effective Date.

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<th>Age</th>
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<td>65-69</td>
<td>67%</td>
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<td>70+</td>
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Dependent Life:

Spouse Amount: Choice of: $5,000, $10,000, $25,000, $50,000 or $100,000
Child Amount: 15 days and over: Choice of: $5,000 or $10,000

The Spouse Amount of Insurance will terminate at your Spouse's attainment of age 70.

The Life amount will be reduced by any benefit paid under the Living Benefit Rider.

CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age are effective on the first of the month following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class (if applicable) are effective on the first of the Policy month coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in Earnings are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively At Work on the date of the change. If you are not Actively At Work when the change should take effect, the change will take effect on the day after you have been Actively At Work for one full day. However, if:

1. you have the right to choose your amount of Supplemental insurance; or
2. the amount of Supplemental insurance is based on Earnings and a change in Earnings would result in an increase in the amount
of Supplemental insurance of 15% or more;

then, proof of good health will be required. Such proof must be approved by us for the increase to take effect.

Premium changes due to your entering into a higher age bracket will occur on the first of the month following your last birthday.

If an increase in, or initial application for, the Amount of Insurance is due to a life event change (such as marriage, birth or specific changes in employment status), proof of good health will not be required provided you apply within thirty (30) days of such life event.

If application for the Amount of Insurance is due to you re-satisfying the Eligible Class requirement, the Amount of Insurance will be the lesser of: (1) the approved Amount of Insurance you were previously insured for before your coverage was terminated; or (2) the guarantee issue amount stated above and proof of good health will not be required.

**CONTRIBUTIONS:** You are not required to contribute toward the cost of the Basic Insurance. You are required to contribute toward the cost of the Supplemental Insurance. It is applicable to you only if you elected Supplemental coverage and are paying the applicable premium. You are required to contribute toward the cost of Dependent Life Insurance.
DEFINITIONS

"We," "us" and "our" means Reliance Standard Life Insurance Company.

"You," "your" and "yours" means a person who meets the eligibility requirements of the Policy and is enrolled for this insurance.

"Actively at work" and "active work" means actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of injury or illness.

"Full-time" means scheduled to work for the Policyholder for a minimum of 36 hours during your regular work week.

"The date you retire" or "retirement" means the effective date of your:

1. retirement pension benefits under any plan of a federal, state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
2. retirement pension benefits under any plan which the Policyholder sponsors, or makes or has made contributions;
3. retirement benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act.

"Earnings", as used in the SCHEDULE OF BENEFITS section, means your annual salary received from the Policyholder on the day just before the date of loss. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic salary.

If hourly employees are insured, the number of hours scheduled to work during a regularly scheduled work week, not the hours actually worked, not to exceed forty (40) hours per week, times fifty-two (52) weeks, will be used to determine annual earnings.

"Total Disability" as used in the WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY section, means your complete inability to engage in any type of work for wage or profit for which you are suited by education, training or experience.

"Loss" as used in the ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE section, with respect to:
(1) hand or foot, means the complete severance through or above the wrist or ankle joint;

(2) the eye, speech or hearing, means total and irrecoverable loss thereof.

"Dependents" as used in the DEPENDENT LIFE INSURANCE section, means:

(1) your legal spouse who is not legally separated or divorced from you; and

(2) your unmarried child(ren), age 15 days to 26 years, who is financially dependent upon you for support. Adoptive, foster and step-children are considered Dependents if they are in your custody; and

(3) your child(ren) beyond the limiting age who is incapable of self-sustaining employment by reason of intellectual disability or physical handicap and who is chiefly dependent on you for support and maintenance.

"Injury" means accidental bodily injury that is caused directly and independently of all other causes by accidental means and which occurs while your coverage under the Policy is in force.
GENERAL PROVISIONS

INCONTESTABILITY

Any statements made by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which you are or any Insured Dependent is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

   (a) it is in a written form signed by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and

   (b) a copy of such written instrument is or has been furnished to you or any Insured Dependent, your or any Insured Dependent's beneficiary or legal representative.

(2) If the statement relates to your or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two (2) years during your or an Insured Dependent's lifetime.

ASSIGNMENT

Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.
EFFECTIVE DATE AND TERMINATION

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: If the Policyholder pays the entire premium, your insurance will go into effect on the date stated on the Schedule of Benefits. If you pay a part of the premium, you must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date stated on the Schedule of Benefits, if you apply on or before that date; or

(2) the first of the month coinciding with or next following the date you apply, if you apply within thirty-one (31) days from the date you first met the eligibility requirements or re-satisfied the Eligible Class requirements; or

(3) the first of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if you apply:

   (a) after thirty-one (31) days from the date you first become eligible and did not elect coverage; or
   (b) after you terminated this insurance but you remained in a class eligible for this insurance; or
   (c) for an Amount of Insurance greater than the Amount of Insurance shown on the Schedule of Benefits as not subject to our approval of a person's good health; or
   (d) for an Amount of Insurance greater than you were insured for under the prior group life insurance plan carrier, if applicable; or
   (e) after being eligible for coverage under a prior group life insurance plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or

(4) the date premium is remitted.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

If you are not actively at work on the day your insurance is to go into effect, the insurance will go into effect on the day you return to active work for one full day.
TERMINATION OF INSURANCE: Your insurance will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for you; or

(4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INSURANCE: Your insurance may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

(1) twelve (12) months, if due to illness or injury; or

(2) sixty (60) days, if due to temporary lay-off or approved leave of absence.

REINSTATEMENT: Your insurance may be reinstated if you are a former Insured who has been:

(1) on an approved leave of absence,

(2) on a temporary lay-off; or

(3) rehired after employment had been terminated.

You must return to active work within the period of time shown on the Schedule of Benefits. You must also be a member of a class eligible for this insurance.

You will not be required to fulfill the eligibility requirements of the Policy again. The insurance will go into effect on the day you return to active work.

If you request insurance after terminating insurance at your own request or for failure to pay premium when due, proof of good health must be approved by us before your insurance coverage may be reinstated.
CONVERSION PRIVILEGE

You can use this privilege when your insurance is no longer in force. It has several parts. They are:

A. If the insurance ceases due to termination of employment or membership in any of the Policy's classes, an individual Life Insurance Policy may be issued. You are entitled to a policy without disability or supplemental benefits. You must make written application for the policy within thirty-one (31) days after you terminate. The first premium must also be paid within that time. The issuance of the policy is subject to the following conditions:

1. The policy will, at your option, be on any one of our forms, except for term life insurance. It will be the standard type issued by us for the age and amount applied for;

2. The policy issued will be for an amount not over what you had before you terminated;

3. The premium due for the policy will be at our usual rate. This rate will be based on the amount of insurance, class of risk and your age at date of policy issue; and

4. Proof of good health is not required.

B. If the insurance ceases due to the termination or amendment of the Policy, an individual Life Insurance Policy can be issued. You must have been insured for at least five (5) years under the Policy. The same rules as in A above will be used, except that the face amount will be the lesser of:

1. The amount of your Group Life benefit under the Policy. This amount will be less any amount you are entitled to under any group life policy issued by us or another insurance company; or

2. $5,000.

C. If the insurance reduces, as may be provided in the Policy, an individual Life Insurance Policy can be issued. The same rules as in A above will be used, except that the face amount will not be greater than the amount which ceased due to the reduction.
D. If you die during the time provided in A above in which you are entitled to apply for an individual policy, we will pay the benefit under the Group Policy that you were entitled to convert. This will be done whether or not you applied for the individual policy.

E. Any policy issued with respect to A, B or C above will be put in force at the end of the thirty-one (31) day period in which application must be made.

F. If you are entitled to have an individual policy issued to you without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. If not, you will have an additional period in order to do so. This additional period will end fifteen (15) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in A above.
BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: The beneficiary will be as named in writing by you to receive benefits at your death. This beneficiary designation must be on file with us or the Plan Administrator and will be effective on the date you sign it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

If you name more than one beneficiary to share the benefit, you must state the percentage of the benefit that is to be paid to each beneficiary. Otherwise, they will share the benefit equally.

The beneficiary's consent is not needed if you wish to change the designation. His/her consent is also not needed to make any changes in the Policy.

If the beneficiary dies at the same time as you, or within fifteen (15) days after your death but before we received written proof of your death, payment will be made as if you survived the beneficiary, unless noted otherwise.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, any benefits due shall be paid to the first of the following classes to survive you:

1. your legal spouse;
2. your surviving child(ren) (including legally adopted child(ren)), in equal shares;
3. your surviving parents, in equal shares;
4. your surviving siblings, in equal shares; or, if none of the above,
5. your estate.

We will not be liable for any payment we have made in good faith.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the beneficiary. Payment to a minor shall not exceed $1,000.

If you have not named a beneficiary, or the named beneficiary is not surviving at your death, we may pay up to $500 of the benefit to the person(s) who, in our opinion, have incurred expenses in connection with your last illness, death or burial.
The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

The benefit will be held with interest at a rate set by us.

We will not be liable for any payment we have made in good faith.
SETTLEMENT OPTIONS

You may elect a different way in which payment of the Amount of Insurance can be made. You must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under $2,000 or option payments of less than $20.00 each are not eligible.

If no instructions for a settlement option are in effect at your death, the beneficiary may make the election, with our consent.

Settlement Options are described in the Policy.
WAIVER OF PREMIUM IN EVENT OF TOTAL DISABILITY

We will extend the Amount of Insurance during a period of Total Disability for one (1) year if:

1. you become totally disabled prior to age 60;
2. the Total Disability begins while you are insured;
3. the Total Disability begins while the Policy is in force;
4. the Total Disability lasts for at least 6 months;
5. the premium continues to be paid; and
6. we receive proof of Total Disability within one (1) year from the date it began.

After proof of Total Disability is approved by us, neither you or the Policyholder is required to pay premiums. Also, any premiums paid from the start of the Total Disability will be returned.

We will ask you to submit annual proof of continued Total Disability. The Amount of Insurance may then be extended for additional one (1) year periods. You may be required to be examined by a Physician approved by us as part of the proof. We will not require you to be examined more than once a year after the insurance has been extended two (2) full years.

The Amount of Insurance extended will be limited to the amount of basic group life coverage and any applicable supplemental group life coverage on your life that was in force at the time that Total Disability began excluding any additional benefits. This amount will not increase. This amount will reduce or cease at any time it would reduce or cease if you had not been totally disabled. If you die, we will be liable under this extension only if written proof of death is received by us.

The Amount of Insurance extended for you will cease on the earliest of:

1. the date you no longer meet the definition of Total Disability; or
2. the date you refuse to be examined; or
3. the date you fail to furnish the required proof of Total Disability; or
4. the date you become age 70; or
5. the date you retire.

You may use the conversion privilege when this extension ceases. Please refer to the Conversion Privilege section for rules. You are not entitled to conversion if you return to work and are again eligible for the
insurance under the Policy. If you use the conversion privilege, benefits will not be payable under the Waiver of Premium in Event of Total Disability provision unless the converted policy is surrendered to us.
ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE

Nothing in this section will change or affect any of the terms of the Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

If you suffer any one of the losses listed below, as a result of an injury, we will pay the benefit shown. The loss must be caused solely by an accident which occurs while you are insured, and must occur within 365 days of the accident. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. The Amount of Insurance can be found on the Schedule of Benefits.

<table>
<thead>
<tr>
<th>LOSS OF:</th>
<th>AMOUNT OF INSURANCE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Life ..................................................</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Both Hands .........................</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Both Feet ..............................</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>The Sight of Both Eyes ..........</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>Speech and Hearing ..............</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and One Foot ..........</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand and the Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Foot and the Sight of One Eye</td>
<td>The Full Amount</td>
</tr>
<tr>
<td>One Hand ..................................</td>
<td>One-Half of the Amount</td>
</tr>
<tr>
<td>One Foot ...................................</td>
<td>One-Half of the Amount</td>
</tr>
<tr>
<td>Speech or Hearing ...............</td>
<td>One-Half of the Amount</td>
</tr>
<tr>
<td>The Sight of One Eye ............</td>
<td>One-Half of the Amount</td>
</tr>
<tr>
<td>Thumb and Index Finger .........</td>
<td>One-Quarter of the Amount</td>
</tr>
</tbody>
</table>
EXCLUSIONS

A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(4) sustained during your commission or attempted commission of an assault or felony; or

(5) to which your acute or chronic alcoholic intoxication is a contributing factor; or

(6) to which your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.
TOTAL LOSS OF USE

We will pay a Total Loss of Use Benefit according to the Schedule of Losses below if, due to an Injury sustained while insured under the Policy, you suffer such a loss within 1 year of the date the Injury occurred provided:

(1) we receive proof that you have experienced a permanent Total Loss of Use for 12 consecutive months from the date the Injury occurred; and
(2) no benefit is payable under the Policy for the same loss under the Accidental Death and Dismemberment Benefit.

"Total Loss of Use" means the permanent inability to use an entire arm, leg or combination of arms and legs, starting at the shoulder or hip and including the hand or foot, due to incurable paralysis, stiffening of joints, or any other Injury that may cause the limb(s) to become permanently non-functional.

SCHEDULE OF LOSSES

For Total Loss of Use of:  Benefit Amount:

Both Arms and Both Legs ............................................. The Full Amount
Both Arms and One Leg or
Both Legs and One Arm ........................................... 3/4 of the Full Amount
Both Arms ............................................................... 2/3 of the Full Amount
Both Legs ............................................................... 3/4 of the Full Amount
One Arm and One Leg ........................................... 2/3 of the Full Amount
One Arm or One Leg ............................................... 1/2 of the Full Amount

The Full Amount can be found in the Schedule of Benefits. Only one benefit (the larger) will be paid for more than one loss resulting from any one accident. In no event will the total of all benefits paid to you under the Policy to you for any one accident, under this benefit and the Accidental Death and Dismemberment Benefit exceed your Amount of Accidental Death and Dismemberment Benefit shown in the Schedule of Benefits.
A benefit will not be payable for a loss:

(1) caused by suicide or intentionally self-inflicted injuries; or

(2) caused by or resulting from war or any act of war, declared or undeclared; or

(3) to which sickness, disease or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(4) sustained during your commission or attempted commission of an assault or felony; or

(5) to which your acute or chronic alcoholic intoxication is a contributing factor; or

(6) to which your voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.
SEAT BELT AND AIR BAG BENEFIT

Seat Belt Benefit

We will pay an additional Seat Belt Benefit if, due to an Injury sustained while driving or riding in a private passenger Four-Wheel Vehicle, you suffer loss of life for which an Accidental Death Benefit is payable under the Policy.

Once we receive the police accident report which confirms that you were properly strapped in a Seat Belt at the time of the accident, we will pay a benefit equal to 10% of the Accidental Death Benefit payable under the Policy.

If the police report does not clearly establish that you were or were not wearing a Seat Belt at the time of the accident which caused your death, the benefit payable will be $1,000 in lieu of the benefit described above.

"Seat Belt" means an unaltered factory-installed lap and/or shoulder restraint designed to keep a person steady in a seat.

Air Bag Benefit

In addition to the Seat Belt Benefit, we will also pay an Air Bag Benefit if such private passenger Four-Wheel Vehicle is equipped with a factory-installed Air Bag and the police accident report clearly establishes that you were positioned in a seat which is designed to be protected by an Air Bag and were properly strapped in the Seat Belt when the Air Bag inflated.

Once we receive the police accident report which confirms that the Air Bag inflated properly upon impact, we will pay a benefit equal to 5% of the Accidental Death Benefit payable under the Policy.

"Air Bag" means an unaltered factory-installed supplemental restraint system designed to inflate upon impact to protect a person from bodily Injury during an accident.

"Four-Wheel Vehicle" means a private passenger automobile, a truck-type vehicle which has a manufacturer’s rated load capacity of 2,000 pounds or less, or a self-propelled motor home, all of which are registered for private passenger use and designated for transportation on public roadways.
Maximum Benefit Payable – The total combined maximum benefit payable under the Seat Belt and Air Bag Benefit is $25,000.

EXCLUSIONS

No benefit is payable for any loss sustained by you:

1. if you were driving or riding in any private passenger Four-Wheel Vehicle which was being used in a race, speed or endurance test, or for acrobatic or stunt driving at the time of the accident;

2. if you were not wearing a Seat Belt for any reason;

3. while you were sharing a Seat Belt; or

4. due to a defect in the Air Bag diagnostic system.
DISAPPEARANCE BENEFIT

We will presume you suffered loss of life due to an injury sustained in an accident while insured under the Policy if:

(1) you were riding in a conveyance that is involved in an accident which is not excluded under the Policy;

(2) the conveyance is wrecked, sinks or disappears as a result of such accident; and

(3) your body is not found within three-hundred and sixty-five (365) days of the accident.
CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include your name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

PAYMENT OF CLAIMS: Payment will be made as soon as proper proof is received. All benefits will be paid to you, if living. Any benefits unpaid at the time of death, or due to death, will be paid to the beneficiary.

Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

PHYSICAL EXAMINATION: At our own expense, we will have the right to have you examined as reasonably necessary when a claim is pending. We can have an autopsy made unless prohibited by law.

LEGAL ACTION: No legal action may be brought against us to recover on the Policy within 60 days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina and Michigan, six (6) years) from the time written proof of loss is required to be submitted.
DEPENDENT LIFE INSURANCE

Nothing in this section will change or affect any of the terms of the Policy other than as specifically set out in this section. All the Policy provisions not in conflict with these provisions shall apply to this section.

When an Insured Dependent dies, we will pay the applicable benefit shown on the Schedule of Benefits to you. If you are deceased, then the benefit will be paid to your beneficiary. Only dependents who meet the definition of Dependents can be insured for this benefit.

A person may not have coverage both as an Insured Person and as a covered dependent. Only one eligible spouse may cover the eligible children as Insured Dependents. The spouse may be covered as a dependent if not covered as an Insured Person.

EFFECTIVE DATE OF DEPENDENT INSURANCE

If the Policyholder pays the entire premium, the insurance for a Dependent will become effective on the later of:

(1) the date you become eligible for Dependent Life Insurance; or

(2) the date the dependent meets the definition of Dependent.

If you pay a portion of the dependent premium, you may insure your dependents by making written application. In this case, the insurance for Dependents will take effect on the later of:

(1) the date you become eligible for Dependent Life Insurance; or

(2) the date the dependent meets the definition of Dependent, if application is made on or before that date; or

(3) the first of the month coinciding with or next following the date of application, if application is made within thirty-one (31) days from the date the dependent first becomes eligible for this insurance; or
(4) the first of the month coinciding with or next following the date we approve any required proof of good health. We require proof of good health if you make application for dependent insurance:

(a) after thirty-one (31) days from the date the dependent first becomes eligible for this insurance; and

(b) after a prior termination of insurance as long as you remain in a class eligible for dependent insurance.

After this Insurance is in force for one dependent, application is not required for added dependents.

For dependents who are confined in a hospital or at home on the date on which they would otherwise become insured, insurance will be effective as of the date the confinement ends.

**TERMINATION OF DEPENDENT LIFE INSURANCE**

The insurance for an Insured Dependent will terminate on the first of the following dates:

1. the date this Section terminates; or

2. the date the dependent is no longer a Dependent as defined; or

3. the end of the period for which premium has been paid by you or the Policyholder; or

4. the date your insurance terminates; or

5. the date you retire.

**CONVERSION OF DEPENDENT LIFE INSURANCE**

If the insurance of an Insured Dependent terminates because:

1. you terminate employment or membership in the classes eligible for this insurance; or

2. you die; or

3. the dependent ceases to be eligible for this insurance;
then the dependent may convert his/her insurance to an individual policy. The conversion is subject to the following rules:

(1) a written application for the conversion policy must be received by us within thirty-one (31) days after the dependent's insurance terminates. The first premium must be sent in with the application; and

(2) the premium due for the policy will be at our usual rates. This rate will be based on the amount of insurance, class of risk and the age of the dependent on the date the policy is issued; and

(3) the policy may be any life plan we currently issue, except term insurance; and

(4) proof of good health is not required; and

(5) the policy issued will be for an amount not over what the dependent had before termination under the Policy; and

(6) the policy issued will not have disability or supplemental benefits.

