

**STANDARD BRED BREEDERS
AND OWNERS ASSOCIATION**

HEALTH BENEFITS TRUST

Summary Plan Description

As Amended and Restated January 1, 2011

Drafted 01/19/2011

**STANDARD BRED BREEDERS
AND OWNERS ASSOCIATION
HEALTH BENEFITS TRUST
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LE 03/09/2011

INTRODUCTION

This Summary Plan Description describes the Medical, Dental, Prescription Drug, and Vision benefits available to members of Standardbred Breeders and Owners Association Health Benefits Trust. The benefits described in this document became effective as of January 1, 2002 and as amended and restated January 1, 2011. This document summarizes the Plan rights and benefits for covered members and their dependents. By carefully reading your summary plan description and understanding your relationship to your plan, you can be an informed participant. So know your plan, what it requires of you, how to become eligible for benefits, and what steps you can take to assure that you will receive your earned benefits.

When you become a Covered Person, you will have available to you a listing of the participating Hospitals and physicians of the Preferred Provider Organization (PPO). At the time of service, it is your responsibility to confirm with the medical provider and/or facility that they continue to participate in the PPO. A telephone number is provided on the front of your health plan Identification Card to contact the network to assist you with locating providers in your area. Additionally, The Loomis Company website www.loomisco.com contains links to many online provider directories under the *Provider List* option. Printed provider directories are also available to you free of charge; however, due to changes the printed directories become obsolete quickly.

If you live within the geographic service area of your PPO network and utilize the services of network providers, the Standardbred Breeders and Owners Association Health Benefits Trust will provide higher levels of benefits to you.

The participating Hospitals and physicians of the network have agreed to extend a discount to those members and covered dependents that utilize their facilities. When your claims for Hospital services are processed, you will see the amount of the discount on the Explanation of Benefits (EOB). This, of course, helps reduce your liability for the cost of the services.

One of the advantages of the PPO network to you, as a consumer of medical care, deals with the determination of what charges are acceptable for benefit payment. As defined later in this booklet, *covered expenses* will be considered only up to the usual, customary and reasonable charge for the geographic area in which the service is rendered. This means that if a network physician bills an amount in excess of the usual, customary and reasonable amount, you cannot be billed for the excess charge. This provision of the Plan can be meaningful and offers additional financial benefits when PPO providers are used for medical care.

IMPORTANT HIGHLIGHTS

NOTE: Any injury involving a horse while at a Training Center, Horse Breeding Facility, Barn, and/or Track is NOT covered under the Health Plan and will be deemed as a work related injury. Personal claims will have the right to appeal to the Insurance Committee.

(1) **MANDATORY PRE-NOTIFICATION**

YOU MUST OBTAIN PRE-NOTIFICATION FOR HOSPITAL ADMISSIONS. Refer to the Pre-Notification Section of this Summary Plan Description.

(2) **YOU MUST NOTIFY THE SBOA HOME OFFICE WHEN ONE OF THE FOLLOWING EVENTS OCCUR.**

- Birth of a child. (*Within 30 days.*)
- **Your covered child turns 26.** (*Within 60 days.*)
- Divorce. (*Within 60 days.*)
- Marriage. (*Within 30 days.*)
- Adoption of a child. (*Within 30 days.*)
- Reinstatement – *If you are termed from the medical plan twice there will be NO reinstatement.*

Failure to notify the SBOA Home Office of these events could result in loss of eligibility and claims being denied.

(3) **YOU MUST BE SURE NETWORK PROVIDERS HAVE CURRENT BILLING INSTRUCTIONS PROVIDED ON YOUR IDENTIFICATION CARD. FAILURE TO SUBMIT CLAIMS PROPERLY WILL RESULT IN DELAYED CLAIMS PROCESSING.**

(4) **BILLS SHOULD BE SUBMITTED FOR PAYMENT IN A TIMELY BASIS.**

Claims filed more than 12 months after the date of service will not be eligible for payment.

**SCHEDULE OF MEDICAL BENEFITS
BLUE PLAN**

Maximum Annual Benefit for Medical Care

\$1,000,000

	PPO	Non-PPO
Calendar year Deductible:		
Member	\$250	\$500
2-3 Persons	\$500 (Member must satisfy \$250 of the \$500)	\$1,000 (Member must satisfy \$500 of the \$1000)
3+ Persons	\$750 (Member must satisfy \$250 of the \$750)	\$1,500 (Member must satisfy \$500 of the \$1,500)
Out-of-Pocket (Deductible Included):		
Member	\$5,000	No maximum
2-3 Persons	\$7,500	No maximum
3+ Persons	\$10,000	No maximum
Benefit Percentage:		
Medical Plan Pays	90%	45%
Covered Person Pays	10%	55%

Benefits and Services	PPO Plan Pays	Non-PPO Plan Pays	Comments
HOSPITAL BENEFIT			
Inpatient Hospital Services	100% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Intensive Care Unit	100% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on hospital's ICU Charge.
Skilled Nursing Facility	90% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on ½ hospital average semiprivate room rate within 2 days of a 3 day stay; 60 days calendar year maximum.
EMERGENCY SERVICES			
Medical Emergency Care within 24 hours	100% Subject to the Deductible	100% of UCR Subject to the Deductible	
Medical Emergency Care after 24 hours	90% Subject to the Deductible	45% of UCR Subject to the Deductible	
Non-Emergent Care	90% Subject to the Deductible	45% of UCR Subject to the Deductible	
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS			
Inpatient Mental Health Treatment	100% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Mental Health Treatment	90% Subject to the Deductible	45% of UCR Subject to the Deductible	
Inpatient Substance Abuse Treatment	100% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Substance Abuse Treatment	90% Subject to the Deductible	45% of UCR Subject to the Deductible	
Partial Hospitalization	100% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i>
MISCELLANEOUS SERVICES AND SUPPLIES			
Home Health Care	90% Subject to the Deductible	45% of UCR Subject to the Deductible	Limited to 60 visits paid per calendar year.

Benefits and Services	PPO Plan Pays	Non-PPO Plan Pays	Comments
MISCELLANEOUS SERVICES AND SUPPLIES <i>continued</i>			
Hospice Care	90% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i>
Bereavement Counseling	90% after a \$15 co-pay per visit Subject to the Deductible	45% of UCR after a \$15 co-pay per visit Subject to the Deductible	Bereavement counseling is limited to a lifetime maximum of 6 visits paid.
Ambulance Service	90% Subject to the Deductible	90% of UCR Subject to the Deductible	
Durable Medical Equipment	90% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required for equipment in excess of \$500.</i>
Wig Following Chemotherapy	90% Subject to the Deductible	45% of UCR Subject to the Deductible	Lifetime maximum of 1 wig.
Pain Management	90% Subject to the Deductible	45% of Allowable Claim Limit Subject to the Deductible	<i>Limited to 15 visits per calendar year.</i>
PROFESSIONAL SERVICES BENEFIT			
Physician's visits • Office Visit	90% after a \$15 co-pay per visit Subject to the Deductible	45% of UCR Subject to the Deductible	
• Hospital Visit or Consultation	90% Subject to the Deductible	45% of UCR Subject to the Deductible	
• Allergy Testing & Treatment	90% after a \$15 co-pay per office visit Subject to the Deductible	45% of UCR after a \$15 co-pay per visit Subject to the Deductible	
• Second Surgical Opinion	100% Subject to the Deductible	100% of UCR Subject to the Deductible	
Diagnostic Laboratory Expenses	90% Subject to the Deductible	45% of UCR Subject to the Deductible	When billed by an independent laboratory.
Extensive Scanning & Imaging	90% Subject to the Deductible	45% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Includes MRI, PET Scans, CT Scans, etc. when billed by an independent facility.
REHABILITATION THERAPY			
Chiropractic Care	90% Subject to the Deductible	45% of UCR Subject to the Deductible	Limited to 26 visits per calendar year.
Outpatient Therapies • Speech Therapy • Respiratory Therapy • Physical Therapy • Occupational Therapy	90% after a \$15 co-pay per visit Subject to the Deductible	45% of UCR after a \$15 co-pay per visit Subject to the Deductible	Limited to 15 visits per condition per calendar year.
PREVENTIVE CARE			
Well Child Care <i>Limited to ages birth up to 18.</i>	100% Deductible Waived	Not Covered	Refer to the <i>Covered Medical Expenses</i> section for benefit details.
Well Woman Care	100% Deductible Waived	Not Covered	
Well Adult Care	100% Deductible Waived	Not Covered	
Preventive Services includes reimbursement for the following services: pap smear, gynecological examination, mammogram, and physical examination.			

**SCHEDULE OF MEDICAL BENEFITS
RED PLAN**

Maximum Annual Benefit for Medical Care

\$1,000,000

	PPO	Non-PPO
Calendar year Deductible:		
Member	\$250	\$500
2-3 Persons	\$500 (Member must satisfy \$250 of the \$500)	\$1,000 (Member must satisfy \$500 of the \$1000)
3+ Persons	\$750 (Member must satisfy \$250 of the \$750)	\$1,500 (Member must satisfy \$500 of the \$1,500)
Out-of-Pocket (Deductible Included):		
Member	\$10,000	No maximum
2-3 Persons	\$10,000	No maximum
3+ Persons	\$10,000	No maximum
Benefit Percentage:		
Medical Plan Pays	80%	40%
Covered Person Pays	20%	60%

Benefits and Services	PPO Plan Pays	Non-PPO Plan Pays	Comments
HOSPITAL BENEFIT			
Inpatient Hospital Services	100% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Intensive Care Unit	100% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on hospital's ICU Charge.
Skilled Nursing Facility	80% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on 1/2 hospital average semiprivate room rate within 2 days of a 3 day stay; 60 days calendar year maximum.
EMERGENCY SERVICES			
Medical Emergency Care within 24 hours	100% Subject to the Deductible	100% of UCR Subject to the Deductible	
Medical Emergency Care after 24 hours	80% Subject to the Deductible	40% of UCR Subject to the Deductible	
Non-Emergent Care	80% Subject to the Deductible	40% of UCR Subject to the Deductible	
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS			
Inpatient Mental Health Treatment	100% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Mental Health Treatment	80% Subject to the Deductible	40% of UCR Subject to the Deductible	
Inpatient Substance Abuse Treatment	100% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Substance Abuse Treatment	80% Subject to the Deductible	40% of UCR Subject to the Deductible	
Partial Hospitalization	100% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i>
MISCELLANEOUS SERVICES AND SUPPLIES			
Home Health Care	80% Subject to the Deductible	40% of UCR Subject to the Deductible	Limited to 60 visits paid per calendar year.

Benefits and Services	PPO Plan Pays	Non-PPO Plan Pays	Comments
MISCELLANEOUS SERVICES AND SUPPLIES <i>continued</i>			
Hospice Care	80% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i>
Bereavement Counseling	80% after a \$15 co-pay per visit Subject to the Deductible	40% of UCR after a \$15 co-pay per visit Subject to the Deductible	Bereavement counseling is limited to a lifetime maximum of 6 visits paid.
Ambulance Service	80% Subject to the Deductible	80% of UCR Subject to the Deductible	
Durable Medical Equipment	80% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required for equipment in excess of \$500.</i>
Wig Following Chemotherapy	80% Subject to the Deductible	40% of UCR Subject to the Deductible	Lifetime maximum of 1 wig.
Pain Management	80% Subject to the Deductible	40% of Allowable Claim Limit Subject to the Deductible	<i>Limited to 15 visits per calendar year.</i>
PROFESSIONAL SERVICES BENEFIT			
Physician's visits • Office Visit	80% after a \$15 co-pay per visit Subject to the Deductible	40% of UCR Subject to the Deductible	
• Hospital Visit or Consultation	80% Subject to the Deductible	40% of UCR Subject to the Deductible	
• Allergy Testing & Treatment	80% after a \$15 co-pay per office visit Subject to the Deductible	40% of UCR after a \$15 co-pay per visit Subject to the Deductible	
• Second Surgical Opinion	100% Subject to the Deductible	100% of UCR Subject to the Deductible	
Diagnostic Laboratory Expenses	80% Subject to the Deductible	40% of UCR Subject to the Deductible	When billed by an independent laboratory.
Extensive Scanning & Imaging	80% Subject to the Deductible	40% of UCR Subject to the Deductible	<i>Pre-notification required.</i> Includes MRI, PET Scans, CT Scans, etc. when billed by an independent facility.
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Chiropractic Care	80% Subject to the Deductible	40% of UCR Subject to the Deductible	Limited to 26 visits per calendar year.
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PREVENTIVE CARE			
Well Child Care <i>Limited to ages birth up to 18.</i>	100% Deductible Waived	Not Covered	Refer to the <i>Covered Medical Expenses</i> section for benefit details.
Well Adult Care	100% Deductible Waived	Not Covered	
Well Woman Care	100% Deductible Waived	Not Covered	
Preventive Services includes reimbursement for the following services: pap smear, gynecological examination, mammogram, and physical examination.			

**SCHEDULE OF MEDICAL BENEFITS
GREEN PLAN**

Maximum Annual Benefit for Medical Care

\$1,000,000

	EPO
Calendar year Deductible:	
Member	\$250
2-3 Persons	\$500
	(Member must satisfy \$250 of the \$500)
3+ Persons	\$750
	(Member must satisfy \$250 of the \$750)
Benefit Percentage:	
Medical Plan Pays	70%
Covered Person Pays	30%

Benefits and Services	EPO Plan Pays	Comments
HOSPITAL BENEFIT		
Inpatient Hospital Services	100% Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Intensive Care Unit	100% Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on hospital's ICU Charge.
Skilled Nursing Facility	70% Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on 1/2 hospital average semiprivate room rate within 2 days of a 3 day stay; 60 days calendar year maximum.
EMERGENCY SERVICES		
Medical Emergency Care within 24 hours	100% Subject to the Deductible	
Medical Emergency Care after 24 hours	70% Subject to the Deductible	
Non-Emergent Care	70% Subject to the Deductible	
MENTAL HEALTH & SUBSTANCE ABUSE BENEFITS		
Inpatient Mental Health Treatment	100% Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Mental Health Treatment	70% Subject to the Deductible	
Inpatient Substance Abuse Treatment	100% Subject to the Deductible	<i>Pre-notification required.</i> Benefit based on Semi-private room rate.
Outpatient Substance Abuse Treatment	70% Subject to the Deductible	
Partial Hospitalization	100% Subject to the Deductible	<i>Pre-notification required.</i>
MISCELLANEOUS SERVICES AND SUPPLIES		
Home Health Care	70% Subject to the Deductible	Limited to 60 visits paid per calendar year.
Hospice Care	70% Subject to the Deductible	<i>Pre-notification required.</i>
Bereavement Counseling	70% after a \$20 co-pay per visit Subject to the Deductible	Bereavement counseling is limited to a lifetime maximum of 6 visits paid.

