PLAN DOCUMENT

FOR

WEST VIRGINIA ANNUAL CONFERENCE
UNITED METHODIST FAMILY

EMPLOYEE MEDICAL AND DENTAL BENEFIT PLAN

EFFECTIVE DATE

05/01/1993

REVISION DATE

01/01/2021

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INTRODUCTION

The information contained in this Plan document and summary plan description describes the benefits under the West Virginia Annual Conference United Methodist Family Employee Medical and Dental Plan. This document is written to be as understandable as possible. However, if any Participant has any questions about the Plan or difficulty understanding any part of the Plan, s/he should contact the Plan Administrator, which is the Employer.

This Plan document and summary plan description is divided into sections under various captions for convenience of reference. These captions are not a part of the document and in no way limit or expand upon the provisions of the Plan. Each provision of this Plan and summary plan description is severable from the others and the invalidity of one or more provisions or portions thereof in the document will not have any effect upon the validity or enforceability of any of the other Plan provisions.

The definitions of capitalized terms are found in the Definitions Section at the end of the Plan document.

EMPLOYER'S RIGHT TO MODIFY AND/OR TERMINATE PLAN

The Employer hopes to continue this Plan indefinitely. However, the Employer reserves the right to amend or terminate, in whole or in part, the Plan, any of its provisions or any coverage offered under the Plan at any time and for any reason and without the consent of or prior notice to any employee, insured, beneficiary or any other person having any interest in the Plan. For example, the Plan could be modified by adding or eliminating certain types of benefits for certain kinds of illnesses or medical/surgical procedures; increasing or decreasing Participant premiums, deductibles, co-insurance, co-payments or overall payment limits; and requiring that certain procedures be followed to make sure that prescribed treatment is necessary or appropriate.

The foregoing list is for purposes of illustration only to emphasize that the Plan or particular benefits or procedures set forth in the Plan may be modified in any way or terminated in whole or in part at any time. Whether the Plan will be amended or terminated and the nature of any amendment is wholly within the discretion of the Employer. Amendments to or termination of the Plan will be made by action of the Employer's Annual Board of Pensions of the United Methodist Church/Pension Funds, Inc.

SECTION I
GENERAL INFORMATION

PLAN NAME ..... West Virginia Annual Conference United Methodist Family Employee Medical and Dental Benefit Plan

TYPE OF PLAN ..... Group Health Plan

This group health plan believes this medical plan is a "nongrandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). This dental plan is an "Excepted" benefit not subject to the Affordable Care Act regulations. Questions regarding this status can be directed to the Plan Administrator. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

EFFECTIVE DATE ..... May 1, 1993

REVISION DATE ..... January 1, 2021

PLAN YEAR ..... April 1 – March 31

PLAN ADMINISTRATOR ..... West Virginia Annual Conference United Methodist Church/Pension funds, Inc.

AGENT FOR LEGAL PROCESS ..... Jamion Wolford, Pension Officer

PLAN NUMBER 501

EMPLOYER/PLAN SPONSOR IDENTIFICATION NUMBER 55-0338656

FUNDING

The Employer makes contributions as needed to pay benefits from its general assets combined with any required Employee Contributions and purchases of insurance from the reinsurance company for claims in excess of self-funded amounts.

TYPE OF PLAN ADMINISTRATION ..... Self-Administered

Contract administration for claims processing through: Benefit Assistance Corporation
PO Box 950, Hurricane, WV 25526

EMPLOYER/PLAN SPONSOR ..... Pension Funds, Inc.
PO Box 2469, Charleston, WV 25329

REINSURANCE COMPANY.....As listed in the Excess Loss Insurance Policy

The Reinsurance company provides reinsurance for claims in excess of the applicable specific deductible. It provides no administrative services for the Plan.

PLAN DOCUMENT APPROVED ON BEHALF OF PLAN ADMINISTRATOR BY:

NAME/TITLE Jamion Wolford, Pension Officer

SIGNATURE _____ 12/14/2020

WITNESS Kathy M Damron

SECTION II
SUMMARY OF MEDICAL BENEFITS

PRECERTIFICATION

All Inpatient Hospital Confinements must be precertified by the Plan's Utilization Review Service, except that precertification shall not apply for any Inpatient Hospital Confinement in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery or less than ninety-six (96) hours following a Cesarean section. For scheduled Hospital Confinements, a request for precertification is made by placing a telephone call to the Utilization Review Service prior to the scheduled confinement. The call may be made by the Participant or the attending Physician. **It is the Participant's responsibility to make sure that precertification is obtained.** For Emergency Hospital Confinements, notice must be given to the Utilization Review Service within forty-eight (48) hours or the first working day (whichever is later) after the confinement begins. **Precertification of a Hospital Admission is a pre-admission determination of the Medical Necessity of an Inpatient Hospital setting and the appropriate length of stay. Precertification is not a guarantee of benefit payment.**

For Precertification Contact:
Benefit Assistance Company, LLC
1-800-982-7838

If it becomes necessary for a Participant to remain in the Hospital beyond the number of precertified days, then the Participant must contact the Utilization Review Service, before the end of the originally-approved stay, and request precertification approval for the additional days.

Failure to seek any precertification for an Inpatient Hospital Confinement will result in a $500.00 reduction of benefits for Covered Medical Expenses relating to the Hospital Confinement. In addition, benefits will be reduced by 50 % for any Hospital days and charges determined by the Utilization Review Service to be not Medically Necessary.

The benefits otherwise payable under this Plan for the following Hospital charges will be reduced by 50 %:

1. Any Hospital charges during an Inpatient Hospital Confinement for which precertification review was performed, which are incurred for any days in excess of the number of days precertified by the Utilization Review Service; and,
2. Any Hospital charges incurred during any Inpatient Hospital Confinement where: precertification review was performed, but the Utilization Review Service declined to approve the Hospital Confinement as Medically Necessary.

Precertification penalties do not count toward any Deductible or the Co-insurance Limit.

Preferred Provider Network (PPO): Cigna
To find a Cigna Medical provider, visit www.myCigna.com

For Eligibility / Benefits / Precertification:
Contact Benefit Assistance Company, LLC 1-800-982-7838

Grace Period: For the period of July 1, 2020 through December 31, 2020, claims received for Zelis/4Most Health PPO providers who are not Cigna PPO Network providers will be paid as though they are In Network.

USUAL, CUSTOMARY & REASONABLE CHARGES

Payment for all benefits under the Plan is limited to Usual, Customary & Reasonable Charges **unless rendered by a provider who participates in the Preferred Provider Organization in which the Plan participates**. Charges are deemed incurred on the date services are actually provided, unless the Plan specified otherwise. The Plan may otherwise limit payment for certain services as specified in Section III with respect to Medical Expense Benefits or as otherwise stated in the Summary of Benefits and elsewhere in this Plan.

MAXIMUM BENEFITS PAYABLE PER CALENDAR YEAR FOR NONESSENTIAL HEALTH BENEFITS (PER PARTICIPANT)

Note: Maximums are in Network and Out-of-Network combined.

Out-of-Network Preventive Care $100

Chiropractic Therapy ..... 12 Visits
(Precertification required after 5th visit.)

Home Health Care ..... 40 Visits

Hospice ..... Up to a 6 month period

Applied Behavioral Analysis for Autism Spectrum Disorders $30,000
Benefit is per year for 1st three consecutive years
from the date treatment commences.

This shall not operate to limit the dollar value of Essential Health Benefits provided by the Plan for a covered individual. Federal regulations define the term “Essential Health Benefits” and specify those services which are considered Essential Health Benefits. Services constituting Essential Health Benefits fall into at least the following general categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and

habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

MAXIMUM COST-SHARING FOR ESSENTIAL HEALTH BENEFITS

Cost-Sharing under the Plan for medical benefits which constitute Essential Health Benefits provided by in Network providers shall not exceed $8,150 for self-only coverage, or $16,300 for other than self-only coverage, **subject to annual inflation** as described under the Affordable Care Act section 1302(c)(4). "Cost-Sharing" includes deductibles, co-insurance, co-payments, or similar charges under the Plan. This Maximum Cost-Sharing Limit does not apply with respect to benefits which are not Essential Health Benefits, and/or benefits which are provided out-of-network.

DEDUCTIBLE

NON-MEDICARE ELIGIBLE PARTICIPANTS

Individual $2,000
Family $4,000

MEDICARE ELIGIBLE PARTICIPANTS

Individual $250

CO-INSURANCE
IN NETWORK

Plan 70%
Participant 30%

CO-INSURANCE
OUT-OF-NETWORK

Plan 50%
Participant 50%

IN NETWORK
OUT-OF-POCKET LIMITS

INDIVIDUAL

Deductible $2,000
Co-Insurance $1,850
(30% of $6,166.67)
Out-of-Pocket $3,850

FAMILY

Deductible $4,000
Co-Insurance..... $3,700
(30% of $12,333.33)
Out-of-Pocket..... $7,700

OUT-OF-NETWORK
OUT-OF-POCKET LIMITS

INDIVIDUAL

Deductible $2,000
Co-Insurance..... $4,100
(50% of $8,200.00)
Out-of-Pocket..... $6,100

FAMILY

Deductible $4,000
Co-Insurance..... $8,200
(50% of $16,400.00)
Out-of-Pocket..... $12,200

The Deductible is not applied if the Plan benefit is 100%, except where indicated.

Once the Co-insurance Out-of-Pocket Limit is reached the Plan will pay 100% of Usual, Customary and Reasonable covered charges for the remainder of the Calendar Year. Prescription Drug Co-payments do not count toward and are not subject to the Co-insurance Limit, but do count toward the Maximum Cost-Sharing Limit.

MEDICAL BENEFITS

Physicians Office Visit Benefit
(Office Charge Only)
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(Subject to Deductible)

Specialist Office Visit Benefit
(Office Charge Only)
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(Subject to Deductible)

Outpatient Diagnostic Services and Treatment
(Office Charge Only)
Physicians Office
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(Subject to Deductible)

Hospital, Independent Lab and X-Ray Facility
(After Deductible)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%

Maternity Care / Physician Charges
(After Deductible)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%

(For initial visit (In Network) to determine pregnancy, $15 Co-pay)
(All subsequent prenatal visits, postnatal visits and delivery, physician charges are covered
at 70% after the Deductible, same as any other surgery In Network)

Emergency Care
(Office Charge Only)
Physicians Office
In Network .....$15 Co-pay
Out-of-Network .....$15 Co-pay

Hospital Emergency Room, Outpatient Facility or Other Urgent Care Facility
(Waived If Admitted)
In Network .....$50 Co-pay
(Except if non-emergency, then 70% after Deductible)
Out-of-Network .....$50 Co-pay
(Except if non-emergency, then 70% after Deductible)

Ambulance
(After Deductible)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 70%

Inpatient Hospital Care
(After Deductible)
In Network ..... Plan pays 70%
Out-of-Network .....$200 Per Admission, the Plan pays 50%

Semi-Private and Private Room
In Network .....Limited to Semi-Private PPO Contract Rate
Out-of-Network .....Limited to Semi-Private Rate

Intensive Care Unit (ICU)
In Network ..... Limited to PPO Contract Rate
Out-of-Network ..... Limited to ICU Daily Rate

Newborn Nursery Inpatient Services
(After Deductible)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%
(Newborn has its own deductible unless family deductible has been met)

Inpatient and Outpatient Surgery
(After Deductible)
Physician and Facility Charge
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%
(Includes surgery in the physicians office)

Recommended Preventive Services
In Network ..... Plan pays 100%
Out-of-Network ..... Plan pays 100%,
Up to $100 per Calendar Year

(Recommended Preventive Services based upon recommendations and guidelines as determined by certain Governmental Agencies. A complete list of all recommendations and guidelines can be obtained at www.HealthCare.gov/prevention or by contacting the Plan Administrator.)

Coronavirus (COVID-19) Provision

Testing
In Network ..... Plan pays 100%
Out-of-Network .....Play pays 100%

As required by federal regulation, this includes waiver of cost-sharing obligations for COVID-19/Coronavirus testing including antibody testing. Any claims related to the initial encounter and related lab charges for are covered with zero cost-share (no deductible, no copay, no coinsurance). This includes physician office visits, urgent care visits, telemedicine visits, virtual office visits, emergency room visits, and related laboratory charges.

Treatment
Treatment is already included as part of your Plan's benefits. All treatment will be processed and paid at the same levels listed in your Plan Document for the

treatment of any other infectious disease or respiratory illness.

Medication Refills

Maintenance medication refills are revised to allow up to a 90-day supply through the end of the Plan Year.

Actively at Work

Employer/Plan Sponsor may need to close their business or layoff/furlough staff due to governmental mandate or other COVID-19/Coronavirus specific impacts. Actively at Work is revised to accommodate such administrative considerations under the Plan Document:

- If business closure or staff layoff/furlough occurs as a result of COVID-19/Coronavirus, the Participating Employee must be "Actively at Work" the day prior to the closure or staff layoff/furlough.
- If the Participating Employee is quarantined due to COVID-19/ Coronavirus, the member must return to work immediately following the end of the quarantine period.
- Failure of any Participating Employee to return to work under these scenarios will follow Plan Document terms regarding continuation of coverage.

Dialysis Benefit

In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%
(See Section III, Coverage for Kidney Dialysis Treatment And Related Services.)

Chiropractic Therapy

Calendar Year Maximum.....12 Visits
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(The Calendar Year Maximum cross accumulates between In Network and Out-of-Network. Precertification required after the 5th visit.)

Home Health Care

(After Deductible, up to a maximum of forty (40) visits per Calendar Year)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%

Outpatient Private Duty Nursing

(After Deductible, separate from Home Health Care)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%

Hospice
(Up to a six (6) month period)
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%
(After Deductible, Three (3) Bereavement Counseling Sessions per occurrence.

Mental Health Condition Inpatient Care
(After Deductible)
In Network ..... Plan pays 70%
Out-of-Network .....$200 Per Admission, the Plan pays 50%

Mental Health Condition Office Visit Benefit
(Office Charge Only)
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(Subject to Deductible)

Substance Use Disorder Inpatient Care
In Network ..... Plan pays 100%
Out-of-Network .....$200 Per Admission, the Plan pays 50%

Substance Use Disorder Office Visit Benefit
(Office Charge Only)
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(Subject to Deductible)

Autism Spectrum Disorders – Inpatient and Outpatient – Diagnosis and Treatment
(Dependent children ages 18 months to 26 years, when diagnosed by age 8)

Applied Behavioral Analysis
Subject to $30,000 Annual Limit for 1st three consecutive years from the date treatment commences. Limited to $2,000/month 4th year of treatment to age 26.

Physicians Office Visit Benefit
(Office Charge Only)
In Network .....$15 Co-pay
Out-of-Network ..... Plan pays 50%
(Subject to Deductible)

Inpatient and Outpatient Hospital/Facility Services
In Network ..... Plan pays 70%
Out-of-Network ..... Plan pays 50%

Prescription Drug Benefit

Non Maintenance Prescription Drugs
(After Deductible)..... Plan pays 75%

Maintenance Mail Order Prescription Drug Benefit
Mail Order..... 30% or $35 Co-pay,
Whichever is greater, to a maximum co-pay of $100

Maintenance Prescriptions for controlled substances that cannot
be obtained through Mail Order..... Plan pays 75%

When mail order is available and you buy
maintenance drugs through another service ..... Plan pays 50%
(After Deductible)

Additional Benefits with Prescription..... Plan pays up to 100%

(Additional Benefits with Prescription may be payable by the Plan as regulations require based upon recommendations and guidelines as determined by certain Governmental Agencies. A complete list of all recommendations and guidelines can be obtained at https://www.HealthCare.gov/prevention or by contacting the Plan Administrator.)

MEDICARE SUPPLEMENTAL BENEFITS

Effective January 1, 2011, this Plan began treating retired participants who are eligible to receive Medicare benefits as though they are Medicare participants whether or not they are actually enrolled in Medicare Part A, Part B and Part D. Claims received by the Plan for Medicare Eligible Retirees are processed for secondary payment only.