If the dependent's insurance ceases due to termination or amendment of the Policy, an individual policy can be issued. The dependent must have been insured for at least five (5) years under the Policy. The same rules as shown above will be used, except that the face amount will be the lesser of:

(1) the amount of dependent life insurance under the Policy. This amount will be less any amount of group life insurance the dependent receives or becomes eligible for within thirty-one (31) days after the Policy terminates; or

(2) $5,000.

If an Insured Dependent should die during the time provided in (1) above in which he/she is entitled to apply for an individual policy, we will pay the benefit under the Group Policy that he/she was entitled to convert. This will be done whether or not the dependent applied for the individual policy.
Any individual policy issued with respect to this section will be effective at the end of the thirty-one (31) day period in which application must be made.

If an Insured Dependent is entitled to have an individual policy issued to him/her without proof of health, then you must be given notice of this right at least fifteen (15) days before the end of the period specified above. If not, you will have an additional period in order to do so. This additional period will end fifteen (15) days after you are given notice. This period will not extend beyond sixty (60) days after the expiration date of the period provided above. This insurance will not be continued beyond the period provided in (1) above.
EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage and that of any Insured Dependent, if applicable, in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage and that of any Insured Dependents, if applicable, in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under this Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as
applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

(1) the date the Policy terminates; or
(2) the end of the period for which premium has been paid for you; or
(3) the date such leave should end in accordance with the Policyholder’s policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated.
GROUP TERM LIFE INSURANCE LIVING BENEFIT RIDER

THIS RIDER ADDS AN ACCELERATED BENEFIT PROVISION. RECEIPT OF THIS ACCELERATED BENEFIT WILL REDUCE THE DEATH BENEFIT AND MAY BE TAXABLE. INSUREDS SHOULD SEEK ASSISTANCE FROM THEIR PERSONAL TAX ADVISOR.

Attached to Group Policy Number: GL 668964
Issued to Group Policyholder: IASIS Healthcare, LLC

This Rider is attached to and made a part of the Policy indicated above. Your Certificate is hereby amended, in consideration of the application for this coverage, by the addition of the following benefit. In this Rider, Reliance Standard Life Insurance Company will be referred to as “we”, “us”, “our”.

DEFINITIONS: This section gives the meaning of terms used in this Rider. The Definitions of the Policy and Certificate also apply unless they conflict with Definitions given here.

"Certified" or "Certification" refers to a written statement, made by a Physician on a form provided by us, as to the Insured’s Terminal Illness.

"Certificate" means the document, issued to each Insured, which explains the terms of his coverage under the Group Life Insurance Policy.

"Death Benefit" means the insurance amount payable under the Certificate at death of the Insured, subject to all Certificate provisions dealing with changes in the amount of insurance and reductions or termination for age or retirement. It does not include any amount that is only payable in the event of Accidental Death.

"Insured" means only a primary Insured. Dependents are not eligible for coverage under this Living Benefit Rider.

"Physician" means a duly licensed practitioner, acting within the scope of his license, who is recognized by the law of the state in which diagnosis is received. The Physician may not be the Insured or a member of his immediate family.

"Policy" means the Group Life Insurance Policy issued to the Group Policyholder under which the Insured is covered.

"Terminally Ill" or "Terminal Illness" refers to an Insured’s illness or physical condition that is Certified by a Physician to reasonably be expected to result in death in less than 12 months.
"Written Request" means a request made, in writing, by the Insured to us.

All pronouns include either gender unless the context indicates otherwise.

**DESCRIPTION OF COVERAGE:** This benefit is payable to the Insured if, after having been covered under this Rider for at least 60 days, an Insured is Certified as Terminally Ill. In order for this benefit to be paid:

1. the Insured must make a Written Request; and
2. we must receive from any assignee or irrevocable beneficiary their signed acknowledgment and agreement to payment of this benefit.

We may, at our option, confirm the terminal diagnosis with a second medical exam performed at our own expense.

**AMOUNT OF THE LIVING BENEFIT:** The Living Benefit will be an amount equal to 75% of the Death Benefit applicable to the Insured under the Policy on the date of the Certification of Terminal Illness, subject to a maximum benefit of $500,000. This benefit may be paid as a single lump sum or in installment payments mutually agreed to by us and the Insured. The Living Benefit is payable one time only for any Insured under this Rider.

**EFFECT OF BENEFIT:** If an Insured becomes eligible for, and elects to receive this benefit, it will have the following effects:

1. The Death Benefit payable for such Insured will be reduced by an amount equal to the Living Benefit paid to such Insured. The amount of the Living Benefit plus the corresponding Death Benefit will not exceed the amount that would have been paid as the Death Benefit in the absence of this Rider.

2. Any amount of insurance that would otherwise be continued under a Waiver of Premium provision will be reduced proportionately, as will the maximum Face Amount available under the Conversion Privilege.

**MISSTATEMENT OF AGE OR SEX:** The Living Benefit will be adjusted to reflect the amount of benefit that would have been purchased by the actual premium paid at the correct age and sex.

**TERMINATION OF AN INDIVIDUAL’S COVERAGE UNDER THIS RIDER:** The coverage of any Insured under this Rider will terminate on
the first of the following:

(1) the date his coverage under the Policy terminates; or

(2) the date of payment of the Living Benefit for his Terminal Illness.

ADDITIONAL PROVISIONS: This Rider takes effect on the Effective Date shown. It will terminate on the date the Group Policy terminates. It is subject to all the terms of the Group Policy not inconsistent herein.

In witness whereof, we have caused this Rider to be signed by our Secretary.

[Signature]

Secretary
IMPORTANT NOTICE TO TENNESSEE POLICYHOLDERS 
AND CERTIFICATE HOLDERS 
(GROUP AND BLANKET)

Reliance Standard Life and your agent appreciate this opportunity to serve your insurance needs.

In the event you need to contact someone about this policy for any reason, please contact your agent. If you are unable to reach your agent or have additional questions, you may contact the Policyowner Service Office of Reliance Standard Life at the following address:

Reliance Standard Life Insurance Company  
3340 Peachtree Road, N.E.  
Suite 2650  
Atlanta, GA 30326  
(800) 535-6018  
(404) 365-8888
SUMMARY PLAN DESCRIPTION
The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

SUMMARY PLAN DESCRIPTION

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

PLAN NAME: IASIS Healthcare Welfare Benefit Plan

PLAN SPONSOR: IASIS Healthcare, LLC
117 Seaboard Lane
Building E
Franklin, TN 37067
(615) 844-2747

SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 20-1150104

PLAN NUMBER: 501

TYPE OF PLAN: Death and Dismemberment Benefit Plan

PLAN BENEFITS: Fully Insured - Group Life and Accidental Death and Dismemberment Insurance Benefits

TYPE OF ADMINISTRATION: The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090.

PLAN ADMINISTRATOR: The Plan Sponsor named above.
AGENT FOR SERVICE OF LEGAL PROCESS: The Plan Sponsor named above.

PLAN YEAR: The plan's fiscal records are kept on a calendar year basis beginning January 1st.

PLAN COSTS: The cost of the benefits provided under the plan are paid for by the employee and the employer.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS: A plan participant or beneficiary can obtain, without charge, a copy of the Plan’s procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION: The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.
CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.
Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically 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, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for
the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims
A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. 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; or 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 to the claimant upon request.
APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and
other information relevant to the claimant’s claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information
necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims
A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable);
5. 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; or 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 to the claimant upon request; and
6. 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 (where applicable)."
### DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

- Was relied upon in making the benefit determination;

- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or

- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

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 the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, 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.
Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**Enforce Your Rights**

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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who 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.
Assistance with Your Questions

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

We certify that the Person whose name appears on the enrollment card attached to this Certificate is insured for the benefits which apply to his/her class, under Group Policy No. VPL 670874 issued to IASIS Healthcare, LLC, the Policyholder.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

Secretary    President

GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE

This Group Long Term Disability Certificate replaces any previous Group Long Term Disability Certificates and is dated September 8, 2014.
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SCHEDULE OF BENEFITS

EFFECTIVE DATE: June 1, 2014

ELIGIBLE CLASSES: Each active, Full-time Employee, except Monthly-Paid Corporate Employees (Manager level and above), Hospital-Based Officers, Hospital-Based Directors, Physician Group Directors, Health Choice Directors, Employee Physicians, Physician Assistants, Nurse Practitioners and Certified Midwives affiliated with OB/GYN healthcare facilities and any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of employment.

YOUR EFFECTIVE DATE: The first of the month coinciding with or next following the date you complete your enrollment form.

INDIVIDUAL REINSTATEMENT: 30 days

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 180 consecutive days of Total Disability.

MONTHLY BENEFIT: If an Eligible Person, you may elect an amount of insurance equal to 60% of your Covered Monthly Earnings, payable in accordance with the section entitled Benefit Provisions.

To figure this benefit amount payable:

(1) multiply your Covered Monthly Earnings by the benefit percentage(s) shown above;
(2) take the lesser of the amount:
   (a) of step (1) above; or
   (b) the Maximum Monthly Benefit shown below; and
(3) subtract Other Income Benefits, as shown below, from step (2), above.

We will pay at least the Minimum Monthly Benefit as follows.

OTHER INCOME BENEFITS: Other Income Benefits are:
(1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s) provided by the Policyholder;
(2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
(3) all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
   (a) Workers' Compensation Laws;
   (b) occupational disease law;
   (c) any other laws of like intent as (a) or (b) above; and
   (d) any compulsory benefit law;

(4) any of the following that you are eligible to receive from the Policyholder:
   (a) any formal salary continuance plan; to the extent that the sum of the Benefit Amount exceeds 100% of Covered Monthly Earnings;
   (b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
   (c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;

(5) that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and

(6) that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and

(7) disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
   (a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
   (b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin with Social Security Normal Retirement Age if you are already receiving Social Security Retirement Benefits while continuing to work beyond the Social Security Normal Retirement Age.
MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to you be less than the greater of:

1. 10% of the Covered Monthly Earnings multiplied by the Monthly Benefit percentage(s) shown above; or
2. $100.

MAXIMUM MONTHLY BENEFIT: $5,000

MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the longer of: the Duration of Benefits; or Normal Retirement Age; specified below:

<table>
<thead>
<tr>
<th>Age at Disablement</th>
<th>Duration of Benefits (in years)</th>
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</thead>
<tbody>
<tr>
<td>61 or less</td>
<td>To Age 65</td>
</tr>
<tr>
<td>62</td>
<td>3 ½</td>
</tr>
<tr>
<td>63</td>
<td>3</td>
</tr>
<tr>
<td>64</td>
<td>2 ½</td>
</tr>
<tr>
<td>65</td>
<td>2</td>
</tr>
<tr>
<td>66</td>
<td>1 ¾</td>
</tr>
<tr>
<td>67</td>
<td>1 ½</td>
</tr>
<tr>
<td>68</td>
<td>1 ¼</td>
</tr>
<tr>
<td>69 or more</td>
<td>1</td>
</tr>
</tbody>
</table>

OR

Normal Retirement Age as defined by the 1983 Amendments to the United States Social Security Act and determined by your year of birth, as follows:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Normal Retirement Age</th>
</tr>
</thead>
<tbody>
<tr>
<td>1937 or before</td>
<td>65 years</td>
</tr>
<tr>
<td>1938</td>
<td>65 years and 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 years and 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 years and 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 years and 8 months</td>
</tr>
<tr>
<td>1942</td>
<td>65 years and 10 months</td>
</tr>
<tr>
<td>1943 thru 1954</td>
<td>66 years</td>
</tr>
<tr>
<td>1955</td>
<td>66 years and 2 months</td>
</tr>
<tr>
<td>1956</td>
<td>66 years and 4 months</td>
</tr>
<tr>
<td>1957</td>
<td>66 years and 6 months</td>
</tr>
<tr>
<td>1958</td>
<td>66 years and 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 years and 10 months</td>
</tr>
<tr>
<td>1960 and after</td>
<td>67 years</td>
</tr>
</tbody>
</table>
CHANGES IN MONTHLY BENEFIT: Increases and decrease in the Monthly Benefit are effective on the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work.

Premium changes due to you entering into a higher age bracket will occur on the first of the month following your last birthday.

If an increase in, or initial application for, the Monthly Benefit is due to a life event change (such as marriage, birth or specific changes in employment status), proof of health will not be required provided you apply within 30 days of such life event. If application for the Monthly Benefit is due to you re-satisfy the Eligible Class requirement, proof of good health will not be required.

CONTRIBUTIONS: You are required to contribute toward the cost of this insurance.

Contributions for you are being made on a post-tax basis. For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as non-taxable. It is recommended that you contact your personal tax advisor.
DEFINITIONS

"You", "your" and "yours" means a person who meets the Eligibility Requirements of the Policy and is enrolled for this insurance.

"We", "us" and "our" means Reliance Standard Life Insurance Company.

"Actively at Work" and "Active Work" mean actually performing on a Full-time basis the material duties pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of an Injury or Sickness.

"Any Occupation" means an occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience.

"Claimant" means you made a claim for benefits under the Policy for a loss covered by the Policy as a result of your Injury or Sickness.

"Covered Monthly Earnings" means your basic monthly salary received from the Policyholder on the day just before the date of Total Disability. Covered Monthly Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as Covered Monthly Earnings.

If you are an hourly paid employee, the number of hours scheduled to work during a regular work week, not the hours actually worked, not to exceed forty (40) hours per week, times 4.333, will be used to determine Covered Monthly Earnings. If you are paid on an annual basis, then the Covered Monthly Earnings will be determined by dividing the basic annual salary by 12.

"Elimination Period" means a period of consecutive days of Total Disability, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Total Disability.

Interruption Period: If, during the Elimination Period, you return to Active Work for less than 30 days, then the same or related Total Disability will be treated as continuous. Days that you are Actively at Work during this interruption period will not count towards the Elimination Period. This interruption of the Elimination Period will not apply to you if you become eligible under any other group long term disability insurance plan.

"Full-time" means scheduled to work for the Policyholder for a minimum of 36 hours during your regular work week.
"Hospital" or "Institution" means a facility licensed to provide care and treatment for the condition causing your Total Disability.

"Injury" means bodily injury resulting directly from an accident, independent of all other causes. The Injury must cause Total Disability which begins while your insurance coverage is in effect.

"Physician" means a duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which a claim is made. The Physician may not be you or a member of your immediate family.

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by your Physician according to generally accepted medical standards in your locality, be of a demonstrable medical value and be necessary to meet your basic health needs.

"Regular Occupation" means the occupation you are routinely performing when Total Disability begins. We will look at your occupation as it is normally performed in the national economy, and not the unique duties performed for a specific employer or in a specific locale.

"Retirement Benefits" mean money which you are entitled to receive upon early or normal retirement or disability retirement under:

(1) any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
(2) Retirement Benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act; or
(3) an employer's retirement plan where payments are made in a lump sum or periodically and do not represent contributions made by you.

Retirement Benefits do not include:

(1) a federal government employee pension benefit;
(2) a thrift plan;
(3) a deferred compensation plan;
(4) an individual retirement account (IRA);
(5) a tax sheltered annuity (TSA);
(6) a stock ownership plan; or
(7) a profit sharing plan; or
(8) section 401(k), 403(b) or 457 plans.
"Sickness" means illness or disease causing Total Disability which begins while your insurance coverage is in effect. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

"Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:

1. during the Elimination Period and for the first 12 months for which a Monthly Benefit is payable, you cannot perform the material duties of your Regular Occupation;
   a. "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness you are capable of performing the material duties of your Regular Occupation on a part-time basis or some of the material duties on a full-time basis. If you are Partially Disabled you will be considered Totally Disabled, except during the Elimination Period;
   b. "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and

2. after a Monthly Benefit has been paid for 12 months, you cannot perform the material duties of Any Occupation. We consider you Totally Disabled if due to an Injury or Sickness you are capable of only performing the material duties on a part-time basis or part of the material duties on a Full-time basis.

If you are employed by the Policyholder and require a license for such occupation, the loss of such license for any reason does not in and of itself constitute "Total Disability".

"Treatment" means care consistent with the diagnosis of your Injury or Sickness that has its purpose of maximizing your medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for the Injury or Sickness and conform with generally accepted medical standards to effectively manage and treat your Injury or Sickness.
TRANSFER OF INSURANCE COVERAGE

If you were covered under any group long term disability insurance plan maintained by the Policyholder prior to the Policy's Effective Date, you will be insured under the Policy, provided that you are Actively At Work and meet all of the requirements for being an Eligible Person under the Policy on its Effective Date.

If you were covered under the prior group long term disability plan maintained by the Policyholder prior to the Policy's Effective Date, but were not Actively at Work due to Injury or Sickness on the Effective Date of the Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

(1) You must have been insured with the prior carrier on the date of the transfer; and

(2) Premiums must be paid; and

(3) Total Disability must begin on or after the Policy's Effective Date.

If you are receiving long term disability benefits, become eligible for coverage under another group long term disability insurance plan, or have a period of recurrent disability under the prior group long term disability insurance plan, you will not be covered under the Policy. If premiums have been paid on your behalf under the Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy the Pre-existing Conditions Limitation of the prior group long term disability insurance plan will be credited towards the satisfaction of the Pre-existing Conditions Limitation of the Policy.

Waiting Period Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy any Waiting Period of the prior group long term disability insurance plan will be credited towards the satisfaction of the Waiting Period of the Policy.
GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: Any statements made by you, will be deemed a representation, not a warranty. After the Policy has been in force for two (2) years from its Effective Date, no statement by you on a written application for insurance shall be used to reduce or deny a claim after your insurance coverage, with respect to which claim has been made, has been in effect for two (2) years.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, the Plan Administrator, or us:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

NOT IN LIEU OF WORKERS' COMPENSATION: The Policy is not a Workers' Compensation Policy. It does not provide Workers' Compensation benefits.

WAIVER OF PREMIUM: No premium is due us while you are receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of your Total Disability, premium payments must begin again if insurance is to continue.
CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after a Total Disability covered by the Policy occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized agent. The notice should include your name, the Policyholder’s name and the Policy Number.

CLAIM FORMS: When we receive the notice of claim, we will send you the claim forms to file with us. We will send them within fifteen (15) days after we receive notice. If we do not, then the proof of Total Disability will be met by giving us a written statement of the type and extent of the Total Disability. The statement must be sent within ninety (90) days after the loss began.

WRITTEN PROOF OF TOTAL DISABILITY: For any Total Disability covered by the Policy, written proof must be sent to us within ninety (90) days after the Total Disability occurs. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as was reasonably possible. In any event, proof must be given within one (1) year after the Total Disability occurs, unless you are legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of Total Disability covered by the Policy, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable.

We will pay benefits to you, if living, or else to your estate.

If you died and we have not paid all benefits due, we may pay up to $1,000 to any relative by blood or marriage, or to the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

ARBbitRATION OF CLAIMS: Any claim or dispute arising from or relating to our determination regarding your Total Disability may be settled by arbitration when agreed to by you and us in accordance with the Rules for Health and Accident Claims of the American Arbitration Association or by any other method agreeable to you and us. In the case of a claim under an Employee Retirement Income Security Act (hereinafter referred to as ERISA) Plan, your ERISA claim appeal remedies, if applicable, must be exhausted before the claim may be submitted to arbitration. Judgment upon the award rendered by the
arbitrators may be entered in any court having jurisdiction over such awards.

