

**SAN ANTONIO POLICE OFFICERS AND FIREFIGHTERS
BENEFIT PLAN**

EMPLOYEE BENEFIT PLAN

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

RESTATEMENT EFFECTIVE: January 1, 2019

CONTRACT ADMINISTRATOR:

Boon-Chapman Benefit Administrators, Inc.

TABLE OF CONTENTS

ADOPTION OF THE PLAN DOCUMENT	1
ADMINISTRATIVE INFORMATION.....	2
SCHEDULE OF DENTAL BENEFITS.....	4
COVERED DENTAL EXPENSES.....	6
DENTAL LIMITATIONS AND EXCLUSIONS	10
EXTENSION OF DENTAL BENEFITS	11
VISION BENEFITS	11
COORDINATION OF BENEFITS	11
SUBROGATION AND REIMBURSEMENT.....	14
ELIGIBILITY AND EFFECTIVE DATES.....	17
TERMINATION OF COVERAGE	21
CONTINUATION OF COVERAGE OPTION (COBRA).....	22
USERRA CONTINUATION COVERAGE AND REINSTATEMENT	26
CLAIM AND APPEAL PROCEDURES.....	28
DEFINITIONS	33
GENERAL PLAN INFORMATION.....	36
STATEMENT OF RIGHTS OF PARTICIPANTS	38
HIPAA PRIVACY RULE AND SECURITY STANDARDS	40

ADOPTION OF THE PLAN DOCUMENT

Adoption

The Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust ("Trustees") hereby adopts this Plan Document and Summary Plan Description (the "Plan Document") as the written description of the employee welfare benefit plan (the "Plan") that is funded by the San Antonio Police Officers and Firefighters Benefit Trust ("Trust"). This Plan Document continues the Plan, and is a restatement of the prior plan document, together with any amendments to the prior plan document, and is effective on January 1, 2019.

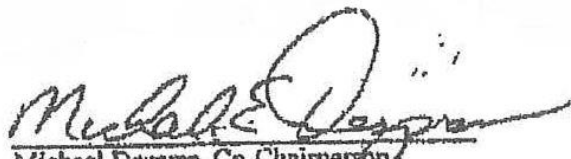
Purpose of the Plan

The Plan is intended to qualify as a voluntary employee's beneficiary association (VEBA) under Section 501 (c)(9) of the Internal Revenue Code of 1986, as amended, and is intended to be a welfare benefit plan, as defined under Employee Retirement Income Security Act of 1974, as amended (ERISA). The purpose of the Plan is to provide dental and vision benefits for Covered Members, Covered Dependents, and Covered Persons.

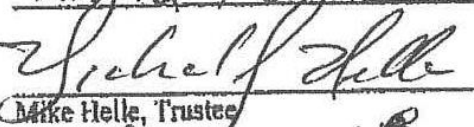
Adoption of the Plan Document

As evidence by the authorized signatures below, and as adopted at a duly held meeting on November 14, 2018, at which a quorum was present, it is HEREBY RESOLVED by the Trustees that the Plan is restated, as set forth below, and effective as of January 1, 2019.

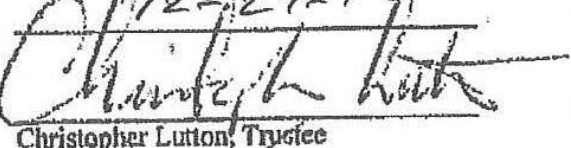
TRUSTEES OF THE SAN ANTONIO POLICE OFFICERS AND FIREFIGHTERS BENEFIT PLAN AND TRUST

By: 
Michael Despres, Co-Chairperson

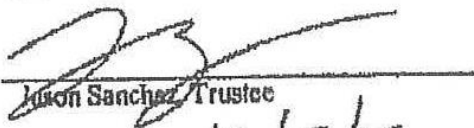
Date: 12-12-18

By: 
Mike Helle, Trustee

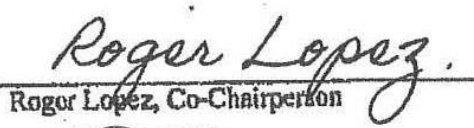
Date: 12-27-18

By: 
Christopher Luton, Trustee

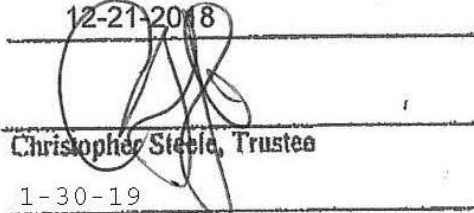
Date: 12-11-18

By: 
Jason Sanchez, Trustee

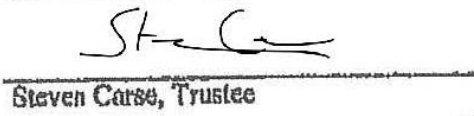
Date: 12/13/18

By: 
Roger Lopez, Co-Chairperson

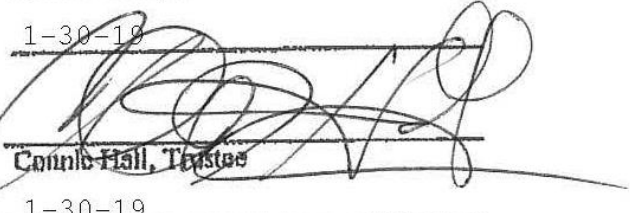
Date: 12-21-2018

By: 
Christopher Steele, Trustee

Date: 1-30-19

By: 
Steven Carse, Trustee

Date: 1-30-19

By: 
Connie Hall, Trustee

Date: 1-30-19

ADMINISTRATIVE INFORMATION

Name of Plan: San Antonio Police Officers and Firefighters Benefit Plan

Plan Sponsor: Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust.

Plan Sponsor ID Number (EIN): 74-2937113

Plan Number: 501

Plan Year: January 1 through December 31

Plan Benefits: Dental and Vision benefits for the eligible employees of the City of San Antonio, Texas and their eligible dependents

Plan Administrator, Named Fiduciaries: The Plan Administrator is the Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust. The members of the Board of Trustees are the Plan's named fiduciaries.

Designated Legal Agent for service of legal process: The Mumey Law Firm, P. L. L. C.
1225 North Loop West, Suite 1000
Houston, Texas 77008

Service of legal process may also be made upon any current Trustee or Board of Trustees.

Contract Administrator: Boon-Chapman Benefit Administrators, Inc.

Street Address of the Contract Administrator and Board of Trustees: 9401 Amberglen Blvd. Building 1, Suite 100
Austin, Texas 78729

Mailing Address of the Contract Administrator and Board of Trustees: P.O. Box 9201
Austin, Texas 78766

Phone number of the Contract Administrator and Board of Trustees: (512) 454-2681 / (800) 936-7689

FAX number of the Contract Administrator and Board of Trustees: (512) 459-1552

Trustees of the Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust:

Michael Despres, Co-Chairperson
1939 NE Loop 410, Suite 300
San Antonio, TX 78217

Mike Helle, Trustee
1939 NE Loop 410, Suite 300
San Antonio, TX 78217

Roger Lopez, Co-Chairperson
8925 IH 10 West
San Antonio, TX 78230

Christopher Steele, Trustee
8925 IH 10 West
San Antonio, TX 78217

Christopher Lutton, Trustee
1939 NE Loop 410, Suite 300
San Antonio, TX 78217

Jason Sanchez, Trustee
1939 NE Loop 410, Suite 300
San Antonio, TX 78217

Steven Carse, Trustee
8925 IH 10 West
San Antonio, TX 78230

Connie Hall, Trustee
8925 IH 10 West
San Antonio, TX 78230

DENTAL BENEFITS

SCHEDULE OF DENTAL BENEFITS

Effective January 1, 2011:

Calendar Year Deductibles:

\$150 Individual – In-Network
 \$250 Individual – Out-of-Network
 \$300 Family – In-Network
 \$500 Family – Out-of-Network

Calendar Year Benefit Maximums

\$2,000 Individual

Lifetime* Orthodontic Benefit

Maximum:

\$1,500 Individual

The following schedule summarizes your dental benefits. Please refer to the remainder of the Plan Document for additional Plan provisions, which may affect your benefits.

Benefit Description	Annual Deductible	Plan Pays	Additional Limitations and Explanations
Preventative Services and Diagnostic Services (Type I)	NO		
In-Network		100%	
Out-of-Network		80%	
Basic Services (Type I)	YES		Subject to the annual calendar year maximum.
Fillings In-Network		80%	
Fillings Out-of-Network		60%	
All Other In-Network		60%	
All Other Out-of-Network		40%	
Major Services (Type II)	YES		Subject to the annual calendar maximum.
In-Network		50%	
Out-of-Network		30%	
Orthodontic Services (Type II)	NO	50%	Subject to the lifetime orthodontic maximum. Orthodontia expenses do not apply toward the annual calendar year maximum.
In-Network and Out-of Network			

***The word "lifetime" refers to the period of time a Covered Person is a participant in this Plan or any other plan sponsored by San Antonio Police Officers and Firefighters Benefit Plan and Trust.**

Type I procedures include covered preventative, diagnostic and basic procedures. Type II procedures include covered major and orthodontic procedures. Both Type I and Type II covered procedures are described in the section entitled "Covered Dental Expenses", below.

General

Dental Benefits provided under this Plan shall be subject to the limitations and exclusions described in this Dental Benefits Section, and to all other terms, provisions, and conditions of this Plan. Except as otherwise stated in this Plan Document, all Dental Benefits shall be paid exclusively for Covered Dental Expenses, subject to the Calendar Year Maximum, the Orthodontic Lifetime Maximum, and any other maximums which may be adopted by the Trustees from time to time.

Free Choice of Dentist

A participant shall have free choice of any legally qualified dentist. If more than one dentist furnishes services or materials for a dental procedure, the Plan shall not be liable for more than its liability had one dentist furnished the services or materials.

About Your Dental Benefits

The Section below, from “Deductibles” to “Benefit Maximums” describes some basic conditions that must be satisfied for this Plan to pay Dental Benefits. These conditions commonly are included in dental benefit plans, but are often overlooked or misunderstood by participants, so it is important that you read them.

Deductibles

A deductible is the amount of Covered Expenses you must pay during a Calendar year before the Plan begins to consider dental care expenses for reimbursement.

Calendar Year Deductible means the deductible to which each Covered Person under this Plan is subject per calendar year for dental Benefits, except that deductibles for Orthodontic Treatment and Preventive and diagnostic procedures, as defined by this Plan, are waived.

Family Deductible means the maximum deductible per calendar year for a Family. After the Family Deductible is met during a calendar year, no further deductible for any Family member shall be required, regardless of the number of persons in the Family. It is calculated as the cumulative sum of all amounts that count toward a Calendar Year Deductible for all Family members; such that the individual Calendar Year Deductible does not have to be met for any Family member as a prerequisite to a Family meeting the Family Deductible, and all amounts that count toward the Calendar year Deductible for any family members are added together to determine if the Family Deductible has been met. The in-network and out-of-network Family Deductibles must be met separately.

The annual individual and family Deductible amounts are shown on the Schedule of Dental Benefits.

Allocation of Deductible

The Plan Administrator reserves the right to allocate the amount of the Deductible to any Covered Dental Expenses, and to apportion the Benefits to the Covered Person and any assignees. Such allocation and apportionment shall be binding upon the Covered Person and all assignees.

Deductible Carry-Over

Covered Expenses incurred in the last three (3) months of a calendar year which were used to meet a participant’s Calendar Year Deductible for that year may be used to meet the Calendar Year Deductible for the immediately following calendar year for that participant.

Co-insurance

Co-insurance percentages represent the portions of Covered Expenses paid by you and by the Plan after satisfaction of any applicable Deductible.

The Plan’s Co-insurance percentages are shown on the Schedule of Dental Benefits. Your co-insurance percentage is the percentage remaining after subtracting the Plan’s from 100%.

Alternative Procedures

If two or more procedures are separately adequate and appropriate treatment for the correction of a specific condition, the amount of the Covered Dental Expenses shall be limited to the charge for the least expensive procedure.

When Expenses Are Incurred

Except as provided otherwise in this paragraph, expenses are considered incurred at the time service is rendered or a supply is furnished. For an appliance, or modification of an appliance, an expense is considered incurred at the time the impression is made. For a crown, bridge, or gold restoration, an expense is considered incurred at the time the tooth or teeth are prepared. For root canal therapy, an expense is considered incurred at the time the pulp chamber is opened.

Benefit Maximums

Total dental payments for each Covered Person are limited to certain maximum benefit amounts. A benefit maximum can apply to specific benefit categories or to all benefits. A benefit maximum also applies to a specific time period, such as annual or lifetime. Whenever the word lifetime appears in this Plan in reference to benefit maximums, it refers to the period of time you participate in this Plan or any other plan sponsored by San Antonio Police Officers and Firefighters Benefit Plan and Trust.