Medicare Supplement Prescription Drug Reimbursement Benefit
(Not Subject to Deductible)

Effective January 1, 2011, the Plan began coordinating prescription drug claims as if the participant is a Medicare participant and began subsidizing reimbursement at 50% of the first dollar of the Medicare Part D "Donut Hole" prescription drug expense of $2,250 to $5,850 up to a maximum reimbursement of $1,800 per Calendar Year. **The "Donut Hole" coverage gap amount is subject to annual change until 12/31/2020 when the gap will be closed.**

Participants are required to provide a pharmacy printout as documentation of proof of expense when submitting claims. Participants who are enrolled in Medicare Part D should also submit a copy of their Social Security Administration Retirement, Survivors and Disability Insurance Notice of Benefits.

$4,020 to $6,350 Prescription Drug Reimbursement Benefit (Medicare Part D Donut Hole for 2020):

Medicare Supplemental Prescription Drug
Reimbursement Benefit ..... Plan Reimburses 50%
Maximum of $1,165/Calendar Year

This Summary of Benefits provides a quick reference but is not a complete description of the Plan. Please read the entire Plan carefully for a full explanation of Plan benefits, limitations and exclusions. In addition, Participating Employees and Participating Dependents may contact the Plan Administrator for additional information concerning coverage for specific benefits, tests, and procedures. There shall be no cost to the Participating Employee or Participating Dependent for requesting and being provided such information.

SECTION III
MEDICAL EXPENSE BENEFITS

Under the medical reimbursement program, payment will be made for Covered Medical Expenses as defined in this Plan, subject to the Premiums, Deductibles, Co-Insurance, Co-payments, maximum benefit levels, and other conditions and limitations described in the Summary of Benefits and in this Section.

The maximum benefit payable for each Participant is listed in the Summary of Benefits (Section II). Benefit reimbursement will not be considered for amounts over the specified maximums listed.

DEDUCTIBLE

The Deductible amounts are listed in the Summary of Benefits and must be satisfied each Calendar Year. All services are subject to the Deductible unless otherwise specified. If the combined Deductible expenses of one or more Participating family members reach the "Per Family" Deductible amount, then the individual Deductibles for all Participating family members are deemed satisfied for that Calendar Year.

Any Covered Medical Expenses incurred in the last three (3) months of a Calendar Year which are used to satisfy the Deductible for that year will also be applied towards the satisfaction of the Deductible for the following Calendar Year.

BENEFITS FOR RECOMMENDED PREVENTIVE SERVICES

The Plan shall cover Recommended Preventive Services received from a network provider without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply. Provided, however, that the following rules shall apply: (a) if a Recommended Preventive Service is billed separately (or tracked as individual encounter data separately) from an office visit, the Plan may impose cost-sharing requirements (including any deductible, copayment or coinsurance requirement) with respect to the office visit; (b) if a Recommended Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is the delivery of the Recommended Preventive Service, the Plan shall not impose cost-sharing requirements (including any deductible, copayment or coinsurance requirement) with respect to the office visit; and (c) if a Recommended Preventive Service is not billed separately (or is not tracked as individual encounter data separately) from an office visit, and the primary purpose of the office visit is not the delivery of the Recommended Preventive Service, the Plan may impose cost-sharing requirements (including any deductible, copayment or coinsurance requirement) with respect to the office visit.

BENEFITS FOR EMERGENCY SERVICES

Notwithstanding anything to the contrary in this Plan, medical expenses covered under the Plan which constitute emergency services shall be covered in accordance with the following rules:

(1) Coverage will be provided without the need for prior authorization, even if emergency services are provided out-of-network;

(2) Coverage for emergency services received from an out-of-network provider will be provided under the Plan without regard to whether the provider is a participating network provider with respect to the services;

(3) Administrative requirements or limitations on coverage for out-of-network emergency services will not be more restrictive than the administrative requirements or limitations that apply to emergency services received from in-network providers;

(4) Coverage for emergency services will be provided without regard to any other term or condition of coverage other than the exclusions, coordination of benefits, or any applicable waiting period set forth in this Plan; and

(5) If emergency services are provided out-of-network, the following shall apply to any cost-sharing provision of this Plan:

Any cost-sharing requirement imposed for out-of-network emergency services that is a copayment or coinsurance requirement cannot exceed the cost-sharing requirement that would be imposed if the services were provided for in-network emergency services; however, any cost-sharing requirement other than a copayment or coinsurance requirement (such as a deductible or out-of-pocket maximum) may be imposed with respect to emergency services provided out-of-network if the requirement generally applies to all other (i.e. non emergency) out-of-network services as well.

COMMON ACCIDENT

If two (2) Participating family members sustain Injuries in the same accident, and incur Covered Medical Expenses for such Injuries during the Calendar Year in which the accident occurs, then no more than one (1) Per Participant Deductible will be applied to the Covered Medical Expenses for these Participants for the remainder of that Calendar Year.

COVERAGE FOR PARTICIPATION IN AN APPROVED CLINICAL TRIAL

The Plan will not deny a Qualified Individual coverage in an approved clinical trial, and will not deny (or impose additional conditions on) coverage of routine patient costs for items and services furnished in connection with the trial, or discriminate against the Qualified Individual based on participation in the trial. The Plan may require

the Qualified Individual to participate in an in-network clinical trial if the provider will accept the Qualified Individual as a participant in the trial. If a Qualified Individual participates in an approved clinical trial outside the state of the Participant's resident, these provisions will apply to the extent the plan provides out-of-network coverage for routine patient costs.

For purposes of this provision:

"Routine patient costs" includes items and services typically provided under the plan for a participant not enrolled in a clinical trial. However, such items and services do not include (a) the investigational item, device or service itself; (b) items and services not included in the direct clinical management of the patient, but instead provided in connection with data collection and analysis; or (c) a service clearly not consistent with widely accepted and established standards of care for the particular diagnosis.

"Approved clinical trial" is a phase I, phase II, phase III, or phase IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is federally funded through a variety of entities or departments of the federal government; is conducted in connection with an investigational new drug application reviewed by the Food and Drug Administration; or is exempt from investigational new drug application requirements.

"Life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

"Qualified individual" is a Participant who is eligible, according to the trial protocol, to participate in an approved clinical trial for the treatment of cancer or other life-threatening disease or condition and either:

— the referring health care professional is a participating provider and has concluded that the Participant's participation in the clinical trial would be appropriate; or

— the Participant provides medical and scientific information establishing that the individual's participation in the clinical trial would be appropriate.

COVERAGE FOR KIDNEY DIALYSIS TREATMENT AND RELATED SERVICES

Kidney Dialysis, Hemodialysis and Peritoneal Dialysis are Covered Medical Expenses if determined by the Plan Administrator to be Medically Necessary.

Covered Medical Expenses for kidney dialysis, regardless of whether or not the participant has End Stage Renal Disease, shall be limited as follows:

An individual receiving outpatient dialysis treatment and related services may or may not be eligible for Medicare coverage. Benefits provided under this Plan for treatment received in connection with outpatient dialysis and related services are

subject to the following provisions:

Although a Participant may not be eligible or obligated to apply for Medicare Part A and/or Part B, the Plan will provide benefits as described below regardless of whether the Participant is eligible to enroll, or actually enrolls, in Medicare coverage.

* During the period of time that Medicare is eligible to become, or would otherwise have become, the secondary payer for outpatient dialysis treatment and related services under the then-current coordination of benefit rules, the Plan will pay these services at 150% of the then-current Medicare allowable charge.

* During the period of time that Medicare is eligible to become, or would otherwise have become, the primary payer for outpatient dialysis treatment and related services, the Plan, as the secondary payer, will coordinate with Medicare pursuant to the then-current coordination of benefit rules. The total Covered Medical Expense for these services paid collectively by Medicare and the Plan will not exceed 100% of the then-current Medicare allowable charge for such services.

MULTIPLE BIRTHS

Not more than one Per Participant Deductible will be applied to the Covered Medical Expenses incurred in a Calendar Year for two or more Dependents born in a multiple birth, if the Covered Medical Expenses are incurred in the same Calendar Year in which the Dependents are born and are the result of: (a) premature birth; (b) abnormal congenital condition; or, (c) Injury which is received or Sickness which starts no more than thirty (30) days after birth.

PRECERTIFICATION

The benefits provided by this Plan are limited to charges for services and supplies which are Medically Necessary to the care and treatment of an Illness or Injury. All Inpatient Hospital Confinements (except as provided in the Summary of Benefits) must be precertified by the Plan's Utilization Review Service as provided in the Summary of Benefits. If a Participant fails to obtain precertification approval as required by the Plan, then benefits will be reduced as provided in the Summary of Benefits.

PRE-ADMISSION TESTING BENEFIT

Expenses of an acute care Hospital or certified Outpatient facility for Outpatient pre-admission laboratory tests or x-ray examination of a Participant who is scheduled to be Confined In A Hospital as an Inpatient, will be payable at the percentage listed in the Summary of Benefits if such tests are performed or x-rays taken no more than seven (7) days prior to the Inpatient Hospital Confinement procedure.

PROVIDER NON-DISCRIMINATION

The Plan will not discriminate with respect to participation under the plan or coverage against any health care provider who is acting within the scope of that provider's license or certification under applicable State law; provided, that this section shall not require the plan to contract with any health care provider willing to abide by the terms and conditions for participation established by the plan or issuer, nor shall this provision be construed as preventing the Plan from otherwise establishing varying reimbursement rates based on quality or performance measures.

ORGAN TRANSPLANT BENEFIT

Organ transplants from human to human of kidney, cornea, bone marrow, heart, lung, pancreas and liver are Covered Medical Expenses if determined by the Plan Administrator to be Medically Necessary and not Experimental or Investigative for a particular Sickness or Injury. Organ transplants must be precertified by the Utilization Review Service. If the organ donor is a Participant under this Plan, then the donor's expenses will be Covered Medical Expenses. If the donor is not a Participant under this Plan, then expenses incurred by the donor will be Covered Medical Expenses to the extent that such expenses are not first payable by any individual or group plan covering the donor.

Covered Medical Expenses will include: (a) charges for evaluating and removing the organ from a cadaver or tissue bank; (b) charges for the Surgical Procedure to implant the organ; and (c) transportation of the organ to the location of the surgery when the location is within a 500-mile radius. Benefits will be payable for transportation of the donor organ outside the 500-mile radius only in case of an Emergency, or when a suitable organ is not reasonably available within the 500-mile limit. In such a case, benefits will be payable only for the acquisition of an organ in the United States or Canada.

If the Plan Administrator, in its sole discretion, determines that an autologous bone marrow transplant or peripheral stem cell rescue is Experimental or Investigational as a treatment for a particular Sickness (e.g., type of cancer), and is therefore not a Covered Medical Expense, then any high dose chemotherapy treatment for the same or related Sickness will also not be a Covered Medical Expense.

MASTECTOMY RELATED BENEFIT

In the case of a Participant who is receiving benefits under the Plan in connection with a Medically Necessary mastectomy, benefits are also provided for: (1) Reconstruction of the breast on which the mastectomy has been performed; (2) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and (3) Prostheses and physical complications at all stages of the mastectomy, including lymph edemas.

MINIMUM INPATIENT HOSPITAL CHILDBIRTH BENEFIT

In the case of a Participant who is eligible to receive Inpatient Hospital benefits under the Plan in connection with childbirth, the mother and newborn child shall be entitled to Inpatient Hospital benefits for a period of not less than forty-eight (48) hours following a vaginal delivery or not less than ninety-six (96) hours following delivery by cesarean section. If it becomes Medically Necessary for the Participant or the newborn child to remain in the Hospital beyond these minimum time periods, then the Participant must contact the Utilization Review Service before the end of the originally approved stay and request precertification approval for the additional days.

BIRTHING CENTER BENEFIT

The reasonable fees of a Birthing Center for services and supplies furnished to a Participating Employee or Dependent spouse for prenatal care, delivery and postpartum care rendered within twenty-four (24) hours of delivery are eligible for reimbursement within the limits specified in the Summary of Benefits. Dependent children are not eligible for this benefit.

HOSPICE CARE BENEFITS

Services and supplies furnished by a Hospice to a Terminally Ill Participant are a Covered Medical Expense if such services and supplies are: (a) ordered by a Physician; (b) needed for palliative and supportive care of the Terminally Ill Participant; and (c) included in a Hospice Care Program. Services and supplies are not a Covered Medical Expense if they are: (d) furnished by volunteers or other persons who do not regularly charge for their services; (e) for funeral arrangements or services; (f) for legal or financial counseling; or (g) provided to family members other than the Terminally Ill Participant.

Benefits are limited to Hospice charges incurred within six (6) months from the date the Terminally Ill Participant enters a Hospice Care Program, and subject to any maximum benefit stated in the Summary of Benefits. All periods of care in a Hospice Care Program will be deemed to have occurred in one (1) period unless separated by at least three (3) consecutive months during which the Terminally Ill Participant is in remission and not receiving Hospice care.

BEREAVEMENT BENEFITS

Charges incurred by a Terminally Ill Participant's Participating Dependents for supportive counseling services provided after the death of the Terminally Ill Participant are Covered Medical Expenses if such counseling services are ordered and received under the Hospice Care Program. This benefit is limited to three (3) chargeable visits for counseling services per family.

CARE MANAGEMENT

The Plan Administrator may, on a case by case basis, approve as a Covered Medical Expense charges for a service or supply not otherwise covered under the Plan if the Plan Administrator determines that the service or supply is: (a) Medically Necessary for treatment of a Sickness or Injury; and (b) of lower cost or more cost-effective than a service or supply which is a Covered Medical Expense under the Plan.

MAINTENANCE MAIL ORDER PRESCRIPTION DRUG BENEFITS

Charges by a Pharmacy for Prescription Drugs are a Covered Medical Expense if the Prescription Drug is Medically Necessary for the treatment of an Injury or Sickness. Benefits are paid after the Participant first pays the Mail Order Prescription Drug Co-payment listed in the Summary of Benefits. The Mail Order Prescription Drug Co-payment must be paid by the Participant for each Prescription Order. **Mail Order Prescription Drug Co-payments are not counted toward and are not subject to the Co-insurance Limit.**

MAINTENANCE MAIL ORDER PRESCRIPTION DRUG BENEFIT EXCLUSIONS

No payment will be made for expenses incurred for:

1. Experimental or Investigational drugs, including but not limited to any drugs labeled "Caution - limited by federal law to investigational use";

2. Medication which is taken or administered, in whole or in part, at the place where it is dispensed or while a Participant is a patient in an institution which operates, or allows to be operated, on its premises a facility for dispensing pharmaceuticals;

3. Any prescription refilled in excess of the number specified by the Physician or dispensed more than one (1) year from the date of a Physician's Prescription Order;

4. More than a ninety (90) day supply when dispensed in any one Prescription Order;

5. Prescriptions for which the Participant is entitled to reimbursement under any Workers' Compensation law or any other municipal, state or federal program;

6. Non-legend or over-the-counter drugs, or the administration or injection of any drug other than insulin or diabetic test strips;

7. Therapeutic devices or appliances, including hypodermic needles, syringes, (except for insulin), support garments, and other non-medical substances, regardless of intended use;

8. Other drugs, services and supplies listed in the Expenses Not Covered section of the Plan.

9. Growth hormones.

10. Retin A if over the age of 25.

11. Infertility medication.

MENTAL HEALTH CONDITION BENEFIT

To be a Covered Medical Expense, treatment for a Mental Health Condition must be provided by a Physician, as defined in this Plan.

SUBSTANCE USE DISORDER BENEFIT

To be a Covered Medical Expense, treatment for a Substance Use Disorder must be provided by a Physician, as defined in this Plan.

AUTISM SPECTRUM DISORDER BENEFIT

Diagnosis and treatment of autism spectrum disorder (ASD) is a Covered Medical Expense for dependent children ages eighteen months to twenty-six years, when diagnosis is made by age eight years and when provided by a Physician, as defined in this Plan. Applied Behavior Analysis (ABA) is subject to an annual limit of $30,000 for the first three consecutive years from the date treatment commences. After three years, ABA is limited to $2,000 per month to twenty-six years of age as long as ABA continues to be medically necessary and provided the individual's condition is improving in response to treatment and the maximum improvement is yet to be attained. Coverage includes diagnostic tests, evaluations, and assessments necessary to determine whether an individual has ASD and medically necessary treatment when ordered or prescribed by a licensed physician or licensed psychologist and in accordance with a treatment plan developed from a comprehensive evaluation by a certified behavior analyst for an individual diagnosed with ASD.