Unless otherwise agreed to by you and us, any such award will be binding on you and us for a period of twelve (12) months after it is rendered assuming that the award is not based on fraudulent information and you continue to be Totally Disabled. At the end of such twelve (12) month period, the issue of Total Disability may again be submitted to arbitration in accordance with this provision.

Any costs of said arbitration proceedings levied by the American Arbitration Association or the organization or person(s) conducting the proceedings will be paid by us.

**PHYSICAL EXAMINATION AND AUTOPSY:** We will, at our expense, have the right to have you interviewed and/or examined:
   1. physically;
   2. psychologically; and/or
   3. psychiatrically;

   to determine the existence of any Total Disability which is the basis for a claim. This right may be used as often as it is reasonably required while a claim is pending.

We can have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought against us to recover on the Policy within sixty (60) days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of loss is received.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you:
   (1) are a member of an Eligible Class, as shown on the Schedule of Benefits page; and
   (2) have completed the Waiting Period, as shown on the Schedule of Benefits page.

WAITING PERIOD: If you are continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits page, then you have satisfied the Waiting Period.

EFFECTIVE DATE OF YOUR INSURANCE: You must apply in writing for the insurance to go into effect. You will become insured on the latest of:
   (1) Your Effective Date, as shown on the Schedule of Benefits page, if you apply on or before that date;
   (2) on the first of the month coinciding with or next following the date you apply, if you apply within thirty-one (31) days from the date you first met the Eligibility Requirements or re-satisfied the Eligible Class requirements; or
   (3) on the first of the month coinciding with or next following the date we approve any required proof of health acceptable to us. We require this proof if you apply:
      (a) after thirty-one (31) days from the date you first met the Eligibility Requirements and did not elect coverage; or
      (b) after you terminated this insurance but remained in an Eligible Class, as shown on the Schedule of Benefits page; or
      (c) after being eligible for coverage under a prior plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or
   (4) the date premium is remitted.

The insurance for you will not go into effect on a date you are not Actively at Work because of a Sickness or Injury. The insurance will go into effect after you are Actively at Work for one (1) full day in an Eligible Class, as shown on the Schedule of Benefits page.
TERMINATION OF YOUR INSURANCE: Your insurance will terminate on the first of the following to occur:
   (1) the date the Policy terminates;
   (2) the date you cease to meet the Eligibility Requirements;
   (3) the end of the period for which Premium has been paid for you; or
   (4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INDIVIDUAL INSURANCE: Your insurance may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than sixty (60) days, if due to a temporary lay-off or approved leave of absence.

YOUR REINSTATEMENT: Your insurance may be reinstated if you are a former Insured who returns to Active Work with the Policyholder within the period of time as shown on the Schedule of Benefits page. You must also be a member of an Eligible Class, as shown on the Schedule of Benefits page, and have been:
   (1) on a leave of absence approved by the Policyholder;
   (2) on temporary lay-off; or
   (3) rehired after employment had been terminated.

You will not be required to fulfill the Eligibility Requirements of the Policy again. The insurance will go into effect after you return to Active Work for one (1) full day. If you request insurance after terminating insurance at your request or for failure to pay Premium when due, proof of health acceptable to us must be submitted before your insurance coverage may be reinstated.
BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if you:
   (1) are Totally Disabled as the result of a Sickness or Injury covered by the Policy;
   (2) are under the regular care of a Physician;
   (3) have completed the Elimination Period; and
   (4) submit satisfactory proof of Total Disability to us.

Please refer to the Schedule of Benefits for the MONTHLY BENEFIT and OTHER INCOME BENEFITS.

Benefits you are entitled to receive under OTHER INCOME BENEFITS will be estimated if the benefits:
   (1) have not been applied for; or
   (2) have been applied for and a decision is pending; or
   (3) have been denied and the denial may be appealed.

The Monthly Benefit will be reduced by the estimated amount. If benefits have been estimated, the Monthly Benefit will be adjusted when we receive proof:
   (1) of the amount awarded; or
   (2) that benefits have been denied and the denial cannot be further appealed.

If we have underpaid any benefit for any reason, we will make a lump sum payment. If we have overpaid any benefit for any reason, the overpayment must be repaid to us. At our option, we may reduce the Monthly Benefit or ask for a lump sum refund. If we reduce the Monthly Benefit, the Minimum Monthly Benefit, if any, as shown on the Schedule of Benefits page, would not apply. Interest does not accrue on any underpaid or overpaid benefit unless required by applicable law.

For each day of a period of Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

COST OF LIVING FREEZE: After the initial deduction for any Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.
**TERMINATION OF MONTHLY BENEFIT:** The Monthly Benefit will stop on the earliest of:

1. the date you cease to be Totally Disabled;
2. the date you die;
3. the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended; or
4. the date you fail to furnish the required proof of Total Disability.

**RECURRENT DISABILITY:** If, after a period of Total Disability for which benefits are payable, you return to Active Work for at least six (6) consecutive months, any recurrent Total Disability for the same or related cause will be part of a new period of Total Disability. A new Elimination Period must be completed before any further Monthly Benefits are payable.

If you return to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total Disability. A new Elimination Period is not required. Our liability for the entire period will be subject to the terms of the Policy for the original period of Total Disability.

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this Recurrent Disability section will not apply to you.
EXCLUSIONS

We will not pay a Monthly Benefit for any Total Disability caused by:
(1) an act of war, declared or undeclared; or
(2) an intentionally self-inflicted Injury; or
(3) the Insured committing a felony; or
(4) an Injury or Sickness that occurs while the Insured is confined in any penal or correctional institution.
LIMITATIONS

MENTAL OR NERVOUS DISORDERS: Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If you were confined in a Hospital or Institution and:
  (1) Total Disability continues beyond discharge;
  (2) the confinement was during a period of Total Disability; and
  (3) the period of confinement was for at least fourteen (14) consecutive days;
then upon discharge, Monthly Benefits will be payable for the greater of:
  (1) the unused portion of the twenty-four (24) month period; or
  (2) ninety (90) days;
but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:
  (1) bipolar disorder (manic depressive syndrome);
  (2) schizophrenia;
  (3) delusional (paranoid) disorders;
  (4) psychotic disorders;
  (5) depressive disorders;
  (6) anxiety disorders;
  (7) somatoform disorders (psychosomatic illness);
  (8) eating disorders; or
  (9) mental illness.

SUBSTANCE ABUSE: Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while you are a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.
If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, you are able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) you are performing all the material duties of your Regular Occupation on a full-time basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied, whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:

1. impairments in social and/or occupational functioning;
2. debilitating physical condition;
3. inability to abstain from or reduce consumption of the Substance;
4. the need for daily Substance use for adequate functioning.

"Substance" means alcohol and those drugs included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

A Substance Abuse Rehabilitation Program means a program supervised by a Physician or a licensed rehabilitation specialist approved by us.

**PRE-EXISTING CONDITIONS**: You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation if:

1. the Total Disability begins in the first twelve (12) consecutive months after your effective date; and
2. you have received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the twelve (12) months immediately prior to your effective date of insurance.

Benefits will not be paid for a Total Disability:

1. caused by;
2. contributed to by; or
3. resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from your effective date of insurance.
With respect to persons electing to change their level of coverage during an approved enrollment period, any benefit increase (due to this change) will not be paid for a Total Disability:

1. caused by;
2. contributed to by; or
3. resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the effective date of the increase. A Pre-existing Condition means any Sickness or Injury for which you received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the twelve (12) months immediately prior to the effective date of the increase (with respect to any increase in benefits).
SPECIFIC INDEMNITY BENEFIT

If you suffer any one of the Losses listed below from an accident resulting in an Injury, we will pay a guaranteed minimum number of Monthly Benefit payments, as shown below. However:

1. the Loss must occur within one hundred and eighty (180) days;
   and
2. you must live past the Elimination Period.

For Loss of:

<table>
<thead>
<tr>
<th>Loss of</th>
<th>Number of Monthly Benefit Payments:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Both Hands</td>
<td>46 Months</td>
</tr>
<tr>
<td>Both Feet</td>
<td>46 Months</td>
</tr>
<tr>
<td>Entire Sight in Both Eyes</td>
<td>46 Months</td>
</tr>
<tr>
<td>Hearing in Both Ears</td>
<td>46 Months</td>
</tr>
<tr>
<td>Speech</td>
<td>46 Months</td>
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<tr>
<td>One Hand and One Foot</td>
<td>46 Months</td>
</tr>
<tr>
<td>One Hand and Entire Sight in One Eye</td>
<td>46 Months</td>
</tr>
<tr>
<td>One Foot and Entire Sight in One Eye</td>
<td>46 Months</td>
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<tr>
<td>One Arm</td>
<td>35 Months</td>
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<tr>
<td>One Leg</td>
<td>35 Months</td>
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<tr>
<td>One Hand</td>
<td>23 Months</td>
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<tr>
<td>One Foot</td>
<td>23 Months</td>
</tr>
<tr>
<td>Entire Sight in One Eye</td>
<td>15 Months</td>
</tr>
<tr>
<td>Hearing in One Ear</td>
<td>15 Months</td>
</tr>
</tbody>
</table>

"Loss(es)" with respect to:

1. hand or foot, means the complete severance through or above the wrist or ankle joint;
2. arm or leg, means the complete severance through or above the elbow or knee joint; or
3. sight, speech or hearing, means total and irrecoverable Loss thereof.

If more than one (1) Loss results from any one accident, payment will be made for the Loss for which the greatest number of Monthly Benefit payments is provided.

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if you return to Active Work. If death occurs after we begin paying Monthly Benefits, but before the Specific Indemnity Benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your
estate, unless a beneficiary is on record with us under the Policy.

Benefits may be payable longer than shown above as long as you are still Totally Disabled, subject to the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.
SURVIVOR BENEFIT - LUMP SUM

We will pay a benefit to your Survivor when we receive proof that you died while:

1. you were receiving Monthly Benefits from us; and
2. you were Totally Disabled for at least one hundred and eighty (180) consecutive days.

The benefit will be an amount equal to 3 times your last Monthly Benefit. The last Monthly Benefit is the benefit you were eligible to receive right before your death. It is not reduced by wages earned while in Rehabilitative Employment.

A benefit payable to a minor may be paid to the minor’s legally appointed guardian. If there is no guardian, at our option, we may pay the benefit to an adult that has, in our opinion, assumed the custody and main support of the minor. We will not be liable for any payment we have made in good faith.

"Survivor" means your spouse. If the spouse dies before you or if you were legally separated, then your natural, legally adopted or step-children, who are under age twenty-five (25) will be the Survivors. If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with us under the Policy.
WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

During the first twelve (12) months of Rehabilitative Employment during which a Monthly Benefit is payable, we will not offset earnings from such Rehabilitative Employment until the sum of:

1. the Monthly Benefit prior to offsets with Other Income Benefits; and
2. earnings from Rehabilitative Employment;

exceed 100% of your Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

CHILD CARE BENEFIT

We will allow a Child Care Benefit if:

1. you are receiving benefits under the Work Incentive Benefit;
2. your Child(ren) is (are) under 14 years of age;
3. the child care is provided by a non-relative; and
4. the charges for child care are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twelve (12) month period in which you are eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of $250 per month, will be added to your Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: your unmarried child(ren), including any foster child, adopted child or step child who resides in your home and is financially dependent on you for support and maintenance.
EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

1. the premium for you continues to be paid during the leave; and
2. the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

1. the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
2. the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.
A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage will cease under this extension on the earliest of:

1. the date the Policy terminates; or
2. the end of the period for which premium has been paid for you; or
3. the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA. Coverage will not be terminated if you become Totally Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy. Any Monthly Benefit which becomes payable will be based on your Covered Monthly Earnings immediately prior to the date of Total Disability.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage will be reinstated.
REHABILITATION BENEFIT

"Rehabilitative Employment" means work in Any Occupation for which your training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed or certified rehabilitation specialist approved by us. Rehabilitative Employment includes work performed while Partially Disabled, but does not include performing all the material duties of your Regular Occupation on a full-time basis.

If you are receiving a Monthly Benefit because you are considered Totally Disabled under the terms of the Policy and are able to perform Rehabilitative Employment, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If you are able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

You will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist approved by us determines that you can perform such employment. If you refuse such Rehabilitative Employment, or have been performing Rehabilitative Employment and refuse to continue such employment, even though a Physician or licensed or certified rehabilitation specialist approved by us has determined that you are able to perform Rehabilitative Employment, the Monthly Benefit will be reduced by 50%, without regard to the Minimum Monthly Benefit.
It is hereby understood and agreed that the Certificate to which this Rider is attached shall be amended by the addition of the following:

**Applicable to Vermont Residents Only**

The following sections/provisions of the Certificate are amended to comply with Vermont law:

1. **Schedule of Benefits section, Elimination Period provision.**
   
The Elimination Period will be the lesser of the number of days shown on the Schedule of Benefits in the certificate or:
   
   For Benefit Periods 2 years and greater: 365 days.
   
   For Benefit Periods greater than 1 year but less than 2 years: 180 days.

2. **Limitations section, Mental or Nervous Disorders and/or Substance Abuse, if such limitations are included in the Certificate.**
   
   If the Certificate contains limitations in coverage for mental or nervous disorders and/or substance abuse, such limitations will not apply to Vermont residents. Coverage for these conditions will be treated the same as other conditions that may entitle you to full benefits.

3. **Limitations section, Pre-existing Conditions, if such limitation is included in the Certificate.**
   
   The pre-existing condition provision time period in the definition of Pre-existing Condition shall be the lesser of the time period shown on the Limitations form in the Certificate or twelve (12) months.
   
   The period of time during which you become Totally Disabled
due to a Pre-existing Condition and a benefit is not payable for such Total Disability is the lesser of the time period as shown in the certificate or twelve (12) months.

All other terms and conditions remain unchanged.

RELIANCE STANDARD LIFE INSURANCE COMPANY

[Signature]

Secretary

LRS-8352-01-0887
IMPORTANT NOTICE TO TENNESSEE POLICYHOLDERS AND CERTIFICATE HOLDERS (GROUP AND BLANKET)

Reliance Standard Life and your agent appreciate this opportunity to serve your insurance needs.

In the event you need to contact someone about this policy for any reason, please contact your agent. If you are unable to reach your agent or have additional questions, you may contact the Policyowner Service Office of Reliance Standard Life at the following address:

Reliance Standard Life Insurance Company
17103 Preston Rd.
Suite 120N
Dallas, TX 75248
(800) 261-0269
(972) 661-8893
The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

SUMMARY PLAN DESCRIPTION

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

PLAN NAME: IASIS Healthcare Welfare Benefit Plan

PLAN SPONSOR: IASIS Healthcare, LLC
117 Seaboard Lane
Building E
Franklin, TN 37067
(615) 844-2747

SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 20-1150104

PLAN NUMBER: 501

TYPE OF PLAN: Welfare Benefit Plan

PLAN BENEFITS: Fully Insured - Voluntary Group Long Term Disability Insurance Benefits

TYPE OF ADMINISTRATION: The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090.

PLAN ADMINISTRATOR: The Plan Sponsor named above.
AGENT FOR SERVICE OF LEGAL PROCESS: The Plan Sponsor named above.

PLAN YEAR: The plan's fiscal records are kept on a calendar year basis beginning January 1st.

PLAN COSTS: The cost of the benefits provided under the plan are paid for by the employee.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS: A plan participant or beneficiary can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION: The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.
CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Matrix Absence Management, Inc.
11221 North 28th Drive
Building E, Suite 100
Phoenix, AZ  85029-5614

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-866-2301.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.
Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically 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, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for
the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims
A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. 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; or 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 to the claimant upon request.
APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and
other information relevant to the claimant’s claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

**TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

**Non-Disability Benefit Claims**

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information
necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims
A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable);
5. 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; or 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 to the claimant upon request; and
6. 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 (where applicable)."
DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

• Was relied upon in making the benefit determination;

• Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

• Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or

• In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

**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 the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, 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.
Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**Enforce Your Rights**

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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who 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.
Assistance with Your Questions

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

IASIS Healthcare, LLC
CERTIFICATE OF INSURANCE

We certify that the Person whose name appears on the enrollment card attached to this Certificate is insured for the benefits which apply to his/her class, under Group Policy No. VPL 670874 issued to IASIS Healthcare, LLC, the Policyholder.

This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all certificates that may have been issued to you earlier.

Secretary

President

GROUP LONG TERM DISABILITY INSURANCE CERTIFICATE

This Group Long Term Disability Certificate replaces any previous Group Long Term Disability Certificates and is dated September 8, 2014.
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SCHEDULE OF BENEFITS

EFFECTIVE DATE: June 1, 2014

ELIGIBLE CLASSES: Each active, Full-time Employee, except Monthly-Paid Corporate Employees (Manager level and above), Hospital-Based Officers, Hospital-Based Directors, Physician Group Directors, Health Choice Directors, Employee Physicians, Physician Assistants, Nurse Practitioners and Certified Midwives affiliated with OB/GYN healthcare facilities and any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of employment.

YOUR EFFECTIVE DATE: The first of the month coinciding with or next following the date you complete your enrollment form.

INDIVIDUAL REINSTATEMENT: 30 days

LONG TERM DISABILITY BENEFIT

ELIMINATION PERIOD: 180 consecutive days of Total Disability.

MONTHLY BENEFIT: If an Eligible Person, you may elect an amount of insurance equal to 60% of your Covered Monthly Earnings, payable in accordance with the section entitled Benefit Provisions.

To figure this benefit amount payable:

(1) multiply your Covered Monthly Earnings by the benefit percentage(s) shown above;
(2) take the lesser of the amount:
   (a) of step (1) above; or
   (b) the Maximum Monthly Benefit shown below; and
(3) subtract Other Income Benefits, as shown below, from step (2), above.

We will pay at least the Minimum Monthly Benefit as follows.

OTHER INCOME BENEFITS: Other Income Benefits are:

(1) disability income benefits you are eligible to receive because of your Total Disability under any group insurance plan(s) provided by the Policyholder;
(2) disability income benefits you are eligible to receive because of your Total Disability under any governmental retirement system, except benefits payable under a federal government employee pension benefit;
all benefits (except medical or death benefits) including any settlement made in place of such benefits (whether or not liability is admitted) you are eligible to receive because of your Total disability under:
(a) Workers' Compensation Laws;
(b) occupational disease law;
(c) any other laws of like intent as (a) or (b) above; and
(d) any compulsory benefit law;

any of the following that you are eligible to receive from the Policyholder:
(a) any formal salary continuance plan; to the extent that the sum of the Benefit Amount exceeds 100% of Covered Monthly Earnings;
(b) wages, salary or other compensation, excluding the amount allowable when engaged in Rehabilitative Employment; and
(c) commissions or monies, including vested renewal commissions, but, excluding commissions or monies that you earned prior to Total Disability which are paid after Total Disability has begun;

that part of disability benefits paid for by the Policyholder which you are eligible to receive because of your Total disability under a group retirement plan; and

that part of Retirement Benefits paid for by the Policyholder which you are eligible to receive under a group retirement plan; and

disability or Retirement Benefits under the United States Social Security Act, the Canadian pension plans, or any other government plan for which:
(a) you are eligible to receive because of your Total Disability or eligibility for Retirement Benefits; and
(b) your dependents are eligible to receive due to (a) above.

Disability and early Retirement Benefits will be offset only if such benefits are elected by you or if election would not reduce the amount of your accrued normal Retirement Benefits then funded.

Retirement Benefits under number (7) above will not apply to disabilities which begin with Social Security Normal Retirement Age if you are already receiving Social Security Retirement Benefits while continuing to work beyond the Social Security Normal Retirement Age.
MINIMUM MONTHLY BENEFIT: In no event will the Monthly Benefit payable to you be less than the greater of:

(1) 10% of the Covered Monthly Earnings multiplied by the Monthly Benefit percentage(s) shown above; or
(2) $100.