Benefits and Services	EPO Plan Pays	Comments
MISCELLANEOUS SERVICES AND SUPPLIES <i>continued</i>		
Ambulance Service	70% Subject to the Deductible	
Durable Medical Equipment	70% Subject to the Deductible	<i>Pre-notification required for equipment in excess of \$500.</i>
Wig following chemotherapy	70% Subject to the Deductible	Lifetime maximum of 1 wig.
Pain Management	70% Subject to the Deductible	<i>Limited to 15 visits per calendar year.</i>
PROFESSIONAL SERVICES BENEFIT		
Physician's visits <ul style="list-style-type: none"> • Office Visit • Hospital Visit or Consultation • Allergy Testing & Treatment • Second Surgical Opinion 	70% after a \$20 co-pay per visit Subject to the Deductible 70% Subject to the Deductible 70% after a \$20 co-pay per office visit Subject to the Deductible 100% Subject to the Deductible	
Diagnostic Laboratory Expenses	70% Subject to the Deductible	When billed by an independent laboratory.
Extensive Scanning & Imaging	70% Subject to the Deductible	<i>Pre-notification required.</i> Includes MRI, PET Scans, CT Scans, etc. when billed by an independent facility.
REHABILITATION THERAPY		
Chiropractic Care	70% Subject to the Deductible	Limited to 26 visits per calendar year.
Outpatient Therapies <ul style="list-style-type: none"> • Speech Therapy • Respiratory Therapy • Physical Therapy • Occupational Therapy 	70% after a \$20 co-pay per visit Subject to the Deductible	Limited to 15 visits per condition.
PREVENTIVE CARE		
Well Child Care <i>Limited to ages birth up to 18.</i>	100% Deductible Waived	Refer to the <i>Covered Medical Expenses</i> section for benefit details.
Well Adult Care	100% Deductible Waived	
Well Woman Care	100% Deductible Waived	
Preventive Services includes reimbursement for the following services: pap smear, gynecological examination, mammogram, and physical examination.		

SCHEULE OF DENTAL BENEFITS

Administered by Delta Dental

Calendar Year Deductible (waived on Preventive & Diagnostic)	\$25 per Covered Person
Calendar Year Maximum	\$1,000 per Patient
Dental Percentage Payable	
<i>Preventive & Diagnostic</i> *Exams, Cleanings, & Bitewing X-rays (each twice per calendar year) *Fluoride Treatment (once in a calendar year, children to age 19) *Sealants	100%
<i>Remaining Basic</i> *Fillings, Simple Extractions	80%
<i>Crowns & Prosthodontics</i> *Crowns, Gold Restorations *Bridgework *Full & Partial Dentures *Endodontics (root canal) *Major Oral Surgery	50%

This program is based upon a network of DeltaPreferred Option USA dental offices, although you may choose any fully licensed dentist to render necessary services. Participating dentists will be paid directly by Delta Dental to the extent that services are covered by the contract.

Non-participating dentists will bill the patient directly, and Delta Dental will make payment directly to the subscriber. Patients who select a non-DeltaPreferred Option USA dentist have benefits paid on a DeltaPreferred Option USA schedule of allowances and are responsible for any part of the dentist's fee which exceeds the allowance except that a Delta Dental participating dentist can only charge up to his/her filed fee or Delta Dental's maximum plan allowance, whichever is less. Maximum benefit may be derived by utilizing the services of a participating DeltaPreferred Option USA dentist.

If you do not have a DeltaPreferred Option dentist, there is a list available with your Plan Administrator listing DeltaPreferred Option USA dentists. You may call 1-800-DELTA-OK and a list of participating dentists located in your area will be mailed directly to your home or you may access the Website at www.deltadentalnj.com.

PRESCRIPTION DRUG EXPENSE BENEFITS

Administered by CVS/Caremark

RETAIL: One 30 day supply and two refills for the following co-payments:

Brand \$20.00 per 30 day supply or less, Generic \$10.00 per 30 day supply or less

MAILORDER: Once the refill limit has been reached for maintenance medications at the retail pharmacy the plan allows for up to a 90 day supply via the mail order pharmacy for the following co-payments:

Brand and Generic \$30.00 per 90 days supply at the mail order pharmacy. Generic mandatory if available

MAINTENANCE AT RETAIL: Up to a 90 day supply of maintenance medications at specific retail pharmacies following co-payments apply:

Brand: \$70.00 per 90 day supply

Generic: \$50.00 per 90 day supply

HOW IT WORKS: Generic Mandatory

Retail:

Locate a CVS/Caremark participating pharmacy (all chain pharmacies participate with CVS/Caremark), then present your prescription and co-payment to the pharmacist. The pharmacists will dispense your medication up to a 30 day supply.

Mail Order:

Step 1 Obtain a CVS/Caremark mail order form or have physician fax order and eligibility to CVS/Caremark.

Step 2 Please mail your completed forms along with your **ORIGINAL PRESCRIPTION(s)** to CVS/Caremark.

ANNUAL PLAN MAXIMUM \$3,500 PER PERSON. ONCE THE PLAN MAXIMUM IS REACHED YOU ARE ELIGIBLE FOR THE GROUP DISCOUNT SO BE SURE TO PRESENT YOUR ID CARD OR USE MAIL ORDER FOR THE BALANCE OF THE PLAN YEAR.

Members who reach the annual Plan maximum will pay at 100% member co-pay with no Plan responsibility.

Generic Reimbursement Plan:

If there is a generic equivalent and you choose the brand name drug over the generic you are responsible for the cost difference between the brand name drug and its generic equivalent plus the applicable co-payment regardless of the physician's instructions.

SBOA Supplemental Program: Once \$3,500 benefit is released you are eligible for additional benefit if

Conditions:

MS

Cancer

Crones Disease

Rheumatoid Arthritis

Infectious Disease

Diabetes

Based on Medical Plan Choice Blue, Red, or Green:

Deductible under Medical Plan will apply

Out of Pocket under Medical Plan will not apply

Plan Maximum on supplemental is \$3,500 for the “conditions listed”

Benefit available via Mail Order and retail stores only

Exposure maximum per year (calendar) if condition applies \$7,000

Members who reach the annual Supplemental Program maximum will pay at 100% member co-pay with no Plan responsibility.

The following categories if listed as covered may have dispensing limitations and/or require pre-certification.

Drug Coverage

<u>CATEGORY:</u>	<u>YES</u>	<u>NO</u>
Federal Legend Drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Oral Contraceptives	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Insulin	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Injectables	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Over The Counter	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Devices	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Needles & Syringes	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nicorette (Zyban/Inhaler)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Injectable Fertility drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Legend Vitamins	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Blood Products	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Biological Serums	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diagnostic Items	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Rhogam	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Genetically Engineered	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Clomid (Oral Fertility)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Immune Altering drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rogaine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Retin-Aup to age 25	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diet drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Anabolic Steroids	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Male Related	<input checked="" type="checkbox"/>	<input type="checkbox"/>
FDA - Various excluded Items	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cough & Cold drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Nicotine Transdermal Patch	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Lipids	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Dexedrine	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Imitrex Vial	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Imitrex with Auto Injector	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Diabetic Supplies	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diabetic Tablets	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diagnosis Only drugs	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Prenatal Vitamins	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Injectable Contraceptives	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Ulcer Treatment drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental Health drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Children's Vitamins	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Anti-Inflammatory drugs	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Bee Sting Kits	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diaphragms	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Yohimbine	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Male Sexual Dysfunction	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Ostomy Products	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Accutane up to age 25 retail only	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diabetic Machines	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Diabetic Lancets	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Growth Hormone Therapy	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Cox Inhibitors - Arthritis	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Intravenous Injectables	<input type="checkbox"/>	<input checked="" type="checkbox"/>
Female Related	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Allergy	<input type="checkbox"/>	<input checked="" type="checkbox"/>

Excluded drugs will be processed at 100% member co-pay with no Plan responsibility.

CATEGORY: **YES** **NO**

SCHEDULE OF VISION BENEFITS

BENEFITS:		
Examination	Once every 12 months	
Lenses	Once every 12 months	
Frames	Once every 24 months	
	Plan pays	Limited to
Examination	100%	\$25.00
Lenses	100%	
• Single Vision		\$20.00
• Bi-Focal		\$25.00
• Tri-Focal		\$30.00
• Lenticular		\$50.00
Frames	100%	\$25.00
Contact Lenses*	100%	\$100.00

* Please note that contact lenses will only be covered under the following circumstances: (1) Vision cannot be corrected to 20/70 in the better eye, except by use of contact lenses; (2) Following cataract surgery; or (3) In conjunction of treatment for keratinous or anisometropia.

Vision Limitations and Exclusions

No vision coverage will be provided for:

Employment-Required Services – Any eye examination, or any corrective eyewear which is required by an employer as a condition of employment.

Medical or Surgical Treatment of the Eye.

Non-Prescription Lenses – Lenses which do not correct refractive error (piano lenses) or which are not obtained upon prescription by an ophthalmologist, optometrist or optician.

Orthoptics – Services or supplies in connection with orthoptics, visual training or other special procedures.

Sunglasses – Charges for sunglasses, including prescription type.

IMPORTANT PLAN FACTS

This Summary Plan Description has been compiled in accordance with Public Law 93-406 (known as the EMPLOYEE RETIREMENT SECURITY ACT OF 1974; “ERISA”).

PLAN NAME & ADMINISTRATOR	Standardbred Breeders and Owners Association 64 Business Route 33 Manalapan, NJ 07726 732-462-2357
PLAN SPONSOR	Standardbred Breeders and Owners Association 64 Business Route 33 Manalapan, NJ 07726 732-462-2357
EMPLOYER I.D. NUMBER	59-3787756
GROUP NUMBER	169
PLAN NUMBER	501
TYPE OF PLAN	Self-Funded Group Health Plan
PLAN EFFECTIVE DATE	January 1 st
PLAN YEAR	January 1 st to December 31 st
PLAN COSTS	Paid by Association & Members
AGENT FOR LEGAL PROCESS	Herbert, VanNess, Cysi & Goodell 22 Chambers Street Princeton, NJ 08542
THIRD PARTY ADMINISTRATOR	The Loomis Company P.O. Box 7011 Wyomissing, PA 19610-6011 Customer Service Number (866) 663-2364
PLAN WAITING PERIOD <ul style="list-style-type: none"> • Members and Dependents eligible after the original effective date: 	The first of the month 90 days after approved application date
DEFINITION OF AN ELIGIBLE MEMBER	Please refer to individual classification requirements

NON-PPO SERVICES WILL BE PAYABLE AT THE PPO RATE UNDER THE FOLLOWING CIRCUMSTANCES:

- Services not available within the PPO system.
- Services rendered by a non-PPO provider when referred by a PPO provider. You may be required to provide evidence that the non-PPO referral is medically necessary and/or appropriate treatment is not available from a PPO provider. The claim may be processed at the Non-PPO rate until the documentation has been received by the Third Party Administrator.
- Services rendered by a non-PPO provider at a PPO facility.
- Services rendered by a non-PPO provider that takes the place or is called in to take the place of a PPO provider in the event the PPO provider is unavailable to provide the treatment.
- Medical emergency.

Note – Reimbursements for these providers will be subject to the usual, reasonable and customary fee schedule. You may be billed for any amounts in excess of the usual, customary and reasonable charges for services rendered by a non-PPO provider.

PLAN PROVISIONS

The Standardbred Breeders and Owners Association Health Benefits Trust (the "Plan") has been designed to provide all eligible member and covered eligible dependents with a program of Health Care Protection. The benefit plan is based on the calendar year. Deductibles are calculated based on expenses incurred during the 12 months of each calendar year. [Covered expenses incurred in, and applied toward the deductible in October, November, and December will be applied toward the deductible in the next calendar year.]

Coinsurance: The percentage of the charge the Covered Person pays.

Common Accident Provision: If two or more members of one family covered by this Plan are involved in the same accident (and have injuries which incur covered expenses), only *one* deductible amount shall be deducted from the total of their covered expenses.

Co-pay: A fixed dollar amount the Covered Person pays for a service.

Deductible: The deductible is the amount of covered expenses, which you ("Covered Persons") must pay before the Plan will pay. The individual deductible applies separately to each Covered Person. The family deductible applies collectively to all Covered Persons in the same family. When the family deductible is satisfied, no further deductible will be applied for any covered family member during the remainder of the calendar year.

Multiple Birth Provision: If two or more children are born to one family at the same time and covered expenses are incurred, only one deductible amount will be deducted from the total covered expenses within the first 30 days of birth.

Out-of-Pocket Maximums: An out-of-pocket maximum is the amount of covered expenses that must be paid during a calendar year before the payment percentage of the Plan increases to 100%. This applies separately to each Covered Person. When a Covered Person reached the annual out-of-pocket maximum, the Plan will pay 100% of additional covered expenses for the individual during the remainder of the calendar year.

The family out-of-pocket maximum applies collectively to all Covered Persons in the same family. When the annual family out-of-pocket maximum is satisfied, the Plan will pay 100% of covered expenses for any covered family member during the remainder of the calendar year.

Certain expenses do not apply toward the out-of-pocket maximum. Please refer to the schedule of benefits for a list of those items.

Lifetime Maximum: The lifetime maximum benefit available to any Covered Person for medical coverage. Under no circumstances does lifetime mean during the lifetime of the Covered Person.

HOW TO FILE A CLAIM

For purposes of this Plan a filed claim for payment of benefits shall mean a completed paper or electronic claim form submitted to the Plan naming the specific claimant, the date of service, the specific medical condition or symptom, a specific treatment or service that was rendered or product provided by a qualified provider.

In-Network (PPO) Claims

When you or a covered dependent utilize the services of PPO Hospitals, physicians and other providers, your involvement in the claims process will be minimal. After you identify yourself as covered through the Standardbred Breeders and Owners Association Health Benefits Trust, bills incurred for covered expenses under this Plan will be sent directly to the address identified on your health plan ID card.

When the Hospital or other provider submits their bills, the payment will be sent to the providers directly. You will receive a copy of the Explanation of Benefits showing the payments made and any deductibles or co-insurance involved in the benefits calculation.

Please ensure the PPO Provider has the current billing instructions provided on your identification card. Failure to submit claims properly will result in delayed claims processing.

Non-Network Claims

When you or a covered dependent have incurred medical expenses for which you believe reimbursement is due under the terms of the Plan, you must file the necessary documentation with The Loomis Company, P.O. Box 7011, Wyomissing, PA 19610.