HOME HEALTH CARE BENEFITS

Services and supplies furnished to a Participant by a Home Health Care Agency are Covered Medical Expenses if such services and supplies are: (a) ordered in writing by the Participant's attending Physician; (b) Medically Necessary for the treatment of a Sickness or Injury; (c) included in a written Home Health Care Plan; and (d) provided by appropriately qualified and trained health care professionals. In addition, the

Participant's attending Physician must certify in writing that Inpatient confinement in a Skilled Nursing Facility or Hospital would be necessary if Home Health Care Agency services were not available.

Home Health Care Agency benefits are limited to a maximum of forty (40) home health care visits per Calendar Year. Each visit by a Home Health Care Agency employee is considered one (1) home health care visit, and each four (4) hours of Home Health Aide services are considered one (1) home health care visit.

COVERED MEDICAL EXPENSES

Covered Medical Expenses are Usual, Customary and Reasonable Charges which are: (a) actually incurred for the services and supplies listed below; (b) approved by the attending Physician; (c) Medically Necessary for the treatment of a Sickness or Injury of a Participant; and (d) subject to the benefit maximums and limitations stated in the Summary of Benefits and elsewhere in this Plan. Covered Medical Expenses include:

1. Private duty nursing services by a registered Nurse other than a Nurse who normally resides in the Participant's home or who is the Participant's spouse, child, brother, sister, parent, or mother/father-in-law;

2. Room, board, and routine nursing service during Confinement in a Hospital;

3. Intensive care;

4. Hospital charges for medical services and supplies;

5. Anesthetics and their administration by a Physician or professional anesthetist;

6. Physician charges for medical care;

7. X-rays (other than dental), microscopic and laboratory tests, and other diagnostic services ordered by a Physician;

8. X-ray and radioactive therapy;

9. Necessary transportation by local professional ambulance to the nearest Hospital equipped to furnish treatment;

10. Medical supplies prescribed by a Physician, including:

a. Drugs and medicines which require a written prescription and which must be dispensed by a Physician or pharmacist, not including vitamins or minerals;

b. Blood which cannot be replaced and other fluids to be injected into the circulatory system;

c. Initial artificial limbs, eyes and other necessary prostheses;

d. Casts, splints, trusses, braces, crutches, and surgical dressings;

e. Rental, up to the purchase price, of Durable Medical Equipment, or Hospital-type equipment including wheelchair, Hospital bed, iron lung or other mechanical equipment for the treatment of respiratory paralysis, and equipment for the administration of oxygen.

11. Routine nursery care and pediatric charges for a well newborn baby, unless otherwise stated in this Plan;

12. Charges incurred in a Skilled Nursing Facility if such confinement: (a) is preceded by at least three (3) consecutive days of Hospital Confinement; (b) is due to the Injury or Sickness which required the Hospital Confinement; (c) commences within fourteen (14) days after such Hospital Confinement; and (d) is Medically Necessary for treatment and is not Custodial Care;

13. Voluntary sterilization for covered Employees and Dependent spouses;

14. Rehabilitation Services, including diagnostic testing, assessment, monitoring or treatment of the following conditions, individually or in combination:

a. stroke;
b congenital deformity;
c. major multiple trauma;
d. brain injury;
e. burns;
f. spinal cord injury;
g. amputation;
h. fracture of femur;
i. polyarthritis, including rheumatoid arthritis;
j. neurological disorders (including, but not limited to: multiple sclerosis, motor neuron diseases, polyneuropathy, muscular dystrophy and Parkinson's disease);
k. cardiac disorders (including, acute myocardial infarction, angina pectoris, coronary arterial insufficiency, angioplasty, heart

transplantation, chronic arrhythmia, congestive heart failure and valvular heart disease).

15. Mammograms for breast cancer screening, once annually or more often if recommended by a Physician;

16. Papanicolaou screening test for women age 18 and older, once annually or more often if prescribed by a Physician;

17. Organ transplants, within the benefit limitations defined in the Plan;

18. Well Child Care;

19. Physical therapy, speech therapy, occupational therapy or physiotherapy when performed by a licensed therapist;

20. Elective second surgical opinion to determine whether or not to perform a Surgical Procedure, if such opinion is given by a board-certified specialist in the appropriate specialty;

21. Charges made by an Ambulatory Surgical Center in connection with a covered Surgical Procedure.

22. Arch supports, corrective or orthopedic shoes, if made from a cast or mold.

23. Smoking cessation programs. Only one (1) complete treatment plan.

EXPENSES NOT COVERED

The following services, supplies or charges shall not be Covered Medical Expenses and no benefits shall be payable under the Plan:

1. Charges made for treatment, services or supplies not listed in this Plan as Covered Medical Expenses;

2. Charges made for treatment resulting from an Injury or Sickness covered by Workers' Compensation or similar laws, or for any Injury or Sickness arising out of any employment for wage or profit;

3. Charges made for medical examinations or laboratory tests for check-up purposes which are not Medically Necessary for the treatment of a Sickness or Injury, except as otherwise stated in this Plan;

4. Charges made for eye refractions, eye examinations, eyeglasses or the fitting thereof, surgical correction of vision including, but not limited to,

radial keratotomy, or eye exercises, except for the initial contact lens or eye glasses following cataract surgery; charges made for hearing aids or the fitting thereof;

5. Charges made for oral surgery, or for care or treatment of teeth, gums, or alveolar process disorder EXCEPT: (a) treatment due to accidental Injury to sound natural teeth including replacement of such teeth; and (b) the setting of a jaw fracture or dislocation caused by an accidental Injury;

6. For or in connection with Cosmetic Surgery unless: (a) a Participant receives an Injury, while enrolled and covered under this Plan, which results in bodily damage requiring the surgery; or (b) the surgery qualifies as reconstructive surgery performed on a person following surgery, and both the surgery and the reconstructive surgery are Medically Necessary;

7. Charges for treatment of a newborn child, other than as provided in the Plan for Well Baby Care prior to initial discharge from the Hospital; however, the following is covered: treatment of premature birth, abnormal congenital conditions, or a Sickness or Injury contracted after birth up to any limits specified in the Plan;

8. Any charges for a Dependent female child relating to, or a complication of, pregnancy;

9. Charges incurred for voluntary or elective surgery treatment not Medically Necessary for Treatment of a Sickness or Injury, **excluding** elective surgery for sterilization;

10. Charges made for treatment of Injury or Sickness due to war, insurrection, participation in a riot, or while engaged in any assault, crime or other illegal act or occupation, whether or not charged or convicted of a violation under local, state or federal law;

11. Custodial Care, intermediate care, respite care; charges incurred in an institution which is a rest home, or home for the aged, except as they may be eligible under the Skilled Nursing Facility Benefit;

12. Charges made for treatment of an Injury or disability due to self-inflicted Injury or attempted suicide, unless such Injury or disability is the result of a medical condition or domestic violence and otherwise covered by the Plan;

13. Charges for education, training, or bed and board while confined or attending to an institution which is a school or other institution for training;

14. Exercise equipment, whirlpool equipment, or any charges made for recreation, exercise, physical conditioning, flexibility or general motivation;

15. Charges incurred as a result of a sports-related Injury if the Participant is engaged in the sport for profit;

16. Environmental control equipment such as, but not limited to, air conditioners, dehumidifiers, humidifiers, air purifiers;

17. Heating pads, hot water bottles, home enema equipment, rubber gloves, wigs or wig styling, or bathroom scales;

18. Equipment or supplies which are primarily for patient comfort or convenience, such as bathtub lifts or seats, massage devices, elevators, stair lifts, hydraulic van or car lifts, orthopedic mattresses, child strollers, recliners, contour chairs or adjustable beds;

19. Personal comfort and convenience services, supplies or items (whether obtained on an Inpatient or Outpatient basis), such as but not limited to televisions, telephones, barber or beauty services, guest services and other similar items and services;

20. Nutritional supplements, food liquidizers, food processors or other food preparation equipment;

21. Medical supplies such as but not limited to tape, alcohol, swabs, bandages, thermometers, diapers (adult or infant), heating pads, ice bags, blood pressure kits or home pregnancy tests;

22. Charges made for electrical power, gas services, water supply, and sanitary waste disposal systems or their installation;

23. Charges of ostomy supplies other than belts, rings and bags;

24. Charges for immunizations or other "preventive" medical care, including but not limited to influenza and pneumonia immunizations, other than as expressly provided for in the Plan;

25. Charges incurred for instruction in alternate life patterns; hypnosis;

26. Charges incurred in a Hospital for weekend days, where the initial non-Emergency confinement begins on a Friday, Saturday, or Sunday, and where no substantial services are rendered prior to the following Monday, or where services which were rendered could have been provided on the following Monday;

27. Treatment or surgical correction of or complications from, or weight loss programs for, any degree of obesity, including without limitation, morbid obesity;

28. Charges for care or treatment: (a) obtained in a U.S. government facility; or (b) for an Injury or Illness contracted while serving in the military or otherwise caused by war (declared or undeclared) or an act of war.

29. To the extent of the exclusions or penalties imposed by any precertification or second opinion requirements shown in the Summary of Benefits section of this Plan;

30. Charges made by a Physician for or in connection with surgery which exceed the following maximum when two or more surgical procedures are performed at one time: the maximum amount payable will be the amount otherwise payable for the most expensive procedure, and one-half (½) of the amount otherwise payable for all other surgical procedures;

31. To the extent that charges or expenses are more than Usual, Customary and Reasonable Charges;

32. For charges which would not have been made if the Participant had no health coverage;

33. Experimental or Investigational services, supplies, procedures or treatment methods;

34. Experimental drugs or substances not approved by the U.S. Food and Drug Administration, or drugs labeled: "Caution-limited by Federal law to investigational use";

35. Supplies, care, treatment or surgery which are not Medically Necessary for the care and treatment of an Injury or Sickness;

36. Charges made by an assistant surgeon in excess of 20% of the surgeon's Usual, Customary and Reasonable Charge; or for charges made by a co-surgeon in excess of the surgeon's Usual, Customary and Reasonable Charge plus 20%;

37. For or in connection with speech therapy, if such therapy is (a) to improve speech skills that have not fully developed; (b) is primarily custodial or educational; or (c) is intended to maintain speech communication; (d) is not restorative in nature;

38. Charges made by any provider who is a member of a Participant’s or Dependent’s family, including but not limited to, mother, father,

grandmother, grandfather, brother, sister, son, daughter, grandson, granddaughter, or any person who resides with the Participant or Dependent;

39. To the extent that benefits are paid or payable for those expenses under the mandatory part of any auto insurance policy written to comply with a "no-fault" insurance law or an uninsured motorist insurance law; the Plan Administrator will take into account any adjustment option chosen under such part by the Participant;

40. For or in connection with an elective abortion unless: (a) the Physician certifies in writing that the pregnancy would endanger the life of the mother; or (b) the expenses are incurred to treat medical complications due to the abortion;

41. Reversal of sterilization;

42. Infertility services, including but not limited to invitro fertilization, artificial insemination or other procedures;

43. Therapy and related services for a patient showing no progress or improvement in functioning; mental health services which will not substantially improve the patient's current level of functioning;

44. Sex transformation operations and associated services and expenses;

45. The difference between private and semi-private room charges;

46. Duplicate procedures or duplicate testing, interpretation or handling fees;

47. Charges made for massage therapy, herbal therapy, aromatherapy, or acupuncture.

SECTION IV
DENTAL BENEFITS

SUMMARY OF DENTAL BENEFITS

NOTE: THE DENTAL BENEFIT PLAN MAY BE ELECTED INDEPENDENTLY OR WITH THE MEDICAL BENEFIT PLAN. PLEASE CONTACT THE WV ANNUAL CONFERENCE OFFICE FOR FURTHER DETAILS.

DEDUCTIBLE

Per Participant Per Calendar Year $25
(Maximum 3 per Family)

Per Family Per Calendar Year $50

Class I - Preventive Care ..... Plan pays 100%
There is no Deductible.

Class II - Basic Restorative ..... Plan pays 80%
Subject to $25 Deductible.

Class III- Major Restorative ..... Plan pays 50%
Subject to $25 Deductible.

Installation of a prosthodontic appliance (fixed bridgework, partial dentures and full upper or lower dentures) or crown, within the first twelve (12) months of continuous coverage are not covered.

Any Covered Dental Expenses incurred in the last three (3) months of a Calendar Year which are used to satisfy the Deductible for that year will also be applied towards the satisfaction of the Deductible for the following Calendar Year.

MAXIMUM BENEFITS (PER PARTICIPANT)

Classes I, II, III Combined
Calendar Year Maximum Benefit $1,000

COVERED DENTAL EXPENSES

Covered Dental Expenses are Usual, Customary and Reasonable Charges incurred by a Participant for the performance by a Dentist of a Dental Service listed in the Dental Services Schedule. Covered Dental Expenses will include only those expenses incurred for a Dental Service which (a) is performed by or under the direction of a Dentist; (b) is essential for the necessary care of the teeth; and (c) starts and is completed while the patient is a Participant under this Plan.

Any portion of charges for a Dental Service that exceeds the Maximum Covered Dental Expense indicated for that service in the Dental Services Schedule is excluded from payment.

A Dental Service is deemed to start when the actual performance of the service starts except that: (a) for fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth are fully prepared; (b) for a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved; and (c) for root canal therapy, it starts when the pulp chamber of the tooth is opened.

If more than one type of Dental Service can provide suitable treatment for a dental condition, the Plan will pay benefits for the least expensive Dental Service which meets accepted standards of dental practice. A Participant may apply the benefit payable to the Dental Service of his or her choice; however, the Participant shall be responsible and the Plan shall not pay for any expenses incurred which exceed the benefits payable for the least expensive acceptable Dental Service.

PRE-DETERMINATION OF BENEFITS

Whenever major or extensive dental work is proposed, a Participant or Participant's Dentist should request a determination from Benefit Assistance Corporation, before the dental work is started, of what expenses will be payable as Covered Dental Expenses under the Plan. The Participant's Dentist should furnish a proposed treatment plan, including a list of services to be performed, the itemized cost of each service, and dental x-rays or models needed to evaluate the proposed plan.

Benefit Assistance Corporation will review the plan and estimate what benefits, if any, the Plan will pay. Pre-determination of benefits is not a guarantee of what the Plan will pay. Actual benefits will depend on what services are actually provided, whether the patient remains a Participant at the time the services are rendered, and other applicable terms and conditions of this Plan.

DENTAL SERVICES SCHEDULE

Covered Dental Expenses will include expenses incurred for Dental Services listed in this Schedule. The Plan Administrator may agree to accept, as a Covered Dental Expense, expenses for services not listed in the Dental Services Schedule, if the expense otherwise meets the definition of a Covered Dental Expense. Any such service should be identified in terms of the American Dental Association Uniform Code of Dental Procedures and Nomenclature and/or by description, and should be submitted to Benefit Assistance Corporation for review by the Plan Administrator.

The Plan Administrator will determine the Maximum Covered Dental Expense for services that it accepts. The Maximum Covered Dental Expense so determined will be consistent with the maximums listed in this Schedule.

A temporary Dental Service is included in the benefit allowance for the final Dental Service and is not a separate Dental Service.

CLASS I SERVICES – DIAGNOSTIC AND PREVENTATIVE

The Maximum Covered Dental Expense for any Class I Service is 100% of the Usual, Customary and Reasonable Charge.

- Periodic oral examination - Limited to two (2) per Participant per Calendar Year.
- Emergency treatment to relieve dental pain when no other definitive Dental Services are performed. Any X-ray taken in connection with such treatment is a separate Dental Service.
- X-rays - Complete series (with or without bitewings). Limited to one (1) per Participant, including Panoramic film, in any three (3) Calendar Years.
- Bitewing X-rays - Limited to two (2) charges per Participant per Calendar Year.
- Panoramic (Panorex) X-ray - Limited to one (1) per Participant in any three (3) Calendar Years.
- Prophylaxis (Cleaning) - Only two (2) per person per Calendar Year.
- Topical application of acid fluoride phosphate - Limited to persons less than 19 years old. Only one (1) per Participant per Calendar Year.
- Space Maintainers, fixed unilateral - Limited to non-orthodontic treatment.

CLASS II SERVICES – BASIC RESTORATIONS, ENDODONTICS, PERIODONTICS, PROSTHODONTIC MAINTENANCE AND ORAL SURGERY

The Maximum Covered Dental Expense for any Class II Service is 80% of the Usual, Customary and Reasonable Charge.