MAXIMUM MONTHLY BENEFIT: $5,000

MAXIMUM DURATION OF BENEFITS: Benefits will not accrue beyond the longer of: the Duration of Benefits; or Normal Retirement Age; specified below:

<table>
<thead>
<tr>
<th>Age at Disablement</th>
<th>Duration of Benefits (in years)</th>
</tr>
</thead>
<tbody>
<tr>
<td>61 or less</td>
<td>To Age 65</td>
</tr>
<tr>
<td>62</td>
<td>3 ½</td>
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<tr>
<td>63</td>
<td>3</td>
</tr>
<tr>
<td>64</td>
<td>2 ½</td>
</tr>
<tr>
<td>65</td>
<td>2</td>
</tr>
<tr>
<td>66</td>
<td>1 ¾</td>
</tr>
<tr>
<td>67</td>
<td>1 ½</td>
</tr>
<tr>
<td>68</td>
<td>1 ¼</td>
</tr>
<tr>
<td>69 or more</td>
<td>1</td>
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</tbody>
</table>

OR

Normal Retirement Age as defined by the 1983 Amendments to the United States Social Security Act and determined by your year of birth, as follows:

<table>
<thead>
<tr>
<th>Year of Birth</th>
<th>Normal Retirement Age</th>
</tr>
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<tbody>
<tr>
<td>1937 or before</td>
<td>65 years</td>
</tr>
<tr>
<td>1938</td>
<td>65 years and 2 months</td>
</tr>
<tr>
<td>1939</td>
<td>65 years and 4 months</td>
</tr>
<tr>
<td>1940</td>
<td>65 years and 6 months</td>
</tr>
<tr>
<td>1941</td>
<td>65 years and 8 months</td>
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<tr>
<td>1942</td>
<td>65 years and 10 months</td>
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<tr>
<td>1943 thru 1954</td>
<td>66 years</td>
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<tr>
<td>1955</td>
<td>66 years and 2 months</td>
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<tr>
<td>1956</td>
<td>66 years and 4 months</td>
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<tr>
<td>1957</td>
<td>66 years and 6 months</td>
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<tr>
<td>1958</td>
<td>66 years and 8 months</td>
</tr>
<tr>
<td>1959</td>
<td>66 years and 10 months</td>
</tr>
<tr>
<td>1960 and after</td>
<td>67 years</td>
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CHANGES IN MONTHLY BENEFIT: Increases and decrease in the Monthly Benefit are effective on the date of the change, provided you are Actively at Work on the effective date of the change. If you are not Actively at Work on that date, the effective date of the increase in the benefit amount will be deferred until the date you return to Active Work.

Premium changes due to you entering into a higher age bracket will occur on the first of the month following your last birthday.

If an increase in, or initial application for, the Monthly Benefit is due to a life event change (such as marriage, birth or specific changes in employment status), proof of health will not be required provided you apply within 30 days of such life event. If application for the Monthly Benefit is due to you re-satisfy the Eligible Class requirement, proof of good health will not be required.

CONTRIBUTIONS: You are required to contribute toward the cost of this insurance.

Contributions for you are being made on a post-tax basis. For purposes of filing your Federal Income Tax Return, this means that under the law as of the date the Policy was issued, your Monthly Benefit might be treated as non-taxable. It is recommended that you contact your personal tax advisor.
DEFINITIONS

"You", "your" and "yours" means a person who meets the Eligibility Requirements of the Policy and is enrolled for this insurance.

"We", "us" and "our" means Reliance Standard Life Insurance Company.

"Actively at Work" and "Active Work" mean actually performing on a Full-time basis the material duties pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off such as vacation, jury duty and funeral leave, but does not include time off as a result of an Injury or Sickness.

"Any Occupation" means an occupation normally performed in the national economy for which you are reasonably suited based upon your education, training or experience.

"Claimant" means you made a claim for benefits under the Policy for a loss covered by the Policy as a result of your Injury or Sickness.

"Covered Monthly Earnings" means your basic monthly salary received from the Policyholder on the day just before the date of Total Disability. Covered Monthly Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as Covered Monthly Earnings.

If you are an hourly paid employee, the number of hours scheduled to work during a regular work week, not the hours actually worked, not to exceed forty (40) hours per week, times 4.333, will be used to determine Covered Monthly Earnings. If you are paid on an annual basis, then the Covered Monthly Earnings will be determined by dividing the basic annual salary by 12.

"Elimination Period" means a period of consecutive days of Total Disability, as shown on the Schedule of Benefits page, for which no benefit is payable. It begins on the first day of Total Disability.

Interruption Period: If, during the Elimination Period, you return to Active Work for less than 30 days, then the same or related Total Disability will be treated as continuous. Days that you are Actively at Work during this interruption period will not count towards the Elimination Period. This interruption of the Elimination Period will not apply to you if you become eligible under any other group long term disability insurance plan.

"Full-time" means scheduled to work for the Policyholder for a minimum of 36 hours during your regular work week.
"Hospital" or "Institution" means a facility licensed to provide care and Treatment for the condition causing your Total Disability.

"Injury" means bodily Injury resulting directly from an accident, independent of all other causes. The Injury must cause Total Disability which begins while your insurance coverage is in effect.

"Physician" means a duly licensed practitioner who is recognized by the law of the state in which treatment is received as qualified to treat the type of Injury or Sickness for which a claim is made. The Physician may not be you or a member of your immediate family.

"Regular Care" means Treatment that is administered as frequently as is medically required according to guidelines established by nationally recognized authorities, medical research, healthcare organizations, governmental agencies or rehabilitative organizations. Care must be rendered personally by your Physician according to generally accepted medical standards in your locality, be of a demonstrable medical value and be necessary to meet your basic health needs.

"Regular Occupation" means the occupation you are routinely performing when Total Disability begins. We will look at your occupation as it is normally performed in the national economy, and not the unique duties performed for a specific employer or in a specific locale.

"Retirement Benefits" mean money which you are entitled to receive upon early or normal retirement or disability retirement under:

(1) any plan of a state, county or municipal retirement system, if such pension benefits include any credit for employment with the Policyholder;
(2) Retirement Benefits under the United States Social Security Act of 1935, as amended, or under any similar plan or act; or
(3) an employer's retirement plan where payments are made in a lump sum or periodically and do not represent contributions made by you.

Retirement Benefits do not include:

(1) a federal government employee pension benefit;
(2) a thrift plan;
(3) a deferred compensation plan;
(4) an individual retirement account (IRA);
(5) a tax sheltered annuity (TSA);
(6) a stock ownership plan; or
(7) a profit sharing plan; or
(8) section 401(k), 403(b) or 457 plans.
"Sickness" means illness or disease causing Total Disability which begins while your insurance coverage is in effect. Sickness includes pregnancy, childbirth, miscarriage or abortion, or any complications therefrom.

"Totally Disabled" and "Total Disability" mean, that as a result of an Injury or Sickness:

(1) during the Elimination Period and for the first 12 months for which a Monthly Benefit is payable, you cannot perform the material duties of your Regular Occupation;
   (a) "Partially Disabled" and "Partial Disability" mean that as a result of an Injury or Sickness you are capable of performing the material duties of your Regular Occupation on a part-time basis or some of the material duties on a full-time basis. If you are Partially Disabled you will be considered Totally Disabled, except during the Elimination Period;
   (b) "Residual Disability" means being Partially Disabled during the Elimination Period. Residual Disability will be considered Total Disability; and

(2) after a Monthly Benefit has been paid for 12 months, you cannot perform the material duties of Any Occupation. We consider you Totally Disabled if due to an Injury or Sickness you are capable of only performing the material duties on a part-time basis or part of the material duties on a Full-time basis.

If you are employed by the Policyholder and require a license for such occupation, the loss of such license for any reason does not in and of itself constitute "Total Disability".

"Treatment" means care consistent with the diagnosis of your Injury or Sickness that has its purpose of maximizing your medical improvement. It must be provided by a Physician whose specialty or experience is most appropriate for the Injury or Sickness and conform with generally accepted medical standards to effectively manage and treat your Injury or Sickness.
TRANSFER OF INSURANCE COVERAGE

If you were covered under any group long term disability insurance plan maintained by the Policyholder prior to the Policy's Effective Date, you will be insured under the Policy, provided that you are Actively At Work and meet all of the requirements for being an Eligible Person under the Policy on its Effective Date.

If you were covered under the prior group long term disability plan maintained by the Policyholder prior to the Policy's Effective Date, but were not Actively at Work due to Injury or Sickness on the Effective Date of the Policy and would otherwise qualify as an Eligible Person, coverage will be allowed under the following conditions:

(1) You must have been insured with the prior carrier on the date of the transfer; and

(2) Premiums must be paid; and

(3) Total Disability must begin on or after the Policy's Effective Date.

If you are receiving long term disability benefits, become eligible for coverage under another group long term disability insurance plan, or have a period of recurrent disability under the prior group long term disability insurance plan, you will not be covered under the Policy. If premiums have been paid on your behalf under the Policy, those premiums will be refunded.

Pre-existing Conditions Limitation Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy the Pre-existing Conditions Limitation of the prior group long term disability insurance plan will be credited towards the satisfaction of the Pre-existing Conditions Limitation of the Policy.

Waiting Period Credit

If you are an Eligible Person on the Effective Date of the Policy, any time used to satisfy any Waiting Period of the prior group long term disability insurance plan will be credited towards the satisfaction of the Waiting Period of the Policy.
GENERAL PROVISIONS

TIME LIMIT ON CERTAIN DEFENSES: Any statements made by you, will be deemed a representation, not a warranty. After the Policy has been in force for two (2) years from its Effective Date, no statement by you on a written application for insurance shall be used to reduce or deny a claim after your insurance coverage, with respect to which claim has been made, has been in effect for two (2) years.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, the Plan Administrator, or us:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.

If appropriate, a fair adjustment of premium will be made to correct a clerical error.

NOT IN LIEU OF WORKERS' COMPENSATION: The Policy is not a Workers' Compensation Policy. It does not provide Workers’ Compensation benefits.

WAIVER OF PREMIUM: No premium is due us while you are receiving Monthly Benefits from us. Once Monthly Benefits cease due to the end of your Total Disability, premium payments must begin again if insurance is to continue.
CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within thirty-one (31) days after a Total Disability covered by the Policy occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Office or to our authorized agent. The notice should include your name, the Policyholder’s name and the Policy Number.

CLAIM FORMS: When we receive the notice of claim, we will send you the claim forms to file with us. We will send them within fifteen (15) days after we receive notice. If we do not, then the proof of Total Disability will be met by giving us a written statement of the type and extent of the Total Disability. The statement must be sent within ninety (90) days after the loss began.

WRITTEN PROOF OF TOTAL DISABILITY: For any Total Disability covered by the Policy, written proof must be sent to us within ninety (90) days after the Total Disability occurs. If written proof is not given in that time, the claim will not be invalidated nor reduced if it is shown that written proof was given as soon as was reasonably possible. In any event, proof must be given within one (1) year after the Total Disability occurs, unless you are legally incapable of doing so.

PAYMENT OF CLAIMS: When we receive written proof of Total Disability covered by the Policy, we will pay any benefits due. Benefits that provide for periodic payment will be paid for each period as we become liable.

We will pay benefits to you, if living, or else to your estate.

If you died and we have not paid all benefits due, we may pay up to $1,000 to any relative by blood or marriage, or to the executor or administrator of your estate. The payment will only be made to persons entitled to it. An expense incurred as a result of your last illness, death or burial will entitle a person to this payment. The payments will cease when a valid claim is made for the benefit. We will not be liable for any payment we have made in good faith.

ARBITRATION OF CLAIMS: Any claim or dispute arising from or relating to our determination regarding your Total Disability may be settled by arbitration when agreed to by you and us in accordance with the Rules for Health and Accident Claims of the American Arbitration Association or by any other method agreeable to you and us. In the case of a claim under an Employee Retirement Income Security Act (hereinafter referred to as ERISA) Plan, your ERISA claim appeal remedies, if applicable, must be exhausted before the claim may be submitted to arbitration. Judgment upon the award rendered by the
arbitrators may be entered in any court having jurisdiction over such awards.

Unless otherwise agreed to by you and us, any such award will be binding on you and us for a period of twelve (12) months after it is rendered assuming that the award is not based on fraudulent information and you continue to be Totally Disabled. At the end of such twelve (12) month period, the issue of Total Disability may again be submitted to arbitration in accordance with this provision.

Any costs of said arbitration proceedings levied by the American Arbitration Association or the organization or person(s) conducting the proceedings will be paid by us.

**PHYSICAL EXAMINATION AND AUTOPSY:** We will, at our expense, have the right to have you interviewed and/or examined:

- (1) physically;
- (2) psychologically; and/or
- (3) psychiatrically;

to determine the existence of any Total Disability which is the basis for a claim. This right may be used as often as it is reasonably required while a claim is pending.

We can have an autopsy made unless prohibited by law.

**LEGAL ACTIONS:** No legal action may be brought against us to recover on the Policy within sixty (60) days after written proof of loss has been given as required by the Policy. No action may be brought after three (3) years (Kansas, five (5) years; South Carolina, six (6) years) from the time written proof of loss is received.
ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

ELIGIBILITY REQUIREMENTS: You are eligible for insurance under the Policy if you:
(1) are a member of an Eligible Class, as shown on the Schedule of Benefits page; and
(2) have completed the Waiting Period, as shown on the Schedule of Benefits page.

WAITING PERIOD: If you are continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits page, then you have satisfied the Waiting Period.

EFFECTIVE DATE OF YOUR INSURANCE: You must apply in writing for the insurance to go into effect. You will become insured on the latest of:
(1) Your Effective Date, as shown on the Schedule of Benefits page, if you apply on or before that date;
(2) on the first of the month coinciding with or next following the date you apply, if you apply within thirty-one (31) days from the date you first met the Eligibility Requirements or re-satisfied the Eligible Class requirements; or
(3) on the first of the month coinciding with or next following the date we approve any required proof of health acceptable to us. We require this proof if you apply:
   (a) after thirty-one (31) days from the date you first met the Eligibility Requirements and did not elect coverage; or
   (b) after you terminated this insurance but remained in an Eligible Class, as shown on the Schedule of Benefits page; or
   (c) after being eligible for coverage under a prior plan for more than thirty-one (31) days but did not elect to be covered under that prior plan; or
(4) the date premium is remitted.

The insurance for you will not go into effect on a date you are not Actively at Work because of a Sickness or Injury. The insurance will go into effect after you are Actively at Work for one (1) full day in an Eligible Class, as shown on the Schedule of Benefits page.
TERMINATION OF YOUR INSURANCE: Your insurance will terminate on the first of the following to occur:
   (1) the date the Policy terminates;
   (2) the date you cease to meet the Eligibility Requirements;
   (3) the end of the period for which Premium has been paid for you; or
   (4) the date you enter military service (not including Reserve or National Guard).

CONTINUATION OF INDIVIDUAL INSURANCE: Your insurance may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than sixty (60) days, if due to a temporary lay-off or approved leave of absence.

YOUR REINSTATEMENT: Your insurance may be reinstated if you are a former Insured who returns to Active Work with the Policyholder within the period of time as shown on the Schedule of Benefits page. You must also be a member of an Eligible Class, as shown on the Schedule of Benefits page, and have been:
   (1) on a leave of absence approved by the Policyholder;
   (2) on temporary lay-off; or
   (3) rehired after employment had been terminated.

You will not be required to fulfill the Eligibility Requirements of the Policy again. The insurance will go into effect after you return to Active Work for one (1) full day. If you request insurance after terminating insurance at your request or for failure to pay Premium when due, proof of health acceptable to us must be submitted before your insurance coverage may be reinstated.
BENEFIT PROVISIONS

INSURING CLAUSE: We will pay a Monthly Benefit if you:
(1) are Totally Disabled as the result of a Sickness or Injury covered by the Policy;
(2) are under the regular care of a Physician;
(3) have completed the Elimination Period; and
(4) submit satisfactory proof of Total Disability to us.

Please refer to the Schedule of Benefits for the MONTHLY BENEFIT and OTHER INCOME BENEFITS.

Benefits you are entitled to receive under OTHER INCOME BENEFITS will be estimated if the benefits:
(1) have not been applied for; or
(2) have been applied for and a decision is pending; or
(3) have been denied and the denial may be appealed.

The Monthly Benefit will be reduced by the estimated amount. If benefits have been estimated, the Monthly Benefit will be adjusted when we receive proof:
(1) of the amount awarded; or
(2) that benefits have been denied and the denial cannot be further appealed.

If we have underpaid any benefit for any reason, we will make a lump sum payment. If we have overpaid any benefit for any reason, the overpayment must be repaid to us. At our option, we may reduce the Monthly Benefit or ask for a lump sum refund. If we reduce the Monthly Benefit, the Minimum Monthly Benefit, if any, as shown on the Schedule of Benefits page, would not apply. Interest does not accrue on any underpaid or overpaid benefit unless required by applicable law.

For each day of a period of Total Disability less than a full month, the amount payable will be 1/30th of the Monthly Benefit.

COST OF LIVING FREEZE: After the initial deduction for any Other Income Benefits, the Monthly Benefit will not be further reduced due to any cost of living increases payable under these Other Income Benefits.

LUMP SUM PAYMENTS: If Other Income Benefits are paid in a lump sum, the sum will be prorated over the period of time to which the Other Income benefits apply. If no period of time is given, the sum will be prorated over sixty (60) months.
TERMINATION OF MONTHLY BENEFIT: The Monthly Benefit will stop on the earliest of:
   (1) the date you cease to be Totally Disabled;
   (2) the date you die;
   (3) the Maximum Duration of Benefits, as shown on the Schedule of Benefits page, has ended; or
   (4) the date you fail to furnish the required proof of Total Disability.

RECURRENT DISABILITY: If, after a period of Total Disability for which benefits are payable, you return to Active Work for at least six (6) consecutive months, any recurrent Total Disability for the same or related cause will be part of a new period of Total Disability. A new Elimination Period must be completed before any further Monthly Benefits are payable.

If you return to Active Work for less than six (6) months, a recurrent Total Disability for the same or related cause will be part of the same Total Disability. A new Elimination Period is not required. Our liability for the entire period will be subject to the terms of the Policy for the original period of Total Disability.

If you become eligible for insurance coverage under any other group long term disability insurance plan, then this Recurrent Disability section will not apply to you.
EXCLUSIONS

We will not pay a Monthly Benefit for any Total Disability caused by:
(1) an act of war, declared or undeclared; or
(2) an intentionally self-inflicted Injury; or
(3) the Insured committing a felony; or
(4) an Injury or Sickness that occurs while the Insured is confined in any penal or correctional institution.
LIMITATIONS

MENTAL OR NERVOUS DISORDERS: Monthly Benefits for Total Disability caused by or contributed to by mental or nervous disorders will not be payable beyond an aggregate lifetime maximum duration of twenty-four (24) months unless you are in a Hospital or Institution at the end of the twenty-four (24) month period. The Monthly Benefit will be payable while so confined, but not beyond the Maximum Duration of Benefits.

If you were confined in a Hospital or Institution and:
   (1) Total Disability continues beyond discharge;
   (2) the confinement was during a period of Total Disability; and
   (3) the period of confinement was for at least fourteen (14) consecutive days;
then upon discharge, Monthly Benefits will be payable for the greater of:
   (1) the unused portion of the twenty-four (24) month period; or
   (2) ninety (90) days;
but in no event beyond the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.

Mental or Nervous Disorders are defined to include disorders which are diagnosed to include a condition such as:
   (1) bipolar disorder (manic depressive syndrome);
   (2) schizophrenia;
   (3) delusional (paranoid) disorders;
   (4) psychotic disorders;
   (5) depressive disorders;
   (6) anxiety disorders;
   (7) somatoform disorders (psychosomatic illness);
   (8) eating disorders; or
   (9) mental illness.