It is your responsibility to provide any information that is necessary for the Plan to make a prompt and fair evaluation of your claim. It is suggested that each time you file a claim the following information is provided:

- Identify yourself by using your Social Security Number and the Plan Number as shown on your Identification Card. If the claim is for a dependent, identify that individual in the same fashion as you did on your enrollment form.
- Have all charges presented on an original itemized bill listing dates of service, type of service and the charge for each service as rendered, including the provider's name, address, telephone number, and tax identification number.
- Either on the claim form or the bill have the attending physician identify the diagnosis for which treatment was rendered.

Claim Timely Filing

If you or a covered dependent claim benefits, a proof of claim must be furnished to The Loomis Company within 12 months following the date of loss. If a written claim form is not furnished to the claims processor within 12 months, the claim may be denied or reduced. Benefits are based on the Plan's provisions at the time that the charges are incurred. Claims submitted after the 12-month period will not be considered for payment or may be reduced unless it is not reasonably possible to submit the claim in that time, such as the person is not legally capable of submitting the claim.

The Plan Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Covered Person seek a second medical opinion.

If a claim is wholly or partially denied, the Covered Person will be notified in writing, of the determination. The denial notification will: (1) State the specific reason(s) for the denial; (2) Refer to the pertinent Plan provisions on which the denial is based; (3) Describe any additional

information needed to perfect the claim and explain why the additional information is necessary; and (4) Describe the Plan's appeal procedures including its time limits.

How To Appeal A Claim Denial

You or your representative has 180 days after receipt of an adverse benefit determination to appeal to the Plan Administrator. To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company. *If any appeal is not filed on time, the right to appeal the adverse benefit determination will be lost.* A full and fair review of the claim will be made with no deference given to the initial benefit determination. As part of the review, you or your representative are allowed to review all Plan Documents and other information that affect the claim and are allowed to submit issues, comments, documents, records or other information that had not previously been submitted.

During the period that the claim is being reconsidered, if there is reason to believe that your medical records contain information that should be disclosed by a physician or other health professional, you or your representative will be referred to the physician for the information before the Plan will provide the requested documents directly to you or your representative. Neither you nor your representative will be provided access to or copies of files of other Plan participants. For any appeal resulting in an adverse benefit determination, the identity of any medical or vocational expert consulted in connection with the appeal will be provided, without regard to whether the advice was relied upon in making the determination. However, the identity will not be provided unless requested by you or your representative.

All interpretations, determinations, and decisions of the reviewing entity with respect to any claim will be its sole decision based upon the Plan documents. All decisions of the Plan Administrator will be deemed final and binding. If appeal is denied, in whole or in part, however, you have a right to bring a civil action under Section 502(a) of ERISA.

This Standardbred Breeders and Owners Association Health Benefits Trust believes this plan is a "non-grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a non-grandfathered health plan provides additional appeal rights to members. Please see the below regarding the appeal procedures.

What if a Covered Person needs help understanding an adverse benefit determination?

Contact The Loomis Company via the customer service phone number on the back of the ID Card for assistance in understanding an adverse benefit determination.

What if a Covered Person doesn't agree with the determination? A Covered Person has a right to appeal any adverse benefit determination.

How does a Covered Person file an initial appeal? To appeal an adverse benefit determination or to review administrative documents pertinent to the claim, send a written request to The Loomis Company within 180 days of receipt of the adverse benefit determination.

What if a situation is urgent? If the situation meets the definition of urgent under the law, the review will be conducted on an expedited basis. Generally, an urgent situation is one in which a Covered Person's health may be in serious jeopardy or, in the opinion of the physician, a Covered Person may experience pain that cannot be adequately controlled while waiting for a decision on the appeal. A Covered Person may request an expedited appeal by contacting customer service at the number on the back of the ID Card.

Who may file an appeal? A Covered Person or someone whose is named to act for a Covered Person (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Covered Person,

including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Can a Covered Person provide additional information about my claim? Yes, a Covered Person may supply additional information to The Loomis Company.

Can a Covered Person request copies of information relevant to my claim? Yes, a Covered Person may request copies (free of charge) by contacting The Loomis Company at the number on the back of the ID Card.

What happens when an initial appeal is filed? When an appeal is filed, the Plan Administrator will review the decision and provide a written determination. If the Plan Administrator continues to deny the payment, coverage, or service requested or a Covered Person does not receive a timely decision, the Covered Person may be able to request an external review of the claim by an independent third party, who will review the denial and issue a final decision.

How does a Covered person request an external review? You have four months from the date of receipt of the benefits denial notice to file your request for an external review. To request an external review, send a written request to The Loomis Company. An independent organization will review the decision and provide the Covered Person with a written determination. If this organization decides to overturn the Plan Administrator's decision, the Plan Administrator will provide coverage or payment for the Covered Person's health care item or service.

If the denial is upheld, there is no further review available under the appeals process. However, the Covered Person may have other remedies available under Federal law, such as filing a lawsuit.

Who may file a request for external review? A Covered Person or someone who is named to act for a Covered Person (an authorized representative) may file an appeal. An authorized representative is a person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Adverse Benefit Determination

Any denial, reduction or termination of a benefit, or failure to provide or make payment (in whole or in part) for a benefit. An adverse benefit determination includes denials made on the basis of eligibility, utilization review, and restrictions involving services determined to be experimental or investigational, or not medically necessary or appropriate.

Compliance with Regulations

It is intended that the claims procedures be administered in accordance with the claims procedure regulations of the Department of Labor as set forth in 29 CFR § 2560.503-1. You have a right to these procedures free of charge. Please call The Loomis Company if you wish to obtain a copy of these procedures.

Authorized Representative

A person who is chosen by and identified to assist or authorized to represent the Covered Person, including a family member, provider, employer representative or attorney. An assignment of benefits by a Covered Person to a health care provider does not constitute designation of an authorized representative.

Other Important Claims Information

If you or your representative fail to file a request for review in accordance with the claims procedures as described above, you or your representative will have no right to review and you or your representative will have no right to bring an action in any court. The denial of your claim will become final and binding except as otherwise provided by ERISA.

Right to Receive and Release Needed Information

Certain facts are needed to adjudicate claims in accordance with the provisions set forth in the Plan. The Plan Administrator has the right to decide which facts are required and may obtain the needed facts from or provide them to any other organization or persons. Each person claiming benefits under this Plan must provide any information required to pay the claim.

Medical Privacy

Medical information that is obtained and maintained in the course of processing claims will be secured and protected in accordance with state and federal laws regarding participant privacy rights.

PRE-EXISTING CONDITIONS LIMITATIONS

The Plan will not compensate any Covered Person for expenses incurred for any condition, regardless of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six month period ending on the enrollment date*. This exclusion will not apply:

- To expenses incurred after the end of the twelve-month period, including any waiting period, beginning on the enrollment date with respect to the Covered Person (this twelve-month period may be reduced by any period of prior creditable coverage).

The Health Insurance Portability and Accountability Act of 1996 provides the following exceptions to pre-existing condition exclusions:

- Pre-existing condition exclusions may not apply members under the age of 19; and
- Pregnancy may not be considered a pre-existing condition.

*Enrollment date is the first day of day of the waiting period.

Portability of Coverage

A Covered Person will receive credit toward satisfaction of the pre-existing condition limitation described in this section for the time he/she was covered under another health plan, but only if:

- Your service begins after the effective date of this Plan; and
- The person was covered, under another health plan that meets the definition of “Creditable Coverage”, within the 63-day period just before his or her enrollment date under this Plan.

Any eligibility waiting period that the person is required to satisfy under this Plan will not be taken into consideration in determining the 63-day period.

If the Covered Person was covered for a period of time under creditable coverage that is:

- Greater than or equal to the time periods referred to in the pre-existing conditions limitation described in this section, then the pre-existing conditions limitation periods will not apply to the person.
- Less than the time periods referred to in the pre-existing conditions limitation described in this section, then the pre-existing conditions limitation periods will be reduced by the number of consecutive days that the person was covered under creditable coverage.

However, for a child who became covered under creditable coverage within 31 days of birth, the pre-existing conditions limitation periods will not apply regardless of how long the child was covered under creditable coverage.

“Creditable Coverage” is defined as coverage under a group health plan, COBRA continuation coverage, individual health insurance coverage, Medicare, Medicaid or other public health plans, CHAMPUS, a medical program of the Indian Health Service or a tribal organization or the Peace Corps, state health benefit risk pools and the Federal Employee Health Benefit Plan (FEHBP).

Significant Break in Coverage – A period of 63 days or more during which a Member or Dependent is not covered by any creditable coverage. Waiting periods are not included in the calculation of the break in coverage period.

It is your responsibility to provide information about creditable coverage in order for the pre-existing conditions limitation under this Plan to be reduced or waived.

Certificates of creditable coverage may be obtained, free of charge, from a Covered Person’s group health plan when coverage under a plan is lost, when a Covered Person becomes entitled to elect COBRA continuation coverage, or when COBRA continuation coverage ceases. The request may be made before a Covered Person loses coverage, or within 24 months after losing coverage.

COST CONTAINMENT PROGRAM

Standardbred Breeders and Owners Association desires to provide you and your family with a health benefit plan that assists you in obtaining quality care and financially protects you from significant health care expenses. While part of increasing health care costs results from new technology and important medical advances, another significant cause is the way health care services are used.

Some studies indicate that a significant percentage of the health care services rendered may be unnecessary. For example, hospital stays can be longer than necessary. Some hospitalization may be entirely avoidable, such as, when surgery could be performed on an outpatient basis with equal quality and safety. Also, surgery is sometimes performed when other treatment could be more effective. Unnecessary or avoidable health services increase costs for you and Standardbred Breeders and Owners Association Health Benefits Trust.

Standardbred Breeders and Owners Association Health Benefits Trust contracts with a professional Utilization Review Administrator to assist you in determining whether or not proposed services are appropriate for reimbursement under the Plan. The program is not intended to diagnose or treat medical conditions, guarantee benefits, or validate eligibility. The medical professionals who conduct the program focus their review on the appropriateness of Hospital stays, proposed surgical procedures and extensive, costly procedures.

Case Management

When a catastrophic condition occurs, such as a spinal cord injury, a degenerative sickness, or a neurological paralytic disease, a person will require long-term, perhaps lifetime care. After the person's condition is stabilized in the Hospital, he or she might be able to be moved out of the Hospital and into another type of care setting – even to his or her home.

The Case Management program is designed to assist the patient and their family in coordinating all the aspects of care that may be required, and to find the most cost effective care while protecting the patient from undue expense. For example, sometimes specialized care or adaptations to the home are required, but are not covered under the Plan. *The Case Management program can help in these situations in which there could be a large cash outlay for non-covered expenses for catastrophic conditions, and appropriate high quality less expensive alternatives could be recommended that might not otherwise be covered.* If you believe you might benefit from case management please contact the Utilization Review Administrator listed on your ID card for further information.

The case manager will coordinate and implement the large case management program by providing guidance and information on available resources and suggesting appropriate treatment alternatives. The Plan Administrator, attending physician, patient and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these normally would not be reimbursed by the Plan.

Please Note: Case Management is a voluntary service. There is no reduction of benefits and no penalties if the patient and family choose not to participate.

Alternative Care

In addition to the benefits specified in this booklet, the Plan may elect to offer benefits for services furnished by any Provider pursuant to an alternate treatment plan approved by the Plan and/or the Utilization Review Administrator for a Covered Person. Alternative care occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Plan shall provide such alternative benefits for as long as the services are medically necessary and cost effective as determined by the Plan and/or Utilization Review Administrator. Once an agreement has been reached, the Plan will reimburse for Medically Necessary expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

The fee, which may be generated due to realizing a savings as the result of utilizing a Cost Containment program or Alternate treatment plan, will be considered as a covered expense under the Plan.

If the Utilization Review Administrator makes a negotiation with a Non-Participating Provider and the discount provides a substantial savings to the Plan, benefits will be considered at the In-Network level of benefits.

If the Plan elects to provide alternative benefits for a Covered Person in one instance, it shall not be obligated to provide the same or similar benefits for other Covered Persons under the Plan in any other instance. Nor shall it be construed as a waiver of the Third Party Administrator's right to administer the Plan thereafter in strict assurance with its express terms.

Non-Participating (Out-of-Network) Pain Management Providers and Non-Participating (Out-of-Network) Surgical Centers:

The Plan has arranged for claim review and auditing in order to identify charges billed in error, charges for excessive or unreasonable fees, and charges for services which are not medically appropriate. Benefits for claims which are selected for review and auditing will be reduced for any charges that are determined to be in excess of Allowable Claim Limits.

This determination of Allowable Claim Limits under this Program will supersede any Plan provisions related to the application of a Usual, Customary, or Reasonable fee determination.

PRE-NOTIFICATION REVIEW

Standardbred Breeders and Owners Association Health Benefits Trust provides pre-notification review programs through Utilization Review Administrators. **These are identified on your health plan ID cards.**

If a physician recommends hospitalization for any Covered Person, a call must be made to the Utilization Review Administrator. This program must be utilized for maximum benefits to be paid to the providers under the terms of Standardbred Breeders and Owners Association Health Benefits Trust.

If a Covered Person is admitted to the Hospital for an overnight stay on an elective, non-emergency basis or receives any of the services listed below without utilizing this program, a \$250 penalty on the billed amount will be applied. In addition to a Hospital admission, the following services also require Pre-notification:

- CT Scan
- Durable Medical Equipment in excess of \$500
- Hospice
- Inpatient Mental Health Treatment
- Inpatient Substance Abuse Treatment
- Inpatient Surgery
- MRI
- PET Scan
- Prosthetics in excess of \$500
- Skilled Nursing Facility

This \$250 penalty cannot be used to satisfy remaining deductible or co-insurance payments due from the Covered Person. In the case of an emergency admission, a contact to the Utilization Review Administrator must be made within 48 hours of confinement. Their office can be reached by dialing the phone numbers identified on your health plan I.D. cards.

After the initial contact by the Covered Person is made, all remaining communication in the review process will be between the Utilization Review Administrator and your physician. Upon completion of the review process, the Utilization Review Administrator will advise you of their recommendation. If a patient will be confined for a period longer than originally certified, contact to the Utilization Review Administrator must be made by the physician. Charges in excess of the approved treatment plan or for a period beyond an approved and pre-notified length of stay will be denied if the confinement was determined not medically necessary by the Utilization Review Administrator.

Newborns' and Mothers' Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay less than 48 hours (or 96 hours). However, this does not preclude a Plan or issuer from requiring pre-notification for any portion of a stay after 48 hours (96 hours), or from requiring pre-notification for the entire stay.

ELIGIBILITY PROVISIONS

If you are a member of Standardbred Industry in New Jersey, you are eligible for coverage under the terms of the Standardbred Breeders and Owners Association Health Benefits Trust. A member is defined as a trainer, driver, groom, farm employee, or training center employee.