- Amalgam Filling - Primary (Baby) Teeth, One (1) Surface.
- Amalgam Filling - Permanent Teeth, One (1) Surface.
- Composite Acrylic Resin Filling, One (1) Surface.
- Root Canal Therapy - Any X-ray, test laboratory exam or follow-up osseous surgery and osseous graft and not a separate Dental Service. If more than one periodontal surgical service is performed per quadrant only the one with the largest maximum Covered Dental Expenses is a Dental Service.
- Periodontal Prophylaxis.
- Periodontal Scaling and Root Planing.
- Periodontal Maintenance (Following active therapy).
- Osseous Surgery.
- Adjustments - Complete Denture. Any adjustment of or repair to a denture within six (6) months of its installation is not a Dental Service.
- Re-cement Bridge.
- Simple Extractions.

- Surgical Extractions - Soft Tissue Impaction, Partial Bony Impaction, Complete Bony Impaction.
- Local anesthetic, analgesic and routine post-operative care for extractions and other oral surgery are part of the allowance for each Dental Service.
- General Anesthetic - The administration of a general anesthetic is a Dental Service covered by this Schedule only: (a) when Medically Necessary in conjunction with oral or dental surgery; and (b) if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the whole body.

CLASS III SERVICES – MAJOR RESTORATION, DENTURES AND BRIDGEWORK

The Maximum Covered Dental Expense for any Class III Service is 50% of the Usual, Customary and Reasonable Charge.

- Gold or Crown restorations are dental services only when the tooth, as a result of extensive cavities or a fracture, cannot be restored with amalgam, silicate, acrylics or plastic restoration.
- Crowns - Porcelain with Gold, Cast Gold - Full, Cast Gold - Three Fourths.
- Fixed or Removable Appliances - Complete (Full) Dentures, Upper or Lower.
- Partial Dentures, Acrylic Base - Lower, with Two Clasps and Chrome Lingual Bar, Upper, with Two Clasps and Chrome Palatal Bar.
- Bridge Pontics - Cast Gold.
- Bridge Pontics - Porcelain Fused to Gold.
- Bridge Pontics - Plastic Processed to Gold.
- Abutment Crowns - Plastic Processed to Gold.
- Abutment Crowns - Porcelain Fused to Gold.
- Abutment Crowns - Full Cast Gold.

EXPENSES NOT COVERED

Covered Dental Expenses will not include and no benefits shall be payable under the Plan for the following services, supplies, appliances or treatment:

1. Services performed primarily for cosmetic reasons;

2. Replacement of a lost or stolen appliance;

3. Replacement of a bridge, crown or denture within five (5) years after the date it was originally installed unless: (a) such replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, has been damaged beyond repair as a result of an injury received while a person is covered as a Participant under this Plan;

4. Any replacement of a bridge, crown or denture which is or can be made usable according to common dental standards;

5. Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimensions; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint; (c) stabilize periodontally involved teeth; or (d) restore occlusion;

6. Porcelain or acrylic veneers of crowns or pontics on or replacing the upper and lower first, second and third molars;

7. Bite restorations, precision or semi-precision attachments, or splinting;

8. A surgical implant of any type including any attached prosthetic device;

9. Instruction for plaque control, oral hygiene or diet;

10. Dental services that do not meet common dental standards;

11. Services that are deemed to be medical services;

12. Services and supplies received from a hospital;

13. Treatment or services needed due to a job-related injury or a condition which benefits are payable under Workers' Compensation or similar laws;

14. Treatment or services which the Participant is not obligated to pay or for which no charge would be made in the absence of dental benefit coverage;

15. Treatment or services which are Experimental or Investigational in nature or which do not meet accepted standards of dental practice.

16. Sealants.

17. Installation of a prosthodontic appliance (fixed bridgework, partial dentures and full upper or lower dentures) or crowns, within the first twelve (12) months of continuous coverage.

18. Orthodontia.

This Summary of Benefits provides a quick reference but is not a complete description of the Plan. Please read the entire Plan carefully for a full explanation of Plan benefits, limitations and exclusions. In addition, Participating Employees and Participating Dependents may contact the Plan Administrator for additional information concerning coverage for specific benefits, tests, and procedures. There shall be no cost to the Participating Employee or Participating Dependent for requesting and being provided such information.

SECTION V
ELIGIBILITY FOR COVERAGE

ELIGIBILITY FOR BENEFITS

Individuals eligible to enroll in the Plan include:

1. Eligible Employees.

2. Dependents.

3. Retired Employees.

   Effective January 1, 2011, this Plan treats retired participants who are eligible to receive Medicare benefits as though they are Medicare participants whether or not they are actually enrolled in Medicare Part A, Part B and Part D. Claims received by the Plan for Medicare Eligible Retirees are processed for secondary payment only.

Upon enrollment in the Plan and payment of any required Employee Contribution, the Eligible Employee, and, if applicable, his or her Dependent(s) shall become Participants eligible to receive benefits as provided by this Plan. If both Spouses are Eligible Employees, each may elect to participate in this Plan as Eligible Employees, but only one Spouse may enroll Dependents under the Plan. In no event may an individual participate both as an Eligible Employee and as a Dependent under the Plan.

If you are in one of the eligible classes shown below, you are eligible for coverage under the Plan:

1. Employees who complete at least twenty (20) hours per week for a participating Employer.

2. All Retired Employees who were under full time Episcopal appointment seven (7) consecutive years prior to their effective retirement date. Persons who have had an interruption in the last seven (7) years of their appointive service, but have remained in relationship with the West Virginia Annual Conference, may have their eligibility reviewed by the Board of Pensions on a case-by-case basis.

3. Seminary students who are Provisional members of the Annual Conference.

4. Divorced spouses of Eligible employees:

   a. One (1) year of eligibility credit will be given for each complete year of marriage prior to the entry of a decree of divorce for divorced

spouses of Eligible Employees, provided they elect to continue coverage under the Plan within thirty-one (31) days of the divorce.

b. Eligibility will cease if the spouse remarries, becomes eligible under another group health plan, attains age 65, or fails to make timely contributions to the Plan. Contributions for eligible Plan Participants under this section are the same as lay employee Plan Participant contributions.

5. All Surviving Spouses of deceased employees of the above groups.

6. All Plan Participants placed on sabbatical leave may continue in the insurance program for a period of twelve (12) months.

7. All Plan Participants appointed to attend school may continue in the insurance program while attending school.

8. Coverage shall end twelve (12) months from the date an employee is placed on Leave of Absence.

If you are out on disability on the date you become eligible, your benefits will begin when you return to full-time active work.

WORKING SPOUSE PROVISION

A "Working Spouse Provision" concerning coverage of eligible employees' spouses has been adopted under the West Virginia Annual Conference United Methodist Family Employee Medical and Dental Plan effective January 1, 2019. In the event that **all** of the following apply, your spouse is not eligible to be covered under the above mentioned conference plan.

- You are married; and
- Your spouse is employed; and
- Your spouse's employer offers a group medical insurance plan;
- Your spouse's required contribution is 50% or less of the total annual single premium.

This policy does not affect eligible employees' ability to enroll their eligible children in the Plan, even if your spouse has the right to enroll them in Other Coverage.

GENERAL ENROLLMENT PROCEDURE

An Eligible Employee may enroll in the Plan within sixty (60) days after becoming an Eligible Employee by making written application for participation on such form(s) as may be prescribed from time to time by the Plan Administrator and by providing the Plan Administrator with such other information as it may request. An Eligible Employee who

enrolls in the Plan within such sixty (60) day period shall become a Participant effective on the first day of the month following receipt of his or her completed application by the Plan Administrator. Participation in the Plan by the Eligible Employee and, if applicable, his or her Dependent(s) shall be contingent upon receipt by the Plan Administrator of such completed application form(s) and any other information requested by the Plan Administrator and, if applicable, payment of any required Employee and/or Salary Paying Unit Contribution. If s(he) enrolls after the initial sixty (60) day enrollment period, s/he must follow the Special Enrollment Procedure or Late Enrollment Procedure, whichever is applicable, detailed below.

SPECIAL ENROLLMENT PROCEDURE

Individuals Losing Other Group Health Plan or Health Insurance Coverage. The Plan permits an Eligible Employee who is not enrolled (or a Dependent of such an Eligible Employee if the Dependent is eligible for coverage under the Plan but not enrolled) to enroll for coverage under the Plan if **each** of the following conditions is met:

1. The Eligible Employee or Dependent was covered under a Group Health Plan or Health Insurance Coverage at the time coverage under the Plan was previously offered to the Eligible Employee or Dependent;

2. The Eligible Employee stated in writing at such time that coverage under a Group Health Plan or Health Insurance Coverage was the reason for declining enrollment; provided, however, this condition shall apply only if the Employer required such a statement at the time coverage under the Plan was offered and provided the Eligible Employee with notice of such requirement and the consequences of failing to enroll at such time;

3. The Eligible Employee's or Dependent's coverage was: (a) under a COBRA Continuation Provision and the coverage under that provision was exhausted; or (b) not under a COBRA Continuation Provision and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions toward such coverage were terminated; and

4. The Eligible Employee requests special enrollment not later than sixty (60) days after the date of exhaustion of coverage described in subparagraph 3. above or termination of coverage; or

Individuals Losing Medicaid or State Child Health Plan Coverage. The Plan permits an Eligible Employee who is not enrolled (or a Dependent of such an Eligible Employee if the Dependent is eligible for coverage under the Plan but not enrolled) to enroll for coverage under the Plan if one of the following conditions is met:

1. The Eligible Employee or Dependent requests special enrollment not later than sixty (60) days after the date of termination of the Eligible Employee's coverage

under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act resulting from a loss of eligibility for such coverage; or

2. The Eligible Employee or Dependent requests special enrollment not later than sixty (60) days after the date the Eligible Employee or Dependent is determined to be eligible for assistance with respect to coverage under the Plan under a Medicaid plan under title XIX of the Social Security Act or under a State child health plan under title XXI of such Act.

Acquisition of a New Dependent. If an Eligible Employee is a Participant or has met any Waiting Period applicable to becoming a Participant and is eligible to be enrolled under the Plan but for a failure to previously enroll, and he acquires a Dependent through marriage, birth, adoption or Placement for Adoption, the following special enrollment period will apply during which period the Eligible Employee and Dependent may be enrolled under the Plan, and in the case of the birth or adoption of a child, the spouse of the Eligible Employee may also be enrolled as a Dependent if otherwise eligible:

1. The Dependent special enrollment period shall be a period of sixty (60) days and shall begin on the date of the marriage, birth or adoption or Placement for Adoption, as the case may be, as described in subparagraph 1 above;

2. The coverage of the Dependent will become effective: (a) in the case of marriage, the first day of the month beginning after the date the completed request for enrollment is received; (b) in the case of a Dependent's birth, as of the date of such birth; or (c) in the case of a Dependent's adoption or Placement for Adoption, the date of such adoption or Placement for Adoption.

OPEN ENROLLMENT PERIOD

If an Eligible Employee and/or his Dependent(s) are not enrolled in the Plan within the applicable sixty (60) day enrollment period, or within a period described under "Special Enrollment Procedure", they may enroll during the Plan's Open Enrollment Period, March 1st – March 31st, a nonparticipating Eligible Employee may elect to enroll themselves singly or with his or her Dependents in the Plan and a Participating Employee may elect to add, modify or eliminate coverage under the Plan. Any changes elected during the Plan's Open Enrolment Period shall be effective as of the first day of the Plan Year, [April 1st], immediately following the close of the Open Enrollment Period. Any new coverage elected during the Plan's Open Enrollment Period shall be subject to all terms and provisions of the Plan.

LATE ENROLLMENT PROCEDURE

Except as provided with respect to Qualified Medical Child Support Orders, if an Eligible Employee and/or his Dependent(s) are not enrolled in the Plan within the applicable sixty (60) day enrollment period or within a period described above under

"Special Enrollment Procedure," the Eligible Employee may enroll himself and/or his or her Dependent(s) in the Plan during any Open Enrollment Period by providing such information regarding the nonparticipating Eligible Employee and/or Dependent(s) as may be required by the Plan Administrator and completing such application form(s) as may be prescribed by the Plan Administrator; provided, however, that late enrollment shall not be based on proof of insurability. The nonparticipating Eligible Employee and/or Dependent(s) shall become Participant(s) effective as of the first day of the Plan Year immediately following the Open Enrollment Period, subject to all other terms and provisions of the Plan.

ENROLLMENT PURSUANT TO QUALIFIED MEDICAL CHILD SUPPORT ORDERS

Notwithstanding anything herein to the contrary, any child of a Participating Employee shall be enrolled herein in accordance with the terms of any Qualified Medical Child Support Order. Participants and beneficiaries can obtain, without charge, a copy of the Plan's procedures governing Qualified Medical Child Support Orders from the Plan Administrator.

COVERAGE FOR PERSONS ELIGIBLE FOR MEDICARE

Participating Employees and their spouses who are sixty-five (65) years of age or older and who are eligible for Medicare benefits have a choice regarding primary coverage. Such Participating Employees and spouses may elect to participate in the Plan or reject such participation and choose Medicare to be primary payor.

1. *Plan as Primary Payor*. If the Participating Employee or his or her spouse chooses the Plan as primary payor, the Plan shall pay the same benefits as if the Participant Employee or spouse were under age sixty-five (65), and any unpaid medical expenses may be coordinated with Medicare as secondary payor.

2. *Medicare as Primary Payor*. If the Participating Employee or spouse rejects the Plan, Medicare shall be primary payor and the Plan shall not pay benefits that are secondary to Medicare.

   Medicare shall be the primary payor for Participants who are eligible for Medicare disability benefits; provided, however, that if an Eligible Employee is participating in this Plan as a result of his or her current employment status with the Employer, or if a Dependent is participating hereunder as a result of a Participating Employee's current employment status with the Employer, the Participating Employee or Dependent, as applicable, will have a choice regarding primary coverage. In this latter instance, such Participating Employee or Dependent may elect to participate in the Plan, in which case the Plan shall be the primary payor, or may reject such participation and choose Medicare to be primary payor.

3. *End Stage Renal Disease.* If a Participating Employee or Dependent becomes eligible for Medicare on the basis of end-stage renal (kidney) disease (ESRD), then the Plan will be the primary payor for the applicable coordination period as it is then defined under federal law (currently thirty (30) months for individuals who become Medicare eligible due to ESRD on or after October 1, 1997), and Medicare will be secondary. After the expiration of the coordination period, Medicare will be the primary payor and the Plan will be secondary. Provided, however, that if Medicare is already the primary payor (on the basis of age or disability) for a Participant who becomes eligible for Medicare due to ESRD, then Medicare will remain the primary payor.

For Participating Retired Employees and their spouses who are 65 years of age or older and who are eligible for Medicare benefits, Medicare will be the primary payor and the Plan will pay benefits secondary to Medicare.

SMALL EMPLOYER EXCEPTION TO THE MEDICARE SECONDARY PAYER ACT (This provision is effective January 1, 2021)

Under the Medicare Secondary Payer Act ("MSPA") and related regulations and interpretation, Medicare beneficiaries ("Beneficiaries") of the West Virginia Annual Conference United Methodist Family Employee Medical and Dental Benefit Plan (the "Plan") may qualify for the small employer exception to the MSPA (the "Small Employer Exception" or "Exception") such that Medicare would be the primary payer for benefits incurred by Plan Beneficiaries who are age 65 or older ("worked aged"). Various churches/employers within the Conference participate in a single group health plan. Medicare currently pays secondary for benefits incurred by working aged Plan Beneficiaries.

If any church participant of the Plan (a "Church Participant") has fewer than twenty (20) employees, then working-aged Beneficiaries (and their spouses) of each such Church Participant may qualify for the Small Employer Exception upon application. Pursuant to this Exception, Medicare would become the primary payer for benefits incurred by these eligible working-aged individuals.

The Small Employer Exception and its applicability to the Plan.

Notwithstanding the MSPA's general application to the Plan's working-aged Beneficiaries, certain working-aged Plan Beneficiaries (and their spouses) may qualify for the Small Employer Exception to the MSPA. The Small Employer Exception provides a mechanism for multi-employer group health plans to apply for an MSP exception vis-à-vis participating employers (in this case, Church Participants) with twenty (20) or fewer full and/or part time employees. To avail itself of the Small Employer Exception, the Plan must affirmatively submit an Exception application identifying, inter alia, all Church Participants with twenty (20) or fewer employees. Church Participants with twenty (20) or more employees are not eligible for the Exception. The Plan delegates

the responsibility for requesting the Small Employer Exception to the Church Participant.