SUBSTANCE ABUSE: Monthly Benefits for Total Disability due to alcoholism or drug addiction will be payable while you are a participant in a Substance Abuse Rehabilitation Program. The Monthly Benefit will not be payable beyond twenty-four (24) months.
If, during a period of Total Disability due to Substance Abuse for which a Monthly Benefit is payable, you are able to perform Rehabilitative Employment, the Monthly Benefit, less 50% of any of the money received from this Rehabilitative Employment will be paid until: (1) you are performing all the material duties of your Regular Occupation on a full-time basis; or (2) the end of twenty-four (24) consecutive months from the date that the Elimination Period is satisfied, whichever is earlier. All terms and conditions of the Rehabilitation Benefit will apply to Rehabilitative Employment due to Substance Abuse.

"Substance Abuse" means the pattern of pathological use of a Substance which is characterized by:

(1) impairments in social and/or occupational functioning;
(2) debilitating physical condition;
(3) inability to abstain from or reduce consumption of the Substance; or
(4) the need for daily Substance use for adequate functioning.

"Substance" means alcohol and those drugs included on the Department of Health, Retardation and Hospitals' Substance Abuse list of addictive drugs, except tobacco and caffeine are excluded.

A Substance Abuse Rehabilitation Program means a program supervised by a Physician or a licensed rehabilitation specialist approved by us.

PRE-EXISTING CONDITIONS: You will be considered to have a Pre-existing Condition and will be subject to the Pre-existing Conditions Limitation if:

(1) the Total Disability begins in the first twelve (12) consecutive months after your effective date; and

(2) you have received medical Treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the twelve (12) months immediately prior to your effective date of insurance.

Benefits will not be paid for a Total Disability:

(1) caused by;
(2) contributed to by; or
(3) resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from your effective date of insurance.
With respect to persons electing to change their level of coverage during an approved enrollment period, any benefit increase (due to this change) will not be paid for a Total Disability:

1. caused by;
2. contributed to by; or
3. resulting from;

a Pre-existing Condition unless you have been Actively at Work for one (1) full day following the end of twelve (12) consecutive months from the effective date of the increase. A Pre-existing Condition means any Sickness or Injury for which you received medical treatment, consultation, care or services, including diagnostic procedures, or took prescribed drugs or medicines for the Sickness or Injury, whether specifically diagnosed or not, causing such Total Disability, during the twelve (12) months immediately prior to the effective date of the increase (with respect to any increase in benefits).
SPECIFIC INDEMNITY BENEFIT

If you suffer any one of the Losses listed below from an accident resulting in an Injury, we will pay a guaranteed minimum number of Monthly Benefit payments, as shown below. However:

(1) the Loss must occur within one hundred and eighty (180) days; and
(2) you must live past the Elimination Period.

For Loss of: Number of Monthly Benefit Payments:

- Both Hands ................................................................. 46 Months
- Both Feet ................................................................. 46 Months
- Entire Sight in Both Eyes ........................................ 46 Months
- Hearing in Both Ears ................................................. 46 Months
- Speech ................................................................. 46 Months
- One Hand and One Foot ........................................ 46 Months
- One Hand and Entire Sight in One Eye ................ 46 Months
- One Foot and Entire Sight in One Eye ................... 46 Months
- One Arm ............................................................ 35 Months
- One Leg ........................................................... 35 Months
- One Hand ............................................................ 23 Months
- One Foot ........................................................... 23 Months
- Entire Sight in One Eye ...................................... 15 Months
- Hearing in One Ear ............................................. 15 Months

"Loss(es)" with respect to:

(1) hand or foot, means the complete severance through or above the wrist or ankle joint;
(2) arm or leg, means the complete severance through or above the elbow or knee joint; or
(3) sight, speech or hearing, means total and irrecoverable Loss thereof.

If more than one (1) Loss results from any one accident, payment will be made for the Loss for which the greatest number of Monthly Benefit payments is provided.

The amount payable is the Monthly Benefit, as shown on the Schedule of Benefits page, with no reduction from Other Income Benefits. The number of Monthly Benefit payments will not cease if you return to Active Work. If death occurs after we begin paying Monthly Benefits, but before the Specific Indemnity Benefit has been paid according to the above schedule, the balance remaining at time of death will be paid to your
estate, unless a beneficiary is on record with us under the Policy.

Benefits may be payable longer than shown above as long as you are still Totally Disabled, subject to the Maximum Duration of Benefits, as shown on the Schedule of Benefits page.
SURVIVOR BENEFIT - LUMP SUM

We will pay a benefit to your Survivor when we receive proof that you died while:

(1) you were receiving Monthly Benefits from us; and
(2) you were Totally Disabled for at least one hundred and eighty (180) consecutive days.

The benefit will be an amount equal to 3 times your last Monthly Benefit. The last Monthly Benefit is the benefit you were eligible to receive right before your death. It is not reduced by wages earned while in Rehabilitative Employment.

A benefit payable to a minor may be paid to the minor’s legally appointed guardian. If there is no guardian, at our option, we may pay the benefit to an adult that has, in our opinion, assumed the custody and main support of the minor. We will not be liable for any payment we have made in good faith.

"Survivor" means your spouse. If the spouse dies before you or if you were legally separated, then your natural, legally adopted or step-children, who are under age twenty-five (25) will be the Survivors. If there are no eligible Survivors, payment will be made to your estate, unless a beneficiary is on record with us under the Policy.
WORK INCENTIVE AND CHILD CARE BENEFITS

WORK INCENTIVE BENEFIT

During the first twelve (12) months of Rehabilitative Employment during which a Monthly Benefit is payable, we will not offset earnings from such Rehabilitative Employment until the sum of:

(1) the Monthly Benefit prior to offsets with Other Income Benefits; and

(2) earnings from Rehabilitative Employment;

exceed 100% of your Covered Monthly Earnings. If the sum above exceeds 100% of Covered Monthly Earnings, our Benefit Amount will be reduced by such excess amount until the sum of (1) and (2) above equals 100%.

CHILD CARE BENEFIT

We will allow a Child Care Benefit if:

(1) you are receiving benefits under the Work Incentive Benefit;
(2) your Child(ren) is (are) under 14 years of age;
(3) the child care is provided by a non-relative; and
(4) the charges for child care are documented by a receipt from the caregiver, including social security number or taxpayer identification number.

During the twelve (12) month period in which you are eligible for the Work Incentive Benefit, an amount equal to actual expenses incurred for child care, up to a maximum of $250 per month, will be added to your Covered Monthly Earnings when calculating the Benefit Amount under the Work Incentive Benefit.

Child(ren) means: your unmarried child(ren), including any foster child, adopted child or step child who resides in your home and is financially dependent on you for support and maintenance.
EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for you continues to be paid during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.

While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.
A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage will cease under this extension on the earliest of:

1. the date the Policy terminates; or
2. the end of the period for which premium has been paid for you; or
3. the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA. Coverage will not be terminated if you become Totally Disabled during the period of the leave and are eligible for benefits according to the terms of the Policy. Any Monthly Benefit which becomes payable will be based on your Covered Monthly Earnings immediately prior to the date of Total Disability.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage will be reinstated.
REHABILITATION BENEFIT

"Rehabilitative Employment" means work in Any Occupation for which your training, education or experience will reasonably allow. The work must be approved by a Physician or a licensed or certified rehabilitation specialist approved by us. Rehabilitative Employment includes work performed while Partially Disabled, but does not include performing all the material duties of your Regular Occupation on a full-time basis.

If you are receiving a Monthly Benefit because you are considered Totally Disabled under the terms of the Policy and are able to perform Rehabilitative Employment, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment.

If you are able to perform Rehabilitative Employment when Totally Disabled due to Substance Abuse, we will continue to pay the Monthly Benefit less an amount equal to 50% of earnings received through such Rehabilitative Employment. This Monthly Benefit is payable for a maximum of twenty-four (24) consecutive months from the date the Elimination Period is satisfied.

You will be considered able to perform Rehabilitative Employment if a Physician or licensed or certified rehabilitation specialist approved by us determines that you can perform such employment. If you refuse such Rehabilitative Employment, or have been performing Rehabilitative Employment and refuse to continue such employment, even though a Physician or licensed or certified rehabilitation specialist approved by us has determined that you are able to perform Rehabilitative Employment, the Monthly Benefit will be reduced by 50%, without regard to the Minimum Monthly Benefit.
It is hereby understood and agreed that the Certificate to which this Rider is attached shall be amended by the addition of the following:

**Applicable to Vermont Residents Only**

The following sections/provisions of the Certificate are amended to comply with Vermont law:

1. **Schedule of Benefits section, Elimination Period provision.**

   The Elimination Period will be the lesser of the number of days shown on the Schedule of Benefits in the certificate or:

   For Benefit Periods 2 years and greater: 365 days.

   For Benefit Periods greater than 1 year but less than 2 years: 180 days.

2. **Limitations section, Mental or Nervous Disorders and/or Substance Abuse, if such limitations are included in the Certificate.**

   If the Certificate contains limitations in coverage for mental or nervous disorders and/or substance abuse, such limitations will not apply to Vermont residents. Coverage for these conditions will be treated the same as other conditions that may entitle you to full benefits.

3. **Limitations section, Pre-existing Conditions, if such limitation is included in the Certificate.**

   The pre-existing condition provision time period in the definition of Pre-existing Condition shall be the lesser of the time period shown on the Limitations form in the Certificate or twelve (12) months.

   The period of time during which you become Totally Disabled
due to a Pre-existing Condition and a benefit is not payable for such Total Disability is the lesser of the time period as shown in the certificate or twelve (12) months.

All other terms and conditions remain unchanged.

RELIANCE STANDARD LIFE INSURANCE COMPANY

[Signature]
Secretary
IMPORTANT NOTICE TO TENNESSEE POLICYHOLDERS
AND CERTIFICATE HOLDERS
(GROUP AND BLANKET)

Reliance Standard Life and your agent appreciate this opportunity to serve your insurance needs.

In the event you need to contact someone about this policy for any reason, please contact your agent. If you are unable to reach your agent or have additional questions, you may contact the Policyowner Service Office of Reliance Standard Life at the following address:

Reliance Standard Life Insurance Company
17103 Preston Rd.
Suite 120N
Dallas, TX 75248
(800) 261-0269
(972) 661-8893
SUMMARY PLAN DESCRIPTION
The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

SUMMARY PLAN DESCRIPTION

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

PLAN NAME: IASIS Healthcare Welfare Benefit Plan

PLAN SPONSOR: IASIS Healthcare, LLC
117 Seaboard Lane
Building E
Franklin, TN  37067
(615) 844- 2747

SPONSOR'S EMPLOYER IDENTIFICATION NUMBER: 20-1150104

PLAN NUMBER: 501

TYPE OF PLAN: Welfare Benefit Plan

PLAN BENEFITS: Fully Insured - Voluntary Group Long Term Disability Insurance Benefits

TYPE OF ADMINISTRATION: The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090.

PLAN ADMINISTRATOR: The Plan Sponsor named above.
AGENT FOR SERVICE OF LEGAL PROCESS: The Plan Sponsor named above.

PLAN YEAR: The plan's fiscal records are kept on a calendar year basis beginning January 1st.

PLAN COSTS: The cost of the benefits provided under the plan are paid for by the employee.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS: A plan participant or beneficiary can obtain, without charge, a copy of the Plan’s procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION: The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.
CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Matrix Absence Management, Inc.
11221 North 28th Drive
Building E, Suite 100
Phoenix, AZ 85029-5614

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-866-2301.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.
Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically 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, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for
the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims
A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. 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; or 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 to the claimant upon request.
APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and
other information relevant to the claimant’s claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

**TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW**

**Non-Disability Benefit Claims**

The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information
necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and

4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable).

**Disability Benefit Claims**

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable);
5. 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; or 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 to the claimant upon request; and

6. 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 (where applicable)."
DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

• Was relied upon in making the benefit determination;

• Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;

• Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or

• In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

**ERISA STATEMENT OF RIGHTS**

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

**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 the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, 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.
Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**Enforce Your Rights**

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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who 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.
Assistance with Your Questions

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

IASIS Healthcare, LLC
CERTIFICATE OF INSURANCE

POLICYHOLDER:  IASIS Healthcare, LLC

GROUP POLICY NUMBER:  VAR 672937

POLICY EFFECTIVE DATE:  June 1, 2014

Subject to the terms of the Group Policy, we certify that you are insured for the benefits which apply to your class as described on the Schedule of Benefits, provided you are an Insured Person, as defined and your completed Enrollment Card is attached. The Group Policy Number, Policyholder, and Policy Effective Date are listed above. This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all Certificates that may have been issued to you earlier.

This Certificate is signed by our President and Secretary.

[Signatures]

GROUP ACCIDENT CERTIFICATE

This Group Accident Certificate replaces any previous Group Accident Certificates and is dated September 8, 2014.
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LRS-8605-002-0790
SCHEDULE OF BENEFITS

ELIGIBILITY: Each active, Full-time Employee, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month coinciding with or next following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 30 days

AMOUNT OF INSURANCE: PRINCIPAL SUM:

INSURED PERSONS:

Choice of: One (1), Two (2), Three (3) or Four (4) times Earnings, rounded to the next higher $1,000, subject to a maximum Principal Sum of $500,000.

INSURED DEPENDENTS (Applicable if you are an employee who is insured under the Basic Life Policy (GL668964) who elects Dependent Accidental Death and Dismemberment coverage and is paying the applicable premiums; employee coverage under this Policy (VAR672937) is not required for Dependent Accidental Death and Dismemberment coverage):

Spouse Amount: Choice of: $25,000, $50,000 or $100,000
Child(ren) Amount: $10,000

For Insured Persons age 65 and over, the Amount of Principal Sum is subject to automatic reduction. Upon the Insured Person's attainment of the specified age below, the Amount of Principal Sum will be reduced to the applicable percentage, rounded to the next higher $1,000. This reduction also applies to Insured Persons who are age 65 or over on their Individual Effective Date.

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<th>Age</th>
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<td>65-69</td>
<td>67%</td>
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**CHANGES IN AMOUNT OF INSURANCE**: Increases and decreases in the Amount of Insurance because of changes in age are effective on the first of the month following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class are effective on the first of the Policy month coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in Earnings are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

Increases and decreases in the Amount of Insurance because of your elections will take effect on the first of the Policy month coinciding with or next following the date we receive the election request.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date the increase is to take effect. If you are not Actively at Work on the date the increase is to take effect, such increase will take effect on the date you return to work.

**CONTRIBUTIONS**: You are required to contribute toward the cost of your insurance coverage. You are required to contribute toward the cost of the Dependent insurance coverage.
DEFINITIONS

"Actively at Work" and "Active Work" means you are actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of Injury or illness.

"Dependents" means:

(1) your legal spouse who is not legally separated or divorced from you; and
(2) your unmarried child(ren), live birth to 26 years, who is financially dependent on you for support. Adoptive, foster and step-children are considered Dependents if they are in your custody.

NOTE: An Eligible Person may not have coverage both as an Insured Person and as an Insured Dependent. Only one Insured spouse may cover the eligible children as Insured Dependents. If insurance is in force for an Insured Dependent, any newly eligible Dependents will be automatically covered.

"Earnings" means the basic annual wages received from the Policyholder on the day just before the date of the Injury. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic wages.

If hourly employees are insured, the number of hours scheduled to work during a regularly scheduled work week, not the hours actually worked, not to exceed 40 hours per week, times 52 weeks, will be used to determine annual Earnings.

"Eligible Person" means a person who meets the Eligibility requirements of the Policy.

"Full-time" means scheduled to work for the Policyholder for a minimum of 36 hours during your regular work week.

"Insured Person" means a person who meets the Eligibility requirements of the Policy and is enrolled for this insurance, and whose insurance under the Policy is in effect.

"Insured Dependent" means a "Dependent", as defined, whose
insurance under the Policy is in effect.

"Insured" means either an Insured Person or an Insured Dependent unless the context indicates otherwise.

"Injury" means accidental bodily injury to an Insured which is caused directly and independently of all other causes by accidental means and which occurs while the Insured's coverage under the Policy is in force.

"Policyholder", shall also include an associated or affiliated company, when referring to premium payments; Active Work; Full-time work; or Earnings.

"We", "us", and "our" means Reliance Standard Life Insurance Company.

"You", "your", and "yours" means the Insured Person.
GENERAL PROVISIONS

CHANGES: No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to the Policy.

INCONTESTABILITY: Any statements made by the Policyholder, any Insured Person, or any Insured Dependent, or on behalf of any Insured Person or any Insured Dependent to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

   (a) it is in a written form signed by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and
   (b) a copy of such written instrument is or has been furnished to you or any Insured Dependent, or your or any Insured Dependent's beneficiary or legal representative.

(2) If the statement relates to your or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during your or any Insured Dependent's lifetime.

ASSIGNMENT: Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, us or the Plan Administrator:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.
If appropriate, a fair adjustment of premium will be made to correct a clerical error.

**MISSTATEMENT OF AGE:** If an Insured's age has been misstated, benefits will be those that apply to his correct age.

**NOT IN LIEU OF WORKER'S COMPENSATION:** The Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

**PRONOUNS:** All pronouns include either gender unless the context indicates otherwise.
INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

WAITING PERIOD: A person who is continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits has satisfied the Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: You must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date as shown on the Schedule of Benefits; or

(2) on the first day of the month coincident with or next following the date you apply.

If you are not Actively At Work on the day your insurance is to go into effect, your insurance will go into effect on the day you return to Active Work for one full day.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

TERMINATION OF INDIVIDUAL INSURANCE: Your coverage will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for your coverage.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.
CONTINUATION OF INDIVIDUAL INSURANCE: Your coverage may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

(1) twelve (12) months, if you cease to be eligible due to illness or Injury; or

(2) sixty (60) days, if you cease to be eligible due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if you are a former Insured Person who has been:

(1) on an approved leave of absence;

(2) on temporary lay-off; or

(3) rehired after employment had been terminated.

You must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits (INDIVIDUAL REINSTATEMENT). You must also be a member of a class eligible for this insurance. The insurance will go into effect on the date you return to Active Work.
DEPENDENT INSURANCE

ELIGIBILITY: You are eligible to enroll your eligible Dependents once you are insured for Basic Life under GL668964.

EFFECTIVE DATE OF DEPENDENT INSURANCE: You may insure your Dependents by making written application. In this case, your Dependent insurance will take effect on the first day of the month coincident with or next following the later of:

(1) the date you first become eligible for Dependent insurance if application is made on or before that date; or

(2) the date the dependent meets the definition of Dependent, if application is made on or before that date; or

(3) the date of enrollment.

After this insurance is in force for one Dependent, application is not required for added Dependents.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

(1) the date this Section terminates;

(2) the end of the period for which premium for Dependent insurance has been paid;

(3) the date your insurance terminates under GL668964; or

(4) the date the dependent is no longer a Dependent as defined. However, coverage for an Insured Dependent child which would otherwise cease when such child attains the maximum age, will not cease while your insurance coverage remains in force if:

(a) the child is unable to provide self-support due to mental retardation or physical handicap; and

(b) he is chiefly dependent on you for support; and
(c) proof of the above conditions is received by us within 120 days after the date this insurance coverage would otherwise end.

We may ask from time to time if the Insured Dependent child remains a disabled and dependent person. This request may be made within 31 days of the time such Insured Dependent attains the maximum age, and later as required. After the 2 year period that follows such Dependent's attainment of the maximum age, this request may not be made more often than once a year. If we do not ask, insurance coverage for such Insured Dependent child will continue as long as:

(a) your coverage remains in effect;

(b) the Insured Dependent child remains in the same condition; and

(c) the proper premium is paid.