The effective date of coverage is the first day of the month following the Insurance Committee of the SBOA's approval at end of a 90-day waiting period. The Insurance Committee of Standardbred Breeders and Owners Association will make all eligibility determinations. The SBOA, as sponsor and administrator of the Plan, will review all insurance applications at its normal monthly Insurance Committee meeting.

Periodic proof of eligibility must be submitted to the Plan. Failure to comply will result in termination of coverage.

You may obtain coverage for you and your eligible dependents by completing the enrollment form and contributing any required amounts as defined by the SBOA Health Care Plan. If you have any questions regarding Eligibility, Enrollment, Contributions or Termination of Benefits, please contact the SBOA for further details.

If your spouse is eligible for health coverage through his or her employer, your spouse **must** enroll for such coverage as his or her primary plan. If it is in your best interests, you may then include your spouse on your coverage as a secondary insurer. If your spouse is eligible for coverage through his or her employer but is not enrolled under said Plan, coverage provided under this Plan will be at the same level as the secondary insurer. It is important to note that the Spousal Coverage Requirement does not extend to dependent children. If both parents are covered through a work-sponsored plan and your children are covered by both, then claims for your children will be paid according to the "Birthday" rule.

An eligible member shall mean any one or more of the following:

Trainer: To qualify as a trainer you must have 36 starts in New Jersey per calendar year with 51% of all starts in New Jersey. Or if over 100 starts in New Jersey, but less than 51% in NJ, as long as they do not qualify for insurance in any other racing jurisdiction. Or otherwise have a significant investment in the industry as determined and approved by the Insurance Committee of Standardbred Breeders and Owners Association. Trainer eligibility is to be reviewed periodically by the Insurance Committee. **If a trainer is ready to retire between the ages of 62 through 64 with 25 years of continuous qualifying participation in New Jersey, they may stay on at the current trainer rate.**

Breeding Farm Member: To qualify as a breeding farm member, the farm must consist of 25+ acres; the farm must board 12 mares and offspring, or sell four (4) offspring per year, or have proof of commercial offering of 20 turnouts; and be approved by the Insurance Committee of Standardbred Breeders and Owners Association. Farm must carry workers comp on all employees.

Training Center Member: To qualify as a training center member, the principal income must be derived from renting stall space; and maintain a racetrack. And be approved by the Insurance Committee of Standardbred Breeders and Owners Association. Training centers must carry workers comp.

Second Trainer: To qualify as a second trainer you must derive your full income from working full time in New Jersey; assisting a trainer with training duties but not earn points or pension monies; appear on a work roster for a New Jersey trainer; own no more than one horse; and be approved by the Insurance Committee of Standardbred Breeders and Owners Association.

Driver: To qualify as a driver you must have 100 New Jersey starts per calendar year with 51% of all starts in New Jersey and derive the majority of your income from driving. If a driver has over

500 New Jersey Starts but fails to get 51% of all starts in New Jersey he is still eligible as long as he does not have the majority of his starts in another racing jurisdiction, and be approved by the Insurance Committee of Standardbred Breeders and Owners Association. Periodically the committee will review eligibility. If a driver is ready to retire between the ages of 62 through 64 with 25 continuous years of qualifying participation in New Jersey, they may stay on at the current driver rate.

Groom: To qualify as a groom you must derive full income from working as a full-time groom licensed by NJRC in New Jersey; appear on a work roster for a licensed New Jersey trainer who is also eligible under this Plan; own no more than one horse; and be approved by the Insurance Committee of Standardbred Breeders and Owners Association. Eligibility is to be reviewed periodically by the Insurance Committee.

Employee: An employee is eligible for coverage if they normally work at least 35 hours per week and is on the regular payroll of the SBOA for that work. Cessation by an employee to be regularly scheduled to work full-time shall be deemed termination of employment.

Post 65 Benefits: For medical benefits for members, who are 65 and older, please refer to the NEBCO plan. They can be reached by dialing 800.242.1991. The dental and prescription benefits can be referenced in this document.

Eligible Dependent:

An eligible dependent shall mean any one or more of the following:

- The lawful spouse of the member under a legally existing marriage. The term spouse shall mean the person recognized as the covered member's husband or wife under the laws of the state of New Jersey. The Plan Administrator will require documentation proving a legal marital relationship.
- Children of the employee, who are under the age of 26 including legally adopted children, children legally placed for adoption, step-children, and foster children, and children for whom the employee and/or the employee's spouse has been appointed guardian by a court of competent jurisdiction.

A spouse or biological child of a covered dependent child will not be eligible for coverage under this Plan.

- Children of the employee, including legally adopted children, children legally placed for adoption, step-children and foster children as defined above who are primarily dependent upon the employee for support and maintenance and who are incapable of self-sustaining employment due to mental or physical disability, provided such disability started before the attainment of age 26. Also, such children must have been covered prior to the attainment of such age and covered continuously thereafter. The Plan Administrator may require proof of the dependents incapacity status. The Plan Administrator reserves the right to have such dependent examined by a physician of the Plan Administrator's choice, at the Plan's expense, to determine the existence of such incapacity.

In order to continue a dependent child's coverage beyond age 26, you must furnish written verification of their incapacity for self-support within 60 days of the child's 26th birthday.

- Alternate recipients under qualified medical child support orders (QMCSO) required to be covered according to the provisions of ERISA Section 609 (a) (2) (A). Any child of a member who is an alternate recipient under a qualified medical child support order shall be considered as having a right to dependent coverage under this Plan with no pre-existing conditions provision applied. Under a QMCSO, the fact that the child is eligible for, is entitled to, or is provided benefits under Title XIX of the Social Security Act, will not affect the child or children's receipt of benefits under the QMCSO.

A **qualified medical child support order** (QMCSO) is a medical child support order issued by a court, which has jurisdiction, under state law requiring a non-custodial parent to provide medical coverage for his or her children that specifies the individuals involved the type of coverage to be provided and the plan that provides the coverage. The QMCSO may not require the Plan to provide any type or form of benefit, or any benefit option, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of Section 1908 of the Social Security Act.

The phrase **child placed with a covered member in anticipation of adoption** refers to a child whom the member intends to adopt, whether or not the adoption has become final, who has not attained the age of eighteen (18) as of the date of such placement for adoption. The term placed means the assumption and retention by such member of legal obligation for total or partial support of the child in anticipation of adoption. The child must be available for adoption and the legal process must have commenced.

These persons are excluded as dependents: other individuals living in the covered member's home, but who are not eligible as defined; the divorced former spouse of the member; any person who is on active duty in any military service of any country; or any person who is covered under the Plan as a member.

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

Reinstatement – If you are terminated from the plan twice there will be NO reinstatement.

Retirees – You must have 25 consecutive years in the New Jersey harness racing business and qualified for coverage during those 25 years.

Funding

Contribution Determinations

The Plan Sponsor will, from time to time, evaluate the costs of the Plan and determine the amount to be contributed by SBOA and the amount to be contributed by each member.

Member Obligations

The coverage afforded to a member by this Plan may require contributions, but will be at least partially funded by SBOA. If a member elects to enroll dependents under the Plan, they may be responsible for payment of all or a portion of the dependent contributions suitable to cover such enrollment.

Association or Employer Obligations

SBOA will make contributions to the Plan for the health care coverage of Members and may contribute to the cost of dependent coverage. SBOA contributions and those paid by Member will be placed in a special account or accounts to provide the non-insured benefits under the Plan. Contributions for insured coverage or ancillary coverage will be paid directly to the provider of such coverage.

ENROLLMENT

If for any reason eligible dependents are not enrolled within the thirty (30) days following their initial eligibility date and coverage is subsequently desired, coverage may be requested during an Open Enrollment Period or if you qualify subject to the Special Enrollment provisions described herein.

Initial Enrollment Period

If you desire Plan benefits, you must enroll in the Plan by properly completing and returning an enrollment form to Standardbred Breeders and Owners Association within 30 days of your eligibility date. If you also desire dependent coverage, you must enroll you eligible dependents by this deadline. If you do not have any eligible dependents at the time of initial enrollment but later acquire eligible dependents, including newborns, you may enroll them under a special enrollment period.

Failure to enroll by the deadline noted above may result in your and/or your dependents' inability to secure coverage under this Plan except as specified in the special enrollment and late enrollment provisions below.

Special Enrollment Period

Those individuals who do not enroll in the Plan at the first opportunity and subsequently lose coverage must be able to enroll in the Plan in compliance with the Health Insurance Portability and Accountability Act of 1996. The enrollment date for anyone who enrolls under a special enrollment period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a waiting period.

An individual must be allowed to enroll under our health benefit plan if:

- The member or dependent had been covered under another group health plan or had an individual health policy at the time coverage was initially offered.
- If required by the Plan Administrator, the member stated at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan.
- The individual lost coverage as a result of a certain event, such as the loss of eligibility for coverage, loss of eligibility due to the Plan no longer offering any benefits to a class of similarly situated individuals (e.g. part-time employees), expiration of COBRA continuation coverage, termination of employment, reduction in the number of hours of employment, or employer contributions towards such coverage were terminated.
- The employee's or dependent's Medicaid or State Child Health Insurance Plan (SCHIP) coverage is terminated as a result of loss of eligibility.
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or SCHIP.

The individual must request special enrollment within 30 days of the date coverage is lost, except in the case of a qualifying event involving Medicaid or SCHIP (loss of eligibility or premium assistance eligibility). For these events, the individual must request special enrollment within 60 days of the event.

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

Dependent Special Enrollment Period

Since the Plan provides dependent coverage and a person becomes a dependent through marriage, birth or adoption, the Plan must provide a dependent special enrollment period of not less than 30 days. If an individual seeks to enroll a dependent during the first 30 days, coverage must become effective:

- In the case of marriage, no later than the first day of the first month beginning after the date the request was completed.
- In the case of a dependent's birth, the date of such birth.
- In the case of adoption or placement for adoption, the date of such adoption or placement of adoption.
- The date the employee or the employee's spouse is required to provide health coverage to a child under a Qualified Medical Child Support Order (QMCSO), National Medical Child Support Notice (NMCSN) or administrative order.
- The date on which legal guardianship status begins.

Newborn Enrollment

A newborn child will automatically be covered for the first 30 days immediately following birth. Such coverage will end 30 days after the birth of the child. If you agree to contribute any required amounts as defined by our personnel practice and complete an enrollment form within the initial 30-day period, coverage on the child may continue.

If for any reason you do not enroll within 30 days after the termination of coverage or within 30 days after marriage, birth or adoption, you and your dependents will not be eligible for coverage. The only exception is for special enrollments related to Medicaid or SCHIP (loss of eligibility or gain of premium assistance eligibility), which must be requested within 60 days of the date of the event.

Late Enrollment

If you or your dependents are not enrolled within 30 days of the date you become eligible, under the terms of this Plan you may only request Plan coverage during the open enrollment period unless you experience a special enrollment situation as outlined above. For late enrollees who meet the Plan's requirements, coverage begins on January 1st. However, you will be subject to an 18-month pre-existing exclusion as outlined in the pre-existing conditions provision unless reduced by evidence of creditable coverage.

Election Changes

In general, you will not be able to revoke or change your election for a plan year. Federal law generally prohibits you from making any changes to your election that affect the dollar amount or taxability of your payroll contributions, except during open enrollment. However, such changes are permitted if they are needed because of a "change of status" and the election is consistent with the change in status. It is possible to experience a "change in status" event, but not have the change affect your eligibility to participate in this Plan or another plan. In this case you cannot make a change in your election.

Consistency Rule – Requires that the change in status result in the Member, Spouse or Dependent gaining or losing eligibility for accident or health coverage under either the cafeteria plan or an accident or health plan of the Spouse's or Dependent's employer, and that the election change correspond with that gain or loss of coverage.

To revoke your election and make a new election, The SBOA must receive the appropriate forms within 30 days of the date of your change of status. If your change in status occurs with less than 30 days remaining in the plan year, the 30-day requirement will extend into the New Year (however, if

you wait until the new year to make your adjustments, it can only affect the benefits you have in the new year). **No change in your election will be permitted after this 30-day period.** You may change your elections once a year during the annual open enrollment period or within 30 days of the following events. These events are referred to as a “Change in Status”:

- **Legal Marital Status** – Events that change your legal marital status, including marriage, death of spouse, divorce, legal separation or annulment.
- **Number of Dependents** – Events that change your number of dependents including birth, adoption, placement for adoption or death of dependent. (Note: Gaining or losing a dependent that is not a tax dependent – such as a parent, domestic parent, or child will not be considered an allowable event for an election change.)
- **Employment Status/Work Schedule** – Events that change your employment status or the employment status of your spouse or dependents that effect your eligibility for benefits including termination or commencement of employment, a strike or lockout, a commencement of or return from an unpaid leave of absence or a change in worksite.
- **Dependent Satisfies or Ceases to Satisfy the Requirements for Dependents** – Events that cause your dependents to satisfy or cease to satisfy the requirements for coverage due to attainment of age or any other similar circumstances.
- **Residence or Worksite** – Events that change your place of residence, the place of residence of your spouse or dependent that effect eligibility for benefits under the Plan.

You may also change your elections within 30 days of the following events:

- **Cost Changes** – If there is an increase or decrease in the cost of a benefit plan, the Plan may automatically change the amount of your premium election to cover the change in cost. If the cost change is a significant increase, you may be allowed to either make a new election of the higher cost or revoke your election, but you must elect similar coverage if available. If the cost change is a significant decrease, you may be allowed to commence participation of the option with a decrease in cost.
- **Significant Curtailment of Coverage** – If your coverage is markedly reduced or eliminated all together you may revoke your election and make a new election for similar coverage under a new benefit package option or drop coverage if no similar benefit package option is available. The loss of a physician in the network would not constitute significant curtailment of coverage.
- **Addition (or Improvement) of a Plan Option Providing Similar Coverage** – If during a period of coverage an option is added to the Plan (or an existing option is significantly improved), you may be allowed to elect the new option (or improved benefit option) prospectively on a pre-tax basis and change your election with respect to the other benefit option providing similar coverage.
- **Change in Coverage of Spouse or Dependent Under Another Employer Plan** – You may make an election change that is on account of and corresponds with a change in coverage under another employer plan (including a plan of the same employer or a plan of the spouse’s or dependent’s employer) if one of two conditions are met (a) The other Plan must permit participants to make an election change; or (b) The period of coverage under the member’s Plan is different from the period of coverage under the other employer plan.
- **Loss of Other Health Coverage** – You may make an election to add coverage under the Plan if you or your covered dependents lose coverage under any group health coverage sponsored by a governmental or educational institution.
- **FMLA Leave** – You may change an election under the Plan upon FMLA and non-FMLA leave.