The benefit maximums applicable to the Plan's dental benefits are shown on the Schedule of Dental Benefits.

COVERED DENTAL EXPENSES

Covered Dental Expenses (Type I and Type II)

Covered dental expenses means Reasonable and Customary Charges incurred for the Necessary Care and Treatment of a Covered Person for any of the Type I or Type II procedures described in this Plan Document, or their equivalents. The Trustees may require pre-determination for any Type II procedure in advance of any such procedure being performed, including all Orthodontic Expense Benefits.

Covered Preventative and Diagnostic Services (Type I)

The Plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered preventative services according to all provisions, requirements and limitations of the Plan. Covered Preventative and Diagnostic Services include, and the deductible is waived, for the following:

Visits and Examinations An initial exam; a periodic exam; an emergency exam; prophylaxis for children under age fourteen (limited to two treatments every 365 days); prophylaxis for individuals age fourteen and over, treatment to include scaling and polishing (limited to two treatments every 365 days, or, if more than two are performed in 365 days, payment shall not exceed 80% of the total cost of all treatments in a 365 day period); and topical application of fluoride, including prophylaxis (limited to two treatments every 365 days).

X-rays All film fees for interpretation and diagnosis, except for Injuries, Sickness or Orthodontia; single film; additional films (up to twelve each); entire denture series consisting of at least fourteen films, including bitewings if necessary (limited to once every three years); intra-oral, occlusal view, maxillary and mandibular, each; superior or inferior maxillary, extra-oral, each additional; two bitewing films, including examination (once every six months); four bitewing films, including examination (once every six months); and panoramic survey, maxilla and mandible film (once every three years).

Other Visits and Consultations Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures); professional visit after hours (payment will be made on the basis of the services rendered or the visit, whichever is greater); special consultation fee by a specialist for case presentation when diagnostic procedures have been performed by a general dentist; and emergency palliative treatment, per visit.

Space Maintainers All adjustments within six months after installation; fixed space maintainer, unilateral; fixed space maintainer, bilateral; removable space maintainer, unilateral; removable space maintainer, bilateral; diagnostic casts; removable appliance to correct thumb sucking; fixed or cemented appliance to correct thumb sucking; and office visit for observation, adjustment, and activation, more than six months after installation.

Covered Basic Services (Type I)

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered basic services according to all provisions, requirements and limitations of the plan. Covered Basic Services include, and the deductible is NOT waived for, the following:

Pathology Biopsy of hard oral tissue; biopsy of soft oral tissue; and histopathologic examination.

Oral Surgery:

Extractions Local anesthesia and routine post-operative visits; single uncomplicated extraction; extractions of each additional tooth; surgical removal of erupted teeth; and post-operative visit (sutures and complications) after multiple extractions and impaction.

Impacted Teeth Removal of tooth (soft tissue); removal of tooth (partially bony); and removal of tooth (completely bony).

Alveolar and gingival reconstruction Alveolectomy (without extractions), per Quadrant; alveolectomy (with extraction), per Quadrant; stomatoplasty, complicated, with ridge extension, per arch; removal of exostosis, maxilla or mandible; and excision of hyperplastic tissue, per arch.

Cysts and Neoplasms Intra-oral incision and drainage of abscess; extra-oral incision and drainage of abscess; excision of pericoronal gingiva; sialolithotomy (removal of salivary calculus); closure of salivary fistula; dilation of salivary duct; transplantation of tooth or tooth bud; removal of foreign body from bone (independent procedure); radical resection of bone for tumor with bone graft; maxillary sinusotomy for removal of tooth fragment or foreign body; closure of oral fistula of maxillary sinus; sequestrectomy for osteomyelitis; condylectomy; and meniscectomy.

Miscellaneous Incision and removal of foreign body from soft tissue; frenectomy; suture of soft tissue wound or injury, up to 5 cm; and crown exposure for orthodontia.

Anesthesia General anesthesia or intravenous sedation related to surgical procedures only; not covered if there are no surgical procedures.

Periodontics Subgingival curettage, root planing, per quadrant; correction of occlusion when performed in conjunction with periodontal procedures, per quadrant; gingivectomy (includes post-surgical visits), per quadrant; gingivectomy, osseous or muco-gingival surgery (includes post-surgical visits), per quadrant; gingivectomy, treatment per tooth (fewer than six teeth); periodontal scaling and root planing; periodontal prophylaxis; bone graft; soft tissue graft; tissue regeneration; and crown lengthening.

Endodontics Direct pulp capping; indirect pulp capping; pulpotomy (in addition to restoration), per treatment; remineralization (Calcium Hydroxide, temporary restoration), as a separate procedure only, per tooth; root canals including necessary S-Rays and cultures but excluding final restoration; anterior tooth; bicuspid; molar; apicoectomy (including filling of root canal); and apicoectomy (separate procedure).

Restoration Dentistry Restoration dentistry Benefits excludes inlays, crowns, and bridges, but includes the following:

Sealants Limited to children under age sixteen and to molars and bicuspid, occlusal surfaces only, and limited to one sealant per tooth every two years.

Amalgam Restorations: Primary Teeth Cavities involving one, two, three, or four tooth surfaces.

Amalgam Restorations: Permanent Teeth Cavities involving one tooth surface; cavities involving two tooth surfaces; cavities involving three tooth surfaces; and cavities involving four or more tooth surfaces.

Synthetic Restorations Silicate cement filling; acrylic or plastic filling; composite resin involving one surface; composite resin involving two surfaces; composite resin involving three surfaces; and sedative filling.

Crowns Stainless steel (primary teeth only).

Covered Major Services (Type II)

The plan will provide benefits as outlined on the Schedule of Dental Benefits for expenses considered major services (Type II) according to all provisions, requirements and limitations of the plan.

Full and Partial Denture Repairs Acrylic Broken dentures, no teeth involved; repair denture, replace one missing or broken tooth; replace additional missing or broken tooth, each tooth; replace missing or broken tooth on denture, no other repairs, and partial denture repairs, based on time and laboratory charges.

Restorative Crowns and gold restorations are covered only when necessitated by decay or Injury. Otherwise, the following restorative Benefits are provided:

Inlays One, two, three, or more tooth surfaces; and onlays per tooth, in addition to inlay allowance.

Crowns Plastic (acrylic); plastic with gold; plastic with nonprecious metal; plastic with semiprecious metal; porcelain; porcelain with gold; porcelain with nonprecious metal; semiprecious metal; gold (full); nonprecious metal (full); semiprecious metal (full); 3/4 gold; and gold dowel pin, in addition to crown.

Prosthetics:

Bridge abutments

Pontics Cast gold; cast nonprecious; cast semiprecious; slotted facing; slotted pontic; porcelain fused to gold; porcelain fused to nonprecious metal; porcelain fused to semiprecious metal; plastic processed to gold; plastic processed to nonprecious metal; plastic processed to semiprecious metal; crown retainer-porcelain; and crown retainer fused to non-precious metal.

Implant Services Surgical placement of implant body (endosteal implant) and abutment placement or substitution (endosteal implant). The maximum Benefit available for one or both of these procedures in connection with any tooth or teeth shall not exceed the maximum Benefit otherwise available for the placement of a corresponding fixed bridge, including any necessary attachments.

Removable (Unilateral Bridges) One piece chrome casting, clasp attachments (all types, per unit).

Recementation Inlay; crown; and bridge.

Repairs, crowns, and bridges

Denture and Partial Fees for dentures, partials, and relining include adjustments within six months after installation. No extra benefit is paid for adjustments because the fees for the dentures, partials, and relining include adjustment fees. Cosmetic techniques and characterizations are not Covered Expenses. Covered Expenses shall include expenses for temporary dentures and partials.

Dentures and partials include: Complete upper denture; complete lower denture partial upper with chrome clasps, acrylic base; partial lower with chrome clasps, acrylic base; partial lower, chrome lingual bar and acrylic base; partial upper,

chrome palatal bar and acrylic base; stress breaker; stayplate, upper; stayplate, lower; immediate splint denture, upper; immediate splint denture, lower; adjustment to dentures more than six months after installation; office reline, complete denture; office reline, partial denture; lab reline, complete denture; lab reline, partial denture; special tissue conditioning, per denture; denture duplication (jump case), complete denture; duplicate of denture; partial denture; addition to teeth of partial denture to replace extracted natural teeth; first tooth, without clasp or abutment; first tooth, with clasp or abutment; each additional tooth; and each additional clasp with rest.

Covered Orthodontic Services (Type II)

The Plan will provide benefits, as outlined on the Schedule of Dental Benefits, for expenses related to orthodontic services according to all provisions, requirements and limitations of the Plan.

Orthodontic Benefits A Covered Person must be covered by the Plan for twelve months before becoming eligible for Orthodontic Benefits. If a Covered Person, while covered for Orthodontic Benefits by the Plan, receives Orthodontic Treatment from a licensed doctor of dentistry, the Plan will pay Benefits in accordance with the following:

Orthodontic Treatment "Orthodontic Treatment" means the movement of teeth by means of active appliances to correct a functional malocclusion, i.e. a malocclusion which interferes with chewing, swallowing or speech, including any one of the following: overbite or overjet; maxillary and mandibular arches in either protrusive or retrusive relation; cross bite; overcrowding of teeth; and all related diagnostic procedures and materials, including x-rays for orthodontic purposes.

Treatment Program "Treatment Program" or "Program" means an interdependent series of orthodontic services prescribed by a licensed doctor of dentistry for orthodontic treatment. A Treatment Program shall begin with generally accepted required diagnostic procedures and shall end when the services are done, or after 24 consecutive months starting with the day the appliances were inserted, whichever is earlier.

Amount of Benefits the Orthodontic Lifetime Maximum for anyone Covered Person shall be subject to the following maximum payment limits:

This Plan will pay one half (50 percent) for any Beginning of Treatment Program Charge, up to a maximum of \$500. "Beginning of Treatment Program Charge" means a provider's initial charge imposed before a Treatment Program is begun or as it is beginning.

For any Monthly Course of Treatment Payment, this Plan will pay the amount monthly which is equal to the amount obtained by subtracting this Plan's portion of any Beginning of Treatment Charge from the Orthodontic Lifetime Maximum, and dividing the remainder by the number of months scheduled by the provider for the Treatment Program. No Monthly Course of Treatment Payment will be made for any month following the month in which the Orthodontic Lifetime Maximum is met or the Treatment Program ends, whichever occurs first. "Monthly Course of Treatment Payment" means a monthly payment for a provider's services rendered under a Treatment Program.

Expenses Incurred An orthodontic expense shall be considered incurred as follows:

For insertion of active appliances: on the date of insertion.

For a service rendered to a person who does not pursue a Program: on the date the service is rendered.

For a person who pursues a Program: at the end of each calendar month of a Program, but not beyond the date the Program ends.

Program Payments With the exception of fees for the initial insertion of active appliances, Covered Expenses and Benefits for a Program shall be based on the estimated cost of the Covered Person's Program, and shall be prorated monthly over the estimated length of the Program, but not for more than a total of 24 consecutive months. The last monthly payment for a Program may be changed if the estimated and actual costs of the Program differ.

Coverage Termination If an individual's Coverage terminates during the course of the individual's Program, the total Benefit shall be equal to the sum of only those monthly Benefits which came due while the individual was a Covered Person.

DENTAL LIMITATIONS AND EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this "Dental Limitations and Exclusions" section. This list is intended to give you a general description of expenses for services and supplies that are not covered by this Plan. The Plan only covers those expenses specifically described as covered in the preceding "Schedule of Dental Benefits" and "Covered Dental Expenses" Sections. There may be expenses in addition to those listed below which are not covered by the Plan. Plan benefits will not be paid for any expenses incurred, as follows:

For any treatment which is primarily for cosmetic purposes or for the correction of congenital malformations. Facings on crowns or pontics beyond the second bicuspid are considered cosmetic;

For the replacement of any prosthetic appliance, crown, inlay or onlay restoration, or fixed bridge within five years of the date of the last placement for any such item, unless replacement is required for a person: (i) as a result of Injury sustained by him or her while a Covered Person; or (ii) for reasons other than a defect of such prosthetic appliance, crown, inlay, onlay, or fixed bridge;

For any procedure begun: (i) before the Covered Person was covered under this Plan; (ii) after such individual's status as a Covered Person terminates; or (iii) for any prosthetic dental appliance finally installed or delivered more than 30 days after termination of the individual's status as a Covered Person;

For the replacement of lost, misplaced, or stolen appliances;

For appliances, restorations, or procedures to alter vertical dimension, restore or maintain occlusion, splint or replace tooth structure lost as a result of abrasion or attrition, or treat disturbances of the temporomandibular joint;

In connection with an Injury arising out of or in the course of any employment for wage or profit;

By an individual in connection with a Sickness for which he or she is entitled to benefits under any Workers' Compensation Act or similar legislation;

For which the individual is not legally required to pay or which would not have been made had no Coverage existed;

For services which do not qualify as Necessary Care and Treatment;

In connection with war or any act of war, whether declared or undeclared;

For any procedure or other item not included in the "Schedule of Dental Benefits" and "Covered Dental Expenses" Sections of this Plan Document. This exclusion shall not apply to any procedure or item which is the equivalent of a procedure or item included in the "Schedule of Dental Benefits" and "Covered Dental Expenses" Sections, as determined by the Trustees;

For education or training in, and supplies used for, dietary or nutritional counseling, personal oral hygiene, or dental plaque control;

For missed appointments or the completion of claim forms;

Which exceed Reasonable and Customary Charges;

Which are for dental care furnished by or through (i) a Health Maintenance Organization, or similar organization; or (ii) the United States Government or any political subdivision thereof;

Which are for dental care that does not meet the standards established by the American Dental Association;

Expenses related to services or supplies of the type intended for sport or home use;

For over dentures, including root canal therapy and supportive restorations;

In connection with orthodontic treatment of a person before that person is a Covered Person for at least twelve consecutive months;

After the Covered Person's coverage terminates, except as provided in section below;

For which payment under this Plan is prohibited by any law of the jurisdiction in which such person is living at the time the expenses are incurred;

For any services other than services performed by a Physician, or by a dental student or dental hygienist working under the direct supervision of a Physician; and

For services or supplies, including drugs and medicines, furnished by a hospital or other facility, except a dental school.