The Small Employer Exception application process.

To request Medicare approval of a Small Employer Exception, the Plan (or administrator on behalf of the Plan) must submit a written request to the CMS Benefits Coordination & Recovery Center (the "BCRC"), and the BCRC must approve the requested Exception. The written request must state that the Plan seeks to elect Medicare as the primary payer for each Plan Beneficiary. A template for the written request, specific instructions and mailing/fax information, as well as other supporting documentation that must be submitted to the BCRC to request an Exception can be obtained from the Plan Sponsor.

The request and supporting documentation require the Plan (or administrator on behalf of the Plan) to individually identify each eligible Beneficiary (and/or spouse) for each eligible Church Participant. This documentation also includes a verification form, which each eligible Church Participant must complete to verify that each such Church Participant has less than twenty (20) employees. The verification form must be signed by both the Church Participant and the Plan (or the Plan's designee).

All approvals of Small Employer Exemption requests are prospective. The date of the request serves as the effective date, unless the request is dated more than seven (7) days prior to the receipt date, in which case, the receipt date is considered the effective date. If the request is returned for missing information, the effective date is the date the completed request is received by the BCRC. At the earliest, an Exception may be requested within three (3) months of an eligible individual attaining the age of sixty-five (65). There is no available guidance specifying the timeframe that it takes BCRC to approve an Exemption application.

The Plan must notify each Beneficiary/spouse when BCRC approves the requested Exception, and additionally must notify such individuals if Medicare once again becomes the secondary payer due to a change in a Church Participant's size. Likewise, the Plan must notify BCRC if a once-excepted Church Participant meets the twenty (20) employee threshold. The Plan must also notify BCRC if there has been a change in a Beneficiary or spouse's GHP coverage. Finally, the Plan is prohibited from offering Beneficiaries/spouses any financial or other benefits as an incentive not to enroll in, or to terminate enrollment in, a group health plan that is, or would be, primary to Medicare. The Plan will likewise not offer any Church Participant any remuneration or other incentives for availing itself of the Small Employer Exception.

SECTION VI
TERMINATION OF COVERAGE

EMPLOYEE

Coverage shall terminate on the last day of the month in which the earliest of the following occurs:

1. The Employee ceases to be an active Employee, unless he or she is a covered Retiree.

2. The Participating Employee, Employer, or salary paying unit fails to contribute the premium for the Plan, or if the Plan is discontinued.

3. All Plan Participants appointed to attend school may continue in the insurance program while attending school.

4. Coverage will remain in force for no longer than twelve (12) consecutive months from the date the Participating Employee begins an approved leave of absence (other than leave under the Family and Medical Leave Act of 1993, as amended, if applicable).

5. Coverage will remain in force for no longer than twenty-nine (29) consecutive months from the date the Participating Employee is certified as Disabled as defined in this Plan Document or is receiving temporary total disability (TTD) benefits from a workers' compensation fund for an occupational injury. The disability must have occurred on or before the 60th day of the continuation of coverage, must last at least until the end of the 18th month of continuation of coverage, and the Participant must notify and provide a copy of the Social Security disability award letter to the Pension Fund within 60 days of the disability determination and before the end of the 18 month continuation of coverage period in order to be entitled to the remaining 11 months of the disability extension.

6. The Participating Employee dies.

DEPENDENT

Coverage for a Dependent shall terminate on the last day of the month in which the earliest of the following occurs:

1. The Participating Employee coverage terminates.

2. The Participating Employee, Employer, or salary paying unit ceases contributions for coverage.

3. In the case of a Dependent child, when the child reaches the maximum age and ceases to be an eligible Dependent as defined under Definitions in this Plan Document.

4. The Dependent commences participation in the Plan as an Eligible Employee.

5. One (1) year of eligibility credit will be given for each complete year of marriage prior to the entry of a decree of divorce for divorced spouse of Eligible Employees, provided they elect to continue coverage under the Plan within thirty-one (31) days of the divorce. Eligibility will cease if the spouse remarries, becomes eligible under another group health plan, attains age 65, or fails to make timely contributions to the Plan. Contributions for eligible Plan Participants under this section are the same as lay employee Plan participant contributions.

With respect to widows or widowers covered under this Plan, benefits will continue until the time that any of the above 1 – 5 occurs.

If the Participating Employee dies, coverage will continue for the surviving spouse and eligible Dependents until the time that any of the above events 1 – 5 occurs.

RESCISSION

Coverage under this Plan may be rescinded (i.e. retroactively cancelled or discontinued) in the case of an act, practice, or omission that constitutes fraud or an intentional misrepresentation of material fact. The Plan will provide at least 30 calendar days advance notice to an individual before coverage is rescinded, regardless of whether the rescission is of group or individual coverage, and regardless of whether the rescission applies to an entire group or only to an individual within the group.

SECTION VII
ADMINISTRATION

QUALIFIED MEDICAL CHILD SUPPORT ORDERS ("QMCSO")

The Plan will honor Qualified Medical Child Support Orders ("QMCSO") presented to the Plan Administrator in accordance with the requirements of ERISA.

Upon receipt of a Medical Child Support Order (“MCSO”), it is the Plan Administrators responsibility in compliance with ERISA to determine if the MCSO is a QMCSO.

The Plan has procedures set up to comply with and administer QMCSOs. A Participant or beneficiary may obtain, without charge, a copy of the Plan’s QMCSO Procedures from the Plan Administrator.

ADMINISTRATION OF PLAN

The Plan is administered by the Employer, which is the Plan Administrator. The Employer has retained the services of Benefit Assistance Corporation to process claims in accordance with the directions of the Employer.

The Plan Administrator shall have such duties and powers as may be necessary to discharge its duties under the Plan, including, but not by way of limitation, the following:

1. To construe and interpret the Plan and to determine all questions arising in the administration, interpretation and application of the Plan, including but not limited to, deciding all disputes of eligibility and determining the amount, manner and time of payment of any benefits hereunder. Any such actions, determinations or decisions of the Plan Administrator shall presumptively be conclusive and binding on all persons;

2. To prescribe procedures to be followed by Participants filing applications or claims for benefits;

3. To prepare and distribute, in such manner as the Plan Administrator determines to be appropriate and in accordance with applicable laws, information explaining the Plan;

4. To receive from the Employer and from Participants such information as may be necessary for the proper administration of the Plan;

5. To receive, review and keep on file (as it deems convenient and proper) reports of benefit payments and reports of disbursements for expenses;

6. To appoint or employ individuals to assist in the administration of the Plan and any other agents it deems advisable, including legal counsel.

7. To prepare and file such reports or returns as may be required from time to time and to provide to Participants such information and disclosures as may be required or appropriate.

8. To notify the claims processor of any and all modifications or amendments to the Plan or any changes in the eligibility of any Participant.

The Plan Administrator may adopt such rules as it deems necessary, desirable or appropriate. All rules and decisions of the Plan Administrator shall be uniformly and consistently applied to all Participants in similar circumstances. The Plan Administrator may require any Participant to complete and file such forms or information as it may from time to time deem necessary or desirable in administering the Plan.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract of employment between the Employer and any Employee or to be a consideration for, or an inducement of, the employment of any Employee. Nothing in the Plan shall be deemed to give any Employee the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Employee at any time.

NO RIGHTS TO ASSETS OF EMPLOYER OR PLAN ASSETS/NON-ALIENATION OF BENEFITS

No Participant shall have any right to, or interest in, any assets of the Employer, or if applicable, any assets of the Plan upon termination of employment or otherwise. All payments of benefits as provided for in the Plan shall be made solely out of the assets of the Plan and none of the fiduciaries shall be liable, therefore, in any manner.

Benefits payable under the Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, charge, garnishment, execution, or levy of any kind, either voluntary or involuntary, and any attempt to anticipate, alienate, sell, transfer, assign, pledge, encumber, charge or otherwise dispose of any right to benefits payable hereunder shall be void. The Plan shall not in any manner be liable for, or subject to, the debts, contracts, liabilities, engagements or torts of any person entitled to benefits hereunder.

APPLICATION OF STATE LAW

Subject to the provisions of ERISA, the Plan, as amended from time to time, shall be administered, construed and enforced according to the laws of the State of West Virginia and in courts situated in that state.

RIGHT TO RECEIVE AND RELEASE INFORMATION

For the purposes of administering this Plan, the Plan Administrator may, without consent of or notice to any person, release to or obtain from any insurance company or other organization or person any information which the Plan Administrator deems to be necessary for such purposes with respect to any Participant claiming benefits under this Plan. Any Participant claiming benefits under this Plan shall furnish to the Plan Administrator such information as it may request from time to time.

CLAIMS PROCESSING PROCEDURES

These claims processing procedures are effective for claims filed on or after the Plan Year beginning on or after September 23, 2010.

The following definitions apply for purposes of these claims processing procedures:

1. "Adverse benefit determination" is any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any denial, reduction, termination, or failure to provide or make a payment (for pre-service or post-service claims) that is based on: a determination that a benefit is not a covered benefit; source-of-injury exclusion, network exclusion, or other limitation on otherwise covered benefits; or a determination that a benefit is experimental, investigational, or not medically necessary or appropriate. An adverse benefit determination also includes a rescission of coverage, whether or not there is an adverse effect on any particular benefit at that time, except when attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

2. "Claimant" is a Participant who files a claim under the Plan.

3. "Post-service claim" means any claim for a benefit under the Plan that is not a pre-service claim or urgent care claim.

4. "Pre-service claim" is any claim for a benefit under the Plan that is conditioned, in whole or in part, upon the approval of the benefit in advance of obtaining medical care.

5. "Review Committee" is the committee (or person) designated from time to time by the Employer to review any Claimant appeal of an adverse benefit determination, provided, however, that no member of the Review Committee shall be either the individual or subordinate of the individual who made the initial benefit determination that is the subject of the appeal.

6. "Urgent Care Claim" is any claim for medical care or treatment which if decided within the time period for pre-service claim determinations could seriously jeopardize the Claimant's life, health or ability to regain maximum function or, in the opinion of a Physician with knowledge of the Claimant's medical condition, would subject the Claimant to severe pain that cannot be adequately managed without the care.

FILING CLAIMS

A Claimant must file a written claim for benefits under the Plan **NO LATER THAN ONE (1) YEAR FROM THE DATE OF SERVICE.** Written claims must be made on such form(s) as may be prescribed from time to time by the Plan Administrator and filed with the Plan's claims processor. The claims processor for the Plan is:

Benefit Assistance Corporation
P.O. Box 950
Hurricane, WV 25526

The claims processor will review claims solely in accordance with the terms of the Plan and at the direction of the Plan Administrator. The claims processor shall have no discretion or authority to construe the terms of the Plan or decide disputes concerning benefit claims, but shall refer all discretionary questions concerning the payment of claims to the Plan Administrator.

If a Claimant fails to follow the Plan's procedures in filing a pre-service claim for benefits, he or she will be notified of the failure and the proper procedures to be followed in filing a claim for benefits. Notification may be oral, unless written notification is requested by the Claimant or authorized representative. This notification will be provided no later than five days following the date of the Claimant's failure to follow the Plan's procedures (or 24 hours in the case of an urgent care claim). However, notification of a failure to follow the Plan's procedures in filing a claim will be provided only if the Claimant has submitted the claim to the claims processor and has named a specific Claimant, a specific medical condition or symptom and a specific treatment, service or product for which approval is requested.

CLAIM NOTIFICATIONS

1. **Time for Providing Notification.** The Plan Administrator will furnish notice of its benefit determinations under the Plan in accordance with the following provisions. For purposes of determining the time periods specified below, the period of time within which a benefit determination is required to be made will begin at the time the claim is filed in accordance with the Plan's procedures, without regard to whether all the information necessary to make a benefit determination accompanies the filing. In the event a period of time to provide notification is extended due to a Claimant's failure to submit information necessary to decide a claim, the

period for making the benefit determination will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information. A Claimant may also voluntarily agree to provide the Plan additional time within which to make a decision on a claim beyond the time limits specified below, including urgent care claims.

a. **Urgent care claims.** The Plan Administrator will notify the Claimant of the Plan's benefit determination (whether adverse or not) involving a claim for urgent care as soon as possible, taking into account the medical exigencies, but not later than twenty-four (24) hours after receipt of the claim. However, if a Claimant fails to provide sufficient information for the claims determination, the Claimant will be notified as soon as possible, but not later than twenty-four (24) hours, after receipt of the claim of the specific information necessary to complete the claim. The Claimant will be provided a reasonable amount of time, but not less than forty-eight (48) hours, to provide the specified information. The Claimant will then be notified of the Plan's benefit determination as soon as possible, but not later than forty-eight (48) hours after the earlier of: (a) the Plan's receipt of the specified information; or (b) the end of the period afforded to provide the specified additional information.

b. **Pre-Service Claims.** The Plan Administrator will notify the Claimant of the Plan's benefit determination for a pre-service claim (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days if the Plan Administrator determines that this extension is necessary due to matters beyond the control of the Plan and notifies the Claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If an extension is necessary due to a Claimant's failure to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least 45 days from receipt of the notice to provide the specified information.

c. **Post-Service Claims.** The Plan Administrator will notify the Claimant of the Plan's benefit determination for a post-service claim within a reasonable period of time, but not later than thirty (30) days after receipt of the claim. This period may be extended one time by the Plan for up to fifteen (15) days if the Plan Administrator determines that the extension is necessary due to matters beyond

the control of the Plan and notifies the Claimant, prior to the expiration of the initial thirty (30) day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If the extension is necessary due to a failure of the Claimant to submit the information necessary to decide the claim, the notice of extension will specifically describe the required information, and the Claimant will be afforded at least forty-five (45) days from receipt of the notice within which to provide the specified information.

d. **Concurrent Care Decisions.** If the Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments, any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) ***before*** the end of such period of time or number of treatments will constitute an adverse benefit determination. The Plan Administrator will notify the Claimant of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the Claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. Any request by a Claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care will be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator will notify the Claimant of the benefit determination, whether adverse or not, within twenty-four (24) hours of receipt of the claim by the Plan, as long as any such claim is made to the Plan at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments. If such request involving urgent care is not made by the Claimant at least twenty-four (24) hours prior to the expiration of the prescribed period of time or number of treatments, the request will be treated as a claim involving urgent care and will be decided in accordance with the above urgent care timeframes. If a request to extend a course of treatment beyond the period of time or number of treatments previously approved by the Plan does not involve an urgent care claim, the request will be treated as a new benefit claim and decided within the timeframe appropriate to the type of claim, i.e., as a pre-service claim or a post-service claim.

2. **Manner and Content of Notification of Benefit Determination.** The Plan Administrator will provide a Claimant with written or electronic notification of any adverse benefit determination, except that in the case of an adverse benefit determination involving a claim for urgent care, the notification may be provided to the Claimant orally as long as a written or

electronic notification is furnished to the Claimant not later than three (3) days after the oral notification. The notification will include the following:

a. Information sufficient to identify the claim involved, including: the date of service, the health care provider, and the claim amount (if applicable, and if knowable or available at the time), the diagnosis code, the treatment code, and the corresponding meanings of these codes;
b. The specific reason(s) for the adverse determination, including the denial code and its corresponding meaning, and any standard that was used in denying the claim;
c. Reference to the specific Plan provisions on which the determination is based;
d. A description of any additional material or information necessary for the Claimant to perfect the claim and an explanation of why such material or information is necessary;
e. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request;
f. If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
g. In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims;
h. A description of the Plan's internal review procedures and the time limits applicable to such procedures, including a statement of the Claimant's right to bring a civil action following an adverse benefit determination on review, as well as a description of any available external review processes, including information regarding how to initiate an appeal; and
i. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with internal claims and appeals and external review processes.

APPEAL OF ADVERSE BENEFIT DETERMINATION

1. **Review Procedures.** If a Claimant is notified of an adverse benefit determination, the Claimant or his or her authorized representative may make a written request for review of the determination by submitting such request to the Plan Administrator within one hundred eighty (180) days after notification of the adverse benefit determination, except in the case of any reduction or termination of a course of treatment (other than by Plan amendment) ***before*** the end of the previously approved period or number of treatments, the Plan Administrator will provide the Claimant sufficient advance notice of the reduction or termination to allow the Claimant to appeal and obtain a determination before the benefit is reduced or terminated (which period is not required to be one hundred eighty (180) days).