- **Judgment, Decree or Order** – If there is a judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that requires a change in accident or health coverage for your dependent child, you may make an election change to add or drop coverage as ordered.
- **Entitlement to Medicare** – If you, your spouse or dependent becomes entitled to Medicare, you may make a prospective election change to cancel health coverage under this Plan. If you, your spouse or dependent lose coverage under Medicare, you may make a prospective election to begin or increase coverage under this Plan.
- **HIPAA Special Enrollment Rights** – If you gain the right to enroll in this Plan or to add coverage for a family member under the special enrollment rights of HIPAA, the Covered Person may revoke an election for coverage during a period of coverage and make a new election.

You may also change your elections within 60 days of the following events:

- **Entitlement to Medicaid or SCHIP** – If you, your spouse or dependent becomes entitled to Medicaid or SCHIP (premium assistance eligibility), you may make a prospective change to cancel health coverage under this Plan. If you, your spouse or dependent loses coverage under Medicaid or SCHIP, you may make a prospective election to begin or increase coverage under this Plan.

If you make a change in election, your new election amount will be effective the date of the qualifying event.

Open Enrollment Period

Every December 1st through December 31st is the annual Open Enrollment Period. Member and their dependents who are Late Enrollees will be able to enroll in the Plan. Also during this time members will be eligible to change some of their benefit decisions based on which benefits and coverage are right for them.

Benefit choices for Late Enrollees made during the Open Enrollment Period will become effective January 1st. Plan participants will receive detailed information regarding Open Enrollment from the Association.

TERMINATION OF BENEFITS

Member's coverage will terminate on the earliest of the following dates:

- The date of the termination of the Plan, the date the Plan ceases for the class of members to which you belong, or the date SBOA terminates its participation in the Plan;
- The end of the month that a member ceases to be member regularly scheduled to work full-time;
- The end of the month of entry to the military service of any country or international organization on a full-time active duty basis other than scheduled drill or other training not exceeding one month in any calendar year;
- The end of the period for which the required contributions have been paid if the charge for the next period is not paid when due; or
- The end of the month of an approved leave of absence under the Family and Medical Leave Act, if the member does not return to work. (*Additional information can be found in the Family and Medical Leave Act section*).

Cessation by a member of the SBOA to meet the eligibility requirements described herein shall be deemed termination of Plan coverage. You may maintain eligibility under the terms of the medical plan for a period of time not to exceed the limit determined by the Insurance Committee of Standardbred Breeders and Owners Association. Your coverage may be continued during that time while the required contributions are made.

Dependent's coverage will terminate on the earliest of the following dates:

- The date a member's coverage is terminated;
- The date of failure to make any required contributions as a regularly scheduled full-time member;
- The last day of an approved leave of absence under the Family and Medical Leave Act, if the member does not return to work;
- The date in which the dependent spouse ceases to meet the definition of a dependent as defined in the Plan;
- The end of the calendar month in which a dependent child ceases to meet the definition of a dependent as defined in the Plan.

Certificates of Coverage will be issued within the time periods specified in federal regulations following loss of coverage in compliance with the provisions of the Health Insurance Portability and Accountability Act of 1996.

REINSTATEMENT

A reinstatement, to be determined in validity by SBOA, will be dated back to their date of termination so that there is no break in coverage. The reinstated member will be required to make all contributions for those months that were delinquent.

NOTE: It is the member's responsibility to notify the SBOA Office in writing within the designated time frames as noted in the "Important Highlights" section when a member or a dependent has a qualifying event occur and that member or dependent is no longer eligible for benefits. **Failure to notify the SBOA Office will result in coverage being terminated as of the original date of the occurrence. Any claims paid after that date must be reimbursed to SBOA.**

Family and Medical Leave Act

The Family and Medical Leave Act (FMLA) provides leaves of absence up to 12 weeks for the birth or adoption of a child, care of an immediate family member with a serious health condition, or because of the member's inability to perform the functions of his or her job due to the member's own serious health condition. Health coverage benefits during your approved leave of absence under The Family and Medical Leave Act will continue as long as you pay any required contributions. If you do not return to work at the end of an approved leave, you will be required to reimburse the employer the difference between any required contributions and the total monthly premium.

Under the law, members are eligible if they have worked for a covered employer for at least one year, and for 1,250 hours over the previous 12 months, and if there are at least 50 members within 75 miles. Standardbred Breeders and Owners will consider the 12-month period to begin on the date the member's FMLA leave first begins.

It is the member's responsibility to request leave under the FMLA and to comply with all requests for information, such as medical certifications, made by your employer. When the need for leave is foreseeable, the member must provide reasonable prior notice and make efforts to schedule leave so as not to disrupt company operations. If you have any questions concerning your rights under the Family and Medical Leave Act, or your employer's responsibilities under the Act, please contact the Human Resource Department.

Service Member Family Leave: An eligible employee who is the spouse, son, daughter, parent, or next of kin of a service member who is recovering from a serious illness or injury sustained in the line of duty on active duty is entitled to 26 weeks of leave in a single 12-month period to care for the service member. This leave is available during a "single 12-month period" during which an eligible employee is entitled to a combined total of 26 weeks of all types of FMLA Leave combined.

Military Leave of Absence

In the event an employee, who is a member of the United States Armed Forces Reserves, is called to active duty he may elect to continue Plan coverage for up to 24 months, beginning on the date the employee's absence starts. The employee may be required to pay up to 102% of the full premium cost for continuation coverage, except a person on active duty for 30 days or less will not be required to pay more than the employee's share, if any, for the coverage. These rights apply only to employees and their dependents covered under the Plan before leaving for military service. If you have any questions regarding military leave of absence, continuation of coverage, the cost of continued coverage or the maximum period of such coverage, please contact the Human Resources Department.

If your participation in this Plan is terminated by reason of service in the uniformed services, your coverage will be reinstated upon re-employment without any exclusions or waiting periods that would not have applied if coverage had not been terminated. However, applicable exclusions may be imposed with respect to coverage of any illness or injury determined by the Secretary of Veterans Affairs to have been incurred or aggravated during service in the military.

COORDINATION OF BENEFITS PROVISION

The purpose of this Plan is to provide you with reimbursement of your covered medical expenses based on the description of coverage as outlined in this Summary Plan Description. In the event that you or any of your covered dependents incur expenses for which benefits are payable under this Plan and at the same time benefits are payable under any other plan, the Plan will coordinate benefits.

In coordinating benefits, one of the two or more Plans involved will be the primary Plan, and the other Plans will be secondary to it. The primary Plan pays without regard to the other Plans. The secondary Plans will coordinate their payments so that the total paid from all plans shall not exceed the allowable expenses.

An allowable expense is defined as any necessary health care service or supply when the service or supply is covered at least in part under any of the Plans involved. An example would be the difference between the cost of a private Hospital room and the cost of a semiprivate Hospital room is not considered an allowable expense if both the plans did not allow the cost.

Benefits, however, will still be limited under our Plan such that we will pay no more than what the plan would have been paid in the absence of this coordination provision. The applicable deductible and co-insurance limits will be applied to those expenses for which this Plan is liable either as the primary Plan or the secondary Plan.

Note: If your spouse is eligible for health coverage through his or her employer, your spouse **must** enroll for such coverage as his or her primary plan. If it is in your best interests, you may then include your spouse on your coverage as a secondary insurer. If your spouse is eligible for coverage through his or her employer but is not enrolled under said Plan, coverage provided under this Plan will be at the same level as the secondary insurer. It is important to note that the Spousal Coverage Requirement does not extend to dependent children. If both parents are covered through a work-sponsored plan and your children are covered by both, then claims for your children will be paid according to the "Birthday" rule.

Examples of other types of coverage with which benefits will be coordinated are:

- Insurance or any other arrangement of benefits for individuals of a group, including coverage for students sponsored by or provided through a school or other educational institution.
- Pre-payment coverage or any other coverage toward the costs of which any employer makes contributions or payroll deductions or any labor union makes contributions.
- Any governmental program or coverage required by statute including Medicare.
- Liability, homeowner's or automobile insurance, which is subject to any Motor Vehicle Financial Responsibility Law. This Plan shall have secondary liability for those medical expenses incurred as a result of a motor vehicle accident, on behalf of a Covered Person subject to any state automobile insurance law, regardless of the terms and conditions of any specific automobile policy. Furthermore, if a Covered Person has no Personal Injury Protection or medical benefits coverage, in a state where such coverage is mandated, coverage under this Plan shall be reduced by the minimum coverage requirement of the state with jurisdiction. In addition to the above, for those Covered Persons subject to no-fault automobile insurance law or the law of any other state which permits issuance of a state mandated motor vehicle policy with an optional high personal injury protection deductible, this Plan shall not recognize as a covered expense, the personal injury protection deductible selected by any Covered Person. Such deductible amount shall be the direct responsibility of the Covered Person.

The Plan will not consider as an allowable expense any charge that would have been covered by an HMO had a Covered Person for whom the HMO would be primary payer used the services of an HMO participating provider. The Plan will not consider any charge in excess of what an HMO provider has agreed to accept as payment in full.

The rules establishing the order of benefit determination are as follows:

Non-Dependent or Dependent

The Plan covering the person other than as a dependent (for example, as a member, subscriber, or retiree) is the primary plan, and the plan covering the person as a dependent is the secondary plan.

Medicare rules provide one exception to this rule. If the person is a Medicare beneficiary and covered as a dependent by a group health plan then Medicare is secondary to the plan covering the person as a dependent.

Member or Retiree

If an individual is covered under one plan as a member and another plan as a retiree, the member plan is primary. However, if an individual is covered both as a retiree under one plan and as a dependent under a spouse's member plan, order of benefit determination is that the retiree plan pays first and the dependent plan pays second.

Continuation Coverage (COBRA)

If an individual has continuation coverage under the federal COBRA law or state continuation laws and also is covered under another group health plan as a member or retiree, then the continuation coverage pays second.

The specific rules establishing the order of benefit determination for a child covered under more than one plan are as follows:

Birthday Rule

The primary plan is the plan of the parent whose birthday is earlier in the year, if the parents are married or if a court order awards joint custody without specifying which parent has responsibility for providing health care coverage.

Court Order

If a court order specifies that one parent is responsible for health coverage, the plan of that parent will be the primary plan.

Parents Are Separated or Divorced

In the absence of a specific court order the order of benefit determination is as follows:

- The plan of the custodial parent.
- The plan of the spouse of the custodial parent.
- The plan of the non-custodial parent.
- The plan of the spouse of the non-custodial parent.

When the above referenced rules fail to establish an order of benefit determination, the plan that has covered the person for the longer period of time is the primary payer.

Right to Receive or Release Necessary Information

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

Facility of Payment

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

Right of Recovery

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

THE EFFECTS OF MEDICARE COVERAGE

There are several sets of circumstances under which an individual who is covered under the Standardbred Breeders and Owners Association Health Benefits Trust may be or become eligible for coverage under Medicare. The purpose of this section is to explain the rules for determining the order of benefit payments under this Plan and Medicare. The intent of this section is to conform the Plan to the requirements of the federal Medicare Secondary Payer law. As the result, the information contained in this section will be adjusted if it is necessary to do so in order that the Plan's benefit payments are neither greater nor less than those required under the law. **Remember:** This section applies from the date a covered person is first eligible for Medicare (either Part A or Part B), whether or not the Covered Person is enrolled and is receiving Medicare benefits.

- If, pursuant to the rules listed below:
 - This Plan is determined to be secondary to Medicare, it will pay secondary to and coordinate its payments with Medicare;
 - This Plan is determined to be primary to Medicare; it will pay without regard to Medicare benefits.

Basis of Medicare Eligibility:

Disability (other than ESRD)
End Stage Renal Disease (ESRD)

This Plan Will:

Be Secondary to Medicare
Be Primary for the first 30 months of ESRD
Medicare coverage; be secondary thereafter.

SUBROGATION, REIMBURSEMENT & THIRD PARTY RECOVERY

The Covered Person may incur medical or dental charges due to injuries, which may be caused by the act or omission of a third party or a third party may be responsible for payment. In such circumstances, the Covered Person may have a claim against the liable third party, including but not limited to any Third Party's liability insurance and uninsured or underinsured motorist. The benefits advanced, or to be advanced by this medical plan will be paid only if the Covered Person fully cooperates with the terms and conditions of the Plan. When the Plan advances benefits for accidental injury or illness or other loss for the benefit of a Covered Person, the Plan shall be subrogated to all rights of recovery that the person, his heirs, guardians, executors, agents or other representatives may have as a result of the loss.

The Covered Person under the Plan who claims and receives an advance(s) of benefits on account of an injury caused by a third party must execute a reimbursement agreement at the time the first claim is submitted. The signed reimbursement agreement indicates that the Covered Person agrees to promptly reimburse the Plan for benefits advanced, out of any monies recovered against the person causing the injury or any other source as the result of judgment, award, settlement or otherwise.

Accepting advanced benefits under this Plan for incurred medical or dental expenses automatically assigns to the Plan any rights the Covered Person may have to recover payments from any third party or insurer. This subrogation right allows the Plan to pursue any claim, which the Covered Person has against any third party, or insurer, whether or not the Covered Person chooses to pursue that claim. The Plan may make a claim directly against the third party or insurer, but in any event, the Plan has a lien on any amount recovered by the Covered Person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement from the first dollars recovered. The Plan specifically states that it has priority over **any and all** funds paid by any party to a Covered Person relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, other costs or expenses, whether or not the Covered Person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the Covered Person will be liable for any and all expenses (whether fees or costs) associated with the Plans attempt to recover such money from the Covered Person. The Plan may not pay for any additional care or treatment for the Covered Person, whether anticipated or unanticipated, until the Plan is reimbursed in accordance with the Plan terms.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds. If the injury or condition giving rise to subrogation involves wrongful death of a Covered Person, this provision applies to the parent, guardian or the executor, agent or other personal representative of the estate.

When a right of recovery exists, the Covered Person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan advance benefits. Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. In addition, the Covered Person will do nothing to prejudice the right of the Plan to subrogate. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan.

The Plan shall have no obligation to share the costs of, or pay any part of, the Covered Person's attorney's fees and costs incurred in obtaining any recovery. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. Please refer to the Defined Terms Section for definitions of Subrogation, Recovery and Reimbursement.

COVERED MEDICAL EXPENSES

Your benefit plan is designed to reimburse you for covered medical expenses you incur for treatment necessary because of an illness or an accident. All expenses must be reasonable and customary in order to be considered for benefit payment.