EXTENSION OF DENTAL BENEFITS

Dental charges incurred by a Covered Person for dental care furnished within 30 days after termination of the individual's status as a Covered Person shall be considered Covered Expenses, according to the terms of the Dental Care Benefits, if such charges would otherwise be payable, and:

the service involves an appliance, or modification of an appliance, for which the impression was taken prior to the termination of the individual's status as a Covered Person;

the service involves a crown, bridge or gold restoration for which the tooth was prepared prior to the termination of the individual's status as a Covered Person; or

the service involves root canal therapy for which the pulp chamber was opened prior to the termination of the individual's status as a Covered Person; and

the procedure is completed within 30 days after termination of the individual's status as a Covered Person.

Payment shall be made under this section only to the extent the Covered Person is not otherwise entitled to payment under any other like dental coverage of any type or source.

VISION BENEFITS

Vision benefits under this Plan shall be provided to Covered Members, Covered Dependents, and Covered Persons through the Ameritas Fully-Insured Focus® VSP. The vision benefits provided are more specifically described in the Ameritas Fully-Insured Focus® VSP Summary Plan Description.

COORDINATION OF BENEFITS

Notwithstanding any other provision of this Plan, all Benefits with respect to a Covered Person, including, but not limited to, lifetime maximum limitations and deductible provisions, shall be coordinated with the benefits received by the Covered Person under any other program of benefits.

Notwithstanding any other provision of this Plan, if the other plan contains no provision for coordination of benefits, that plan shall be primary and this Plan shall be secondary.

This Plan's maximum expenditure amount under this "Coordination of Benefits" Section shall be the amount the Plan would have paid as a secondary Plan if the other plan has a limitation of coverage that shifts primary payment responsibility to this Plan for benefits that, without such limitation, would have been covered under the other plan.

For Covered Expenses incurred by a Covered Member who is covered under another plan as a dependent, this Plan shall be primary and the other plan secondary; except that: if the person is also a Medicare beneficiary, and as a result of the rule established by Title XVIII of the Social Security Act and implementing regulations, Medicare is (i) secondary to the plan covering the person as a dependent and (ii) primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the plan covering the person as a dependent shall be primary and the plan covering that person as other than a dependent shall be secondary. When Medicare is to be the primary payer, this Plan shall base its payment upon benefits that would have been paid by Medicare under Parts A and B, regardless of whether or not the person was enrolled under both of those parts.

For Covered Expenses incurred by a Covered Person when covered by another plan as a laid off or retired employee, or as the dependent of such employee, this Plan shall be primary and the other plan shall be 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.

Covered Expenses under this "Coordination of Benefits" Section include only those expenses for which the Covered Person has completed all necessary steps for payment by the other plan. This Plan will not consider expenses Covered Expenses if the other plan does not pay for the expenses because the Covered Person did not complete such steps. In such a case, this Plan will consider expenses as Covered Expenses only to the extent that such expenses would have been billed and payable under the provisions of this Plan had the Covered Person completed all such steps with the other plan.

When this Plan provides COBRA continuation coverage for a Qualified Beneficiary who is covered under another plan, this Plan shall be secondary and the other plan, if it covers that same person as an active employee or the dependent of an active employee, shall be primary. In such a case, however, this Plan shall be primary for a preexisting condition to the extent such condition is excluded under the other plan. 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.

For Covered Expenses incurred by a Dependent who is covered under another plan as an employee or member, the other plan shall be primary and this Plan shall be secondary.

If a Child is covered under plans of both parents, of which this Plan is one, then the plan covering the parent whose birthday, excluding year of birth, falls earlier in the calendar year shall be primary and the plan of the other parent secondary. If the other plan has a rule based on the gender of the parent, and if, as a result, the plans do not agree on the order of benefit, the rule based on the gender of the parent shall determine the order of benefits. However, when parents are separated or divorced, the primary plan for the Dependent Child shall be the plan of the parent who has custody of the Child. Secondary liability for the Dependent Child rests with the plan of the stepparent who has custody of the Dependent Child, and will be determined before the plan of

the parent who does not have custody of the Child.

If the specific terms of a divorce decree state which parent has responsibility for the medical expenses of a Dependent Child, then the plan of that parent shall be primary and the plan of the other parent shall be secondary.

If the specific terms of a divorce decree state that the parents shall share joint custody, without stating that one of the parents is responsible for the health care expenses of the Child, the plans covering the Child shall follow the rule outlined in Section above.

When none of the rules stated above are determinative for a person, the plan which has covered that person continuously for the longer period of time shall be primary.

Definitions

Allowable Expenses means the Reasonable and Customary Charges incurred by a Covered Person, all or a portion of which is covered under at least one of the plans covering that Covered Person. When a plan provides benefits in the form of services rather than cash payments, the Reasonable and Customary cash value of each service rendered shall be considered both Allowable Expenses and a Benefit Charge.

Claim Determination Period means a calendar year or that portion of a calendar year during which a person was covered under a plan.

Plan when not capitalized in this Section, means any of the following which provide benefits for, or services in the form of, medical, vision, or dental care or treatment:

group insurance or any other arrangement of coverage persons in a group, including health maintenance organizations ("HMOs"), whether on an insured or uninsured basis;

coverage on a group basis through Blue Cross, Blue Shield or any other prepayment plan;

any coverage for students which is sponsored by, or provided through, a school or other educational institution;

any coverage under government programs, and any other coverage required or provided by any statute; or

any coverage under "No-Fault" Auto Insurance, by whatever names it is called.

Primary means that this Plan provides Benefits without regard to payment by any other plan.

Secondary means that this Plan pays Benefits and adjusts payment so that the total of benefits available from this Plan and any other plan will not exceed 100% of Allowable Expenses.

Amount of Benefits

The total amount of Benefits payable under this Plan for expenses incurred or services provided for a Covered

Person during any Claim Determination Period, shall not exceed the amount which would be payable under this Plan in the absence of this "Coordination of Benefits" Section; or, if this Plan is secondary, the total Allowable Expenses less the benefits payable under all other plans.

Right of Recovery

The Plan shall have the right to recover any payment made in excess of its obligation as determined by this "Coordination of Benefits" Section from among one or more of the following: any person, health care provider, insurer, organization, or other person or entity that the Trustees deem appropriate, including the person to or for whom such payment was made.

SUBROGATION AND REIMBURSEMENT

Rights to Subrogation and Reimbursement

The Plan shall have subrogation and reimbursement rights if a Covered Person suffered an injury or illness for which any Other Party is legally liable, and benefits are payable to or on behalf of the Covered Person under the Plan for such injury or illness. The Plan shall be subrogated to all the rights of recovery of a Covered Person against any Third Party. The Plan has the right to be reimbursed from the proceeds of any settlement, judgment, award, or other payment obtained by the Covered Person from or on behalf of any Third Party.

Definitions

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

Covered Person shall mean the person to whom or for whom benefits are payable or are paid under the Plan and includes that person's guardian, agent, personal representative, attorney, payee as defined in General Plan Information Section, and/or other agent or representative.

Third Party or Other Party shall mean any person or entity other than the Covered Person to whom or for whom benefits are payable or paid under the Plan, including, but not limited to, any insurance company, business, corporation, government agency, attorney, or other person or entity.

Legal Claim for Damages Asserted by Covered Person

If the Covered Person asserts any legal claim for damages, sues, or takes other legal action to recover for the injury or illness for which benefits are payable, the Plan can join or intervene in the claim, suit, or action. The Covered Person must allow joinder or intervention of the Plan in any such claim, suit, or action. The Covered Person's claim[s] or damages must include the amount of benefits payable or paid to or on behalf of the Covered Person under the Plan's provisions. The Plan is not obligated to intervene or record any notices of liens to preserve its subrogation and reimbursement rights.

Plan's Right to Assert Legal Claim against Third Party

If the Covered Person does not promptly attempt to recover the benefits paid by the Plan or which the Plan may be obligated to pay, the Plan is entitled to sue or take other legal action against the responsible party or parties in the Covered Person's name, in the Plan's name, or in the Trustees' names. The Plan may prosecute claims, suits, or other actions against any Third Parties and/or Other Parties potentially liable to the Covered Person to recover monies paid or owed by the Plan. If requested in writing by the Plan, the Covered Person shall take, either on his or her own behalf or through any representative designated by the Plan, any action that may be necessary or appropriate to recover payment. The Plan may file a lien with the person or entity that is responsible for the illness or injury, with the responsible party's agent or with a court

having jurisdiction in the matter.

Scope of Plan's Right to Recovery

If the Covered Person recovers against any Third Party legally responsible for the injury or illness for which benefits were paid or payable under this Plan, the Plan shall be reimbursed out of the first funds of such recovery or payment received by or on behalf of the Covered Person, regardless of how those sums are characterized and regardless of whether the recovery is large enough to make the Covered Person whole for his or her loss.

The Plan's rights of subrogation and reimbursement shall be "First Dollar" and first priority rights and shall be an automatic prior lien against any proceeds recovered by the Covered Person. The Plan is entitled to reimbursement of the full amount of the benefits paid or payable by the Plan. The Plan is also entitled to reimbursement of the attorney's fees, costs and expenses incurred by the Plan in enforcing its subrogation and reimbursement rights. The Plan's rights shall not be defeated or reduced by the application of any so-called "make-whole doctrine," any doctrine purporting to defeat the Plan's recovery rights by allocating the proceeds to non-medical expense damages, or any law or legal theory that attempts to limit, reduce, or eliminate the Plan's subrogation and reimbursement rights. The Plan the right to be reimbursed from any payment, regardless of whether it is designated as payment for medical expenses, pain and suffering, emotional distress, lost compensation, lost earning capacity, any other specified damages, attorney's fees, or any other item.

A Covered Person shall not incur attorney's fees, costs or expenses on behalf of the Plan. The Plan shall not be responsible for the payment of any of the Covered Person's attorneys' fees, costs, and expenses, on a pro rata basis or otherwise, without the Trustees' prior written consent. No attorney's fees, costs, or expenses may be deducted from the Plan's recovery, unless the Trustees, in their sole discretion, give their prior express written consent. This right shall not be defeated by a "common fund doctrine" or any other doctrine.

Amounts recovered in excess of the Plan's reimbursement, attorney's fees, and costs shall be paid to the Covered Person, but such excess shall apply as a credit against the liability of the Plan for further payment to or on behalf of the Covered Person, which has arisen or may arise from the injury or illness that forms the basis of the claim asserted by or on behalf of the Covered Person.

Obligations of Covered Person

The Covered Person is obligated to do whatever is requested by the Plan to secure the Plan's rights to subrogation and reimbursement. The Covered Person is further obligated to avoid doing anything that would prejudice the Plan's rights. The Covered Person's obligations include, but are not limited to, the following:

to furnish all information requested by the Contract Administrator;

to notify the Contract Administrator of any claim for damages made by or on behalf of the Covered Person in connection with the injury or illness;

to complete, sign and deliver to the Contract Administrator a legally enforceable subrogation and reimbursement agreement acceptable to the Trustees;

to complete, sign and deliver all other documents or papers requested by the Contract Administrator;

to take any action or give any other assistance requested by the Contract Administrator or Trustees to enforce the Plan's subrogation and reimbursement rights;

to notify the Trustees and obtain their prior written approval of any proposed settlement or release of the Covered Person's claims; and

to notify the Contract Administrator and obtain the Trustees' prior written approval of any agreement to distribute any recovery or payment to trusts, including a special needs trust, to third parties, including the Covered Person's attorneys, or to accounts or other entities not in the control of the Covered Person.