   A Claimant's written request for review will be forwarded by the Plan Administrator to the Review Committee for a full and fair review. The Claimant will be provided the opportunity to submit written comments, documents, records and other information relating to the claim for benefits. The Claimant will also be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claimant's claim for benefits. If the Plan considers, relies upon or generates new or additional evidence in connection with the claim, the Plan will provide the Claimant, free of charge, with such evidence, as soon as possible and in advance of the date on which the notice of adverse benefit determination on review is required to be provided. If the Plan intends to issue an adverse benefit determination based on a new or additional rationale, the Plan will provide the Claimant, free of charge, with such rationale, as soon as possible and in advance of the date on which the notice of adverse benefit determination on review is required to be provided. The Review Committee will conduct its review without deference to the initial benefit determination and taking into account all comments, documents, records and other information submitted by the Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Review Committee will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor a subordinate of such individual. The Review Committee will also provide for the identification of medical or vocational experts whose advice was

obtained on behalf of the Plan in connection with a Claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

In the case of a claim involving urgent care, the Review Committee will provide for an expedited review process pursuant to which a request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the Claimant and all necessary information, including the Plan's benefit determination on review, will be transmitted between the Plan and the Claimant by telephone, facsimile, or other available similarly expeditious method.

2. **Timing of Notification of Benefit Determination on Review.** The Plan Administrator will notify a Claimant of the Plan's benefit determination on review as follows. For purposes of determining the time periods specified below, the period of time within which a benefit determination on review is required to be made will begin at the time an appeal is filed in accordance with the Plan's procedures, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. In the event a period of time is extended due to a Claimant's failure to submit information necessary to decide a claim, the period for making the benefit determination on review will be tolled from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant responds to the request for additional information.

   a. **Urgent Care Claims.** In the case of a claim involving urgent care, the Plan Administrator will notify the Claimant of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than seventy-two (72) hours after receipt of the Claimant's request for review of an adverse benefit determination by the Plan. However, if the requested services have already been provided between the time the claim was denied and a request for review is filed, the claim no longer involves urgent care and will be processed on review as a post-service claim.

   b. **Pre-Service Claims.** In the case of a pre-service claim, the Plan Administrator will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after receipt by the Plan of the Claimant's request for review.

   c. **Post-Service Claims.** In the case of a post-service claim, the Plan Administrator will notify the Claimant of the Plan's benefit determination on review within a reasonable period of time, but not

later than sixty (60) days after receipt by the Plan of the Claimant's request for review of an adverse benefit determination.

3. **Manner and Content of Notification of Benefit Determination on Review.** The Plan Administrator will provide a Claimant with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification will set forth the following:

   a. Information sufficient to identify the claim involved, including: the date of service, the health care provider, and the claim amount (if applicable, and if knowable or available at the time), the diagnosis code, the treatment code, and the corresponding meanings of these codes;
   b. The specific reason(s) for the adverse determination, including the denial code and its corresponding meaning, and any standard that was used in denying the claim;
   c. Reference to the specific Plan provisions on which the benefit determination is based;
   d. A statement that the Claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the Claimant's claim for benefits;
   e. A statement describing voluntary appeal procedures offered by the Plan (if any);
   f. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol or other criterion will be provided free of charge to the Claimant upon request;
   g. If an adverse benefit determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Claimant's medical circumstances, or a statement that such an explanation will be provided free of charge upon request;
   h. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."
   i. A description of any available external review processes, including information regarding how to initiate an appeal; and

j. The availability of, and contact information for, any applicable office of health insurance consumer assistance or ombudsman established under Section 2793 of the Public Health Service Act to assist individuals with internal claims and appeals and external review processes.

AVAILABILITY OF EXTERNAL REVIEW

A Claimant may have a right to obtain external review by an independent review organization (IRO) of a final internal adverse benefit determination. Except for approved expedited external reviews, this external review is only available once the Claimant has exhausted the internal appeal procedures. Upon request the Administrator will provide you with a copy of the full external review procedure.

AUTHORIZED REPRESENTATIVE

A Claimant is permitted to designate an authorized representative to act on behalf of a Claimant with respect to a benefit claim or appeal of an adverse benefit determination. Designation of an authorized representative must be made in writing on such form as the claims processor will provide from time to time and must be signed by the Claimant. However, in the case of an urgent care claim, the Plan will permit a health care professional with knowledge of the Claimant's condition (such as a treating Physician) to act as the authorized representative of the Claimant. This provision in the case of urgent care claims is intended to enable a health care professional to pursue a claim on behalf of a claimant under circumstances where, for example, the Claimant is unable to act on his or her own behalf.

If a Claimant designates an authorized representative to act on his or her behalf as provided above, the Plan will direct all information and notifications to which the Claimant is otherwise entitled to the authorized representative with respect to the aspect of the claim for which the representative is designated (for example, initial determination, request for documents, appeal, etc.), unless the claimant directs otherwise.

PAYMENT OF CLAIMS

The above claims processing procedures address only the time frames within which claims must be decided and not the periods within which payments that have been granted must be actually paid.

FACILITY OF PAYMENT PROCEDURE

All or any portion of the benefits provided by the Plan may be, at the option of the Plan Administrator, paid directly to the individual or institution on whose charges the claim is based. Any Plan benefits which remain unpaid at the Participant's death may be

paid directly to the individual or institution on whose charges the claim is based or to the executor or administrator of the Participant's estate.

Any payment by the Plan in accordance with this facility of payment procedure will discharge the Plan from all further liability to the extent of the payment made.

When any person entitled to benefits under the Plan is under legal disability or, in the Plan Administrator's opinion, is in any way incapacitated so as to be unable to manage his or her affairs, the Plan Administrator may cause such person's benefits to be paid to such person's legal representative for his or her benefit or to be applied for the benefit of such person in any other manner that the Plan Administrator may determine.

SECTION VIII
LOSS, SUSPENSION, REDUCTION OR RECOVERY OF BENEFITS

NOTICE OF LOSS

If, for any reason, benefits are not paid or payable pursuant to the Plan, the Plan Participant may be required to provide such payment.

ASSIGNMENT

The Participant's benefits may not be assigned except by consent of the Employer. However, this Plan has the right to pay any benefits hereunder directly to the service provider.

RIGHT OF REIMBURSEMENT AND/OR SUBROGATION

REIMBURSEMENT

This section applies when the Participant has recovered damages, by verdict, settlement or otherwise, for an Injury or Sickness (including an occupational Injury or Sickness) caused by a third party. The Plan does not provide benefits, including the reasonable value of services to treat an Injury or Sickness or the treatment of such an Injury or Sickness, if such Injury or Sickness if caused by the negligent or wrongful act(s) of a third party.

However, if the Plan pays for or provides benefits for such an Injury or Sickness caused by a third party, the Participant shall promptly repay to the Plan the amount of benefits paid on his or her behalf out of any recovery made from the third party (or insurer) until the Plan has been fully reimbursed for benefits it paid for or provided.

The Plan shall have, and the Participant hereby grants to the Plan, an equitable lien on any proceeds recovered from the third party or insurer equal to the amount of benefits paid or provided by the Plan. The Plan shall have a right of first recovery with respect to any such proceeds recovered from the third party or insurer up to the amount of benefits paid or provided by the Plan. The Participant shall sign and deliver, at the Plan's request, any documents needed to protect this lien. This lien applies:

* regardless of whether the Participant has been made whole or fully reimbursed by the third party for his or her damages;

* regardless of any classification of such recovered proceeds as medical expenses; and

* without reduction for legal expenses incurred by the Participant in connection with the recovery against the third party or insurer unless agreed to in writing.

The Participant shall cooperate with the Plan, including signing and delivering any documents the Plan reasonably requests to protect its rights of reimbursement,

providing any relevant information, and taking such actions the Plan may otherwise request in order to recover the full amount of benefits paid or provided.

SUBROGATION

This section applies when another party is, or may be considered, liable for a Participant's Injury or Sickness and the Plan has provided or paid benefits.

To the extent of the benefits provided by the Plan, the Plan is subrogated to all of the Participant's rights against any party (including any first party automobile coverage) or for the payment for the medical treatment of such injury of sickness. The Plan may assert its rights independently of the Participant. The Plan shall be subrogated to such rights of the Participant regardless of whether the Participant has been made whole or fully reimbursed by the third party for his/her damages and regardless of any classification of such recovered proceeds as medical expenses.

The Participant assigns to the Plan the Participant's rights and benefits under any insurance coverage, whether liability or no-fault, to the extent of the Plan's subrogation claims under this section.

If the Participant enters in litigation or settlement negotiations regarding the obligations of other parties, the Participant must not prejudice, in any way, the recovery rights of the Plan under this Section. In addition, the Plan shall have the right to enjoin any Participant or beneficiary from entering into any settlement that does not provide for or require full reimbursement for settlement or judgment proceeds of whatever nature, both of which would be violative of the Plan pursuant to this provision.

The cost of legal representation of the Plan in matters related to subrogation shall be borne solely by the Plan. The costs of legal representation of the Participant in matters related to subrogation shall be borne solely by the Participant.

The Participant is obliged to cooperate with the Plan in order to protect the Plan's subrogation rights. Such cooperation shall include providing the Plan with any relevant information, signing and delivering such documents as the Plan reasonably requests to secure its subrogation claim, and obtaining the Plan's consent before releasing any party from liability for payment of medical expenses.

COOPERATION BY PLAN PARTICIPANTS

The Participant shall cooperate with the Plan, including signing and delivering any documents the Plan reasonably requests to protect its rights of reimbursement and/or subrogation, providing any relevant information, and taking such actions as detailed below, as well as any actions the Plan may otherwise request in order to recover the full amount of benefits provided.

With respect to the Plan's right of reimbursement and/or subrogation, by accepting benefits paid or provided by the Plan, Participant hereby agrees:

(i) Upon making a claim for benefits under the Plan, to execute and deliver to the Plan, if requested by the Plan, a separate agreement or agreements in which Participant reaffirms its recognition of the Plan's reimbursement and subrogation rights hereunder. Regardless of whether such separate agreement is executed, by accepting benefits paid under the Plan, Participant agrees to abide by the reimbursement and subrogation provisions set forth herein;

(ii) To provide the Plan with information respecting any insurance policies or policies covering or potentially covering any Injury or Sickness of Participant, including but not limited to contact information for the insurance company or companies providing such coverage;

(iii) To notify the Plan, prior to or immediately upon filing, of any legal action or administrative proceeding against a third party or insurer based on any alleged negligence or wrongful act that may have caused or contributed to the Injury or Sickness that resulted in the Plan's payment of benefits, and to inform the Plan of all material developments with respect to all such claims, actions, or proceedings, including any settlement offers or negotiations of any kind. Further, the Participant shall provide the contact information for counsel for Participant and counsel for any other parties to any such legal action or administrative proceeding, and Participant understands and agrees that the Plan may intervene, enjoin, or otherwise take action respecting any such legal action or administrative proceeding or settlement negotiations relating thereto, in order to preserve and protect the reimbursement and subrogation rights, and any applicable lien, of the Plan. Failure of the Plan to take any such action shall in no way impair the rights of the Plan hereunder.

(iv) To immediately remit to the Plan any proceeds recovered by Participant out of any such insurance coverage (including first party coverage,) claim, verdict, lawsuit, settlement or otherwise for an Injury or Sickness (including an occupational Injury or Sickness) caused by a third party and with respect to which the Plan is due reimbursement hereunder, and, in the event that Participant disputes any such reimbursement, to segregate such proceeds from the Participant's general assets in a separate investment account and to immediately inform the Plan of the location of such account and the amount and manner of investment thereof. Participant agrees that the lien of the Plan in such proceeds extends to such account.

The Participant shall not prejudice the Plan's right of reimbursement and/or subrogation. Participant understands and acknowledges that acceptance of the coverage afforded under this Plan means the Participant is accepting the terms and conditions of the Plan, including but not limited to the reimbursement and subrogation provisions of this Plan.

REMEDIES AVAILABLE TO THE PLAN

If the Participant fails to abide by the provisions herein with respect to the Plan's right of reimbursement and/or subrogation, the Plan may, at its sole discretion:

(i) apply any future Plan benefits that may become payable on behalf of the Participant to the amount not reimbursed; or

(ii) obtain a judgment against the Participant and/or injured or ill beneficiary from a court for the lien created herein, and garnish or attach the wages or earnings of the Participant.

MEDICAID ASSIGNMENT OF RIGHTS AND REIMBURSEMENT

Payment of benefits under the Plan will be made in accordance with any assignment of rights made by or on behalf of a Participant as required by a state plan for medical assistance approved under title XIX of the Social Security Act pursuant to Section 1921(a)(1)(A) of such Act (as in effect on the date of the enactment of the Omnibus Budget Reconciliation Act of 1993). Provided further that to the extent that payment has been made under such state plan in any case in which the Plan has a legal liability to make payment for items or services constituting such assistance payment of benefits under the Plan will be made in accordance with any state law.

SECTION IX
COORDINATION OF BENEFITS

PURPOSE

A Participant may have medical or dental benefits under this Plan and another plan. In this instance, this Plan will coordinate what it pays in benefits with the other plan or plans, so that the total benefits paid by all plans do not exceed the actual charges incurred.

If any Participant in this Plan is also covered under one or more other plans, and the sum of the benefits payable under this Plan and the other plans exceeds the covered person's Allowable Expense during any Claim Determination Period, then the benefits payable under all the plans involved shall not exceed the Allowable Expenses for such period. Benefits payable under another plan are included, whether or not claim has been made.

If an Eligible Employee's Spouse is eligible for medical or dental benefits through such Spouse's employment, the Eligible Employee's Spouse is not eligible for primary or secondary coverage under this Plan. The rules governing coordination of benefits under this Plan will not apply. (See Section V Eligibility For Coverage).

"Claim Determination Period" as used herein, means calendar year.

"Allowable Expense" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan. "Allowable Expense" will not include the following: (a) charges specifically excluded from benefits under this Plan which may also be eligible under any other plans covering the person for whom the claim is made; (b) charges for services covered under this Plan which are in an amount in excess of the lowest negotiated rates, if any, applicable to such services; or in the absence of negotiated rates, any charges in excess of this Plan's Usual and Customary Charges; and (c) any amount reduced from a primary plan's allowable expenses when that reduction is related to the failure of the primary plan Participant to obtain health care service from the primary plan's in-network providers.

OTHER PLANS WITH WHICH THIS PLAN COORDINATES

For purposes of coordination of benefits, "other plan" shall mean the following plans providing benefits or services for medical or dental care or treatment:

1. Group insurance or any other arrangement for coverage for individuals in a group whether on an insured or uninsured basis. This includes prepayment (such as an HMO), group practice or individual practice coverage, and Blue Cross/Blue Shield.

2. Coverage under a governmental plan, including Medicare but not including Medicaid, or coverage required or provided by law.

3. No-fault automobile coverage.

For purposes of this Section, in states with compulsory no fault automobile insurance laws, each individual shall be deemed to have no-fault coverage to the maximum available in that state. This Plan will coordinate benefits with no-fault coverage as defined in the state of residence of the individual required to carry such no-fault coverage, whether or not the individual is in compliance with the law, and whether or not the individual carries the maximum coverage available.

ORDER OF BENEFITS DETERMINATION

If a Participant is covered under this Plan and one or more plans, the order in which benefits will be paid shall be determined in accordance with the following rules. **If a plan has no coordination of benefits provision, it shall pay benefits first.** If this Plan and at least one other plan have coordination provisions, then the order in which benefits will be paid shall be as follows:

1. The plan covering the person as an employee, member, subscriber or alternate payee under a qualified child medical support order (that is, other than as a dependent) pays benefits first. The plan covering the person as a dependent pays benefits second.

2. Except as stated in paragraphs1 above and 3 below, when this Plan and another plan cover the same child as a dependent of different persons (called “parents”), the plan covering the parent whose birthday (month and day of birth, not year) falls earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second.

   However, if the other plan does not have this rule, but instead has a rule based upon the gender of the parent, and if as a result the plans do not agree on the order of benefits, then the rule in the other plan will determine the order of benefits.