Usual, Customary and Reasonable (UCR) means the usual charge made by the physician, Hospital or other medical professional providing the service or medical supplies. However, this is limited also in that the charge shall not be in excess of the normal charges for similar services or supplies within the local area in which your service is rendered. Generally, the local area is defined as a county or such additional area as is necessary to obtain a reasonable cross section of other medical professionals or institutions providing such services or supplies.

When possible, it is recommended that the Covered Person obtain from their medical professionals an indication of what services are to be rendered, and the cost of those services prior to the actual treatments being performed. This information should then be forwarded to the Plan for review. The Plan will provide the Covered Person with a written statement in advance of the treatment, identifying how much of the expense can be reimbursed through the benefit schedule.

Allowable Claim Limits means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of illness or injury, but only to the extent that such fees are within the Allowable Claim Limits. Determination that a charge is within the Allowable Claim Limit will be made by the Plan Administrator and will include, but not be limited to, the following guidelines:

- **Non-participating (Out-of-Network) Pain Management Providers, Non-participating (Out-of-Network) Surgical Centers, and all other Non-Participating (Out-of-Network) providers for whom a Usual, Reasonable, and Customary amount is not defined:** The Allowable Claim Limit for charges will be based upon 135% of the provider's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio").

Ambulance – Professional ground ambulance service when used to transport the Covered Person from the place where they are injured or stricken by a Sickness to the nearest Hospital where treatment can be given, and transportation from a hospital when deemed medically necessary.

The Plan will also cover air ambulance to transport the Covered Person to the nearest medical facility equipped to provide care when required because the life of the patient would be endangered through the use of any other form of transportation.

Bone Marrow Transplant – Expenses related to Bone Marrow Transplant Services when deemed medically necessary and medically appropriate by the Plan.

Breast Reconstruction – In accordance with The Women's Health and Cancer Rights Act of 1998, the following coverage is offered to a covered person who elects the following services in connection with a mastectomy:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce symmetrical appearance; and
- Coverage for prostheses and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation with the attending physician and the patient.

Chiropractic Care – Modalities (hot, cold therapy, etc.) manipulation and adjunctive therapy by a covered provider to anatomically correct vertebral disorders such as incomplete dislocation, off-centering, misalignment, misplacement, abnormal spacing, sprain or strain.

Diabetic Self-Management Program – The following diabetic supplies, education and self-management programs are covered:

- All physician prescribed medically appropriate and necessary equipment and supplies used in the management and treatment of diabetes, including diabetic supplies not covered under the Prescription Drug Card program; and
- Diabetes outpatient self-management training and education, including medical nutrition therapy that is provided by a certified, registered, or licensed health care professional working in a program consistent with the national standards of diabetes self-management education as established by the American Diabetes Association. Coverage is provided for individuals with gestational, Type I or Type II diabetes.

Diagnostic Services – Diagnostic laboratory and x-ray expense, including charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar diagnostic tests generally approved by physicians throughout the United States. This benefit includes professional fees from a physician, as well as facility charges for diagnostic services.

Durable Medical Equipment – Rental of durable basic (i.e. non-luxury) medical equipment (not to exceed the purchase price) or purchase of such equipment where only purchase is permitted or where purchase is more cost-effective due to a long-term need for the equipment. This will also include repair, maintenance, delivery services and disposable supplies of such medical equipment. Such equipment must be prescribed by a Physician and required for therapeutic use in treatment of an active Sickness or Accidental Injury.

Durable medical equipment includes such items as braces, crutches, wheelchairs, hospital beds, traction apparatus, head halters, cervical collars, oxygen and dialysis equipment, etc. which:

- Can withstand repeated use.
- Are primarily and customarily used to serve a medical purpose.
- Generally are not useful to a person in the absence of Sickness or Accidental Injury.
- Are appropriate for use in the home.

Home Health Care – These are the charges made by a home health care agency, for the following services and supplies furnished to a Covered Person in his/her home. A Physician must certify the services as medically necessary.

- Part-time or intermittent nursing care by a registered graduate nurse (R.N.) or by a licensed practical nurse (L.P.N.), if the services of a registered graduate nurse (R.N.) are not available.
- Part-time or intermittent home health aide services which consist primarily of caring for the patient.
- Visits by any of the following professionals including licensed midwives or nurse midwives, licensed nutritionists or dieticians.
- Physical therapy, occupational therapy, respiratory therapy, and speech therapy as deemed Medically Necessary.
- Medical supplies, drugs and medicines prescribed by a physician, and laboratory services provided by or on behalf of a hospital, but only to the extent that such charges would have been covered if the family member had remained in the hospital.

Each visit by a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) or therapist, will count as one home health care visit. Four hours of home health aide services shall be considered as one home health care visit.

Limitations

Home health care expenses will not be included as covered medical expenses if they are for:

- Services or supplies not specified in the home health care plan;

- Services of a member of your family, your spouse's family, or your household;
- Services of any social worker;
- Transportation services.

Hospice Care Benefits – The Plan will cover as an eligible expense those charges incurred by a terminally ill patient and rendered by a Hospice care provider either in the patient's home or a Hospice facility. These services must be developed by a Hospice care program in consultation and in agreement with the patient's physician. The prognosis of the patient's life expectancy must be 6 months or less.

Hospice care shall consist of the following services and supplies:

- Room & Board, including special diets (not to exceed the semi-private room rate);
- Services of a Physician, RN, LPN, home health aide and nutritionist;
- Medical supplies, nutritional supplements, drugs and medicines prescribed by a physician, and laboratory services, durable medical equipment, oxygen and any other eligible expenses normally covered under this Plan; and.
- Family counseling directly related to the patient's terminal condition, which must be furnished within six months after the patient's death.

Hospice care must meet all of the following tests:

- It has obtained any required state or governmental Certificate of Need approval.
- It provides service 24 hours a day and 7 days a week.
- It is under the direct supervision of a physician.
- It has a nurse coordinator who is a graduate registered nurse.

Limitations

This benefit is limited by all the limitations as listed in this section, as well as all limitations of the Plan as a whole. No hospice care benefits will be provided for:

- Medical care rendered by a private physician not affiliated with the Hospice Care Agency.
- Volunteers who do not regularly charge for services.
- Pastoral services.
- Homemaker services.
- Food or home delivered meals.

Hospital Services – Inpatient and outpatient hospital expenses will be eligible for coverage if they are determined to be medically necessary and appropriate for the proper treatment of the covered person's condition. Inpatient hospital stays will be payable according to the average semi-private room rate. Also covered under hospital services are:

Ambulatory Surgical Center – Services and supplies provided by an ambulatory surgical center in connection with a covered outpatient surgery.

Birthing Center – Services and supplies provided by a birthing center in connection with a covered pregnancy.

Blood – Charges for whole blood or blood plasma, administration of blood, blood processing and materials and supplies of technicians. *Please note that the cost for blood or plasma replaced by or for the patient is not reimbursed under the Plan.*

Diagnostic X-ray and Laboratory – Facility fees for diagnostic x-ray and laboratory examinations.

Emergency Medical Care – The initial treatment of a sudden onset of a medical condition with acute symptoms of sufficient severity to require immediate medical attention. Outpatient emergency hospital services and supplies to treat injuries caused by an accident.

Intensive Care Unit – Hospital charges for intensive care accommodation.

Medical Care or Supplies – Special hospital charges for inpatient medical care or supplies received during any period room and board charges are made. This does not include personal supplies or convenience items.

Pre-Admission Testing – Outpatient tests and studies required for your scheduled admission to a hospital. Pre-admission testing must be done within 14 days before a pre-scheduled hospital confinement.

Private Room Allowance – If a Covered Person is confined to a hospital’s private room, the Plan will pay the private room rate only if:

- The private room confinement is recommended by a physician and is medically essential for the necessary care and treatment of an injury or sickness; or
- A semi-private room is not available and the use of a private room is therefore necessary.

Otherwise, the Plan will pay the semi-private room rate.

Maternity – Pregnancy expenses are covered to the same extent as any other Sickness. Coverage will NOT include expenses incurred by a dependent daughter or “common law wife.”

Medical Supplies – Disposable medical supplies such as casts, splints, crutches, orthopedic or prosthetic devices, trusses, surgical dressings, colostomy bags and related supplies, insulin and other supplies used in the care and monitoring of diabetic patients and catheters.

Mental Health – For Plan purposes, a mental health condition will include schizophrenic disorders, paranoid disorders, affective disorders (depression, mania, and manic depressive illness), anxiety disorders, somatoform disorders, personality disorders, and disorders of infancy, childhood and adolescence, except for those conditions that are expressly excluded in the list of Medical Limitations and Exclusions section. Psychiatrists (M.D.), psychologists (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through those professionals.

Midwife – Services of a registered nurse midwife when provided in conjunction with a Covered Pregnancy.

Newborn Care – Hospital nursery services and a Physician’s exam provided during the first eight (8) days of the birth confinement to a covered well newborn child, including a PKU test and circumcision.

Nursing Services (Private Duty) – Services of a registered graduate nurse (R.N.) or licensed practical nurse (L.P.N.) for private duty nursing services when medically necessary and prescribed in writing by the attending physician or surgeon specifically as to duration and type.

Partial Hospitalization – Partial hospitalization must be a medically necessary alternative to Inpatient hospitalization and is designed for patients who do not require 24-hour care, but who would benefit from more intensive treatment than ordinarily offered on an outpatient basis.

Physician Services – Medical and surgical treatment by a physician (M.D. or D.O.) including office, home or Hospital visits, clinic care and consultations.

Allergy Testing and Treatment – Including coverage for allergy injections. If the Allergy treatment includes an office visit the benefit will be subject to a co-payment applied to the office visit.

Hospital Visits – Physician consultation services during your hospital confinement and expenses for inpatient visits by a physician. The physician visits are limited to one visit per day per physician, excluding the day of surgery.

Office Visits – Covered services for office visits include expenses for most services and supplies provided in the physician office. Office visits also include x-rays and lab tests ordered during an office visit and performed at an independent facility.

Preventive Care – The Plan will provide preventive health care services as described in the *Schedule of Medical Benefits*. Preventative care includes, but is not limited to the services described below as well as those recommended by the United States Department of Health and Human Services (HHS) Preventive Services Task Force. Please visit the following web address to see the list of eligible services:

<http://www.healthcare.gov/law/about/provisions/services/lists.html>.

NOTE: The HHS Preventive Services list is subject to change without notice so please check the link periodically for updates.

Well Child Care – Preventive Care services for children follow the HHS Preventive Services Task Force and the American Academy of Pediatrics guidelines (including vaccination schedules). Please visit the above link for additional covered services.

Well Adult Care – Preventive Care services for adults (including a complete medical history based on age, sex and medical background) follows the guidelines set by the American Medical Association and the HHS Preventive Services Task Force. For a list of additional services, visit the HHS Preventive Services list at the above web address.

Colonoscopy – Age 50 and over one every 10 years unless medically necessary.

Prostate Exams – Annual exams for men age 40 and over.

Well Woman Care – Wellness examinations (including a complete medical history based on age and medical background) follow the guidelines set by the American Medical Association and the HHS Preventive Services Task Force. For a list of additional services, please visit the HHS Preventive Services list at the above web address.

OBGYN/PAP – An annual gynecological examination and one pap smear test per calendar year.

Mammogram – Annual screening for women age 40 and older.

Prosthetics – Charges for services and supplies including manmade limbs or eyes for the replacing of natural limbs or eyes (initial replacement of natural limbs only). Covered services include: purchase, fitting and adjustments to prosthetics and supplies; orthopedic braces; eyeglasses or contact lenses to replace function of the human lens; corneal or sclera lenses; replacement of a prosthetic for a dependent child due to the normal growth process; oxygen and related supplies for use in a patient's home. Please note: Pre-notification is required for prosthetics in excess of \$500.

Second Surgical Opinion – A second surgical opinion consultation following a surgeon's recommendation for surgery. The Physician rendering the second opinion regarding the Medical Necessity of a proposed surgery must be qualified to render such a service, either through experience, specialist training or education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery.

A third opinion consultation will be covered if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such service and must not be affiliated in any way with the Physician who will be performing the surgery.

Skilled Nursing Facility – Benefits are provided for semi-private room and board and ancillary supplies that are provided by a skilled nursing facility, but only when confinement:

- Is not for custodial care.
- Covered person is admitted to the skilled nursing facility within two (2) days following discharge from an accredited hospital wherein services were rendered for the same or related conditions of at least five days.
- The attending physician certifies that the confinement is needed for further care of the condition that caused hospital confinement.
- The attending physician completes a treatment plan that includes a diagnosis, the proposed course of treatment and the projected date of discharge.

Substance Abuse – For Plan purposes substance abuse is physical and/or emotional dependence on drugs, narcotics, alcohol or other addictive substances to a debilitating degree. It does NOT include tobacco dependence or dependence on ordinary drinks containing caffeine. Psychiatrists (M.D.), Psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must be under the direction of and must bill the Plan through these professionals.

Surgical Expenses – Professional service charges made by a physician for medical services including surgery.

- *Anesthesia* – Anesthetics and services of a Physician or registered nurse anesthetist for the administration of anesthesia.
- *Assistant Surgeon* – The services of an assistant surgeon not to exceed 20% of the maximum eligible charge of the primary surgeon.
- *Multiple Surgical Procedures* – When two or more surgical procedures are performed during the same session through the *same* incision, natural body orifice or operative field. The amount eligible for consideration is the maximum eligible charge for the largest amount billed for one procedure, plus 50% of the maximum eligible charge for the next largest procedure, and 25% of the sum of maximum eligible charges for all other procedures performed.
- *Oral Surgery* which includes:
 - Tumors;
 - Extraction of teeth not through the gum; and
 - Hospital charges for extraction of teeth or other dental processes provided hospitalization is certified by a licensed physician or a doctor of dental surgery as being necessary to safeguard the health of the person confined.
- *Primary Surgeon* – Professional service charges made by a physician for medical services incurred related to the surgery.
- *Surgical Dressings* – Expenses related to surgical dressings, splints, casts and other devices used in the reduction of fractures and dislocations.

Therapy – The Plan covers the following services you receive from a professional provider:

- *Cardiac Therapy* – The services must be rendered in accordance with a Physician's written treatment plan and used for the treatment of a sickness or injury to promote recovery.