Payment of Benefits Conditioned on Covered Person's Performance of Obligations

If the Covered Person fails or refuses to complete and sign subrogation and reimbursement agreement or any other document required by the Contract Administrator or Trustees, fails or refuses to provide any requested information, fails to assist the Plan in connection with its subrogation and reimbursement rights, or otherwise fails to perform any obligations described in this Section, the Plan may withhold payment of benefits. A claim will be considered incomplete and may be denied if a subrogation and reimbursement agreement and/or any request for information is not timely returned. If the Employee or Dependent is a minor or otherwise incapacitated, his or her parent, legal guardian, or legal representative is responsible for fulfilling the obligations set forth in this Section.

Plan's Right to Seek Reimbursement

If a Covered Person refuses or fails to reimburse the Plan in accordance with this "Subrogation and Reimbursement" Section, the Plan may take any available legal action against the Covered Person or any Third Party or entity that has possession, custody, or control over funds recovered by or on behalf of the Covered Person to recover the benefits payable or paid, including, but not limited to, an action for a constructive trust. At its discretion, the Plan may withhold benefit payments or deduct the amounts owed from future benefits payable to the Covered Person and any other Dependent of the Covered Member, whether or not related to the injury or illness in question, including payments for unrelated subsequent or previously existing claims, in order to satisfy its reimbursement and subrogation rights. The Plan is entitled to payment of all reasonable costs and expenses, including attorney's fees, which are incurred or expended in attempting to obtain reimbursement under this "Subrogation and Reimbursement" Section, plus pre-judgment and post-judgment interest.

Miscellaneous

The rights to subrogation and reimbursement apply to payments made to or on behalf of the Covered Person under his or her own insurance coverage, including automobile, uninsured or underinsured motorist, homeowner's, renter's, property, business or any other liability insurance coverage. However, to the extent that payments from other coverage sources are subject to the Coordination of Benefits provisions of the Plan, those provisions apply, including Coordination of Benefits Section regarding the Plan's right of recovery.

The Trustees shall have the absolute discretion to settle claims on any basis they deem warranted and appropriate under the circumstances.

The Plan's subrogation and reimbursement rights exist regardless of whether benefit payments have been made.

If services or goods, rather than a cash payment, have been or are due to be provided as a benefit under the Plan, the Plan has the right to recover the reasonable cash value of the services or goods.

The Plans' subrogation and reimbursement rights shall apply to any payments made to the Covered Person or to persons or entities, other than the Covered Person, including the Covered Person's spouse, dependent, parent, heir, guardian, personal representative, or other agent or representative, by a Third Party because of the Third Party's responsibility for the injury or illness of the Covered Person for which benefits have been paid or are payable under the Plan.

The Plan is entitled to reimbursement of all expenses, costs, and attorneys' fees incurred by it in connection with the prosecution and collection of the Plan's subrogation and reimbursement interests.

ELIGIBILITY AND EFFECTIVE DATES

Members

“Member” means a person who is not yet entitled to Benefits because the eligibility requirements described in the Section entitled “Eligibility and Coverage Effective Date – Members and Dependents, Except for New Dependents”, below, have not been met, and who is:

A member of a bargaining unit covered by a collective bargaining agreement between an employer and an Association that requires contributions to the Trust;

An employee of an Association, provided the Association has entered into a participation agreement with the Trustees or Trust;

A peace officer as such term is defined by the legislature of the State of Texas, or a firefighter, who is employed by a political subdivision of the State of Texas, which has entered into a participation agreement with the Trustees or Trust;

An employee of the San Antonio Police Officers and Firefighters Prepaid Legal Plan and Trust (“Legal Plan”), provided the Legal Plan has agreed to participate in this Plan, in a manner approved by the Trustees.

“Covered Member” means a person who has reached the Coverage Effective Date, described below in the Section entitled “Eligibility and Coverage Effective Date – Members and Dependents, Except for New Dependents”.

Dependents

“Dependent” means a person who is:

The Spouse of a Member or Covered Member;

The Child of a Member or Covered Member provided the Child is one or more of the following:

A Child, or descendant of such a Child, who, during the applicable calendar tax year: (i) lived with the Member or Covered Member for more than half of the year, except in the case of missing children, as specified in Internal Revenue Code Section 152(f); (ii) did not provide more than half of his or her own support, (iii) did not file a joint return with his or her spouse; (iv) was younger than the Member or Covered Member; (v) was less than the age of 19 years; or less than the age of 24 years through the end of the most recent, verified full-time school attendance period, unless a Medically Necessary Leave of Absence applies, in which case the provision below entitled “Student Dependent’s Medically Necessary Leave of Absence from School” controls; and (vi) as may otherwise be provided under Internal Revenue Code §152(c); or

A Child, or descendant of such a Child, under the age of 19, during the applicable calendar tax year: (i) for whom the Member or Covered Member provided over one-half of the Child's support for the year; (ii) who is not a qualifying child, as otherwise described in this “Eligibility Requirements –

Dependents” Section, of the Member, Covered Member or any other taxpayer for the year; (iii) whose gross income for the calendar year is less than the exemption amount provided by the Internal Revenue Code; and (iv) who did not file a joint return with his or her spouse; or

A Child of any age who, during the applicable calendar tax year: (i) was permanently and totally disabled, (ii) lived with the Member or Covered Member for more than half of the applicable calendar tax year, (iii) was primarily dependent upon the Member or Covered Member for support, and (iv) did not file a joint return with his or her spouse.

Each Dependent Child of parents who both are Members shall be considered the Dependent of one or the other, but not both. "Dependent" does not include any person who is: (i) eligible for Coverage as a Member; (ii) not a citizen or national of the United States, unless such individual is a resident of the United States or a country contiguous to the United States; or (iii) on active duty with the armed forces of any country or international authority.

In order for the Plan to provide all the benefits available, the Contract Administrator must be notified if:

You need to add Dependents to your Plan coverage (please submit certified copies of the birth or adoption certificates).

You experience a divorce or legal separation (please submit court certified divorce/legal separation papers).

You marry (please submit a certified copy of the marriage license or a certificate of common law marriage).

You or a Dependent die (please submit a certified copy of the death certificate).

A dependent ceases to be an eligible Dependent (for example, the dependent gets a job, turns age 19, is 19 but less than 24 years old and is no longer a full-time student and does not qualify for a medical leave of absence as provided in this booklet, or marries).

“Covered Dependent” means a Dependent of a Covered Member.

Eligibility and Coverage Effective Date – Members and Dependents, Except for New Dependents

Except for a New Dependent, subject to receipt by the Contract Administrator of the required City, Association, or Legal Plan contributions on behalf of a Member, a Member, and any Dependent of a Member whom the Member enrolls, become eligible for Benefits upon the Coverage Effective Date. The “Coverage Effective Date” means the first day following both (A)(i) the Member's graduation date from the police or firefighter's academy for cadets, or (ii) the hire date for all other Members, and (B) the Contract Administrator's receipt of the Member's Plan enrollment form providing the information the form requests concerning the Member and concerning any Dependent of the Member whom the Member is enrolling.

Eligibility and Effective Coverage Date — New Dependents

Concerning a Covered Member's Dependent who was not enrolled on the Covered Member's Coverage Effective Date, the Dependent becomes eligible for Benefits upon the New Dependent Coverage Effective Date. The "New Dependent Coverage Effective Date" means:

For an individual who first becomes a Dependent of the Covered Member after the Covered Member's Coverage Effective Date due to marriage, birth, adoption, placement for adoption, or other event resulting in the individual becoming a Dependent of the Covered Member, the date on which the individual becomes the Covered Member's Dependent, if, within 60 days after that date, the Contract Administrator receives the Plan's enrollment form providing the information requested on the form concerning the Covered Member and the new Dependent. If that

enrollment form is provided after that 60 days, then the New Dependent Coverage Effective Date will be the first day of the month following the date on which that form is received by the Contact Administrator.

The soonest administratively feasible date after the Contract Administrator determines that Benefits must be provided for a Dependent under the terms of a Qualified Medical Child Support Order.

For any of the following, the first day of the month following the date on which both (i) any of the following events occurs and (ii) the Contract Administrator receives the Plan's enrollment form providing the information requested on the form concerning the Covered Member and the Dependent:

Concerning a Dependent who has other dental or vision coverage that is not COBRA continuation coverage: (a) the other health coverage terminates as a result of Loss of Eligibility (defined below); or (b) current or former employer contributions towards the Dependent's coverage terminate.

Concerning a Dependent who has dental or vision coverage under a different welfare plan that is COBRA continuation coverage, such coverage is exhausted. This includes an individual who has a Loss of Eligibility, does not enroll in this Plan, and instead elects and exhausts COBRA continuation coverage under a different welfare plan.

The Covered Member or the Covered Member's Dependent becomes eligible to participate in a state-sponsored premium assistance program under Medicaid or State Children's Health Insurance Program ("CHIP").

For purposes of the New Dependent Coverage Effective Date, "**Loss of Eligibility**" means the date of:

Loss of eligibility under other health coverage as a result of legal separation, divorce, cessation of dependent status (such as attaining the maximum age to be eligible as a dependent child under the other plan); death of an employee; termination of employment, or reduction in the number of hours of employment; or loss of eligibility after a period that is measured by reference to any of these;

Concerning coverage offered, in either (i) the individual market or (ii) the group market when no other benefit package is available to the individual, through a health maintenance organization ("HMO"), or other arrangement that does not provide benefits to individuals who no longer reside, live, or work in a service area, a loss of coverage because the individual no longer resides, lives, or works in the service area (whether or not within the choice of the individual);

An individual incurring a dental or vision claim that exceeds the lifetime limit on such benefits under other dental or vision coverage;

A plan no longer offering any benefits to a class of similarly-situated individuals, as defined in 26 C.F.R. §54.9802-1(d), that includes the individual; or

The date on which the Dependent loses eligibility for Medicaid or CHIP coverage.

Loss of Eligibility does not include a loss based upon the non-payment or untimely payment of premiums or termination of coverage for cause, as described in 26 C.F.R. §54.9801-6.

Student Dependent's Medically Necessary Leave of Absence from School

A Dependent Child who was a Covered Dependent under the Plan as a full-time student immediately before the date on which a Medically Necessary Leave of Absence began, shall continue to be a Covered Dependent for the shortest of either (i) one year after the date on which the Medically Necessary Leave of Absence began, or (ii) the date on which the Dependent Child attained the age of 24. This extension of Coverage shall apply only if the Contract Administrator receives written certification from the treating physician which states that the Dependent is suffering from a serious illness or injury and that the leave of absence or change in enrollment is medically necessary. A change in the Coverage of the Covered Member to another form of Coverage under the Plan, such as COBRA coverage, shall not shorten or extend the period during which the Dependent's Coverage extension under this provision applies.

A "Medically Necessary Leave of Absence" means a leave of absence from or other change in enrollment at a post-secondary educational institution which begins while a Dependent Child is suffering from a serious illness or injury, is medically necessary, and would cause the Dependent Child to lose student status under the Plan in the absence of this provision.

No Dual Coverage under this Plan, and No New Effective Date

No person shall have both COBRA or USERRA continuation coverage and non-COBRA or non-USERRA Coverage under this Plan at the same time. Regardless of any other provision in this Plan, if a person has COBRA or USERRA continuation coverage under this Plan on the day before the individual's Coverage would otherwise begin, the change from COBRA or USERRA continuation coverage to Coverage shall not result in a new effective date of Coverage under the Plan.

Other Provisions Relating to Effective Dates

A Covered Person's effective date of Coverage shall not change upon the occurrence of any of the following:

Upon the Covered Person becoming a Dependent of another Covered Person who has Dependent Coverage;

Upon the Covered Person becoming a Dependent of another Covered Person who has no Dependent Coverage, provided that the other Covered Person satisfies the enrollment requirements for the Covered Person who becomes a Dependent;

Upon the Covered Person's status changing from Dependent to Covered Person; or

Upon, if a Covered Person is a Dependent Child, his or her coverage terminating by one Covered parent, and the Dependent Child being enrolled by the other Covered parent by submission of an enrollment form.

Family and Medical Leave Act of 1993 (FMLA)

Coverage under this Plan shall continue during a Covered Member's FMLA leave of absence, on the same terms as Coverage was provided immediately before the first day of the FMLA leave, and as otherwise required by the Department of Labor. Any changes in this Plan while a Covered Member is on FMLA leave shall apply to the Covered Member and his or her Covered Dependents as if the Covered Member were not on leave.