3. Except as stated in paragraph 1 above with respect to an alternate payee under a qualified medical child support order, in the event that the parents of the covered dependent are divorced or separated, the following order of benefit determination applies:

   a. The plan covering the parent with custody pays benefits first.

   b. If the parent with custody has not remarried, then the plan covering the parent without custody pays benefits second.

c. If the parent with custody has remarried, then the plan covering the step-parent pays benefits second and the plan covering the parent without custody pays benefits third.

d. However, if divorce decree places the financial responsibility for the child's health care expense on one of the parents, then the plan covering that parent pays benefits first.

e. The plan covering a person as an employee (or as that person's dependent) who is neither laid-off nor retired pays benefits first. The plan covering that person as a laid-off or retired employee (or as that person's dependent) pays benefits second.

RIGHT TO INFORMATION

For the purpose of coordination of benefits, the Plan:

1. May release to, or obtain from, any other insurance company or other organization or person any claim information. Any person claiming benefits under the Plan must furnish any information which the Plan Administrator may require.

2. Has the right, if an overpayment is made, to recover such overpayment from any other person, insurance company or organization.

3. Has the right to reimburse any other organization if payments which should have been made by the Plan have been made by such organization.

NONCOMPLIANCE WITH PRIMARY PLAN PROVISIONS

If this Plan is secondary and the primary plan does not pay benefits because a Participant has not complied with the primary plan's rules, including without limitation rules relating to claims processing, utilization review, and/or any other provisions of such primary plan, this Plan shall deny your benefit claim in full.

SECTION X
PRIVACY & SECURITY OF PROTECTED HEALTH INFORMATION AND ELECTRONIC PROTECTED HEALTH INFORMATION

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI) AND ELECTRONIC PROTECTED HEALTH INFORMATION (EPHI)

The provisions of this Section relating to the Plan's obligations under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996 ("Privacy Rule") shall be effective on April 14, 200*3*, or such other later date provided by federal law or regulations.

The provisions of this Section relating to the Plan's obligations under the security regulations of the Health Insurance Portability and Accountability Act of 1996 ("Security Rule") shall be effective on April 21, 200*5,* or such other later date provided by federal law or regulations.

A. PRIVACY OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information (PHI) to the extent of and in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations. By law, the Plan has required all of its business associates to also observe HIPAA's privacy rules. In particular, the Plan will not, without authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

Under HIPAA, you have certain rights with respect to your protected health information, including certain rights to see and copy the information, receive an accounting of certain disclosures of the information and, under certain circumstances, amend the information. You also have the right to file a complaint with the Plan or with the Secretary of the U.S. Department of Health and Human Services if you believe your rights under HIPAA have been violated.

This Plan maintains a privacy notice, which provides a complete description of your rights under HIPAA's privacy rules. For a copy of the notice, if you have questions about the privacy of your health information, or if you wish to file a complaint under HIPAA, please contact Jamion Wolford, Pension Officer, West Virginia Annual Conference United Methodist Church/Pension Funds, Inc., PO Box 2469, Charleston, WV 25329, Phone 1-304-344-8331. A more detailed description of HIPAA's privacy provisions applicable to the Plan is provided below in this Section.

Payment includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of plan benefits which

relate to an individual to whom health care is provided. These activities include, but are not limited to, the following:

- determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and co-payments as determined for an individual's claim);
- adjudication of health benefit claims (including appeals and other payment disputes);
- subrogation of health benefit claims;
- establishing employee contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
- obtaining payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, preauthorization, concurrent review and retrospective review;
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for payment purposes: name and address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and
- reimbursement to the plan.

Health Care Operations include, but are not limited to, the following activities:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care

coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;

- rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

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

- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvements of payment methods or coverage policies;

- business management and general administrative activities of the Plan, including, but not limited to:

    - management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or

    - customer service, including the provision of data analyses for policyholders, plan sponsors or other customers;

- resolution of internal grievances; and

- due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a "covered entity" under HIPAA or, following completion of the sale or transfer, will become a covered entity.

THE PLAN MAY USE AND DISCLOSE PHI FOR TREATMENT, PAYMENT AND OPERATIONS, AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE PARTICIPANT OR BENEFIT

The Plan may, without the consent or authorization of the individual, use and disclose PHI for health care treatment, health care payment, and health care operations, and for such other uses or disclosures to the full extent permitted by regulations promulgated by the Secretary of Health and Human Services to implement HIPAA, subject to more stringent state privacy laws which do not conflict with HIPAA.

The Plan may also disclose PHI to such other persons and for such other purposes when authorized by the individual on a form and in a manner provided for in regulations promulgated by the Secretary of Health and Human Services to implement HIPAA.

The Plan may also disclose summary health information to the plan sponsor if requested by the plan sponsor for the purpose of obtaining bids from health plans for providing health insurance coverage, or for modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor information on whether the individual is participating in the group health plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

FOR PURPOSES OF THIS SECTION WEST VIRGINIA ANNUAL CONFERENCE UNITED METHODIST CHURCH / PENSION FUNDS, INC. IS THE PLAN SPONSOR

The Plan will disclose PHI to the Plan Sponsor only upon receipt of a certification from the Plan Sponsor that the plan documents have been amended to incorporate the following provisions.

WITH RESPECT TO PHI, THE PLAN SPONSOR AGREES TO CERTAIN CONDITIONS

The Plan Sponsor agrees to:

- Not use or further disclose PHI other than as permitted or required by the plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan Sponsor unless authorized by an individual;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to an individual in accordance with HIPAA’s access requirements;

- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

- Make available the information required to provide an accounting of disclosures;

- Make internal practices, books and records relating to the use and disclosure of PHI received from Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

- If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

ADEQUATE SEPARATION BETWEEN THE PLAN AND THE PLAN SPONSOR MUST BE MAINTAINED

In accordance with HIPAA, only the following classes of employees may be given access to PHI:

- The benefits manager

- Staff designated by the benefits manager

- Claims processors

LIMITATIONS OF PHI ACCESS AND DISCLOSURE

The persons given access to PHI described in the previous section may only have access to and use and disclose PHI for plan administration functions which the Plan Sponsor performs for the Plan.

NON-COMPLIANCE ISSUES

If the persons given access to PHI described in the above section do not comply with this plan document, the Plan Sponsor shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

B. SECURITY OF ELECTRONIC PROTECTED HEALTH INFORMATION

Where Electronic Protected Health Information ("EPHI") 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 EPHI as follows:

1. The Plan Sponsor shall implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the EPHI that the Plan Sponsor creates, receives, maintains or transmits on behalf of the Plan;

2. 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;

3. The Plan Sponsor shall ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such information; and

4. The Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:

    a. The Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware, any Security Incident that results in unauthorized access, use, disclosure, modification or destruction of the Plan's EPHI; and

    b. The Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every year, or more frequently upon the Plan's request.

SECTION XI
DEFINITIONS

DEFINITIONS NOT NOTED IN THE FOLLOWING SECTION ARE SUBJECT TO THE MOST CURRENT EDITION OF THE UNITED METHODIST CHURCH BOOK OF DISCIPLINE.

ALLOWABLE EXPENSE For purposes of coordination of benefits, any Medically Necessary, Usual, Customary and Reasonable Charge at least a portion of which is a Covered Medical Expense or Covered Dental Expense under this Plan. "Allowable Expense" will not include charges specifically excluded from benefits under this Plan.

AMBULATORY SURGICAL CENTER A Hospital's Outpatient surgical facility or a specialized facility which fully meets all of the following requirements :

1. It is established, equipped and operated in accordance with applicable laws in the jurisdiction in which it is located, and is operated primarily for the purpose of performing Outpatient Surgical Procedures.

2. It is operated under the full-time supervision of a licensed doctor of medicine (M.D.) or doctor of osteopathy (D.O.), and permits a Surgical Procedure to be performed only by a duly qualified M.D. or D.O. who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital in the area.

3. It requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthesia and remain present throughout the surgical procedure.

4. It provides at least one operating room and at least one post-anesthesia recovery room, is equipped to perform diagnostic x-ray and laboratory examinations, and has trained personnel and necessary equipment (including but not limited to a defibrillator, tracheotomy set, and blood bank or blood supplies) available to handle emergency situations.

5. It provides the full-time services of one or more registered graduate Nurses (R.N.) for patient care in the operating rooms and in the post-anesthesia recovery room.

6. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement.

7. It maintains an adequate medical record for each patient, such record to contain an admitting diagnosis, and also including, for all patients except those undergoing a procedure under local anesthesia, a preoperative

examination report, medical history and laboratory tests and/or x-rays, an operative report and a discharge summary; and

8. It is accredited or certified by the Joint Commission on the Accreditation of Healthcare Organizations, the Association for Ambulatory Care, or Medicare.

APPLIED BEHAVIOR ANALYSIS means the design, implementation, and evaluation of environmental modifications using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement, and functional analysis of the relationship between environment and behavior.

AUTISM SPECTRUM DISORDER means any pervasive developmental disorder, including autistic disorder, Asperger's Syndrome, Rett syndrome, childhood disintegrative disorder, or Pervasive Development Disorder as defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders of the American Psychiatric Association.

BIRTHING CENTER A health facility, not part of a Hospital, which mainly provides care and treatment during uncomplicated pregnancy, routine full-term delivery, and the immediate post-partum period. A Birthing Center must: (a) be licensed and operated in accordance with the laws pertaining to Birthing Centers in the jurisdiction where such facility is located; (b) provide facilities only for obstetrical delivery and short term recovery after delivery ; (c) provide care under the full-time supervision of a Physician and a registered graduate Nurse; and (d) have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require post-delivery confinement.

CALENDAR YEAR A period of one year, beginning on January 1.

CERTIFIED BEHAVIOR ANALYST means an individual who is certified by the Behavior Analyst Certification Board or certified by a similar nationally recognized organization.

CHIROPRACTIC SERVICES Any services performed by a licensed chiropractor practicing within the scope of his license, including office visits and x-rays.

CHURCH PARTICIPANT means each individual church/employer of the West Virginia Annual Conference United Methodist Family participating in the Plan.

CLAIM DETERMINATION PERIOD A Calendar Year.

CO-INSURANCE The portion of a Provider's Usual, Customary and Reasonable charges for a Covered Medical Expense that is the Participant's responsibility to pay.

Co-insurance does not include Deductibles, expenses that are not Covered Medical Expenses, or charges in excess of Usual, Customary and Reasonable charges.

CO-INSURANCE LIMIT The limit, specified in Section II (Summary of Benefits), on the amount of Co-insurance which a Participant or Participating family must pay for a Calendar Year. Deductibles and Co-insurance for Prescription Drugs do not count toward the Co-insurance Limit. If Co-insurance paid by a Participant for Covered Medical Expenses incurred during a Calendar Year reach the Co-insurance Limit, then the Plan will pay 100% for Covered Medical Expenses incurred during the remainder of the Calendar Year. If the combined Co-insurance made by a Participating Employee and his or her Participating Dependents reach the family Co-insurance Limit, then the Plan will pay 100% for Covered Medical Expenses incurred by Participating family members during the remainder of the Calendar Year. The Co-insurance Limit does not apply to: (a) Co-insurance for Prescription Drugs; (b) charges in excess of Usual, Customary and Reasonable Charges; (c) charges exceeding Plan maximum benefits (lifetime or Calendar Year); or (d) precertification penalties.

COSMETIC SURGERY Surgical procedures, usually, but not limited to, plastic surgery, directed toward preserving beauty or correcting scars, burns or disfigurements.

COVERED DENTAL EXPENSES Those expenses defined and listed in Section IV (Dental Benefits) of this Plan.

COVERED MEDICAL EXPENSES Those expenses defined and listed in Section III (Medical Expense Benefits) of this Plan.

CREDITABLE COVERAGE. With respect to an individual, coverage under any of the following: (a) a Group Health Plan; (b) Health Insurance Coverage; (c) Part A or Part B of the Title XVIII of the Social Security Act; (d) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under Section 1928 of such Act; (e) Chapter 55 of title 10, United Stated Code; (f) a medical care program of the Indian Health Service or of a tribal organization; (g) a state health benefits risk pool; (h) a health plan offered under chapter 89 of title 5, United States Code; (i) a public health plan, as defined in regulations issued under ERISA; (j) a health benefit plan under Section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)). The term Creditable Coverage does not include coverage consisting solely of coverage of excepted benefits, as defined in Section 706(c) of ERISA.

CUSTODIAL CARE Services and supplies provided primarily to assist an individual in daily living activities or which under medical standards cannot be reasonably expected to substantially improve the individual's medical condition.

DEDUCTIBLE The designated amount of Covered Medical Expenses or Covered Dental Expenses which the Participant must pay each Calendar Year before the Plan begins to pay benefits. The Deductible amounts for Covered Medical Expenses are set forth in Section II (Summary of Benefits) of this Plan. The Deductible

amounts for Covered Dental Expenses are set forth in Section IV (Dental Benefits) of the Plan.

DENTAL SERVICE A service performed by or under the direction of a Dentist which is listed in the Dental Services Schedule in Section IV of this Plan.

DENTIST A person licensed to practice dentistry or oral surgery who is acting within the scope of his license. The term Dentist also includes a Physician operating within the scope of his license when he performs any of the Covered Dental Services described in the Plan .

DEPENDENT (a) an Eligible Employee's spouse; (b) a child, step child, legally adopted child and child Placed for Adoption with the Eligible Employee, who is less than 26 years of age.

DISABILITY A Participant is considered disabled if he or she is unable to perform the usual and customary duties of his or her employment by reason of bodily injury, disease, or mental or emotional disease or disorder that will presumably last for at least six months. This is known as "own occupation" definition. A Participant will receive benefits for the first 29 months under the "own occupation" definition. Disability status must be verified by the individual's Physician. The Participant must notify and provide a copy of the Social Security disability award letter to the Pension Fund within 60 days of the disability determination and before the end of the 18 month continuation of coverage period in order to be entitled to the remaining 11 months of the disability extension.

DURABLE MEDICAL EQUIPMENT The term Durable Medical Equipment means equipment which: (a) can withstand repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of Sickness or Injury; and (d) is appropriate for use in the home.

ELECTRONIC PROTECTED HEALTH INFORMATION The term Electronic Protected Health Information has the meaning set forth in 45 C.F.R. § 160.103, as amended from time to time, and generally means protected health information that is transmitted in any electronic media.

ELIGIBLE EMPLOYEE (a) a full-time Employee normally scheduled to work a minimum of thirty (30) hours per week; or (b) an individual who was formerly an Eligible Employee as described in (a) and who is taking a leave pursuant to the Family and Medical Leave Act of 1993, as amended, if applicable.

EMERGENCY The sudden and unexpected onset of a medical condition manifesting itself by acute symptoms, including severe pain, which are severe enough that the lack of immediate medical attention could reasonably be expected to result in: (1) placing the patient's health in serious jeopardy; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part.

EMPLOYEE CONTRIBUTION The amount, if any, specified from time to time by the Employer that a Participating Employee is required to contribute to this Plan in order for such Eligible Employee and, if applicable, his or her Dependent(s) to participate hereunder.

EMPLOYEE Any individual lawfully and legally employed by the Employer.

EMPLOYER West Virginia Annual Conference United Methodist Family.

ENROLLMENT DATE. With respect to a Participant, the date of enrollment in the Plan, or if earlier, the first day of the Waiting Period for such enrollment.

ESSENTIAL HEALTH BENEFITS Essential Health Benefits has the meaning under section 1302(b) of the Patient Protection and Affordable Care Act (PPACA) and applicable regulations. Federal regulations define the term "Essential Health Benefits" and specify those services which are considered Essential Health Benefits. Services constituting Essential Health Benefits fall into at least the following general categories: (1) ambulatory patient services; (2) emergency services; (3) hospitalization; (4) maternity and newborn care; (5) mental health and substance use disorder services, including behavioral health treatment; (6) prescription drugs; (7) rehabilitative and habilitative services and devices; (8) laboratory services; (9) preventive and wellness services and chronic disease management; and (10) pediatric services, including oral and vision care.

EXPERIMENTAL OR INVESTIGATIONAL Services and supplies which are determined by the Plan Administrator, in its discretion, to be experimental or investigational in nature, meaning any treatment, procedure, facility, equipment, drugs, drug usage, devices, or supplies not generally recognized as accepted medical or dental practice and including any such services or supplies requiring federal or other governmental agency approval not granted at the time services were rendered. Services and supplies will also be deemed Experimental or Investigational if the treatment is: (a) the subject of Phase I, II or III clinical trials; (b) considered by the U.S. Health Care Financing Administration Medicare Coverage Issues Manual to be either experimental or investigational or not reasonable and necessary; (c) furnished in connection with medical or other research; or (d) for dental services or supplies, not approved by the American Dental Association.