Proof of the Insured Dependent child's status as a disabled and dependent person must be furnished to us within 31 days of the inquiry. If it is not, we may stop the insurance of such Insured Dependent when he attains the maximum age, or later.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.
NEWLYWED PROVISION: If you marry and had not previously elected Dependent coverage, your new spouse shall automatically become an Insured Dependent.

Such spouse shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

(1) you request, in writing and within such 31 day period, continuation of such Dependent coverage; and

(2) the additional premium is paid for such coverage.

In the event your new spouse suffers a covered loss during the 31 day period during which you may request coverage, and written election has not been made (or, if made, has not been received and processed by the Policyholder), we will pay benefits based upon the minimum principal sum available for that spouse.

NEWBORN CHILDREN: If a child is born to you, and you had not elected Dependent coverage, such child shall be an Insured Dependent from the moment of birth.

The newborn child shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

(1) you request, in writing and within such 31 day period, continuation of such Dependent coverage; and

(2) the additional premium is paid for such coverage.

The above coverage will also be extended to newly adoptive, foster or step children, as of the date they become financially dependent on you for support, provided they otherwise meet the definition of Dependent.
CONVERSION PRIVILEGE

You can use this privilege when your Accidental Death and Dismemberment insurance coverage is no longer in force for any reason, except termination of the group Policy. Insured Dependents can use this Conversion Privilege if they cease to be eligible for any reason other than termination of the group Policy. Written application for the converted policy must be made within 31 days after coverage ends. The first premium must also be paid within that time. The issuance of the converted policy is subject to the following conditions:

1. the converted policy will take effect on the date of the termination of this insurance, or on the date of application for the converted policy, whichever is later;

2. proof of health will not be required; and

3. the premium will be applicable to the class of risk to which the Insured belongs, at his attained age, and to the form and amount of insurance provided.

The converted policy's Principal Sum will be the lower of:

1. the Amount of Principal Sum applicable to the Insured under the Policy; or

2. $250,000.

The converted policy may provide that it will be renewable on any anniversary with our consent, subject to a maximum age limit.

The converted policy may exclude any condition or hazard which applied to the Insured at the time coverage terminated. Benefits will not be paid under the converted policy for a claim originating under the Policy.

The Insured may convert to any individual Accidental Death and Dismemberment policy we offer in the state where he lives.
BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Policyholder. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Certificate.

If you have not named a beneficiary, or an Insured's named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

1. the Insured's legal spouse;
2. the Insured's surviving children (including legally adopted children), in equal shares;
3. the Insured's surviving parents, in equal shares;
4. the Insured's surviving siblings, in equal shares; or, if none of the above,
5. the Insured's estate.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the
beneficiary. Payment to a minor shall not exceed $1,000.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to $1,000 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

We will not be liable for any payment we have made in good faith.
CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

TIME PAYMENT OF CLAIMS: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

PAYMENT OF CLAIMS: If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

PHYSICAL EXAMINATION AND-autopsy: We have the right to have a doctor of our choice examine the Insured as often as we think necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to make an autopsy in case of death, unless the law forbids it. We will pay for the cost of both the examination and the autopsy.

LEGAL ACTION: No lawsuit or action in equity can be brought to recover on the Policy:

(1) before 60 days following the date written proof of loss was furnished to us; or
(2) after 3 years following the date written proof of loss is required (6 years in South Carolina and 5 years in Kansas).
SETTLEMENT OPTIONS

You may elect a single sum payment or a different way in which the beneficiary will receive payment of the Principal Sum. If other than a single sum payment is desired, you must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under $2,000 or option payments of less than $20 each are not allowed.

If no instructions for a settlement option are in effect at the death of an Insured, the beneficiary may make the election, with our consent.

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the beneficiary’s estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the 3 set out in the Policy may be made. A mutual agreement must be reached between the individual entitled to elect and us.

OPTION A - FIXED TIME PAYMENT OPTION: Equal monthly payments will be made for any period chosen, up to 30 years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change the minimum monthly payment. These changes will apply only to requests for settlement elected after the change.

Option A Table
Minimum Monthly Payment Rates for each $1,000 Applied

<table>
<thead>
<tr>
<th>Years</th>
<th>Years</th>
<th>Years</th>
<th>Years</th>
<th>Years</th>
<th>Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$84.47</td>
<td>7</td>
<td>$13.16</td>
<td>13</td>
<td>$7.71</td>
</tr>
<tr>
<td>2</td>
<td>42.86</td>
<td>8</td>
<td>11.68</td>
<td>14</td>
<td>7.26</td>
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<tr>
<td>3</td>
<td>28.99</td>
<td>9</td>
<td>10.53</td>
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<td>6.87</td>
</tr>
<tr>
<td>4</td>
<td>22.06</td>
<td>10</td>
<td>9.61</td>
<td>16</td>
<td>6.53</td>
</tr>
<tr>
<td>5</td>
<td>17.91</td>
<td>11</td>
<td>8.86</td>
<td>17</td>
<td>6.23</td>
</tr>
<tr>
<td>6</td>
<td>15.14</td>
<td>12</td>
<td>8.24</td>
<td>18</td>
<td>5.96</td>
</tr>
</tbody>
</table>
OPTION B - FIXED AMOUNT PAYMENT OPTION: Each payment will be for an agreed fixed amount. The amount of each payment will not be less than $20 for each $2000 applied. Interest will be credited and added each month on the unpaid balance. This interest will be at a rate set by us, but not less than the equivalent of 3% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

OPTION C - INTEREST PAYMENT OPTION: We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 3% per year.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DESCRIPTION OF COVERAGE

LOSS OF LIFE, LIMB, SIGHT, SPEECH OR HEARING: If, due to Injury, an Insured suffers any one of the following specific Losses within 365 days from the date of the accident we will pay the Benefit Amount listed below. However, if more than one listed loss results from any one accident, we will only pay the one largest applicable benefit as listed below.

<table>
<thead>
<tr>
<th>LOSS</th>
<th>BENEFIT AMOUNT:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Loss of Life</td>
<td>the Insured's Principal Sum</td>
</tr>
<tr>
<td>Loss of Two or More Members</td>
<td>the Insured's Principal Sum</td>
</tr>
<tr>
<td>Loss of Speech and Hearing</td>
<td>the Insured's Principal Sum</td>
</tr>
<tr>
<td>Loss of One Member</td>
<td>1/2 of the Insured's Principal Sum</td>
</tr>
<tr>
<td>Loss of Speech or Hearing</td>
<td>1/2 of the Insured's Principal Sum</td>
</tr>
<tr>
<td>Loss of Thumb and Index Finger of the Same Hand</td>
<td>1/4 of the Insured's Principal Sum</td>
</tr>
</tbody>
</table>

DEFINITIONS:

"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

1. a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;

2. an eye, Loss means the total and irrecoverable loss of sight;

3. speech, Loss means the total and irrecoverable loss of the function;

4. hearing, Loss means the total and irrecoverable loss of the hearing in both ears;

5. a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.
COVERAGE FOR MEMBERS OF RESERVE-NATIONAL GUARD

DESCRIPTION OF COVERAGE: We will pay plan benefits for a loss due to Injury of any Insured which is sustained while such Insured is a member of an organized Reserve Corps or National Guard Unit and is:

(1) attending any regularly scheduled or routine training of less than 60 days, or is enroute to or from such training;

(2) attending a Service School no matter how long it is, or is enroute to or from that school;

(3) taking part in any authorized inactive duty training; or

(4) taking part as a unit member in a parade or exhibition authorized by official orders.

No benefit is payable for any loss that occurs during active duty.

DEFINITION:

"Service School" means one operated by or on behalf of the United States of America or Canada.
COVERAGE OF EXPOSURE AND DISAPPEARANCE

DESCRIPTION OF COVERAGE

EXPOSURE: Any loss that is due to exposure will be covered as if it were due to Injury, provided such loss results directly and independently of all other causes from accidental exposure to the elements which occurs while the Insured's coverage under the Policy is in force.

DISAPPEARANCE: We will presume an Insured suffered loss of life due to an Injury, if:

1. while covered under the Policy, such Insured is riding in a conveyance that is involved in an accident, not excluded from coverage;

2. the conveyance is wrecked, sinks or disappears as a result of such accident; and

3. the Insured's body is not found within 1 year of the accident.
DESCRIPTION OF COVERAGE: We will pay a sum equal to 10% of the Insured's Principal Sum if:

(1) the Insured dies as the result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;

(2) a police report establishes that the Insured was properly strapped in a Seat Belt at the time;

(3) Loss of Life benefits are payable for the Insured's death hereunder.

We will pay an additional 5% if the Insured is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System. The Insured must be positioned in a seat which is designed to be protected by an air bag and must be properly strapped in the Seat Belt when the air bag inflates. In addition to the above requirements, the police report must establish that the air bag inflated properly upon impact.

The total maximum benefit payable is $25,000.

No benefit will be paid for any loss sustained:

(1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving; or

(2) if the Insured is not wearing a Seat Belt for any reason; or

(3) while the Insured is sharing a Seat Belt; or

(4) due to a defect in the Supplemental Restraint System's diagnostic system.

If the police report does not clearly establish that the Insured was or was not wearing a Seat Belt at the time of the accident causing the Insured's death, we will pay a sum equal to $1,000 in lieu of the benefit described above.
DEFINITIONS:

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint and includes a government approved child restraint device when used in accordance with manufacturer's directions. In the case of small children the restraint must:

(1) meet the standards of the National Safety Council; and

(2) must be properly secured and utilized in accordance with applicable State law and the recommendations of its manufacturer for children of like age and weight.

An air bag is not considered a Seat Belt.

"Supplemental Restraint System" means an air bag which inflates for added protection to the head and chest areas.

"Four-Wheel Vehicle" means a vehicle listed below provided it is: duly licensed for passenger use; and designated primarily for use on public streets and highways:

(1) a private passenger automobile; or

(2) a station wagon; or

(3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or

(4) a self-propelled motor home.
TOTAL LOSS OF USE BENEFIT

DESCRIPTION OF COVERAGE: We will pay the benefit shown below if, due to Injury, an Insured suffers a Total Loss of Use that is listed below, provided:

(1) the Insured suffers such Total Loss of Use within 1 year of the Injury;

(2) the Total Loss of Use continues for a period of 12 consecutive months after the onset;

(3) it is shown by proper medical authority at the end of these 12 months that the Total Loss of Use has been continuous and will be permanent; and

(4) no benefit is payable for such loss under the Accidental Death and Dismemberment Benefit of this Certificate.

BENEFITS: Only one benefit (the larger) will be paid for more than one Total Loss of Use resulting from any one accident.

For Total Loss of Use of: Benefit Amount:

Both Arms and Both Legs .............................. the Insured's Principal Sum
Both Arms ........................................... 2/3 of the Insured's Principal Sum
Both Legs ............................................. 3/4 of the Insured's Principal Sum
One Arm and One Leg ........................... 2/3 of the Insured's Principal Sum
Both Arms and One Leg or
Both Legs and One Arm ........................... 3/4 of the Insured's Principal Sum
One Arm or One Leg .............................. 1/2 of the Insured's Principal Sum

In no event will the total of all benefits paid for any one Insured for any one accident, under this benefit and the Accidental Death and Dismemberment Benefit, exceed that Insured's Principal Sum.

DEFINITION:

"Total Loss of Use" means loss of the ability to function because of:

(1) incurable paralysis; or

(2) stiffening.
In addition, "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.
EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage and that of any Insured Dependent, if applicable, in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

1. the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave; and
2. the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

1. the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
2. the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage and that of any Insured Dependents, if applicable, in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.
While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

1. the date the Policy terminates; or
2. the end of the period for which premium has been paid for you; or
3. the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated.
EXCLUSIONS

The Policy does not cover any loss:

(1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(2) caused by suicide, or intentionally self-inflicted injuries; or

(3) caused by or resulting from war or any act of war, declared or undeclared; or

(4) caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to us for any period not covered by the Policy while the Insured is in such service will be returned pro rata); or

(5) caused by or resulting from riding in, getting into or out of any aircraft, unless:
   (a) the Insured is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and
   (b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured, or any other employer of the Insured, unless a specific written agreement has been obtained from us; or

(6) sustained during the Insured's commission or attempted commission of an assault or felony; or

(7) to which the Insured's acute or chronic alcoholic intoxication is a contributing factor; or

(8) to which the Insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.
IMPORTANT NOTICE TO TENNESSEE POLICYHOLDERS
AND CERTIFICATE HOLDERS
(GROUP AND BLANKET)

Reliance Standard Life and your agent appreciate this opportunity to serve your insurance needs.

In the event you need to contact someone about this policy for any reason, please contact your agent. If you are unable to reach your agent or have additional questions, you may contact the Policyowner Service Office of Reliance Standard Life at the following address:

Reliance Standard Life Insurance Company
3340 Peachtree Road, N.E.
Suite 2650
Atlanta, GA  30326
(800) 535-6018
(404) 365-8888
Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

**COVERAGE**

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.
EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contractholder, not individuals).

LIMITS ON AMOUNT OF COVERAGE

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages

LRS-8580-0610
$300,000 for disability and long term care insurance

$500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243
Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association  
1200 One Nashville Place  
150 4th Avenue North  
Nashville, TN 37219

Tennessee Department of Commerce and Insurance  
500 James Robertson Parkway  
Nashville, TN 37243

Reliance Standard Life Insurance Company  
3340 Peachtree Road, N.E.  
Suite 2650  
Atlanta, GA 30326  
(800) 535-6018  
(404) 365-8888
SUMMARY PLAN DESCRIPTION
The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

**SUMMARY PLAN DESCRIPTION**

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

**PLAN NAME:** IASIS Healthcare Welfare Benefit Plan

**PLAN SPONSOR:** IASIS Healthcare, LLC
117 Seaboard Lane
Building E
Franklin, TN 37067
(615) 844-2747

**SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 20-1150104

**PLAN NUMBER:** 501

**TYPE OF PLAN:** Death and Dismemberment Benefit Plan

**PLAN BENEFITS:** Fully Insured - Voluntary Group Accidental Death and Dismemberment Insurance Benefits

**TYPE OF ADMINISTRATION:** The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090.

**PLAN ADMINISTRATOR:** The Plan Sponsor named above.
AGENT FOR SERVICE OF LEGAL PROCESS: The Plan Sponsor named above.

PLAN YEAR: The plan's fiscal records are kept on a calendar year basis beginning January 1st.

PLAN COSTS: The cost of the benefits provided under the plan are paid for by the employee.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS: A plan participant or beneficiary can obtain, without charge, a copy of the Plan’s procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION: The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.
CLAIM PROCEDURES FOR CLAIMS FILED WITH
RELIANCE STANDARD LIFE INSURANCE COMPANY
ON OR AFTER JANUARY 1, 2002

CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.
Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically 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, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for
the claimant to perfect the claim and an explanation of why such material or information is necessary; and

4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims

A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. 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; or 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 to the claimant upon request.
APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and
other information relevant to the claimant’s claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and

   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information
necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and

4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims
A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable);
5. 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; or 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 to the claimant upon request; and

6. 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 (where applicable)."
DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

ERISA STATEMENT OF RIGHTS

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

**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 the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, 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.
Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**Enforce Your Rights**

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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who 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.
Assistance with Your Questions

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

IASIS Healthcare, LLC
CERTIFICATE OF INSURANCE

POLICYHOLDER: IASIS Healthcare, LLC

GROUP POLICY NUMBER: VAR 672937

POLICY EFFECTIVE DATE: June 1, 2014

Subject to the terms of the Group Policy, we certify that you are insured for the benefits which apply to your class as described on the Schedule of Benefits, provided you are an Insured Person, as defined and your completed Enrollment Card is attached. The Group Policy Number, Policyholder, and Policy Effective Date are listed above. This Certificate is not a contract of insurance. It contains only the major terms of insurance coverage and payment of benefits under the Policy. It replaces all Certificates that may have been issued to you earlier.

This Certificate is signed by our President and Secretary.

[Signatures]

GROUP ACCIDENT CERTIFICATE

This Group Accident Certificate replaces any previous Group Accident Certificates and is dated September 8, 2014.
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SCHEDULE OF BENEFITS

ELIGIBILITY: Each active, Full-time Employee, except any person employed on a temporary or seasonal basis.

WAITING PERIOD: 30 days of employment.

INDIVIDUAL EFFECTIVE DATE: The first of the month coinciding with or next following completion of the Waiting Period.

INDIVIDUAL REINSTATEMENT: 30 days

AMOUNT OF INSURANCE: PRINCIPAL SUM:

INSURED PERSONS:

Choice of: One (1), Two (2), Three (3) or Four (4) times Earnings, rounded to the next higher $1,000, subject to a maximum Principal Sum of $500,000.

INSURED DEPENDENTS (Applicable if you are an employee who is insured under the Basic Life Policy (GL668964) who elects Dependent Accidental Death and Dismemberment coverage and is paying the applicable premiums; employee coverage under this Policy (VAR672937) is not required for Dependent Accidental Death and Dismemberment coverage):

Spouse Amount: Choice of: $25,000, $50,000 or $100,000
Child(ren) Amount: $10,000

For Insured Persons age 65 and over, the Amount of Principal Sum is subject to automatic reduction. Upon the Insured Person's attainment of the specified age below, the Amount of Principal Sum will be reduced to the applicable percentage, rounded to the next higher $1,000. This reduction also applies to Insured Persons who are age 65 or over on their Individual Effective Date.

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<th>Age</th>
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<td>65-69</td>
<td>67%</td>
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CHANGES IN AMOUNT OF INSURANCE: Increases and decreases in the Amount of Insurance because of changes in age are effective on the first of the month following the date of the change. Increases and decreases in the Amount of Insurance because of changes in class are effective on the first of the Policy month coinciding with or next following the date of the change. Increases and decreases in the Amount of Insurance because of changes in Earnings are effective on the date of the change.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date of the change. If you are not Actively at Work when the change should take effect, the change will take effect on the day after you have been Actively at Work for one full day.

Increases and decreases in the Amount of Insurance because of your elections will take effect on the first of the Policy month coinciding with or next following the date we receive the election request.

With respect to increases in the Amount of Insurance, you must be Actively at Work on the date the increase is to take effect. If you are not Actively at Work on the date the increase is to take effect, such increase will take effect on the date you return to work.

CONTRIBUTIONS: You are required to contribute toward the cost of your insurance coverage. You are required to contribute toward the cost of the Dependent insurance coverage.
DEFINITIONS

"Actively at Work" and "Active Work" means you are actually performing on a Full-time basis each and every duty pertaining to your job in the place where and the manner in which the job is normally performed. This includes approved time off for vacation, jury duty and funeral leave, but does not include time off as a result of Injury or illness.

"Dependents" means:

(1) your legal spouse who is not legally separated or divorced from you; and
(2) your unmarried child(ren), live birth to 26 years, who is financially dependent on you for support. Adoptive, foster and step-children are considered Dependents if they are in your custody.

NOTE: An Eligible Person may not have coverage both as an Insured Person and as an Insured Dependent. Only one Insured spouse may cover the eligible children as Insured Dependents. If insurance is in force for an Insured Dependent, any newly eligible Dependents will be automatically covered.

"Earnings" means the basic annual wages received from the Policyholder on the day just before the date of the Injury. Earnings does not include commissions, overtime pay, bonuses, incentive pay or any other special compensation not received as basic wages.

If hourly employees are insured, the number of hours scheduled to work during a regularly scheduled work week, not the hours actually worked, not to exceed 40 hours per week, times 52 weeks, will be used to determine annual Earnings.

"Eligible Person" means a person who meets the Eligibility requirements of the Policy.

"Full-time" means scheduled to work for the Policyholder for a minimum of 36 hours during your regular work week.