- *Chemotherapy* – The Plan covers the treatment of malignant disease by chemical or biological antineoplastic agents.
- *Dialysis* – Charges for dialysis therapy when used for the treatment of a sickness or injury, and rendered in accordance with a Physician’s written treatment plan. This includes, but not limited to dialysis equipment rental, supplies, upkeep and the training of the insured individual (or the one who attends him) to run the equipment.
- *Infusion Therapy* – Coverage is available for infusion therapy, which is treatment by placing therapeutic agents into the vein, including intravenous feeding. This also includes enteral nutrition, which is the delivery of nutrients by tube into the gastrointestinal tract.
- *Occupational Therapy* – Coverage is available for occupational therapy, which is treatment to restore a physically disabled person’s ability to perform activities such as walking, eating, drinking, dressing, toileting, transferring from wheelchair to bed, and bathing.
- *Physical Therapy* – Coverage is available for physical therapy, which is treatment by physical means to relieve pain, restore function, and prevent disability following disease, injury, or loss of limb.
- *Radiation Therapy* – Radiation Therapy is covered including the rental or cost of radioactive materials. It covers the treatment of disease by x-ray, radium, cobalt, or high energy particle sources.
- *Respiratory Therapy* – Coverage for respiratory therapy that is the introduction of dry or moist gases into the lungs to treat illness or injury.
- *Speech Therapy* – Speech therapy is covered for the correction of a speech impairment that results from disease, surgery, injury, congenital anatomical anomaly, or prior medical treatment.

MEDICAL EXCLUSIONS AND LIMITATIONS

No payment will be made under any provision of this Plan for expenses incurred by a Covered Person for:

Abortion – Unless the life of the mother would be endangered if the fetus were carried to term, or the pregnancy is the result of rape or incest.

Acupuncture – The insertion of needles into the human body to control the flow and balance of energy in the body and to cure and relieve any ailment or disease of the mind or body or any wound, bodily injury or deformity.

Administration Fees – Expenses for missed appointments, completion of claim forms or provided medical information to determine coverage, and/or charges for telephone consultations.

Auto Accidents – For expenses in connection with an injury arising out of or relating to an accident involving the maintenance or use of a motor vehicle. This exclusion shall apply to those expenses up to the minimum amount required by law in the state of residence for any injury arising out of an accident of the type for which benefits are or would be payable under automobile insurance, regardless of whether or not automobile insurance is in force and regardless of any benefit limits under such insurance.

Biofeedback – Care, services as related to Biofeedback.

Blood – Blood and blood plasma to the extent a refund or credit is made as a result of operation of a group blood bank, replaced by or for the patient, or otherwise.

Comfort Items – Personal care or comfort items during hospitalization, such as, but not limited to, barber/beautician services, radio, television, and telephone services, guest meals, guest cots, rental of humidifiers, massage equipment, air conditioners, air-purification units, electric heating units, orthopedic mattresses, nonprescription drugs and medicines, elastic bandages or stockings, and first-aid supplies and non-hospital adjustable beds. Expenses for personal hygiene and convenience items considered personal comfort items are excluded from Plan coverage.

Complications of Non-covered Treatments – Care, services or treatment required as a result of complications from a treatment not covered under the Plan, except as specified in the Plan.

Cosmetic Surgery – Cosmetic or reconstructive procedures and any related service or supplies, which alter appearance but do not restore or improve impaired physical function, *except as specifically provided, or when performed for the:*

- Repair, within one year of the accident, of defects resulting from an accident;
- Replacement of diseased tissue surgically removed; or
- Treatment of congenital abnormalities that causes functional impairment.

Counseling – Expenses for religious, marital, family or relationship counseling.

Court-Ordered Care – Any care, confinement or treatment of a Covered Person in a public or private institution as the result of a court order.

Custodial Care – Services or supplies provided mainly as a rest cure, maintenance or Custodial Care.

Donor/Procurement – Services in conjunction with a transplant.

Ecological or Environment Medicine – Chelation or chelation therapy, orthomolecular substances, use of substance of animal, vegetable, chemical or mineral origin which are not specifically approved by the FDA as effective for treatment.

Educational or Vocational Testing – Services for educational or recreational therapy; vocational testing or training; learning disabilities; behavior modification therapy; any form of non-medical self-care or self-help training, including any related diagnostic testing; music therapy; health club memberships; aquatic or pool therapies.

Excess Charges – The part of an expense for care and treatment of an Injury or Sickness that is in excess of the Usual and Reasonable Charge.

Exercise Program – Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.

Experimental or Investigational – Drugs, medicines, treatments, procedures and therapies. A drug or medicine will be considered experimental unless, at the time it is provided, it is commercially available and approved for general use by the United States Food and Drug Administration as effective for treatment or diagnosis of the condition for which the charge is made. The approval must not be on a limited or an experimental basis. A treatment, procedure or therapy will be considered experimental unless at the time it is provided or performed, it is considered effective for the treatment or diagnosis of the condition for which the charge is made. The treatment, procedure or therapy must not be considered effective on a limited or an experimental basis.

Eye Care – Radial keratotomy, or other refractive surgery techniques; exercise for the eyes. Eye refraction, eye glasses, contact lenses, the fitting of eyeglasses. *The first pair of eyeglasses or contact lenses after cataract surgery is covered.*

Foot Care – Expenses for routine foot care, such as corns, calluses, flat foot conditions, supportive devices for the foot-unless deemed as medically necessary, treatment of subluxations of the foot (except capsular or bone surgery), toe nails (except surgery for ingrown nails), fallen arches, weak feet, chronic foot strain, and symptomatic complaints of the feet.

Foreign Travel – Care, treatment or supplies out of the U.S. if travel is for the sole purpose of obtaining medical services. Charges incurred outside the United States or Canada are excluded, unless the Covered Person is a resident of the United States or Canada and the charges are incurred while traveling on business or for pleasure.

Government Coverage – Care, treatment or supplies furnished by a program or agency funded by any government for which the Covered Person is not liable for payment. This does not apply to covered expenses rendered by a United States Veteran's Administration Hospital when services are provided for a non-service related illness or injury, Medicaid or when otherwise prohibited by law.

Hair Loss – Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician.

Hearing Aids and Exams – Charges for services or supplies in connection with hearing aids, routine hearing exams, including the fitting of hearing aids.

Holistic or Homeopathic Medicine – Services, supplies or accommodations provides in connection with holistic or homeopathic treatment, including drugs.

Hospital Employees – Professional services billed by a Physician or nurse who is an employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.

Hypnosis – Services supplies or treatment for hypnotherapy.

Illegal Acts – Charges for services received as a result of Injury or Sickness caused by or contributed to by engaging in an illegal act or occupation; by committing or attempting to commit any crime, criminal act, assault or other felonious behavior; or by participating in a riot or public disturbance.

Illegal Drugs or Medications – Services, supplies, care or treatment to a Covered Person for Injury or Sickness resulting from that Covered Person’s voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Covered Persons other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan.

No Charge – Charges for which the Covered Person and/or the Plan are not legally required to pay, including charges, which would not have been made if no coverage existed.

Infertility Treatment – Expenses for the promotion of conception including, but not limited to artificial insemination, in vitro fertilization, GIFT (Gamete Intra Fallopan Transfer). Fertility studies, sterility studies or procedures, drugs or supplies to correct infertility or to restore or enhance fertility; non-surgical procedures and related treatment.

Maintenance Care – Services or supplies that cannot or not expected to lessen the Covered Person’s disability or to enable him to live outside of an institution.

No Fault Auto Accidents – Expenses incurred for the treatment of injuries resulting from a motor vehicle accident to the extent such expenses are eligible for payment under the personal injury protection or compulsory medical payments provisions of a motor vehicle insurance contract or under similar provisions of a motor vehicle insurance contract required by any federal or state no-fault motor vehicle insurance law. This exclusion applies whether or not a proper and timely claim for payment is made under the motor insurance contract.

No Obligation to Pay – Expenses for services, which are furnished under conditions, which the Covered Person has no legal obligation to pay. This exclusion will not apply to eligible expenses that may be covered by state Medicaid coverage where federal law requires the Employer’s plan to be primary.

No Physician Recommendation – Care, treatment, services or supplies not recommended, prescribed, performed or approved by a legally qualified Physician; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician. Regular care means ongoing medical supervision or treatment that is appropriate care for the injury or sickness.

Not Medically Necessary – All charges that are determined not to be medically necessary are excluded by the Plan. Ambulance service where no medical necessity or medical emergency exists will not be payable under the Plan.

Not Specified as Covered – Services, treatments and supplies that are not specified as covered under the Plan.

Obesity – Treatment for expenses incurred specific to obesity due to overeating, weight reduction, dietary or weight control. Medically Necessary charges for Morbid Obesity will be covered by the Plan.

Occupational and/or Work Related – Expenses for or in connection with any injury or illness which arises out of or in the course of any occupation for wage or profit; or for which the Covered Person would be entitled to compensation under any Worker’s Compensation Law or occupational disease law or similar legislation. This applies even if the Covered Person’s rights have been waived or qualified.

NOTE: Any injury involving a horse while at a Training Center, Horse Breeding Facility, Barn, and/or Track is NOT covered under the Health Plan and will be deemed as a work related injury. Personal claims will have the right to appeal to the Insurance Committee.

Orthotics

Organ and Soft Tissue Transplants – Expenses for services and supplies related to organ transplants and soft tissue transplants.

Penalties – For a charge refused by another Plan as a penalty assessed due to non-compliance with that Plan's rules and regulations.

Relative Giving Services – Charges for treatment or services of physicians, nurses, chiropractors, physiotherapists, or other practitioners, who live in your home and/or if the provider of service is the member, member's spouse, child, brother, sister or parent, whether the relationship is by blood or exists in law.

Replacement Braces – Replacement of braces of the leg, arm, back, neck or artificial arms or legs.

Routine Care – Charges for the examinations, subsequent diagnostic testing, or corresponding forms including, but not limited to the following: premarital exams; physicals for college, camp, sports or travel; examinations for insurance, licensing or employment. Immunizations and inoculations are also excluded, except where specifically covered by the Plan.

Self-Inflicted – For any intentionally self-inflicted injury or illness. In compliance with the Health Insurance Portability and Accountability Act, if an injury (including self-inflicted injury) results from a medical condition or act of domestic violence, the plan will not deny benefits for the injury. A medical condition includes both physical and mental illnesses.

Services Before or After Coverage – Charges for services and/or supplies provided before the effective date of coverage under the Plan, or provided after termination of coverage under the Plan.

Sex Changes – Care, services or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change. This exclusion includes medications, implants, hormone therapy, surgery, medical or psychiatric treatment.

Sexual Dysfunction – Expenses for services, supplies or drugs related to sexual dysfunction not related to organic disease; sex therapy.

Sleep Disorders – Care and treatment for sleep disorders unless deemed Medically Necessary.

Smoking Cessation – Care and treatment for smoking cessation programs, is including, but not limited to, smoking deterrent patches and smoking deterrent gums. Unless Medically Necessary due to a severe active lung illness such as emphysema or asthma.

Surgical Sterilization Reversal – Care and treatment for the reversal of surgical sterilization.

Temporomandibular Joint Disorders (TMJ) – Charges for care and treatment of jaw joint conditions, including temporomandibular joints (TMJ).

Travel or Accommodations – Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined as a covered expense.

War – Treatment of injury or illness that is occasioned by insurrection or war or any act of war, whether declared or undeclared.

DEFINED TERMS

Accidental Injury – Unforeseen and unintended injury.

Allowable Claim Limits means the charges for services and supplies, listed and included as Covered Medical Expenses under the Plan, which are Medically Necessary for the care and treatment of illness or injury, but only to the extent that such fees are within the Allowable Claim Limits. Determination that a charge is within the Allowable Claim Limit will be made by the Plan Administrator and will include, but not be limited to, the following guidelines:

- **Non-participating (Out-of-Network) Pain Management Providers, Non-participating (Out-of-Network) Surgical Centers, and all other Non-Participating (Out-of-Network) providers for whom a Usual, Reasonable, and Customary amount is not defined:** The Allowable Claim Limit for charges will be based upon 135% of the provider's most recent departmental cost ratio, reported to the Centers for Medicare and Medicaid Services ("CMS") and published in the American Hospital Directory as the "Medicare Cost Report" (the "CMS Cost Ratio").

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

Amendment (Amend) – A formal document signed by the representatives of Standardbred Breeders and Owners Association Health Benefits Trust. The amendment adds, deletes, or changes the provisions of the Plan and applies to all Covered Person, including those persons covered before the amendment becomes effective, unless otherwise specified.

Assignment of Benefits – Authorization by the member for the Plan to pay benefits directly to the provider of the service.

Association – The Association is Standardbred Breeders and Owners Association and any affiliates who have adopted the Plan.

Baseline – The initial test results to which the results in future years will be compared in order to detect abnormalities.

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

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery (no more than 24 hours); provide care under the full-time supervision of a physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Biofeedback – Provides training to help an individual gain some element of voluntary control over autonomic body functions.

Business Associate – A person who, on behalf of a covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement:

- Performs, or assists in the performance of a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management and repricing; or

- Provides, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the person.

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

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

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

Company – The Company is Standardbred Breeders and Owners Association Health Benefits Trust, and any affiliates who have adopted the Plan.

Cosmetic Surgery – Medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Entity – In terms of the HIPAA Privacy Regulations a Covered Entity Includes a health plan; a health care provider who transmits any health information in electronic form in connection with a covered transaction; or a health care clearinghouse that handles electronic claims from a provider.

Covered Expenses – Those expenses charged by a covered provider and medically necessary for the treatment of illness or injury.

Covered Person – Includes all currently employed, retired, widowed, spouse of disabled and farm members or dependents, who are covered under this Plan.

Creditable Coverage – Includes most health coverage, such as coverage under a group health plan (including COBRA continuation coverage), HMO membership, individual health insurance policy, Medicaid, or Medicare. Creditable coverage does not include coverage consisting solely of dental or vision benefits.

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

Durable Medical Equipment – Equipment which (a) Can withstand repeated use, (b) Is primarily and customarily used to serve a medical purpose, (c) Generally is not useful to a person in the absence of an illness or injury and (d) Is appropriate for use in the home.

Emergency Medical Condition – A medical condition manifesting itself by acute symptoms of sufficient severity including, but not limited to, severe pain, or by acute symptoms developing from a chronic medical condition that would lead a prudent layperson, possessing an average knowledge of health and medicine, to reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the health of an individual, or with respect to a pregnant woman, the health of the woman or her unborn child, in serious jeopardy.

- Serious impairment to bodily functions.
- Serious dysfunction of any bodily organ or part.

Emergency Services – Health care items and services furnished or required to screen for or treat an emergency medical condition until the condition is stabilized, including pre-hospital care and ancillary services routinely available to the emergency department of a hospital.

Employer – Standardbred Breeders and Owners Association.

End Stage Renal Disease – A condition that may qualify the covered person for Medicare benefits. Should a covered person become eligible for Medicare benefits because of ESRD, this plan will provide primary coverage or coordinate against Medicare benefits, in accordance with the rules promulgated by Medicare regarding the liability of Medicare to provide benefits for care related to ESRD, including but not limited to dialysis or transplant, when group coverage is available.