Qualified Medical Child Support Order (QMCSO)

If an order is issued by a court or through an administrative process under state law that requires you to carry dental or vision coverage for your Child(ren), the Trustees or their designee will determine if the court order is a Qualified Medical Child Support Order ("QMCSO") as defined by federal law, and that determination will be binding upon you.

Compliance

This Plan shall comply with any QMCSO, as that term is defined by ERISA Section 609, 29 U.S.C. §1169.

QMCSO Procedures

This Plan has procedures in place to determine if a medical child support order or National Medical Support Notice is a qualified medical child support order. Such procedures shall comply with the requirements of ERISA Section 609, 29 U.S.C. §1169, and any applicable federal laws or regulations. Any participant or beneficiary may obtain a copy of these procedures, without charge, upon request to the Plan Administrator.

Qualifications

To be qualified, an order must contain specific information, must be submitted to the Contract Administrator, and must be approved by the Plan Administrator or its designee. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires the Plan to provide coverage for a Child of a Member who is not Covered by the Plan.

Notice

If an order is determined to be a QMCSO, and if you are eligible for Plan benefits, the Contract Administrator or its designee will so notify you, the custodial parent or legal guardian, any designated representative of the Child(ren), and each Child. The Contract Administrator will advise you and the other parties of the Plan's procedures that must be followed to provide coverage for the Child(ren).

Keep the Plan Informed

For the Plan to provide all the Benefits available to a Covered Person, you or your representative must notify the Contract Administrator if:

You need to add new Dependents to your Plan coverage (please submit certified copies of the birth or adoption certificates).

You experience a divorce or legal separation (please submit court certified divorce/legal separation papers).

You marry (please submit a certified copy of the marriage license or a certificate of common law marriage).

You or a Dependent die (please submit a certified copy of the death certificate).

A dependent ceases to be an eligible Dependent (for example, the dependent gets a job, turns age 19, is 19 but less than 24 years old and is no longer a full-time student and does not qualify for a Student Dependent's Medically Necessary Leave of Absence from School or marries).

TERMINATION OF COVERAGE

Member Coverage Termination

A Covered Member's Coverage under this Plan shall terminate upon the earliest of the following:

the date of termination of the Plan;

the end of the calendar month during which he or she ceases to be a Covered Member;

the last day of the most recent period for which any required contribution for the Covered Member's Coverage has been made, if such contribution ceases;

the last day of the most recent period for which any required COBRA or USERRA Continuation Coverage premium payment has been made, if such premium payments cease; or

the date the Contract Administrator receives a request in writing signed by the Covered Member to terminate the Coverage, or the date specified in such writing.

Dependent Coverage Termination

A Covered Dependent's Coverage under this Plan shall terminate upon the earliest of the following:

the date of termination of the Plan;

the last day of the most recent period for which any required contribution for that Coverage has been

made, if contributions cease;

the end of the calendar month during which the Covered Dependent ceases to be a Dependent as defined in this Plan;

the last day of the most recent period for which any required COBRA or USERRA Continuation Coverage premium payment has been made, if such premium payments cease; or

the date the Covered Member's Coverage terminates.

Disabled Child

"Disabled Child" means a Covered Member's Dependent Child who is physically or mentally unable to earn a living and is primarily dependent upon the Covered Member for support and maintenance. If a Disabled Child reaches the age at which he or she would otherwise cease to be a Dependent, this Plan shall continue to consider the Disabled Child as a Dependent while he or she remains a Disabled Child if the Member submits to the Contract Administrator proof of the Disabled Child's incapacity to earn a living. The Trustees shall have the right to require satisfactory proof of continuance of the incapacity of a Disabled Child and the right to require a medical examination of such Child, but not more than once a year. Upon failure to submit such required proof or to undergo such an examination when requested, or when such Child ceases to be so incapacitated, Coverage with respect to that Child shall cease. Continuance of coverage shall be subject to all provisions of this Plan relating to termination of Coverage, except as modified in this section.

Survivor Benefit

Regardless of any other provision of this Plan to the contrary, if a Covered Member is killed while performing his or her duties as a peace officer or firefighter, the Plan Coverage in effect at that time for the Covered Member's Dependents shall continue while this Plan is in force, at no cost to those Dependents, for a period of 12 consecutive months. At the end of such period, the Coverage for those Dependents shall terminate, subject to COBRA Continuation Coverage and USERRA Continuation Coverage and Reinstatement.

CONTINUATION OF COVERAGE OPTION (COBRA)

COBRA Continuation Coverage

A Qualified Beneficiary may elect to continue Coverage upon the occurrence of a Qualifying Event. (The definitions of capitalized terms specific to this "Continuation of Coverage Option" Section are at the end of this Section. The definitions for all other capitalized terms are in the Definitions Section near the end of this Plan Document.)

Type of Coverage

This Plan provides the same Coverage and enrollment opportunities to a Qualified Beneficiary that it provides to all Covered Persons.

Effective Date of COBRA Continuation Coverage

If the notice and election requirements of the Sections entitled "Member and Qualified Beneficiary Notice Requirements" and "Election Procedure", below, are met, then COBRA continuation coverage becomes effective retroactively to the date Coverage would otherwise have ended. However, if, during an election period described in the "Election Procedure" Section, a Qualified Beneficiary waives COBRA continuation coverage and later revokes that waiver within the election period, the continuation coverage will be effective as of the postmark date of a written notice to the Contract Administrator revoking the waiver.

Duration of COBRA Continuation Coverage

No Qualifying Event can give rise to COBRA continuation coverage that ends more than 36 months after the date of the first Qualifying Event. COBRA continuation coverage shall end as of the earliest of the following dates:

The last day of the Maximum Coverage Period;

The first day of any period for which a required payment for a Qualified Beneficiary is not made as specified in the "Payment for COBRA Continuation Coverage" Section below;

The date this Plan ceases to exist;

The first date, following election of COBRA continuation coverage, on which the Qualified Beneficiary first becomes: (i) covered by another group health plan with dental or vision benefits which does not contain any exclusion or limitation with respect to any preexisting condition of the Qualified Beneficiary, unless such limitation or exclusion does not apply to, or is satisfied by, the Qualified Beneficiary due to Creditable Coverage; or (ii) enrolled in Medicare Part A or B, whichever occurs earlier, and subject to any other federal laws that apply; or

If a Qualified Beneficiary is entitled to a Disability Extension, the later of: (i) either 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination by the SSA that the disabled Qualified Beneficiary is no longer disabled, whichever is earlier; or (ii) the end of the Maximum Coverage Period that applies to the Qualified Beneficiary without regard to the Disability Extension.

Payment for COBRA Continuation Coverage

A person electing COBRA continuation coverage must pay to the Contract Administrator on a monthly basis the entire amount due for such coverage, subject to the following rules:

The amount due shall be no more than 102% of the actual monthly cost if a Disability Extension does not apply;

The amount due during a Disability Extension shall be no more than 150% of the monthly cost for each month of coverage after the initial 18-month period, if the coverage would not be required to be made available in the absence of a Disability Extension. Thus, if a Qualified Beneficiary experiences a second Qualifying Event within the initial 18-month period, the amount due shall not exceed 102% of the applicable premium, without regard to the applicability of a Disability Extension. If the second Qualifying Event occurs after the initial 18-month period, the amount due shall be no more than 150% of the applicable premium for the period following the initial 18 months, as long as the disabled Qualified Beneficiary is included in the coverage;

The first payment must cover the period from the date Coverage would otherwise have terminated until the end of the month in which the first payment is made. The first payment must be postmarked or received by the Contract Administrator no later than 45 days after COBRA continuation coverage is elected; and

Subsequent payments will be due and payable on the first day of each month, subject to a 30-day grace period.

If a payment is made later than the first day of the month for which the payment is due, but before the end of the 30-day grace period for the coverage period, Coverage under the Plan shall be suspended as of the first day of the coverage period, and then retroactively reinstated back to the first day of the coverage period when the payment is received. Any claim submitted for Benefits while Coverage is suspended may be denied and may have to be resubmitted once Coverage is reinstated.

General Notice of COBRA Continuation Coverage

The Contract Administrator will provide written information, as required by Department of Labor regulations found at 29 C.F.R. § 2590.606-1, to each Covered Member and Covered Member's Spouse, if any, of the right to COBRA continuation coverage not later than the earlier of: (a) 90 days after the date on which such individual's

Coverage begins; or (b) the first date on which the Plan is required, as described in the "Election Notice" Section, below, to send a Covered Person notice of a Qualified Beneficiary's right to elect COBRA continuation coverage. Such a general notice is deemed to be provided at the time of commencement of Coverage under the Plan. The general notice may be provided as part of this Plan Document if the timing requirements described in this "General Notice of COBRA Continuation Coverage" are met.

Member, Covered Member and Qualified Beneficiary Notice Requirements

It is the responsibility of a Member, Covered Member or a Qualified Beneficiary to notify the Contract Administrator of every applicable event described below within the periods described. There shall be no right to

COBRA continuation coverage if the required notice described in this “Member, Covered Member and Qualified Beneficiary Notice Requirements Section” is not given. The Member, Covered Member or Qualified Beneficiary must notify the Fund Office:

Within 60 days of the later of: (a) a Qualifying Event; (b) the date on which a Qualified Beneficiary would lose Coverage because of such event; or (c) the date on which a Qualified Beneficiary is informed of both the responsibility to provide notice and this Plans procedures for providing such notice, to the Contract Administrator, for the following:

the Members divorce or legal separation from the Members Spouse, or of a Child losing Dependent status under this Plan; or

a determination of disability of a Qualified Beneficiary by the SSA. The notice must include a copy of the SSA ruling letter of such disability determination and must be received by the Contract Administrator before the expiration of the initial 18-month COBRA continuation period.

Within 30 days after the later of: (a) a final determination by the SSA that the Qualified Beneficiary for whom the Disability Extension applies is no longer disabled; or (b) the date on which the Qualified Beneficiary is informed, through the furnishing of this Plan Document or the initial notice of COBRA continuation coverage rights of both the responsibility, and this Plans procedures, for providing such notice to the Contract Administrator.

Election Notice

If the Contract Administrator determines that an individual is entitled to COBRA continuation coverage, the Contract Administrator shall send an election notice to each Qualified Beneficiary within 14 days after the Contract Administrator receives notice that a Qualifying Event has occurred.

Election Procedure

A Qualified Beneficiary must elect COBRA continuation coverage within 60 days after the later of the date: (a) the Qualified Beneficiary would lose Coverage because of a Qualifying Event; or (b) the date the Qualified Beneficiary receives notice from the Fund Office of the right to elect COBRA continuation coverage. An election is considered made on the earliest of the date postmarked or received by the Contract Administrator.

Notice of Unavailability of COBRA Continuation Coverage

If the Contract Administrator determines that an individual is not entitled to COBRA continuation coverage, the Contract Administrator shall send a notice explaining why the individual is not entitled to such coverage within 14 days after the Contract Administrator receives notice that a Qualifying Event has occurred.

Notice of Termination of COBRA Continuation Coverage

The Contract Administrator shall send to each Qualified Beneficiary who is receiving COBRA continuation coverage a notice of termination of such coverage as soon as practical after the Contract Administrator determines that COBRA continuation coverage shall terminate, if such termination is effective earlier than the end of the applicable Maximum Coverage Period.

Special Notice Rules

The Plan’s notice requirements shall be met if the Contract Administrator sends a single notice either (1) to a Covered Member and the Covered Member’s Spouse, or (2) to a Covered Member or the Covered Members Spouse and Qualified Beneficiaries who are the Covered Member’s Dependents, if the most recent information available to the Contract Administrator is that either group of individuals reside at the same address. The notice requirement of the “Election Notice” Section will be met if the Contract Administrator sends a single notice to the Covered Member and the Covered Members Spouse, if the Spouse is a Covered Dependent prior to the date the notice must be sent, and the most recent information available to the Contract Administrator is that the Spouse resides at the same address as the Covered Member.

Certificate of Creditable Coverage

The Contract Administrator will provide a Covered Person with a certificate of creditable coverage, in the form prescribed by the United States Department of Labor, that indicates the period of time the Covered Person was Covered under this Plan as follows:

Upon request if made by, or on behalf of, a Covered Person at any time while the individual is a Covered Person and up to 24 months after Coverage ceases. A certificate shall be provided even if the individual has previously received a certificate, and shall be provided by the earliest date the Contract Administrator, acting in a reasonable and prompt fashion, can provide the certificate;

Automatically:

No later than the time a COBRA notice is required for a Qualified Beneficiary entitled to elect COBRA continuation coverage due to the occurrence of a Qualifying Event; and

Within a reasonable amount of time after Coverage for a Covered Person ends, including when COBRA continuation coverage ends.