EXTENDED CARE FACILITY Means a nursing home, Skilled Nursing Facility or any other similar facility which is approved by Medicare.

FIDUCIARY A person able to exercise discretionary authority or control over Plan administration or who renders investment advice for a fee or other compensation.

GROUP HEALTH PLAN An employee welfare benefit plan as defined in Section 3(1) of ERISA to the extent that such plan provides for Medical Care to eligible employees or their dependents through insurance, reimbursement or otherwise.

HEALTH INSURANCE COVERAGE Benefits consisting of Medical Care provided directly, through insurance or reimbursement or otherwise, and including items and services paid for as Medical Care under any Hospital or medical service policy or certificate, Hospital or Medical service plan contract or health maintenance organization contract offered by a Health Insurance Issuer.

HEALTH INSURANCE ISSUER An insurance company, insurance service or insurance organization (including a health maintenance organization) which is licensed to engage in the business of insurance in a state and which is subject to state law which regulates insurance within the meaning of Section 514(b)(2) of ERISA. Such term does not include a Group Health Plan.

HIPAA The Health Insurance Portability and Accountability Act of 1996, as amended from time to time, together with its related rules and regulations. References to any section of HIPAA shall include any successor provision(s) thereto.

HOME HEALTH AIDE The term Home Health Aide means a person who: (a) provides care of medical or therapeutic nature; and (b) reports to and is under the direct supervision of a Home Health Care Agency.

HOME HEALTH CARE AGENCY An agency or organization which provides a program of home health care to persons with a Sickness or Injury, designed to reduce or eliminate Confinement in a Hospital. A Home Health Care Agency must be: (a) certified by Medicare; (b) licensed and operated in accordance with all applicable laws in the jurisdiction in which it is located; and (c) provide services according to a Home Health Care Plan.

HOME HEALTH CARE PLAN A written plan for care and treatment of a person in his or her home. The plan must be established, approved, and periodically reviewed in writing by a Physician who certifies that the patient would require Confinement in a Hospital or Skilled Nursing Facility if the patient did not have the care and treatment recommended in the Home Health Care Plan.

HOSPICE A facility which provides palliative and supportive care for Terminally Ill patients under a coordinated Hospice Care Program. Care may be provided on an Inpatient, Outpatient, or in-home basis. A Hospice must meet all state licensing and other applicable laws and be either: (a) certified by Medicare; or (b) accredited by the National Hospice Organization.

HOSPICE CARE PROGRAM A formal, written, coordinated program, directed by a Physician, for providing palliative and supportive care to meet the special needs of a Terminally Ill patient. “Palliative and supportive care” means care and support

directed at controlling pain or symptoms, rather than attempting to cure the terminal illness.

HOSPITAL An institution which: (a) is engaged primarily in providing medical care and treatment to injured and sick persons on an Inpatient basis, at the patient's expense: (b) maintains facilities for surgical and medical diagnosis and treatment by or under the supervision of a staff of duly qualified Physicians; (c) provides twenty-four (24) hour-a-day nursing service by Nurses; (d) is not, other than incidentally, a place for rest, for the aged, for rehabilitation, for Custodial Care, for treatment of pulmonary tuberculosis, or for treatment of drug or alcohol addiction; and (e) is not an Extended Care Facility or remedial training institution.

A Hospital also must: (f) be duly licensed by the state in which it operates; (g) have a governing board legally responsible for the conduct of the institution; (h) employ an administrator to whom the governing board delegates the full-time responsibility for the operation of the institution in accordance with established policies; (i) have an organized medical staff to which the governing board delegates responsibility for maintaining proper standards of surgical and medical care; (j) maintain current and complete medical records for each patient; (k) have pharmacy, diagnostic X-ray, clinical laboratory and anatomical pathology, and operating room services with facilities and staff for a variety of procedures; (l) offer a food service meeting the nutritional requirements of the patients; and (m) be accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL CONFINEMENT OR CONFINED IN A HOSPITAL A Participant will be considered Confined in a Hospital or in a Hospital Confinement if he is:

1. a registered bed patient in a Hospital upon the recommendation of a Physician; or

2. an Outpatient in a Hospital because of (a) chemotherapy treatment; (b) surgery; or (c) planned tests ordered by a Physician before Inpatient admission to the same Hospital; or

3. receiving Emergency Care in a Hospital for an Injury on his first visit as an Outpatient within forty-eight (48) hours after the Injury is received; or

4. Partially Confined for treatment of a mental health condition, substance use disorder or other related illness. Two (2) days of being Partially Confined will be equal to one (1) day of being Confined in a Hospital. The term "Partially Confined" means continually treated for at least three (3) hours but not more than twelve (12) hours in any twenty-four (24) hour period.

ILLEGAL DRUGS Any classification of drug listed by the U.S. Drug Enforcement Administration as illegal.

INJURY A medical condition caused by accidental means which results in damage to the Participant's body from an external force. A hernia of any kind and however caused will be considered a Sickness, not an Injury.

INPATIENT A person who is admitted to a Hospital or other institution as a registered bed patient and who is confined to bed for health care.

LATE ENROLLEE A Participant who enrolls under the Plan other than during (a) the first period in which the individual is eligible to enroll under the Plan or (b) the special enrollment period.

MATERNITY Pregnancy, childbirth, miscarriage, or complications arising there from.

MEDICAID A state program of medical aid for needy persons established under Title XIX of the Social Security Act of 1965, as amended.

MEDICAL CARE Amounts paid for: (a) the diagnosis, cure, mitigation, treatment or prevention of disease, or amounts paid for the purpose of affecting any structure or function of the body; (b) amounts paid for transportation primarily for and essential to medical care referred to in (a); and (c) amounts paid for insurance covering medical care referred to in (a) and (b).

MEDICALLY NECESSARY CARE (OR MEDICAL NECESSITY OR MEDICALLY NECESSARY) Services or supplies provided by a Hospital, Physician or other covered provider which are required to identify or treat a Sickness or Injury and which, as determined by the Plan Sponsor, are: (a) directed and supervised by a Physician; (b) consistent with the symptoms, diagnosis and treatment of the Sickness or Injury; (c) appropriate, safe and effective according to standards of good medical practice and generally-accepted clinical evidence; (d) not primarily for the convenience of the patient, Physician, or other provider; and (e) the most appropriate supply or level of services which can safely be provided to the patient. When applied to an Inpatient, “Medically Necessary” also means that the patient's condition cannot safely be treated on an Outpatient basis.

THE MEDICAL NECESSITY OF A SERVICE OR SUPPLY SHALL BE DETERMINED BY THE PLAN ADMINISTRATOR, IN ITS DISCRETION. THE FACT THAT A PHYSICIAN MAY PRESCRIBE, ORDER, RECOMMEND, OR APPROVE A SERVICE OR SUPPLY DOES NOT, OF ITSELF, MAKE IT MEDICALLY NECESSARY OR MAKE THE CHARGE A COVERED MEDICAL EXPENSE, EVEN THOUGH IT IS NOT SPECIFICALLY LISTED AS AN EXCLUSION.

MEDICARE Health insurance for the aged as provided under both parts A and B, Title XVIII of the Social Security Act, as amended from time to time.

MENTAL HEALTH CONDITION Any disorder, other than a disorder induced by a substance use disorder, which is not otherwise excluded from coverage under the terms of the Plan, which impairs the behavior, emotional reaction or thought process of a person, regardless of medical origin, and which is listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

NONESSENTIAL HEALTH BENEFITS Any covered benefits, items or services which do not constitute Essential Health Benefits.

NURSE A registered graduate Nurse (R.N.) or a licensed practical Nurse (L.P.N.), or a licensed vocational Nurse (L.V.N.), unless otherwise specified, who is licensed or certified under the laws of the state in which he/she resides.

OUTPATIENT Means a person who is not admitted as an Inpatient but who receives health care.

PARTICIPANT OR PARTICIPATING An eligible Employee or Dependent who is properly enrolled in this Plan.

PHARMACY An establishment where Prescription Drugs are dispensed by a licensed pharmacist.

PHYSICIAN Means a duly licensed doctor of medicine (M.D.), doctor of dental surgery (D.D.S), doctor of podiatry (D.P.M.), doctor of osteopathy (D.O.), doctor of optometry (O.D.), doctor of chiropractic (D.C.), physician's assistant (P.A. or P.A.C.), nurse practitioner (N.P.), licensed professional counselor (L.P.C), licensed clinical social worker (L.C.S.W.), clinical psychologist or nurse-midwife who is lawfully rendering services within the scope of his or her respective license, and who is not an intern, resident, fellow or other participant in a residency training program.

PLACED FOR ADOPTION or **PLACEMENT FOR ADOPTION** The assumption and retention of a legal obligation for total or partial support of a child in anticipation of the adoption of the child.

PLAN The West Virginia Annual Conference United Methodist Family Employee Medical and Dental Benefit Plan.

PLAN ADMINISTRATOR West Virginia Annual Conference United Methodist Church/Pension funds, Inc.

PLAN SPONSOR Pension Funds, Inc.

PLAN YEAR April 1st – March 31st.

PREFERRED PROVIDER / PREFERRED PROVIDER ORGANIZATION An individual or network of Providers that have agreed to provide health care services at negotiated discounted rates to Plan Participants.

PRESCRIPTION DRUGS The following are considered Prescription Drugs under the Plan: (a) a Federal Legend Drug (which means any medicinal substance which the Federal Food, Drug and Cosmetic Act, as amended, requires to be labeled: "Caution: Federal law prohibits dispensing without a prescription."); (b) oral or injectable insulin (not including any device for administration of injectable insulin); (c) a compound medication which has at least one ingredient that is a Federal Legend Drug or that requires a prescription under any state law; and (d) any other drug which, under federal or state law, may only be dispensed upon the written prescription of a Physician.

PRESCRIPTION ORDER A Physician's prescription for a single Prescription Drug. If more than one Prescription Drug is prescribed at the same time, then each separate Prescription Drug prescribed will be considered a separate Prescription Order. Each Physician-authorized refill of a Prescription Order will be considered a separate Prescription Order.

RECOMMENDED PREVENTIVE SERVICES The following services, when received from a network provider, which are covered by the Plan without regard to any deductible, copayment, or coinsurance requirement that would otherwise apply: (a) evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force with respect to the Eligible Employee or Dependent involved; (b) immunizations for routine use that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the Eligible Employee or Dependent involved; (c) with respect to Eligible Employees or Dependents who are infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and (d) with respect to Eligible Employees or Dependents who are women, such additional preventive care and screenings not described in paragraph (a) as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

For purposes of this definition, a Recommended Preventive Service shall mean only those items described above which have had in effect the requisite recommendation for at least one year prior to the first day of the current Plan Year. Once a Preventive Service ceases to qualify as a Recommended Preventive Service, the Plan shall not longer be obligated to cover the service without regard to any deductible, copayment or coinsurance requirement that would otherwise apply.

In addition, for purposes of this definition, the United States Preventive Services Task Force recommendations regarding breast cancer screening, mammography, and prevention issued in or around November 2009 are not be considered current recommendations, and the Plan shall instead consider as a current recommendation the

recommendation regarding breast cancer screening, mammography, and prevention issued in 2002. A complete list of all recommendations and guidelines can be obtained at http://www.HealthCare.gov/center/regulations/prevention.html or by contacting the Administrator.

REHABILITATION SERVICES Services that are: (a) designed to remediate a patient's condition or to restore a patient to his or her optimal physical, medical, psychological, social, emotional, vocational or economic status; (b) rendered by a licensed Hospital that meets Medicare requirements for rehabilitation hospitals, or by a distinct part rehabilitation unit in a licensed Hospital that meets U.S. Health Care Financing Administration requirements for cardiac rehabilitation; and (c) for one of the conditions listed in paragraph 14 under Covered Medical Expenses, in Section III of this Plan. "Rehabilitation Services" does not include rehabilitation which is primarily educational or cognitive in nature.

RETIRED EMPLOYEE A former Eligible Employee retired by the Plan Administrator who receives retirement income either from the Plan Administrator or as a result of service with the Plan Administrator. **REFER TO MOST CURRENT EDITION OF THE UNITED METHODIST CHURCH BOOK OF DISCIPLINE FOR SPECIFIC RETIREMENT ELIGIBILITY REQUIREMENTS.**

ROOM AND BOARD Means room, board, general duty nursing and any other necessary services and supplies regularly furnished by a Hospital as a condition of occupancy, but not including professional services of Physicians or special nursing services rendered outside of an intensive care unit by whatever name called.

SECURITY INCIDENTS The term Security Incidents has the meaning set forth in 45 C.F.R. § 164.304, as amended from time to time, and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

SICKNESS Physical or mental illness or disease. All recurrences, complications and related conditions will be considered as one Sickness. For purposes of this Plan, the term "Sickness" also includes pregnancy. Expenses incurred for routine Hospital and pediatric care of a newborn child prior to discharge from the Hospital nursery will be considered to be incurred as a result of Sickness.

SKILLED NURSING FACILITY A licensed institution (other than a Hospital) which is certified by Medicare and which specializes in: (a) physical rehabilitation on an Inpatient basis; or (b) skilled nursing and medical care on an Inpatient basis, but only if that institution maintains on the premises all facilities necessary for medical treatment, provides such treatment for compensation under the supervision of Physicians, and provides Nurses' services.

SUBSTANCE USE DISORDER Any disorder of intoxication, dependence, abuse, and substance withdrawal caused by various substances, both legal and illegal, which is not otherwise excluded from coverage under the terms of the Plan, and which is listed in the most current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM).

SURGICAL PROCEDURE Any of the following:

1. To incise, exercise or electro cauterize any organ or body part, except for dental service;

2. To repair, revise, or reconstruct any organ or body part;

3. To reduce by manipulation a fracture or dislocation;

4. Using endoscopy to explore for or to remove a stone or other object from the larynx, bronchus, trachea, esophagus, stomach, intestines, urinary bladder, or ureter;

5. A puncture for aspiration;

6. An injection for contract media testing.

Any other procedure not stated above may be considered a Surgical Procedure if deemed such by the Plan Administrator with the agreement of any insurer which may insure a portion of any benefits under this Plan.

TERMINALLY ILL A person who, because of a terminal illness, has a life expectancy of six (6) months or less, as certified in writing by his or her attending Physician.

TOTAL DISABILITY The complete and total inability to perform the normal duties of one's occupation or of a similar occupation for which the individual is reasonably capable due to education and training.

USUAL, CUSTOMARY AND REASONABLE CHARGE The maximum reimbursement allowed under the Plan for a Covered Medical Expense. For Hospitals or institutional providers, the Usual, Customary and Reasonable Charge is the amount determined by the Plan Administrator, in its sole discretion, to be reasonable. Unless otherwise specified in this Plan, for Physicians and other professional providers, it is an amount determined by the Plan Administrator in accordance with the following criteria:

1. Usual - The standard fee consistently charged by a Physician (or provider) to patients for a specific service or supply;

2. Customary - A fee that is within the range of usual charges for a given service or supply billed by most Physicians (or providers) with like training and experience within a geographical area;

3. Reasonable - A fee that is Usual and Customary, or that is otherwise determined by the Plan Administrator to be appropriate, taking into consideration any exceptional circumstances which might require additional time, skill or expense.

UTILIZATION REVIEW SERVICE The entity which performs precertification review services for the Plan.

WAITING PERIOD The period that must pass before an individual who is a potential Participant is eligible to participate in the Plan. The Waiting Period for this Plan is the first day of full-time continuous employment and participation shall become effective on the first day of the month following receipt of the completed application by the Plan Administrator. If you are out on disability on the date you become eligible, your benefits will begin when you return to full-time active work.

WELL BABY CARE Charges for routine nursery care, routine Physician examinations, and routine procedures for a Participating Dependent newborn baby during the initial Hospital Confinement at the time of birth. Well Baby Care does not include any services provided after the newborn leaves the Hospital, and does not include treatment of an Injury or Sickness.

WELL CHILD CARE For a Participating Dependent child for health history, developmental assessment, immunizations, and physical examination.