"Insured Person" means a person who meets the Eligibility requirements of the Policy and is enrolled for this insurance, and whose insurance under the Policy is in effect.

"Insured Dependent" means a "Dependent", as defined, whose
insurance under the Policy is in effect.

"Insured" means either an Insured Person or an Insured Dependent unless the context indicates otherwise.

"Injury" means accidental bodily injury to an Insured which is caused directly and independently of all other causes by accidental means and which occurs while the Insured's coverage under the Policy is in force.

"Policyholder", shall also include an associated or affiliated company, when referring to premium payments; Active Work; Full-time work; or Earnings.

"We", "us", and "our" means Reliance Standard Life Insurance Company.

"You", "your", and "yours" means the Insured Person.
GENERAL PROVISIONS

CHANGES: No agent has authority to change or waive any part of the Policy. To be valid, any change or waiver must be in writing, signed by a President, Vice President or Secretary and attached to the Policy.

INCONTESTABILITY: Any statements made by the Policyholder, any Insured Person, or any Insured Dependent, or on behalf of any Insured Person or any Insured Dependent to persuade us to provide coverage, will be deemed a representation, not a warranty. This provision limits our use of these statements in contesting the amount of insurance for which an Insured is covered. The following rules apply to each statement:

(1) No statement will be used in a contest unless:

   (a) it is in a written form signed by you or any Insured Dependent, or on your behalf or any Insured Dependent's behalf; and
   (b) a copy of such written instrument is or has been furnished to you or any Insured Dependent, or your or any Insured Dependent's beneficiary or legal representative.

(2) If the statement relates to your or any Insured Dependent's insurability, it will not be used to contest the validity of insurance which has been in force, before the contest, for at least two years during your or any Insured Dependent's lifetime.

ASSIGNMENT: Ownership of any benefit provided under the Policy may be transferred by assignment. An irrevocable beneficiary must give written consent to assign this insurance. Written request for assignment must be made in duplicate at our Administrative Offices. Once recorded by us, an assignment will take effect on the date it was signed. We are not liable for any action we take before the assignment is recorded.

CLERICAL ERROR: Clerical errors in connection with the Policy or delays in keeping records for the Policy, whether by the Policyholder, us or the Plan Administrator:

(1) will not terminate insurance that would otherwise have been effective; and

(2) will not continue insurance that would otherwise have ceased or should not have been in effect.
If appropriate, a fair adjustment of premium will be made to correct a clerical error.

**MISSTATEMENT OF AGE:** If an Insured's age has been misstated, benefits will be those that apply to his correct age.

**NOT IN LIEU OF WORKER'S COMPENSATION:** The Policy is not a Worker's Compensation Policy. It does not provide Worker's Compensation benefits.

**PRONOUNS:** All pronouns include either gender unless the context indicates otherwise.
INDIVIDUAL ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

WAITING PERIOD: A person who is continuously employed on a Full-time basis with the Policyholder for the period specified on the Schedule of Benefits has satisfied the Waiting Period.

EFFECTIVE DATE OF INDIVIDUAL INSURANCE: You must apply in writing for the insurance to go into effect. You will become insured on the later of:

(1) the Individual Effective Date as shown on the Schedule of Benefits; or

(2) on the first day of the month coincident with or next following the date you apply.

If you are not Actively At Work on the day your insurance is to go into effect, your insurance will go into effect on the day you return to Active Work for one full day.

Changes in your amount of insurance are effective as shown on the Schedule of Benefits.

TERMINATION OF INDIVIDUAL INSURANCE: Your coverage will terminate on the first of the following to occur:

(1) the date the Policy terminates; or

(2) the date you cease to be in a class eligible for this insurance; or

(3) the end of the period for which premium has been paid for your coverage.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.
CONTINUATION OF INDIVIDUAL INSURANCE: Your coverage may be continued, by payment of premium, beyond the date you cease to be eligible for this insurance, but not longer than:

(1) twelve (12) months, if you cease to be eligible due to illness or Injury; or

(2) sixty (60) days, if you cease to be eligible due to temporary lay-off or approved leave of absence.

INDIVIDUAL REINSTATEMENT: Insurance may be reinstated if you are a former Insured Person who has been:

(1) on an approved leave of absence;

(2) on temporary lay-off; or

(3) rehired after employment had been terminated.

You must return to Active Work with the Policyholder within the period of time shown on the Schedule of Benefits (INDIVIDUAL REINSTATEMENT). You must also be a member of a class eligible for this insurance. The insurance will go into effect on the date you return to Active Work.
DEPENDENT INSURANCE

ELIGIBILITY: You are eligible to enroll your eligible Dependents once you are insured for Basic Life under GL668964.

EFFECTIVE DATE OF DEPENDENT INSURANCE: You may insure your Dependents by making written application. In this case, your Dependent insurance will take effect on the first day of the month coincident with or next following the later of:

1. the date you first become eligible for Dependent insurance if application is made on or before that date; or
2. the date the dependent meets the definition of Dependent, if application is made on or before that date; or
3. the date of enrollment.

After this insurance is in force for one Dependent, application is not required for added Dependents.

TERMINATION OF DEPENDENT INSURANCE: The insurance for an Insured Dependent will terminate on the first of the following dates:

1. the date this Section terminates;
2. the end of the period for which premium for Dependent insurance has been paid;
3. the date your insurance terminates under GL668964; or
4. the date the dependent is no longer a Dependent as defined. However, coverage for an Insured Dependent child which would otherwise cease when such child attains the maximum age, will not cease while your insurance coverage remains in force if:
   
   (a) the child is unable to provide self-support due to mental retardation or physical handicap; and
   
   (b) he is chiefly dependent on you for support; and
(c) proof of the above conditions is received by us within 120 days after the date this insurance coverage would otherwise end.

We may ask from time to time if the Insured Dependent child remains a disabled and dependent person. This request may be made within 31 days of the time such Insured Dependent attains the maximum age, and later as required. After the 2 year period that follows such Dependent's attainment of the maximum age, this request may not be made more often than once a year. If we do not ask, insurance coverage for such Insured Dependent child will continue as long as:

(a) your coverage remains in effect;

(b) the Insured Dependent child remains in the same condition; and

(c) the proper premium is paid.

Proof of the Insured Dependent child's status as a disabled and dependent person must be furnished to us within 31 days of the inquiry. If it is not, we may stop the insurance of such Insured Dependent when he attains the maximum age, or later.

Any loss which occurs prior to the termination of this insurance coverage will not be affected.
NEWLYWED PROVISION: If you marry and had not previously elected Dependent coverage, your new spouse shall automatically become an Insured Dependent.

Such spouse shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

1. you request, in writing and within such 31 day period, continuation of such Dependent coverage; and

2. the additional premium is paid for such coverage.

In the event your new spouse suffers a covered loss during the 31 day period during which you may request coverage, and written election has not been made (or, if made, has not been received and processed by the Policyholder), we will pay benefits based upon the minimum principal sum available for that spouse.

NEWBORN CHILDREN: If a child is born to you, and you had not elected Dependent coverage, such child shall be an Insured Dependent from the moment of birth.

The newborn child shall be an Insured Dependent for 31 days. He shall then cease to be an Insured Dependent unless:

1. you request, in writing and within such 31 day period, continuation of such Dependent coverage; and

2. the additional premium is paid for such coverage.

The above coverage will also be extended to newly adoptive, foster or step children, as of the date they become financially dependent on you for support, provided they otherwise meet the definition of Dependent.
CONVERSION PRIVILEGE

You can use this privilege when your Accidental Death and Dismemberment insurance coverage is no longer in force for any reason, except termination of the group Policy. Insured Dependents can use this Conversion Privilege if they cease to be eligible for any reason other than termination of the group Policy. Written application for the converted policy must be made within 31 days after coverage ends. The first premium must also be paid within that time. The issuance of the converted policy is subject to the following conditions:

1. the converted policy will take effect on the date of the termination of this insurance, or on the date of application for the converted policy, whichever is later;

2. proof of health will not be required; and

3. the premium will be applicable to the class of risk to which the Insured belongs, at his attained age, and to the form and amount of insurance provided.

The converted policy's Principal Sum will be the lower of:

1. the Amount of Principal Sum applicable to the Insured under the Policy; or

2. $250,000.

The converted policy may provide that it will be renewable on any anniversary with our consent, subject to a maximum age limit.

The converted policy may exclude any condition or hazard which applied to the Insured at the time coverage terminated. Benefits will not be paid under the converted policy for a claim originating under the Policy.

The Insured may convert to any individual Accidental Death and Dismemberment policy we offer in the state where he lives.
BENEFICIARY AND FACILITY OF PAYMENT

BENEFICIARY: If you die, any death benefit payable and any other accrued benefits will be paid to the beneficiary named in records maintained by the Policyholder. A beneficiary designation will be effective as of the date you signed it. Any payment made by us before receiving the designation shall fully discharge us to the extent of that payment.

You will be the beneficiary of any benefit payable at the death of an Insured Dependent, unless another beneficiary has been named and placed on file as required.

You can change the beneficiary by telling us in writing on our form. The consent of a revocable beneficiary is not needed. The change will take effect only when it is received and approved by us or an authorized Plan Administrator. We cannot attest to the validity of such a change.

If an Insured's beneficiary dies at the same time as the Insured, or within 15 days after his death but before we receive written proof of the Insured's death, payment will be made as if the Insured survived the beneficiary, unless noted otherwise in another provision of this Certificate.

If you have not named a beneficiary, or an Insured's named beneficiary is not surviving at the Insured's death, any benefits due shall be paid to the first of the following classes to survive the Insured:

1. the Insured's legal spouse;
2. the Insured's surviving children (including legally adopted children), in equal shares;
3. the Insured's surviving parents, in equal shares;
4. the Insured's surviving siblings, in equal shares; or, if none of the above,
   5. the Insured's estate.

FACILITY OF PAYMENT: If a beneficiary, in our opinion, cannot give a valid release (and no guardian has been appointed), we may pay the benefit to the person who has custody or is the main support of the
beneficiary. Payment to a minor shall not exceed $1,000.

If the Insured has not named a beneficiary or the beneficiary is not surviving at the Insured's death, we may pay up to $1,000 of the benefit to the person(s) who, in our opinion, has incurred expenses in connection with the Insured's last illness, death or burial. Payment may also be made to the executor or administrator of the Insured's estate, or to any relative of the Insured by blood or marriage.

The balance of the benefit, if any, will be held by us, until an individual or representative:

(1) is validly named; or
(2) is appointed to receive the proceeds; and
(3) can give valid release to us.

We will not be liable for any payment we have made in good faith.
CLAIMS PROVISIONS

NOTICE OF CLAIM: Written notice must be given to us within 31 days after the Loss occurs, or as soon as reasonably possible. The notice should be sent to us at our Administrative Offices or to our authorized agent. The notice should include the Insured's name and the Policy Number.

CLAIM FORMS: When we receive written notice of a claim, we will send claim forms to the claimant within 15 days. If we do not, the claimant will satisfy the requirements of written proof of loss by sending us written proof as shown below. The proof must describe the occurrence, extent and nature of the loss.

PROOF OF LOSS: For any covered Loss, written proof must be sent to us within 90 days. If it is not reasonably possible to give proof within 90 days, the claim is not affected if the proof is sent as soon as reasonably possible. In any event, proof must be given within 1 year, unless the claimant is legally incapable of doing so.

TIME PAYMENT OF CLAIMS: When we receive written proof of loss, we will pay any benefits due. Benefits that provide for periodic payment will be paid accordingly.

PAYMENT OF CLAIMS: If you die, we will pay any death benefit and any other accrued benefits in accordance with the Beneficiary and Facility of Payment provisions. All other benefits will be paid to you.

PHYSICAL EXAMINATION AND AUTOPSY: We have the right to have a doctor of our choice examine the Insured as often as we think necessary. This section applies while a claim is pending or while we are paying benefits. We also have the right to make an autopsy in case of death, unless the law forbids it. We will pay for the cost of both the examination and the autopsy.

LEGAL ACTION: No lawsuit or action in equity can be brought to recover on the Policy:

(1) before 60 days following the date written proof of loss was furnished to us; or
(2) after 3 years following the date written proof of loss is required (6 years in South Carolina and 5 years in Kansas).
SETTLEMENT OPTIONS

You may elect a single sum payment or a different way in which the beneficiary will receive payment of the Principal Sum. If other than a single sum payment is desired, you must provide a written request to us, for our approval, at our Administrative Office. If the option covers less than the full amount due, we must be advised of what part is to be under an option. Amounts under $2,000 or option payments of less than $20 each are not allowed.

If no instructions for a settlement option are in effect at the death of an Insured, the beneficiary may make the election, with our consent.

If a beneficiary dies while receiving payments under one of these options and there is no contingent beneficiary, the balance will be paid in one sum to the beneficiary’s estate, unless otherwise agreed to in the instructions for settlement.

Requests for settlement options other than the 3 set out in the Policy may be made. A mutual agreement must be reached between the individual entitled to elect and us.

OPTION A - FIXED TIME PAYMENT OPTION: Equal monthly payments will be made for any period chosen, up to 30 years. The amount of each payment depends on the amount applied, the period selected and the payment rates we are using when the first payment is due. The rate of any monthly payment will not be less than shown in the table below. We reserve the right to change the minimum monthly payment. These changes will apply only to requests for settlement elected after the change.

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OPTION B - FIXED AMOUNT PAYMENT OPTION: Each payment will be for an agreed fixed amount. The amount of each payment will not be less than $20 for each $2000 applied. Interest will be credited and added each month on the unpaid balance. This interest will be at a rate set by us, but not less than the equivalent of 3% per year. Payments continue until the amount we hold runs out. The last payment will be for the balance only.

OPTION C - INTEREST PAYMENT OPTION: We will hold any amount applied under this section. Interest on the unpaid balance will be paid each month at a rate set by us. This rate will not be less than the equivalent of 3% per year.
ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

DESCRIPTION OF COVERAGE

LOSS OF LIFE, LIMB, SIGHT, SPEECH OR HEARING: If, due to Injury, an Insured suffers any one of the following specific Losses within 365 days from the date of the accident we will pay the Benefit Amount listed below. However, if more than one listed loss results from any one accident, we will only pay the one largest applicable benefit as listed below.

LOSS                     BENEFIT AMOUNT:
Loss of Life ................................. the Insured's Principal Sum
Loss of Two or More Members ............... the Insured's Principal Sum
Loss of Speech and Hearing ................... the Insured's Principal Sum
Loss of One Member ........................... 1/2 of the Insured's Principal Sum
Loss of Speech or Hearing ................... 1/2 of the Insured's Principal Sum
Loss of Thumb and Index Finger of the Same Hand ........... 1/4 of the Insured's Principal Sum

DEFINITIONS:

"Member(s)" means: hand, foot or eye.

"Loss(es)" must result directly and independently from Injury, with no other contributing cause. As used in this benefit with respect to:

(1) a hand or foot, Loss means the complete severance through or above the wrist or ankle joints;

(2) an eye, Loss means the total and irrecoverable loss of sight;

(3) speech, Loss means the total and irrecoverable loss of the function;

(4) hearing, Loss means the total and irrecoverable loss of the hearing in both ears;

(5) a thumb and index finger, Loss means the complete severance through or above the metacarpophalangeal joint.
COVERAGE FOR MEMBERS OF RESERVE-NATIONAL GUARD

DESCRIPTION OF COVERAGE: We will pay plan benefits for a loss due to Injury of any Insured which is sustained while such Insured is a member of an organized Reserve Corps or National Guard Unit and is:

1. attending any regularly scheduled or routine training of less than 60 days, or is enroute to or from such training;

2. attending a Service School no matter how long it is, or is enroute to or from that school;

3. taking part in any authorized inactive duty training; or

4. taking part as a unit member in a parade or exhibition authorized by official orders.

No benefit is payable for any loss that occurs during active duty.

DEFINITION:

"Service School" means one operated by or on behalf of the United States of America or Canada.
COVERAGE OF EXPOSURE AND DISAPPEARANCE

DESCRIPTION OF COVERAGE

EXPOSURE: Any loss that is due to exposure will be covered as if it were due to Injury, provided such loss results directly and independently of all other causes from accidental exposure to the elements which occurs while the Insured's coverage under the Policy is in force.

DISAPPEARANCE: We will presume an Insured suffered loss of life due to an Injury, if:

(1) while covered under the Policy, such Insured is riding in a conveyance that is involved in an accident, not excluded from coverage;

(2) the conveyance is wrecked, sinks or disappears as a result of such accident; and

(3) the Insured's body is not found within 1 year of the accident.
SEAT BELT AND AIR BAG BENEFIT

DESCRIPTION OF COVERAGE: We will pay a sum equal to 10% of the Insured's Principal Sum if:

(1) the Insured dies as the result of a bodily Injury sustained while riding in or operating a Four-Wheel Vehicle;

(2) a police report establishes that the Insured was properly strapped in a Seat Belt at the time;

(3) Loss of Life benefits are payable for the Insured's death hereunder.

We will pay an additional 5% if the Insured is driving in or riding in a Four-Wheel Vehicle which is equipped with a factory-installed Supplemental Restraint System. The Insured must be positioned in a seat which is designed to be protected by an air bag and must be properly strapped in the Seat Belt when the air bag inflates. In addition to the above requirements, the police report must establish that the air bag inflated properly upon impact.

The total maximum benefit payable is $25,000.

No benefit will be paid for any loss sustained:

(1) while driving or riding in any Four-Wheel Vehicle used: in a race; in a speed or endurance test; or for acrobatic or stunt driving; or

(2) if the Insured is not wearing a Seat Belt for any reason; or

(3) while the Insured is sharing a Seat Belt; or

(4) due to a defect in the Supplemental Restraint System's diagnostic system.

If the police report does not clearly establish that the Insured was or was not wearing a Seat Belt at the time of the accident causing the Insured's death, we will pay a sum equal to $1,000 in lieu of the benefit described above.
DEFINITIONS:

"Seat Belt" means an unaltered Seat Belt or lap and shoulder restraint and includes a government approved child restraint device when used in accordance with manufacturer's directions. In the case of small children the restraint must:

(1) meet the standards of the National Safety Council; and

(2) must be properly secured and utilized in accordance with applicable State law and the recommendations of its manufacturer for children of like age and weight.

An air bag is not considered a Seat Belt.

"Supplemental Restraint System" means an air bag which inflates for added protection to the head and chest areas.

"Four-Wheel Vehicle" means a vehicle listed below provided it is: duly licensed for passenger use; and designated primarily for use on public streets and highways:

(1) a private passenger automobile; or

(2) a station wagon; or

(3) a van, jeep, or truck-type vehicle which has a manufacturer's rated load capacity of 2,000 pounds or less; or

(4) a self-propelled motor home.
TOTAL LOSS OF USE BENEFIT

DESCRIPTION OF COVERAGE: We will pay the benefit shown below if, due to Injury, an Insured suffers a Total Loss of Use that is listed below, provided:

(1) the Insured suffers such Total Loss of Use within 1 year of the Injury;

(2) the Total Loss of Use continues for a period of 12 consecutive months after the onset;

(3) it is shown by proper medical authority at the end of these 12 months that the Total Loss of Use has been continuous and will be permanent; and

(4) no benefit is payable for such loss under the Accidental Death and Dismemberment Benefit of this Certificate.

BENEFITS: Only one benefit (the larger) will be paid for more than one Total Loss of Use resulting from any one accident.

For Total Loss of Use of: Benefit Amount:

Both Arms and Both Legs ......................... the Insured's Principal Sum
Both Arms ........................................ 2/3 of the Insured's Principal Sum
Both Legs ........................................ 3/4 of the Insured's Principal Sum
One Arm and One Leg ......................... 2/3 of the Insured's Principal Sum
Both Arms and One Leg or
Both Legs and One Arm ....................... 3/4 of the Insured's Principal Sum
One Arm or One Leg ........................... 1/2 of the Insured's Principal Sum

In no event will the total of all benefits paid for any one Insured for any one accident, under this benefit and the Accidental Death and Dismemberment Benefit, exceed that Insured's Principal Sum.