Definitions

Disability Extension means the 11 months of additional COBRA continuation coverage available if a Qualified Beneficiary is disabled, as determined in a ruling by the SSA, at any time before and including the first day, or during the first 60 days, of COBRA continuation coverage; provided that the Contract Administrator receives notice as required in the Section entitled “Member, Covered Member and Qualified Beneficiary Notice Requirements”, above. If the Disability Extension is for a Qualified Beneficiary who is a Child born to, or placed for adoption with, a Covered Member, the first 60 days of COBRA continuation coverage is measured from the date of birth or placement for adoption. The Disability Extension applies independently to each Qualified Beneficiary entitled to COBRA continuation coverage because of the initial Qualifying Event, including any non-disabled Qualified Beneficiary.

Maximum Coverage Period means:

The 18-month period following the Qualifying Event if Coverage originally terminated because of employment termination (except for misconduct) or reduction of hours of a Covered Members employment.

The 18-month period described above shall be extended to 36 months if another Qualifying Event occurs after the employment termination (except for misconduct) or reduction of hours of employment of the Covered Member, other than the bankruptcy Qualifying Event described in the definition of “Qualifying Event” below, and during the first 18 months of COBRA continuation coverage (or the first 29 months if a Disability Extension applies).

If a Covered Member experiences a Qualifying Event based on employment termination (except for misconduct) or reduction in employment hours that occurs less than 18 months after the date the Covered Member became entitled to benefits under Medicare, the period of coverage for Qualified Beneficiaries other than the Covered Member will be 36 months.

For any Qualifying Event other than one based on employment termination, reduction in employment hours, or the type of bankruptcy described in the definition of “Qualifying Event” below, the date which is 36 months after the date of the Qualifying Event.

Qualified Beneficiary means:

(1) a Covered Member whose Coverage ends because of employment termination (for any reason other than gross misconduct) or reduction of hours of employment, or the Chapter 11 bankruptcy of the Covered Members employer; (2) any other individual who is a Covered Person on the day before a Qualifying Event that would otherwise cause the individual to lose Coverage; and (3) any Child born to, or placed for adoption with, a Covered Member during a period of COBRA continuation coverage. A Qualified Beneficiary who does not elect COBRA continuation coverage in connection with a Qualifying Event ceases to be a Qualified Beneficiary at the end of the COBRA election period, as described in the “Election Procedure” Section, above.

Qualifying Event means any one of the following events, if the event causes the Covered Person to lose Coverage while this Plan is subject to COBRA:

Death of a Covered Member;

Termination (for any reason other than gross misconduct) or reduction of hours of a Covered Members employment;

Divorce or legal separation of a Covered Member;

The Covered Member becoming entitled to Medicare benefits;

A Covered Dependent Child ceasing to be a Dependent under this Plan;

A Covered Member, who is Covered on the day before the first day of the Covered Member's FMLA leave or who becomes Covered during the FMLA leave, and who does not return to work in a Unit at the end of the FMLA leave. This Qualifying Event occurs on the last day of the Covered Member's FMLA leave and the Maximum Coverage Period is measured from that date; or

A proceeding in bankruptcy under U.S.C. Title 11 with respect to a contributing employer from whose employment a Covered Member retired at any time.

USERRA CONTINUATION COVERAGE AND REINSTATEMENT

USERRA

The Plan shall allow a Covered Member who is performing Uniformed Service to continue Coverage, or to re-enroll in Coverage, for the Covered Member and the Covered Member's Dependents, if any, under this Plan if the requirements of this "USERRA Continuation Coverage and Reinstatement" Section are met.

Duration of USERRA Continuation Coverage

A Covered Member in Uniformed Service may elect to continue coverage in this Plan for a period of time, and such coverage shall end as of the earliest of the following dates:

The date that is 24 months after the Uninformed Service began;

The date the individual returns or applies to return to work in a Unit, in a manner and on a form approved by the Board of Trustees, within the Reemployment Period. If the individual does not return or apply to return to work as provided above, the individual shall be deemed to have terminated status as a Covered Member as of the date the individual's Uniformed Service began. Such period begins on the date on which the Covered Member's absence for the purpose of performing Uniformed Service begins; or

The first day of any period for which a required USERRA continuation coverage payment is not made as specified in this "USERRA Continuation Coverage and Reinstatement" Section.

Election Procedure

A Covered Person who is eligible to continue Coverage due to Uniformed Service must notify the Contract Administrator of his or her election to obtain such continuation coverage as provided below:

If the Covered Member fails to give advance notice of service and fails to elect USERRA continuation coverage within 60 days following beginning Uniformed Service, the Contract Administrator shall cancel the Covered Member's Coverage, effective the day the Covered Member began Uniformed Service. However, if the Covered Member's failure to give advance notice of service is excused under USERRA because it was impossible, unreasonable, or precluded by military necessity, and the Covered Member provides proof of such to the Contract Administrator, the Contract Administrator shall reinstate the Coverage retroactively upon the Covered Member's election to continue coverage and payment of all unpaid amounts due. No administrative reinstatement costs shall be charged to the Covered Member.

If the Covered Member gives advance notice of service, but fails to elect USERRA continuation coverage within 60 days following beginning Uniformed Service, the Contract Administrator shall cancel the Covered Member's Coverage, effective the day the Covered Member began Uniformed Service. Such a Covered Member may elect USERRA continuation coverage any time within the 60-day period, and such coverage will be retroactive to the date the Covered Member's Coverage would otherwise have ended.

Payment for USERRA Continuation Coverage

A Covered Member electing USERRA continuation coverage must pay to the Contract Administrator on at least a monthly basis, the entire amount due for such coverage, subject to the following rules:

If the Covered Member's Uniformed Service is for less than 31 days, there is no cost for coverage due from the Covered Member.

If the Covered Member's Uniformed Service is for 31 or more days, the Covered Member shall pay up to 102% of the actual monthly cost for Coverage under the Plan, with such amount to be determined by the Board of Trustees.

The first payment must cover the period from the date Coverage would otherwise have terminated until the end of the month in which the first payment is made. The first payment must be postmarked or received by the Contract Administrator no later than 45 days after USERRA Continuation Coverage is elected.

Subsequent payments are due and payable on the first day of each month, subject to a 30-day grace period.

If a payment is made later than the first day of the month for which the payment is due, but before the end of the 30-day grace period for the coverage period, Coverage under the Plan shall be suspended as of the first day of the coverage period and then retroactively reinstated back to the first day of the coverage period when the payment is received. Any claim submitted for Benefits while Coverage is suspended may be denied and may have to be resubmitted once Coverage is reinstated.

Non-Covered Persons

This Plan shall not provide a USERRA continuation coverage election period for new coverage for a Member, or any coverage for a Member who is not a Covered Member prior to the date Uniformed Service began.

Reinstatement of Plan Coverage

An individual's Coverage, including Coverage for Dependents, shall be reinstated upon reemployment in a Unit after Uniformed Service, and shall not be subject to a waiting period or any pre-existing condition exclusion. Such reinstatement is unrelated to whether or not the individual elected to obtain USERRA continuation coverage while performing Uniformed Service. The Board of Trustees retains the discretion to add such an exclusion or waiting period related to illnesses or injuries determined by the Secretary of Veteran's affairs to have been incurred in, or aggravated during, Uniformed Service.

Uniformed Service Definition

"Uniformed Service" means the performance of duty on a voluntary or an involuntary basis in a uniformed service under competent authority. Uniformed Service includes active duty; active and inactive duty for training; National Guard duty under Federal statute; a period for which a person is absent from a position of employment for an examination to determine the fitness of the person to perform such duty; a period for which a person is absent from employment to perform funeral honors duty as authorized by law (10 U.S.C. §12503 or 32 U.S.C. §115); service as an intermittent disaster-response appointee upon activation of the National Disaster Medical System or as a participant in an authorized training program as provided by the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, Pub. L. 107-188; or as may otherwise be defined by 20 C.F.R. §1002.5.

Reemployment Period Definition

“Reemployment Period” means:

If the individual's period of Uniformed Service is 180 or more days, the individual must submit an application to return to work (verbal or written) in a Unit no later than 90 days after completing service.

If the individual's period of Uniformed Service is more than 30 days but less than 180 days, the individual must submit an application to return to work (verbal or written) in a Unit within 14 days after discharge, or, if that is impossible or unreasonable through no fault of the individual, not later than the next full calendar day after it becomes possible to do so.

If the individual's period of Uniformed Service is less than 31 days, or is for a USERRA leave for a fitness examination of any period, the individual must report back to the employer not later than the beginning of the individual's first regularly-scheduled work period after completing service, but no sooner than eight hours after the individual's return home. If that is impossible or unreasonable through no fault of the individual, he or she must report back to the employer as soon as possible after the expiration of the eight- hour period.

However, if the individual is recovering from an injury caused or aggravated by Uniformed Service, the above time limits may be extended until the individual recovers, up to a maximum period of two years. The recovery period may exceed two years if circumstances beyond the individual's control make notification within the two- year period impossible or unreasonable, as such exception is described 20 C.F.R. §1002.116.

CLAIM AND APPEAL PROCEDURES

Benefit Claim

A benefit claim is a request for a Plan Benefit(s) made by a Covered Person, or his or her authorized representative (the "Claimant"), in accordance with this “Claim and Appeal Procedures” Section. A benefit claim includes any pre-service claims, as defined below, but does not include a general inquiry regarding Benefits. A Claimant shall submit a claim for Benefits according to the reasonable procedures of the Plan either on forms provided by the Contract Administrator or by presenting the Benefit card at the time of service, as may be required by the Trustees.

Claim Submission Time Limit

Claims must be received by the Contract Administrator no later than three (3) months after the date of a person's termination of Coverage, or within one (1) year after the date the expense or loss is incurred for Covered Persons.

Urgent Care Claim for Benefits

An urgent care claim for benefits is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations could seriously jeopardize the life or health of the Covered Person, or the ability of the Covered Person to regain maximum function, or, in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the Covered Person to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a claim is an urgent care claim is to be determined by the Contract Administrator, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine; except that, any claim that a Physician with knowledge of the Covered Person's medical condition determines is an urgent care claim shall be treated as such for purposes of this “Claim and Appeal Procedures” Section.

Pre-service Claim for Benefits

A pre-service claim for benefits means any claim for a Benefit under the Plan, with respect to which the Plan conditions receipt of the Benefit, in whole or in part, on approval of the Benefit in advance of obtaining medical care.

Post-service Claim for Benefits

A post-service claim for Benefits means any claim for a benefit under the Plan that is not a pre-service claim.

Claimant's Failure to Follow Plan Claim Procedures

In the case of a failure by a Claimant to follow the Plan's claim procedures for filing a pre-service claim, the Contract Administrator shall notify the Claimant of the failure and the proper procedures to be followed in filing a claim for Benefits. This notification shall be provided to the Claimant as soon as possible, but not later than five (5) days (24 hours in the case of a failure to file a claim involving urgent care) following the failure. Such notification may be oral, unless written notification is requested by the Claimant. This "Claimant's Failure to Follow Plan Claim Procedures" Section shall apply only in the case of a failure (a) that is a communication by a Claimant received by the Contract Administrator; and (b) that names a specific Covered Person, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested.

Notice of Pre-service Claim Disposition

Written notice of the disposition of any pre-service claim for Benefits, whether adverse or not, shall be furnished to the Claimant within a reasonable period of time, not to exceed fifteen (15) days after receipt of the claim by the Plan.

Notice of Post-service Claim Disposition

Written notice of the disposition of any post-service claim for Benefits which is wholly or partially denied (also called an "adverse benefit determination") shall be furnished to the Claimant within a reasonable period of time, not to exceed thirty (30) days after the claim is received by the Contract Administrator. This period may be extended one time for up to an additional fifteen (15) days, due to special circumstances beyond the control of the Plan requiring an extension of time for processing the claim, provided that the Contract Administrator furnishes written notice of the extension to the Claimant, within the initial thirty-day period, that indicates the special circumstances requiring the extension, and the date by which the Contract Administrator expects to provide a determination regarding the claim. If such an extension is necessary due to a failure of the Claimant to submit the information necessary to decide the Claim, the notice of extension shall specifically describe the required information, and the Claimant shall have forty-five (45) days from receipt of the notice within which to provide the specified information.

Claim Determinations

The Contract Administrator shall make all initial dental claim determinations as to the right of any person to receive a Dental Benefit. Such determination shall be based on this Plan Document. The Ameritas claims administrator shall make all initial vision claim determinations as to the right of any person to receive a Vision Benefit. Such determination shall be based on the Ameritas Fully-Insured Focus® VSP Plan Document.

Content of Notice of Claim Denial

The denial of a claim for Benefits under the Plan, whether a denial in whole or in part, shall be stated in a written instrument provided to the Claimant. Such written instrument shall set forth:

The specific reason(s) for the denial;

Reference to the specific Plan provision(s) on which the denial is based;

A description of any additional material or information necessary for the Claimant to perfect a claim and an explanation of why such material or information is necessary; A description of the Plan's appeal procedures and the time limits applicable to such procedures;

A statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following an adverse appeal determination;

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 was relied upon in making the adverse determination and that a copy of such will be provided free of charge to the Claimant upon request;

If the adverse benefit determination is based on a necessary care and treatment or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

In the case of a denial concerning an urgent care claim, a description of the expedited appeal process applicable to such claims. The information required to be provided by this Section may be provided to the Claimant orally within the 72-hour period, provided that a written notification is furnished to the Claimant within three (3) days after the oral notification.

Review of an Adverse Benefit Determination ("Appeal")

The Trustees shall make all appeal determinations.

An appeal request must be delivered to the Contact Administrator no later than 180 days after receipt by the Claimant of written notification of the claim denial.

Claimants shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for Benefits.

Claimants requesting an appeal shall be provided, upon request and free of charge, reasonable access to, and copies of, all Relevant Documents.

The Trustees' review 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.

The Trustees' review will not afford deference to the initial claim decision and shall not include any individual who made the claim decision that is the subject of appeal, nor the subordinate of such an individual.

In deciding an appeal of a claim denial based on a medical judgment, including a determination regarding whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Trustees shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment. A "health care professional" means a Physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

The Trustees shall identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claim, without regard to whether the advice was relied upon in making the determination.

The health care professional engaged for purposes of a consultation regarding this Section shall be an individual who is neither an individual who was consulted in connection with the claim determination that is the subject of the appeal, nor the subordinate of any such individual.

Urgent Care Expedited Appeal and Notice of Appeal Determination

In the case of a claim involving urgent care, in addition to the requirements in this Section, the Trustees shall provide an expedited review. A request for an expedited appeal of a denied claim may be submitted orally or in writing by the Claimant. All necessary information, including the Plan's appeal determination, shall be transmitted between the Contract Administrator and the Claimant by telephone, facsimile, or other available similarly expeditious method. The Contract Administrator shall notify the Claimant of the Trustees' appeal determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the Claimant's request for an appeal.

Notice of Pre-service Appeal Determination

The Trustees will make a final decision, and the Contract Administrator shall notify the Claimant, regarding a pre-service claim appeal within a reasonable period of time appropriate to the medical circumstances, but no later than thirty (30) days after receipt by the Contract Administrator of the Claimant's request for a claim review.

Notice of Post-service Appeal Determination

The Trustees will make a final decision, and the Contract Administrator shall notify the Claimant, regarding a pre-service claim appeal within a reasonable period of time, but no later than sixty (60) days after receipt by the Contract Administrator of the Claimant's request for a claim review.

Content of Notice of Appeal Denial

An appeal denial by the Trustees, whether in whole or in part, shall be stated in a written instrument provided to the Claimant. Such written instrument shall set forth:

The specific reason(s) for the denial;

Reference to the specific Plan provision(s) on which the denial is based;

A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all Relevant Documents;

If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse appeal determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such was relied upon in making the adverse determination and that a copy of such will be provided free of charge to the Claimant upon request;

If the adverse appeal determination is based on a necessary care and treatment or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and

A statement of the Claimant's right to bring an action under ERISA Section 502(a).

Communications

All communications from the Contract Administrator or Trustees to the Claimant shall be written in a manner calculated to be understood by the Claimant.

Safeguards

In deciding a Claim, including on appeal, the Contract Administrator or the Trustees, as applicable, shall assure that decisions on Claims and on appeals are made in accordance with the documents governing the Plan and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated Claimants.

Relevant Document Definition

"**Relevant Document**" means a document, record, or other information 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 the administrative processes and safeguards required by 29 C.F.R. §2560.503-1(b)(5) in making the Benefit determination; constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or Benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the Benefit determination.

Authorized Representative

A Covered Person may designate an authorized representative to act on the Covered Person's behalf with respect to a Benefit claim or appeal of a denied Benefit claim by completing a form provided by the Contract Administrator. In the case of an urgent care claim, a health care professional with knowledge of a Covered Person's medical condition shall be permitted to act as the authorized representative of the Covered Person.

Trustee Discretion

The Trustees shall have complete fiduciary authority and discretion to interpret and construe the Plan, decide all questions of eligibility and Benefits, review any claim decision made by the Contract Administrator, and determine the final outcome of all appeals. The Trustees' appeal determination shall be final and binding on all interested parties.

Limitation on Filing a Lawsuit

Before a lawsuit to obtain Benefits may be filed, all of the Plan claims and appeals procedures stated in

this "Claim and Appeal Procedures" Section must be exhausted, and either (i) a final decision must have been made on an appeal, or (ii) the appropriate time frame described in this "Claim and Appeal Procedures" Section for a Trustee decision on appeal ("Decision Date"), must have elapsed without a final decision having been made on the claim or appeal. Such a lawsuit may be filed no later than 12 months after the Decision Date described in the preceding sentence. However, if such time limitation is less than that required by applicable law, then the time limitation is extended to agree with the minimum permitted by applicable law.

Uncashed Checks

If any claim payment check remains uncashed for a period that is more than two years as of February 1 each year and the payee has not been located through reasonable efforts adopted by the Board of Trustees, the uncashed check shall be void and no longer negotiable and the monies to fund payment of such check shall remain the property of, and constitute assets of, the San Antonio Police Officers and Firefighters Benefit Plan & Trust, and shall be available to pay other Plan obligations or to be invested until a valid replacement, is validly presented for payment.

DEFINITIONS

When used in this Plan Document, the following items shall have the meanings shown below. The following definitions are not an indication that charges for particular care, supplies or services are eligible for payment under the Plan; please refer to the appropriate sections of the Plan Document for that information.

Association

The San Antonio Police Officers' Association or the International Association of Firefighters Local 624.

Benefits

The benefits provided by this Plan.

Calendar Year

The period of time commencing at 12:01 a. m. on January 1 of each year and ending at 12:00 midnight on the next December 31. Each succeeding, like period will be considered a new Calendar Year.

Calendar Year Maximum Benefit

The most in Benefits that the Plan will pay for Covered Expenses of a Covered Person incurred during a Calendar Year.

Certificate of Coverage or Certificate of Creditable Coverage

A written certification provided by any source that offers health care coverage, including this Plan, for the purpose of confirming the duration and type of an individual's previous coverage.

Child

The Member's or Covered Member's son or daughter; legally adopted child; step-child; foster child or a child placed for adoption with the Member or Covered Member. A child is "placed for adoption" when a Member or Covered Member assumes and retains a legal obligation for total or partial support of the child placed with the Member or Covered Member in anticipation of the child's adoption. The child's placement for adoption ends upon the termination of such legal obligation.

Claimant

Any Covered Person on whose behalf a request for a Plan Benefit(s) is submitted in accordance with the Plan's claims procedures.

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Co-insurance

See the Schedule of Benefits.

Contract Administrator

The office of the third-party administrator appointed by the Trustees to administer the day-to-day operations of the Plan.

Coverage and Covered

When used in reference to a Member or Dependent, as opposed to in reference to an expense or benefit, these terms mean that the individual is entitled to receive the Plan's Benefits.

Covered Expense

An expense incurred by a Covered Person that is payable by the Plan as Co-insurance or is payable by the Covered Person as a deductible, as Co-insurance, as a Co-payment or because of a benefit.

Covered Person, Covered Member and Covered Dependent

A Member, Dependent, or both, respectively, eligible to receive Benefits under this Plan because the eligibility and enrollment requirements have been met.

Creditable Coverage

Prior medical coverage that an individual had from any of the following sources: a group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the uniformed services and their dependents, a medical care program of the Indian Health Service or tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act, provided the coverage did not consist solely of excepted benefits under federal law.

Deductible

An amount of Covered Expenses payable by the Covered Person which must be incurred before any Benefit can be paid by the Plan. See the Schedule of Benefits for information concerning the Deductible amounts.

HIPAA

Health Insurance Portability and Accountability Act of 1984, as amended.

Injury

Accidental bodily injury sustained by a Covered Person. Such injury must result in loss directly and independently of all other causes. All bodily injuries caused by one (1) accident shall be considered as one (1) Injury.

Medicare

Health insurance for the aged as established by Title I of Public Law 89-98 including parts A & B and Title XVIII of the Social Security Act, as amended from time to time.

Necessary Care Treatment

Any confinement, treatment, service, or item that is: (a) prescribed by a Physician; (b) necessary and appropriate; (c) non-experimental; (d) consistent with professionally recognized national standards of quality; and (e) customarily employed nationwide for treatment, considering the Covered Person's condition.

Physician

A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who is licensed to practice medicine or osteopathy where the care is provided.

"Physician" also includes the following providers, but only when the provider is licensed to practice where the care is rendered and is rendering a service within the scope of that license:

Dentist (D.D.S. or D.M.D.);

Optometrist (O.D.);

Podiatrist or Chiropodist (D.P.M., D.S.P., or D.S.C.);

Psychologist (Ph.D.); and

Chiropractor (D.C.).

For purposes of certifying Total Disability, "Physician" will include only Doctors of Medicine (M.D.) and Doctors of Osteopathy (D.O.).

Plan

The San Antonio Police Officers and Firefighters Benefit Plan, as set forth in this document, and as may be amended from time to time.

Plan Administrator

The Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust.

Plan Sponsor

The Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust.

Plan Year

The period beginning January 1 and ending December 31 each calendar year.

Reasonable and Customary Charge

The usual charge of a provider for Necessary Care and Treatment that is not more than the prevailing charge for a like service or supply by similar providers in the same geographic area, as determined by a fee schedule approved by the Board of Trustees. As of September 1, 2009, Guardian's dental fee schedule is used, but the fee schedule used may be changed at any time in the discretion of the Board of Trustees. Charges incurred outside the United States or its territories shall be considered as if incurred in the geographic area of the Plan's San Antonio, Texas claims paying office. If the usual and prevailing charge for a service or supply cannot be determined because of the unusual nature of the service or supply, the Contract Administrator shall determine what is the most closely analogous service or supply based on (a) the complexity of the service involved, (b) the use being made of the supply, (c) the degree of professional skill required under the circumstances, or (d) other pertinent factors, as determined in the discretion of the Board of Trustees.

Sickness

Any condition of ill health; disease; complications of pregnancy, labor or delivery; bodily or mental abnormality; infirmity; or disorder. All sicknesses due to the same or related causes shall be considered as one Sickness.

Spouse

A person who is regarded as legally married to a Covered Person under applicable state law. An individual shall be deemed to be a Spouse of a Covered Person with respect to any expense which is payable or reimbursable under this Plan if that individual is regarded as legally married to the Covered Person under applicable state law at the time the expense is incurred.

SSA

The United States Social Security Administration

Trust

The San Antonio Police Officers and Firefighters Benefit Trust

Trust Agreement

The San Antonio Police Officers and Firefighters Benefit Plan & Trust, Trust Agreement as of January 1, 2000, as amended.

Trustees

The members of the Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust. Such Trustees are the named fiduciaries of the Plan, as the term "fiduciary" is defined in ERISA.

Unit

A group of Members for whom the group constitutes any one of the following: the employees of an Association who are the subject of a participation agreement between the Association and the Trustees or Trust; members of a collective bargaining unit for whom contributions to the Trust are required by a collective bargaining agreement; or employees of a political subdivision who are the subject of a participation agreement between the political subdivision and the Trustees or Trust. Participants and beneficiaries may obtain, upon written request to the Plan Administrator, information concerning whether their employer is subject to a participation agreement or a collective bargaining agreement concerning contributions on their behalf to the Trust.

USERRA

The Uniformed Services Employment and Reemployment Rights Act of 1994, as amended.

GENERAL PLAN INFORMATION

The name and type of Plan

The San Antonio Police Officers and Firefighters Benefit Plan is a group dental and vision welfare plan administered by the Board of Trustees of the San Antonio Police Officers and Firefighters Benefit Trust ("Trustees" or "Board of Trustees"). The Board of Trustees is made up of equal numbers of police and firefighter Association-appointed Trustees. The Plan is maintained in accordance with collective bargaining agreements between the Associations and the City of San Antonio. A copy of each of the most recent collective bargaining agreements is available upon written request to the Plan Administrator, and also is available for examination at the street address of the Plan Administrator set forth in the section of this document entitled "Administrative Information." The Plan's benefits include vision and dental benefits.

Amendment

The Trustees shall have the full, absolute, and discretionary power to amend or modify this Plan in whole or in part, at any time, for any and all participants and beneficiaries, as those terms are defined by ERISA §3(7, 8), 29 §1102(7, 8), of this Plan without prior notice to, or the consent of, any person. Any such action may be effected as authorized under the Trust Agreement.

Clerical Error/Delay

Clerical errors on records of the Contract Administrator and delays in making entries on such records shall not affect Benefit coverage. Upon discovery of any such error or delay which has caused an erroneous contribution or COBRA or USERRA Continuation Coverage premium payment to be made, the Contract Administrator shall make an equitable adjustment of the contribution or premium payment.