DEFINITION:

"Total Loss of Use" means loss of the ability to function because of:

(1) incurable paralysis; or

(2) stiffening.
In addition, "Total Loss of Use" must affect the entire arm or leg from the shoulder or hip, including the hand or foot attached to it.
EXTENSION OF COVERAGE UNDER THE FAMILY AND MEDICAL LEAVE ACT AND UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

Family and Medical Leave of Absence:

We will continue your coverage and that of any Insured Dependent, if applicable, in accordance with the Policyholder's policies regarding leave under the Family and Medical Leave Act of 1993, as amended, or any similar state law, as amended, if:

(1) the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave; and
(2) the Policyholder has approved your leave in writing and provides a copy of such approval within thirty-one (31) days of our request.

As long as the above requirements are satisfied, we will continue coverage until the later of:

(1) the end of the leave period required by the Family and Medical Leave Act of 1993, as amended; or
(2) the end of the leave period required by any similar state law, as amended.

Military Services Leave of Absence:

We will continue your coverage and that of any Insured Dependents, if applicable, in accordance with the Policyholder's policies regarding Military Services Leave of Absence under USERRA if the premium for you and your Insured Dependents, if applicable, continues to be paid during the leave.

As long as the above requirement is satisfied, we will continue coverage until the end of the period required by USERRA.

The Policy, while coverage is being continued under the Military Services Leave of Absence extension, does not cover any loss which occurs while on active duty in the military if such loss is caused by or arises out of such military service, including but not limited to war or any act of war, whether declared or undeclared.
While you are on a Family and Medical Leave of Absence for any reason other than your own illness, injury or disability or Military Services Leave of Absence you will be considered Actively at Work. Any changes such as revisions to coverage due to age, class or salary changes, as applicable, will apply during the leave except that increases in the amount of insurance, whether automatic or subject to election, will not be effective if you are not considered Actively at Work until you have returned to Active Work for one (1) full day.

A leave of absence taken in accordance with the Family and Medical Leave Act of 1993 or USERRA will run concurrently with any other applicable continuation of insurance provision in the Policy.

Your coverage and that of any Insured Dependents, if applicable, will cease under this extension on the earliest of:

1. the date the Policy terminates; or
2. the end of the period for which premium has been paid for you; or
3. the date such leave should end in accordance with the Policyholder's policies regarding Family and Medical Leave of Absence and Military Services Leave of Absence in compliance with the Family and Medical Leave Act of 1993, as amended and USERRA.

Should the Policyholder choose not to continue your coverage during a Family and Medical Leave of Absence and/or Military Services Leave of Absence, your coverage as well as any dependent coverage, if applicable, will be reinstated.
EXCLUSIONS

The Policy does not cover any loss:

(1) to which sickness, disease, or myocardial infarction, including medical or surgical treatment thereof, is a contributing factor; or

(2) caused by suicide, or intentionally self-inflicted injuries; or

(3) caused by or resulting from war or any act of war, declared or undeclared; or

(4) caused by an accident that occurs while in the armed forces of any country, except as shown under the Reserve-National Guard Benefit (any premium paid to us for any period not covered by the Policy while the Insured is in such service will be returned pro rata); or

(5) caused by or resulting from riding in, getting into or out of any aircraft, unless:

(a) the Insured is a passenger (not a pilot or crew member) in a tested and approved civilian aircraft being operated as passenger transport in compliance with the then current rules of the authority having jurisdiction over its operation; and

(b) the aircraft is not owned, leased or operated by or on behalf of the Policyholder, the Insured, or any other employer of the Insured, unless a specific written agreement has been obtained from us; or

(6) sustained during the Insured's commission or attempted commission of an assault or felony; or

(7) to which the Insured's acute or chronic alcoholic intoxication is a contributing factor; or

(8) to which the Insured's voluntary consumption of an illegal or controlled substance or a non-prescribed narcotic or drug is a contributing factor.
IMPORTANT NOTICE TO TENNESSEE POLICYHOLDERS 
AND CERTIFICATE HOLDERS 
(GROUP AND BLANKET)

Reliance Standard Life and your agent appreciate this opportunity to serve your insurance needs.

In the event you need to contact someone about this policy for any reason, please contact your agent. If you are unable to reach your agent or have additional questions, you may contact the Policyowner Service Office of Reliance Standard Life at the following address:

Reliance Standard Life Insurance Company 
3340 Peachtree Road, N.E. 
Suite 2650 
Atlanta, GA 30326 
(800) 535-6018 
(404) 365-8888
NOTICE CONCERNING COVERAGE UNDER
THE TENNESSEE LIFE AND HEALTH INSURANCE
GUARANTY ASSOCIATION ACT

Residents of Tennessee who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in the state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however. And, as noted below, this protection is not a substitute for consumers' care in selecting companies that are well-managed and financially stable.

The state law that provides for this safety-net coverage is called the Tennessee Life and Health Insurance Guaranty Association Act. The following is a brief summary of this law's coverages, exclusions and limits. This summary does not cover all provisions of the law or describe all of the conditions and limitations relating to coverage. This summary does not in any way change anyone's rights or obligations under the act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Life and Health Insurance Guaranty Association if they live in this state and hold a life or health insurance contract, an annuity, or if they are insured under a group insurance contract issued by an insurer authorized to conduct business in Tennessee. Health insurance includes disability and long term care policies. The beneficiaries, payees or assignees of insured persons are protected as well, even if they live in another state.
EXCLUSIONS FROM COVERAGE

However, persons holding such policies are not protected by this Guaranty Association if:

(1) they are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insured who live outside that state);

(2) the insurer was not authorized to do business in this state;

(3) their policy was issued by an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policyholder is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does not provide coverage for:

(1) any policy or portion of a policy which is not guaranteed by the insurer or for which the individual has assumed the risk, such as a variable contract sold by prospectus;

(2) any policy of reinsurance (unless an assumption certificate was issued);

(3) interest rate yields that exceed an average rate;

(4) dividends;

(5) credits given in connection with the administration of a policy by a group contractholder;

(6) employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
(7) unallocated annuity contracts (which give rights to group contractholder, not individuals).

**LIMITS ON AMOUNT OF COVERAGE**

The act also limits the amount the Guaranty Association is obligated to pay out. The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. For any one insured life, the Guaranty Association guarantees payments up to a stated maximum no matter how many policies and contracts there were with the same company, even if they provided different types of coverage. These aggregate limits per life are as follows:

- $300,000 for policies and contracts of all types, except as described in the next point
- $500,000 for basic hospital, medical and surgical insurance and major medical insurance issued by companies that become insolvent after January 1, 2010

Within these overall limits, the Guaranty Association cannot guarantee payment of benefit greater than the following:

- life insurance death benefits - $300,000
- life insurance cash surrender value - $100,000
- present value of annuity benefits for companies insolvent before July 1, 2009 - $100,000
- present value of annuity benefits for companies insolvent after June 30, 2009 - $250,000
- health insurance benefits for companies declared insolvent before January 1, 2010 - $100,000
- health insurance benefits for companies declared insolvent on or after January 1, 2010:
  - $100,000 for limited benefits and supplemental health coverages
• $300,000 for disability and long term care insurance

• $500,000 for basic hospital, medical and surgical insurance or major medical insurance

The Tennessee Life and Health Insurance Guaranty Association may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions, and require continued residency in Tennessee. You should not rely on coverage by the Tennessee Life and Health Insurance Guaranty Association in selecting an insurance company or in selecting an insurance policy.

Coverage is NOT provided for your policy or any portion of it that is not guaranteed by the insurer for which you have assumed the risk, such as a variable contract sold by prospectus.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243
NOTICE

Residents of this state who purchase life insurance, annuities or health insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Tennessee Life and Health Insurance Guaranty Association. The purpose of this association is to assure that policyholders will be protected, within limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of insured persons who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by these insurers through the Guaranty Association is not unlimited, however, and is not available at all for some policies.

COVERAGE IS NOT PROVIDED FOR YOUR POLICY OR ANY PORTION OF IT THAT IS NOT GUARANTEED BY THE INSURER OR FOR WHICH YOU HAVE ASSUMED THE RISK, SUCH AS A VARIABLE CONTRACT SOLD BY PROSPECTUS.

Insurance companies or their agents are required by law to give or send you this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

Tennessee Life and Health Guaranty Association
1200 One Nashville Place
150 4th Avenue North
Nashville, TN 37219

Tennessee Department of Commerce and Insurance
500 James Robertson Parkway
Nashville, TN 37243

Reliance Standard Life Insurance Company
3340 Peachtree Road, N.E.
Suite 2650
Atlanta, GA 30326
(800) 535-6018
(404) 365-8888

LRS-8580-0610
SUMMARY PLAN DESCRIPTION
The following section entitled Summary Plan Description was prepared by Reliance Standard Life Insurance Company at the request of and on behalf of the Plan Sponsor. Reliance Standard Life Insurance Company assumes no responsibility for the accuracy or sufficiency of the information in this section.

**SUMMARY PLAN DESCRIPTION**

The following information and the description of benefits provided in this booklet constitute the Summary Plan Description.

**PLAN NAME:** IASIS Healthcare Welfare Benefit Plan

**PLAN SPONSOR:** IASIS Healthcare, LLC
117 Seaboard Lane
Building E
Franklin, TN 37067
(615) 844-2747

**SPONSOR'S EMPLOYER IDENTIFICATION NUMBER:** 20-1150104

**PLAN NUMBER:** 501

**TYPE OF PLAN:** Death and Dismemberment Benefit Plan

**PLAN BENEFITS:** Fully Insured - Voluntary Group Accidental Death and Dismemberment Insurance Benefits

**TYPE OF ADMINISTRATION:** The plan is administered in accordance with the terms of the Group Policy issued by the Reliance Standard Life Insurance Company, 2001 Market Street, Suite 1500, Philadelphia, PA 19103-7090.

**PLAN ADMINISTRATOR:** The Plan Sponsor named above.
AGENT FOR SERVICE OF LEGAL PROCESS: The Plan Sponsor named above.

PLAN YEAR: The plan's fiscal records are kept on a calendar year basis beginning January 1st.

PLAN COSTS: The cost of the benefits provided under the plan are paid for by the employee.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO) DETERMINATIONS: A plan participant or beneficiary can obtain, without charge, a copy of the Plan’s procedures governing Qualified Medical Child Support Order (QMCSO) determinations from the Plan Administrator named above.

AMENDMENT AND TERMINATION: The Plan Sponsor reserves the right, at any time, to amend or terminate the Plan or amend or eliminate benefits under the Plan for any reason.
CLAIMS FOR BENEFITS

Claims may be submitted by mailing the completed form along with any requested information to:

Reliance Standard Life Insurance Company
Claims Department
P.O. Box 8330
Philadelphia, PA 19101-8330

Claim forms are available from your benefits representative or may be requested by writing to the above address or by calling 1-800-644-1103.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
If a non-disability claim is wholly or partially denied, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 90 days after our receipt of the claim, unless it is determined that special circumstances require an extension of time for processing the claim. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 90-day period. In no event shall such extension exceed a period of 90 days from the end of such initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the benefit determination is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing.
Disability Benefit Claims
In the case of a claim for disability benefits, the claimant shall be notified of the adverse benefit determination within a reasonable period of time, but not later than 45 days after our receipt of the claim. This period may be extended for up to 30 days, provided that it is determined that such an extension is necessary due to matters beyond our control and that notification is provided to the claimant, prior to the expiration of the initial 45-day period, of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered. If, prior to the end of the first 30-day extension period, it is determined that, due to matters beyond our control, a decision cannot be rendered within that extension period, the period for making the determination may be extended for up to an additional 30 days, provided that the claimant is notified, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date by which a decision is expected to be rendered. In the case of any such extension, the notice of extension shall specifically 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, and the claimant shall be afforded at least 45 days within which to provide the specified information.

Calculating time periods. The period of time within which a benefit determination is required to be made shall begin at the time a claim is filed, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event that a period of time is extended due to a claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION

Non-Disability Benefit Claims
A Claimant shall be provided with written notification of any adverse benefit determination. The notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for
the claimant to perfect the claim and an explanation of why such material or information is necessary; and
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review.

Disability Benefit Claims
A claimant shall be provided with written notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
4. A description of the review procedures and the time limits applicable to such procedures, including a statement of the claimant’s right to bring a civil action under section 502(a) of the Employee Retirement Income Security Act of 1974 as amended ("ERISA") (where applicable), following an adverse benefit determination on review; and
5. 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; or 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 to the claimant upon request.
APPEALS OF ADVERSE BENEFIT DETERMINATIONS

Appeals of adverse benefit determinations may be submitted in accordance with the following procedures to:

Reliance Standard Life Insurance Company
Quality Review Unit
P.O. Box 8330
Philadelphia, PA 19101-8330

Non-Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 60 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
5. No deference to the initial adverse benefit determination shall be afforded upon appeal;
6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual; and
7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination.

Disability Benefit Claims
1. Claimants (or their authorized representatives) must appeal within 180 days following their receipt of a notification of an adverse benefit determination, and only one appeal is allowed;
2. Claimants shall be provided with the opportunity to submit written comments, documents, records, and/or other information relating to the claim for benefits in conjunction with their timely appeal;
3. Claimants shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and
other information relevant to the claimant’s claim for benefits;

4. The review on (timely) appeal shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;

5. No deference to the initial adverse benefit determination shall be afforded upon appeal;

6. The appeal shall be conducted by an individual who is neither the individual who made the (underlying) adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

7. Any medical or vocational expert(s) whose advice was obtained in connection with a claimant’s adverse benefit determination shall be identified, without regard to whether the advice was relied upon in making the benefit determination; and

8. In deciding the appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, the individual conducting the appeal shall consult with a health care professional:

   (a) who has appropriate training and experience in the field of medicine involved in the medical judgment; and
   (b) who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal; nor the subordinate of any such individual.

TIMING OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 60 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 60-day period. In no event shall such extension exceed a period of 60 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information
necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Disability Benefit Claims
The claimant (or their authorized representative) shall be notified of the benefit determination on review within a reasonable period of time, but not later than 45 days after receipt of the claimant’s timely request for review, unless it is determined that special circumstances require an extension of time for processing the appeal. If it is determined that an extension of time for processing is required, written notice of the extension shall be furnished to the claimant prior to the termination of the initial 45-day period. In no event shall such extension exceed a period of 45 days from the end of the initial period. The extension notice shall indicate the special circumstances requiring an extension of time and the date by which the determination on review is expected to be rendered.

Calculating time periods. The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is timely filed, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event that a period of time is extended as above due to a claimant’s failure to submit information necessary to decide a claim, the period for making the benefit determination on review shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

MANNER AND CONTENT OF NOTIFICATION OF BENEFIT DETERMINATION ON REVIEW

Non-Disability Benefit Claims
A claimant shall be provided with written notification of the benefit determination on review. In the case of an adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits; and

4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable).

Disability Benefit Claims

A claimant must be provided with written notification of the determination on review. In the case of adverse benefit determination on review, the notification shall set forth, in a manner calculated to be understood by the claimant, the following:

1. The specific reason or reasons for the adverse determination;
2. Reference to the specific plan/policy provisions on which the determination is based;
3. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant’s claim for benefits;
4. A statement of the claimant’s right to bring an action under section 502(a) of ERISA (where applicable);
5. 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; or 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 to the claimant upon request; and
6. 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 (where applicable)."
DEFINITIONS

The term "adverse benefit determination" means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant’s or beneficiary’s eligibility to participate in a plan.

The term "us" or "our" refers to Reliance Standard Life Insurance Company.

The term "relevant" means:

A document, record, or other information shall be considered relevant to a claimant’s claim if such document, record or other information:

- Was relied upon in making the benefit determination;
- Was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
- Demonstrates compliance with administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with governing plan documents and that, where appropriate, the plan provisions have been applied consistently with respect to similarly situated claimants; or
- In the case of a plan providing disability benefits, constitutes a statement of policy or guidance with respect to the plan concerning the denied benefit of the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.
The term "Reliance Standard Life Insurance Company" means Reliance Standard Life Insurance Company and/or its authorized claim administrators.

**ERISA STATEMENT OF RIGHTS**

As a participant in the Group Insurance Plan, you may be entitled to certain rights and protections in the event that the Employee Retirement Income Security Act of 1974 (ERISA) applies. ERISA provides that all Plan Participants shall be entitled to:

**Receive Information About Your Plan and Benefits**

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, 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, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for the copies.

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

**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 the employee benefits plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interests of you and other Plan Participants and Beneficiaries. No one, including your employer, your union, 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.
Reliance Standard Life Insurance Company shall serve as the claims review fiduciary with respect to the insurance policy and the Plan. The claims review fiduciary has the discretionary authority to interpret the Plan and the insurance policy and to determine eligibility for benefits. Decisions by the claims review fiduciary shall be complete, final and binding on all parties.

**Enforce Your Rights**

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.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of the Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal Court. If it should happen that Plan Fiduciaries misuse the Plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who 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.
Assistance with Your Questions

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

| **What is the Employee Assistance Program?** | The Employee Assistance/Work-Life Program (EAP) is a voluntary, confidential service that provides professional counseling and referral services designed to help with personal, job or family related problems. The EAP can help you and your family members identify, resolve and gain control over personal problems that may be interfering with work and daily life. |
| **Who is eligible?** | All IASIS Healthcare employees and household members are eligible for EAP services. The same services are available to everyone. |
| **What types of problems does the Employee Assistance Program handle?** | Professional counselors speak with you in private about concerns such as, but not limited to: marriage/relationship problems mental health/stress family issues legal referrals elder care financial issues alcohol or drug use grief issues parenting work-related issues gambling addiction |
| **How do I access the Employee Assistance Program?** | First, call the Employee Assistance Program hotline at 1-800-767-5320, to speak directly with a counselor about your issue. The counselor will assess the situation and provide you with options. The EAP is available 24 hours a day – seven days a week – 365 days a year. Some problems are resolved over the phone, or you may be referred to an HMSA affiliated counselor in your geographic area. You and the counselor may find that a referral to ongoing counseling, treatment or other help is needed. If so, referral to qualified resources usually occurs in the first contact, or as soon as the problem is assessed. You are entitled to three short term face to face (3) sessions. |
Your EAP also offers a wealth of work-life resources through the Online EAP/Work-Life Resource Portal. You can find articles, podcasts, health and wellness, self assessments, financial and legal tools, eldercare and childcare.

Visit: www.my-life-resource.com
Username: hmsa
Password: myresource

<table>
<thead>
<tr>
<th>Where are the EAP counseling sites?</th>
<th>The EAP has offices in your community and throughout the country. The counselor you speak with over the phone will help arrange a meeting in an office most convenient for you.</th>
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<tbody>
<tr>
<td>Who pays for the Employee Assistance Program?</td>
<td>Your employer has paid for all direct EAP services. There is no cost to you for up to three (3) visits. The EAP is separate from the health insurance plan. If you are referred to resources outside of the EAP, there may be costs for which you or your health insurance plan are responsible. The EAP counselor can help you understand this.</td>
</tr>
<tr>
<td>Why use the Employee Assistance Program?</td>
<td>When you or any of your dependents have a problem, it can affect how you feel and act. Stress can impair your family life and work, but prompt help can restore your well being, both at home and on the job.</td>
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The EAP is confidential to the greatest extent the law allows.

When you need help, call
1-800-767-5320

Health Management Systems of America
601 Washington Blvd
Detroit, MI 48226