Compliance with Federal Law

This Plan shall comply with all federal laws and regulations to which it is subject. If any provision of this Plan is in conflict with any such law or regulation, the law or regulation shall prevail. If, in the opinion of the Trustees, the applicability of any such law or regulation is unclear, the Trustees shall have the right to decide the question of such applicability until the law is clarified by the appropriate governmental authority.

Contribution Source

Contributions to the Plan are made by the City, Legal Plan, and Associations. In addition, the Trust receives some contributions from participants in the form of copayments, deductibles, and self-payments.

Designation of a Payee

Covered Member Incompetent

In the event the Plan determines that the Covered Member is incompetent or incapable of executing a valid receipt or otherwise managing his or her affairs relevant to the Plan, and no guardian has been appointed, the Plan may, during the lifetime of the Covered Member, pay any amount otherwise payable to the Covered Member to another individual, as specified under the laws of the State of Texas.

Death of Covered Member

In the event of the death of the Covered Member before all amounts payable under the Plan have been paid, the Plan shall pay any amount otherwise payable to the Covered Member to the deceased Covered Member's designated beneficiary. If there is no designated beneficiary on file with the Contract Administrator, the Plan shall pay such amount to the deceased Covered Member's surviving Spouse. If there is no surviving Spouse, and there is no designated beneficiary, the Plan shall pay such amount to the deceased Covered Member's estate.

Full Discharge of Plan Obligations

Any payment in accordance with this provision shall discharge the obligation of the Plan to the extent of such payment.

Effect of Changes

All changes to this Plan shall become effective as of the date established by the Trustees.

Eligibility Information

The Plan's requirements about eligibility, as well as circumstances that may result in disqualification, ineligibility, denial, or loss of any benefit are described in this booklet.

Entire Contract

This Plan and the enrollment forms of the Covered Persons shall constitute the entire contract of Benefit coverage between the Trust and the Covered Persons.

Funding Method

Benefits are funded primarily by City, Legal Plan, and Association contributions to the Trust. Benefits are paid pursuant to provisions of collective bargaining and participation agreements, the Trust Agreement, and the Plan. Contributions and any interest or other earnings are held in the Trust for the purpose of providing benefits to Covered Persons and defraying reasonable operating expenses. Benefits for vision and dental benefits are self-funded by the Trust.

Headings

The headings used in this Plan are for convenience only. In all cases, the full text of this Plan shall control.

Misstatements

If any relevant information has been misstated or omitted by, or on behalf of, a person to obtain Benefit coverage, correct information shall be used to determine whether and to what extent such shall be in force. If such coverage is rescinded upon the discovery of any misstatement or omission, the Trustees shall make any equitable adjustment for any contributions which they deem, in their sole discretion, are appropriate.

No Waiver

The Trustees' failure to enforce strictly a provision of this Plan shall not be construed as a waiver of the provision. The Trustees reserve the right to enforce strictly each and every provision of this Plan at any time, regardless of the nature or number of prior occurrences or the similarity of the circumstances.

Plan Change or Termination

The Trustees reserve the right to change or discontinue the types and amounts of benefits under the Plan. Plan benefits and eligibility rules are not guaranteed, may be changed or discontinued by the Trustees, are subject to rules and regulations adopted by the Trustees, and are subject to the Trust Agreement. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time a Claim occurs. If the Plan is changed or discontinued, it will not affect your or your beneficiary's right to any insured benefit to which you have already become entitled.

Plan Regulations

All of the types of benefits provided by the Plan are set forth in this booklet. Complete terms of the benefits are set forth in the Plan.

Plan Documents and Reports

You may examine the following documents at the Contract Administrator during regular business hours, Monday through Friday, except holidays: (a) the trust agreement; (b) participation agreements; (c) plan documents and all amendments; (d) Form 5500 or full Annual Report filed with the Department of Labor; and (e) a list of Plan Sponsors. You may obtain copies of these documents by asking for them in writing from the Contract Administrator, and paying the reasonable cost of making the copies. Please ask the cost before requesting copies. If you prefer, you can arrange to examine these reports, during normal business hours, at your local Association office. To do so, call or write the Contract Administrator. A summary of the Annual Report, which gives details of the financial information about the Plan's operation, is furnished free of charge to all participants.

Representations

Statements made by, or on behalf of, any person to obtain Benefit coverage under this Plan shall be deemed representations and not warranties.

Termination of this Plan

The Plan shall continue until all the collective bargaining agreements providing for contributions to the Trust have expired, and there is no extension of any such collective bargaining agreement. This Plan may be terminated earlier only by the affirmative action of all Associations to terminate the Trust. Any such action must be by a vote of each Association's governing body to terminate the Trust at any regular or special meeting of that body.

Words in Singular or Plural

Wherever the context admits, a word in the singular shall include the plural and vice-versa.

Workers' Compensation

This Plan is not instead of, and does not affect, any requirement for coverage by workers' compensation insurance.

STATEMENT OF RIGHTS OF PARTICIPANTS

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

Receive Information about Your Plan and Benefits

1. Examine, without charge, at the Contract Administrator's office and at other specified locations, such as Association's, all documents governing the Plan, including insurance contracts, collective bargaining agreements, 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. The annual report is also available at the Public Disclosure Room of the Employee Benefits Security Administration.
2. 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 Contract Administrator may make a reasonable charge for the copies.
3. 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.
4. Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependents may have to pay for such coverage. Review this Plan Document and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Continue Group Health Plan Coverage

You may be able to continue health care coverage for yourself, and/or your Dependents, if there is a loss of coverage under the Plan as a result of a qualifying event. This coverage is called "COBRA coverage." You or your Dependents may have to pay for such coverage. Review this Plan Document for information about your COBRA coverage rights. You should be provided a Certificate of Coverage, free of charge, from the Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA coverage, or when your COBRA coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in a group health plan. This Plan has no preexisting condition exclusions.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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 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.

Enforce Your Rights

If your claim for a benefit under this Plan 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 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 Contract 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. As of November 1, 2018, the hotline's number is 866-444-3272. You may check the website of the Employee Benefits Security Administration to obtain the hotline's current number, or to locate certain publications.

HIPAA PRIVACY RULE AND SECURITY STANDARDS

HIPAA PRIVACY RULES

This Plan will use and disclose protected health information ("PHI"), as defined in 45 C.F.R. §160.103, to the extent of, and in accordance with, the uses and disclosures permitted or required by HIPAA and the "Standards for Privacy of Individually Identifiable Health Information," as set forth in 45 C.F.R. Part 160 and Part 164, Subpart E ("Privacy Regulations"). Specifically, this Plan will use and disclose PHI for treatment, payment, and health care operations of this Plan, as those terms are defined in 45 C.F.R. §164.501, and as otherwise allowed under HIPAA and applicable federal regulations.

Authorization

When an authorization is required by HIPAA, this Plan will use, disclose, and request PHI as permitted by authorization of a Covered Person; provided that authorization meets the requirements of 45 C.F.R. §164.508.

Plan Disclosure of PHI to Plan Sponsor

This Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that this Plan document contains the provisions required by 45 C.F.R. §164.504(f), and that the Trustees agree to such provisions. The signatures of the members of the Plan Sponsor on this Plan Document constitutes such certification.

Disclosure of Members' Protected Health Information – Disclosure by the Plan Sponsor

The Plan Sponsor will not use or further disclose the PHI other than as permitted or required by this Plan Document or by law.

The Plan Sponsor will ensure that any agents, including a subcontractor, to whom it provides PHI received from this Plan, agree to the same restrictions and conditions that apply to the Plan sponsor with respect to such information.

The Plan Sponsor will not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

The Plan Sponsor will report to this Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures provided for in HIPAA or this Plan Document of which they become aware.

The Plan Sponsor will make the Protected Health Information of the individual who is the subject of the Protected Health Information available to such individual in accordance with 45 C.F.R. §164.524.

The Plan Sponsor will make an individual's Protected Health Information available for amendment and incorporate any amendments to the individual's Protected Health Information in accordance with

45 C.F.R. §164.526.

The Plan Sponsor will make and maintain an accounting so that it can make available those disclosures of individual's Protected Health Information that it must account for in accordance with 45 C.F.R. § 164.528.

The Plan Sponsor will make its internal practices, books and records relating to the use and disclosure of individual's Protected Health Information received from the Plan available to the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the HIPAA Privacy Rule.

The Plan Sponsor will, if feasible, return or destroy all individuals' Protected Health Information received from the Plan (or a health insurance issuer or HMO with respect to the Plan) that the Plan Sponsor still maintains in any form after such information is no longer needed for the purpose for which the use or disclosure was made. Additionally, the Plan Sponsor will not retain copies of such Protected Health Information after such information is no longer needed for the purpose for which the use or disclosure was made. If, however, such return or destruction is not feasible, the Plan Sponsor will limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

The Plan Sponsor will ensure that the required adequate separation, described below, is established and maintained.

Required separation between the Plan and the Plan Sponsor

Only the following individuals or classes of individuals engaged by the Plan Sponsor for this Plan or Trust shall have access to PHI that is disclosed to or otherwise obtained by the Plan Sponsor from this Plan:

1. Actuary
2. Attorney
3. Auditor
4. Benefits Consultant
5. Health Insurance Issuer
6. Third Party Administrator
7. Any Other Service Provider

This list reflects the persons or classes of persons who receive individual's Protected Health Information relating to payment under, health care operations of, or other matters pertaining to plan administration functions that the Plan Sponsor provides for the Plan. These individuals will have access to members' Protected Health Information solely to perform these identified functions. The Plan Sponsor shall resolve issues of noncompliance by a person listed who is given access to Protected Health Information and who does not comply with the Plan's documents, including disciplinary sanctions up to and including termination of any employment or service contract with such person, in a manner appropriate to the circumstances, as decided in the Plan Sponsor's sole and exclusive discretion.

The Plan Sponsor will cooperate with the Plan to correct and mitigate any noncompliance.

Limited Disclosure by a Health Insurance Issuer

It shall be a condition of any engagement agreement between the Plan Sponsor and any health insurance issuer that the issuer shall not disclose PHI to the Plan Sponsor, except as permitted by this Plan document or applicable law.

Other Permitted disclosure of individual's Protected Health Information to the Plan Sponsor

Regardless of any other provisions of this Plan Document, PHI may be disclosed to the Plan Sponsor if:

The PHI is disclosed pursuant to an authorization that meets the requirements of 45 C.F.R. § 164.508;

The PHI is summary health information, as defined in 45 C.F.R. §164.504, and the Plan Sponsor requests the summary health information for the purpose of obtaining premium bids for providing health insurance coverage under this Plan, or for the purpose of modifying, amending, or terminating this Plan; or

This Plan discloses to the Plan Sponsor information regarding whether an individual is participating in, is enrolled in, or has disenrolled from this Plan or part of this Plan.

Minimum Necessary

To the extent required by HIPAA, when using or disclosing PHI, or when requesting PHI from another party, the Plan Sponsor will make reasonable efforts to limit PHI to the minimum necessary to accomplish the intended purpose of the use or disclosure, and limit any request for PHI to the minimum necessary to satisfy the purpose of the request.

Interpretation

Any ambiguity in this Section entitled “HIPAA Privacy Rule and Security Standards”, or in determining controlling provisions of this Plan, will be resolved in favor of an interpretation that permits this Plan to comply with HIPAA and other federal and state laws, and that provides the greatest privacy protections for PHI. In the event of an inconsistency between the provisions of this Section “HIPAA Privacy Rule and Security Standards” and mandatory provisions of HIPAA, the HIPAA provisions shall control.

SECURITY STANDARDS

Plan Sponsor Obligations

This “Security Standards” Section shall only apply if this Plan is required to comply with the "Security Standards for the Protection of Electronic Protected Health Information," 45 C.F.R. Parts 160, 162 and 164, Subpart C ("Security Regulations") created under HIPAA. Where Electronic Protected Health Information will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the Electronic Protected Health Information as follows:

The Plan Sponsor will apply the HIPAA Privacy Rules, above, to Electronic Protected Health Information;

The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic Protected Health Information that the Plan sponsor creates received, maintains, or transmits on behalf of the Plan;

The Plan Sponsor shall ensure that the adequate separation that is required by 45 C.F.R. § 164.504(f)(2)(iii) of the HIPAA Privacy Rule is supported by reasonable and appropriate security measures;

The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides Electronic Protected Health Information agrees to implement reasonable and appropriate security measures to protect such Information; and

The Plan Sponsor shall report to the Plan any Security Incident of which it becomes aware within a reasonable time after becoming aware of it. “**Security Incident**” means that attempted or successful unauthorized access, use, disclosure, modification, or destruction of the Plan’s Electronic Protected Health Information or the attempted or successful interference with system operations in the Plan’s information system.