Enrollment Date – First day of coverage, or first day of waiting period if there is a waiting period.

ERISA – The Employee Retirement Income Security Act of 1974, as amended.

Experimental/Investigational – Any treatment, procedure, facility, equipment, drugs, drug usage or supplies that are not recognized by the national board of the appropriate medical specialty as a generally accepted course of treatment for the medical condition being treated or which is performed for research or educational purposes or which has not been approved by a federal or state agency having jurisdiction and authority to approve such treatment, procedure, facility, equipment, drug or supplies.

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

- If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration (FDA), or other governmental agency and such approval has not been granted at the time of its use or proposed use;
- If the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval;
- If reliable evidence shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or
- If reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure. Drugs are considered experimental if they are

not commercially available for purchase and/or they are not approved by the Food and Drug Administration for general use.

Extended Care Facility/Skilled Nursing Facility – Any or all of these facilities shall mean an institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care, rehabilitation and treatment for individuals convalescing from an injury or illness. These services shall be under the supervision of a physician and/or registered graduate nurse while providing 24 hours per day of nursing services.

Family Unit – The family member who are covered as dependents under the Plan.

Fiduciary – The person or organization that has the authority to control and manage the operation and administration of the Plan. The fiduciary has discretionary authority to determine eligibility for benefits or to construe the terms of the Plan. The named fiduciary for this Plan is the Insurance Committee of Standardbred Breeders and Owners Association.

Foster Child – A child under the limiting age shown in the dependent Eligibility Section of this Plan for whom a covered Member has assumed a legal obligation.

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

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

Group Health Plan – Any individual or group plan, private or governmental, that provides or pays for medical care, to the extent specified in the HIPAA Privacy Regulations, 65 Fed. Reg. No. 250 (82463).

HIPAA – The Health Insurance Portability and Accountability Act of 1996.

Home Health Care Agency – An organization that meets all of these tests: its main function is to provide home health care services and supplies; it is federally certified as a home health care agency; and it is licensed by the state in which it is located, if licensing is required.

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

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

Hospice Agency – An agency where its main function is to provide hospice care services and supplies and it is licensed by the state in which it is located, if licensing is required.

Hospice Care Plan – A plan of terminal patient care that is established and conducted by a hospice agency and supervised by a physician.

Hospice Care Services and Supplies – Those provided through a hospice agency and under a hospice care plan and include inpatient care in a hospice unit or other licensed facility, home care, and family counseling during the bereavement period.

Hospice Unit – A facility or separate hospital unit, that provides treatment under a hospice care plan and admits at least two unrelated persons who are expected to die within six months.

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

The definition of hospital shall be expanded to include the following:

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

Illness – Sickness or disease, including pregnancy, mental or nervous disorder, alcoholism and substance abuse, requiring treatment by a physician.

Injury – Accidental physical injury caused by unexpected external means requiring treatment by a physician.

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

Late Enrollee – A covered person who enrolls under the Plan other than during the earliest date on which coverage can become effective under the terms of the plan; or during a special enrollment period.

Legal Guardian – A person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

Lifetime – Refers to benefit maximums and limitations while covered under this Plan. Under no circumstances does *Lifetime* mean during the lifetime of the covered person.

Medical Care Facility – A hospital, a facility that treats one or more specific ailments or any type of Skilled Nursing Facility.

Medical Emergency – Accidental injury or sudden onset of a medical condition for which failure to get immediate medical care could be life threatening, cause serious harm to bodily functions, or

seriously damage a body organ or part with acute symptoms requiring immediate medical care, including, but not limited to, conditions as heart attacks, cardiovascular accidents, poisonings, loss of consciousness or respiration, convulsions or other such acute medical conditions.

Medically Necessary (Medical Necessity) – Care and treatment recommended or approved by a physician and when necessary under the terms of this Plan, reviewed by the Utilization Review Administrator, which is consistent with the patient's condition and accepted standards of medical practice, medically proven to be effective treatment of the condition, not performed solely for the convenience of the patient or provider, not conducted for investigative, educational, experimental or research purposes, and is the most appropriate level of service that can be safely provided to the patient. The fact that a physician may prescribe, order, recommend, or approve a service does not, of itself, make it medically necessary or make the charge a covered expense, even though it is not specifically listed as an exclusion under this Plan.

Medicare – The program established by Title 1 of Public Law 89.97 (79 Stat. 291) as amended, entitled Health Insurance for the Aged Act, and which includes: Part A - Hospital Insurance Benefits for the Aged; Part B - Supplementary Medical Insurance Benefits for the aged.

Medicare Entitlement – Means receiving coverage from Medicare. Normally this is accomplished when an individual who is age 65 signs up for Social Security benefits, which automatically enrolls the individual in the Medicare Program. Medicare coverage also is possible for individuals with kidney (end-stage renal) disease, generally beginning three months after treatment begins, or for individuals younger than age 65 who Social Security deems disabled, effective on the first day of the 25th month after the date the individual's Social Security disability began. Social Security disability benefits do not begin until the sixth full month of disability.

Member – A member is defined as a member, trainer, driver, groom, farm member, or the spouse or dependent of a disabled or deceased member.

Mental Disorder – Any disease or condition that is classified as a mental disorder in the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Member – A person directly employed in the regular business of, and compensated for services by Standardbred Breeders and Owners Association on a regularly scheduled, full-time basis, and regularly scheduled to work for the employer in a member/employer relationship.

Morbid Obesity – A diagnosed condition in which a person's body mass index (BMI) calculated value is 40 kg/m² or greater.

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

Outpatient Care – Treatment including services, supplies and medicines provided and used at a hospital under the direction of a physician to a person not admitted as a registered bed patient; or services rendered in a physician's office, laboratory or X-ray facility, an ambulatory surgical center, or the patient's home.

Partial Hospitalization – A medically necessary alternative to Inpatient hospitalization with continuous treatment for at least four hours, but not more than 12 hours, in any consecutive 24 hour period in a Hospital or treatment center.

Pharmacy – A licensed establishment where covered prescription drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician – Physician shall mean a legally qualified and licensed Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Chiropractic (D.C.), Doctor of Dentistry (D.M.D. or D.D.S.), Doctor of Podiatry (D.P.M.), Doctor of Ophthalmology or Optometry (O.D. or M.D.).

A **Provider** shall include an Audiologist, Certified Nurse Anesthetist, Licensed Professional Physical Therapist, Midwife, Physician Assistant, Occupational Therapist, Speech Language Pathologist, Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Licensed Professional Counselor or a Licensed MSW. Any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license must be pre-approved by the Plan Administrator. Coverage will not be provided if such a physician/provider is the covered person, the covered person's spouse, child, brother, sister, or parent.

Plan – Standardbred Breeders and Owners Association Health Benefits Trust Member Benefits Plan, which is a benefits plan for certain members of Standardbred Breeders and Owners Association and is described in this document.

Plan Administrative Functions – Activities are limited to activities that would meet the definition of payment or health care operations, but do not include functions to modify, amend, or terminate the plan or solicit bids from prospective issuers. Plan administration functions include quality assurance, claims processing, auditing, monitoring, and management of carve-out plans – such as vision and dental. Protected Health Information for these purposes may not be used by or between Covered Entities or Business Associates of a Covered Entity in a manner inconsistent with HIPAA's Privacy Regulation, absent an authorization from the individual. Plan administration specifically does not include any employment-related functions.

Plan Participant – A SBOA member, retiree or dependent thereof who is covered under this Plan.

Plan Sponsor – Distinguished from Health Plan for privacy purposes. Defined at section 3(16)(B) of ERISA, 29 U.S.C. 1002 (16)(B).

Plan Year – The 12-month period beginning on either the effective date of the Plan or on the day following the end of the first plan year, which is a short plan year.

Preferred Provider Organization (PPO) – A company that contracts with a selected group of Hospitals and physicians (preferred providers) offering quality care. Utilization management techniques are applied to covered services. The Plan pays network providers on a fee-for-service basis, usually at discounted rates. The Plan is designed to provide financial incentives in the form of increased benefits to members utilizing preferred providers.

Pregnancy – Childbirth and conditions associated with pregnancy, including complications.

Pre-Existing Condition – A condition (regardless of the cause of the condition) for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to the person's enrollment date under this Plan. For a condition to be a pre-existing condition, treatment must have actually been recommended or received by a licensed professional. Genetic information cannot be treated as a pre-existing condition in the absence of a diagnosis of the condition related to the genetic information. Treatment includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

The pre-existing condition limitation does not apply to pregnancy or to members under the age of 19.

Pre-Notification – Prior assessment by the designated Utilization Review entity that proposed services, such as hospitalization are medically necessary.

Prescription Drug – Any of the following: a drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed physician. Such drug must be medically necessary in the treatment of a sickness or injury.

Preventive/Wellness Care – This includes services and supplies for screening procedures used to establish a baseline and regularly scheduled exams performed for the purpose of promoting good health and early detection of disease.

Protected Health Information – Information that is created or received by Plan, or a Business Associate of the Plan, whether oral, written, or in electronic form, and relates to the past, present, or future physical or mental health or condition of a member; the provision of health care to a member; or the past, present, or future payment for the provision of health care to a member; and that identifies the member or for which there is a reasonable basis to believe the information can be used to identify the member. Individually Identifiable Health Information includes information of persons living or deceased.

Qualified Medical Child Support Order – An issued order, judgment, decree or settlement agreement by a court of competent jurisdiction that requires a non-custodial parent to provide medical coverage for his or her child who might not otherwise be eligible for coverage. A qualified order includes information regarding: 1) The Covered Person's name and address; 2) The name and last known mailing address of the alternate recipient (i.e., the child); 3) The name of the Plan the child will be covered by; 4) A reasonable description of the type and scope of health coverage provided under the Plan; 5) The period of time to which the order applies; and 6) The order must be signed by the Judge, Commissioner or Magistrate who is presiding over the divorce. The enacted Omnibus Budget Reconciliation Act of 1993 (OBRA '93) provides for the recognition of qualified medical child support orders (QMCSO) by group health plans.

Recovery – Monies paid to the Covered Person by way of judgment, settlement or otherwise to compensate for all losses caused by the injuries or sickness whether or not said losses reflect medical, dental or other charges covered by the Plan.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a covered person recovers under an uninsured or underinsured motorist plan, homeowner's plan, renter's plan or any liability plan.

Rehabilitation Inpatient – Inpatient Rehabilitative Admission for physical therapy, speech therapy and occupational therapy when Medically Necessary to restore and improve function that was previously normal but lost following an accidental injury or illness. The Covered Person must have been covered under this or a prior medical plan with the Company when the injury or illness occurred and must have been continuously covered by the Company since that time. Treatment must occur within three years from the date of the Covered Persons first Hospital or rehabilitative care admission while covered under a plan with the Company.

Reimbursement – Repayment to the Plan for medical or dental benefits that it has advanced toward care and treatment of the injury or sickness.

Retiree – An individual over age 65, who was a member of the Standardbred Breeders and Owners Association on the day immediately proceeding their 65th birthday.

Routine Care – The medical treatment or services neither directly related nor medically necessary for the diagnosis or treatment of a specific Injury, Sickness or pregnancy-related condition, which is known or reasonably suspected.

Sickness/Illness – Disease or medical condition and pregnancy diagnosed and requiring treatment by a physician.

Significant Break in Coverage – A period of 63 days or more during which a member or dependent is not covered by any creditable coverage. Waiting periods are not included in the calculation of the break in coverage period.

Subrogation – The Plan's right to pursue the covered person's claims for medical or dental charges against the person causing injury.

Substance Abuse – The condition caused by regular excessive compulsive drinking of alcohol and/or physical habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

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

Total Disability – The member's complete inability to perform any and every duty of his or her regular or customary occupation or similar occupation for which the member is reasonable capable due to education and training, as a result of illness or injury, or a dependent's inability to perform the normal activities of a person of like age and sex who is in good health.

Treatment Center – A facility licensed as a psychiatric, alcohol or substance abuse treatment facility by the state in which it is located that provides a planned program of treatment for mental and nervous disorders, or alcohol or substance abuse based on a written plan established and supervised by a physician.

Urgent Care – Medical treatment which if the regular time periods observed for claims were adhered to: (a) Could seriously jeopardize the life or health of the plan participant or their ability to regain maximum function; or (b) Would in the opinion of a physician with knowledge of the plan participant's medical condition, subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Usual, Customary, Reasonable (UCR) – **Usual** means the provider's most frequent charge for the service or treatment. **Customary** means the charge made, for the same service in the same area, by other physicians or medical service providers with similar training and experience. **Reasonable** means the medical care or supplies; usually given and the fee usually charged for the cases in that area. The Plan will reimburse the actual charge billed if it is lesser than the usual and reasonable charge. The Plan Administrator has the discretionary authority to decide whether a charge is usual, customary and reasonable.

Utilization Review Administrator – Utilization Review Administrator is a group designed to monitor your proposed inpatient admissions and some surgical/diagnostic procedures (refer to the Cost Containment Program provisions of this booklet and health plan identification card).

Waiting Period – The period that must pass before a member or dependent is eligible to enroll under the terms of a group health plan. If a member or dependent enrolls as a late enrollee or on a special enrollment date, any period before such late or special enrollment is not a waiting period.

GENERAL PROVISIONS

Administration – This plan of benefits is administered through the Standardbred Breeders and Owners Association (“SBOA”). As Plan Administrator, Standardbred Breeders and Owners Association shall have the discretionary power and authority to: determine eligibility for benefits; interpret or construe the terms of the Plan and any other writing affecting the establishment or operation of the Plan; determine questions of fact which arise in connection with the Plan; and decide all matter arising under the Plan, based on the applicable facts and circumstances. The Loomis Company has been retained to provide independent services in the area of claims processing.

Assignment of Benefits – In the event a Plan participant has executed an Assignment of Benefits, the Plan shall direct amounts payable under the terms of this Plan to the provider of service. If the Plan receives notification from a provider that the provider has the Plan participant’s authorization to assign benefits on file, then that shall be acceptable notice to the Plan that an Assignment of Benefits has been executed. Benefits may not, however, be assigned to anyone other than the provider of service without the approval of Standardbred Breeders and Owners Association.

Funding – The benefits outlined in this booklet are paid directly from a trust established to receive, hold and pay funds in connection with this Plan. The Trust is separate from the SBOA, and benefits are not paid by the SBOA. The Trust may purchase insurance to reimburse itself if claims paid during a Plan Year exceed expected total amounts, expected individual amounts, or both.

Plan Amendment or Termination – Standardbred Breeders and Owners Association Health Benefits Trust, as sponsor of the Plan, reserves the full, absolute and discretionary right to amend, modify, suspend, withdraw, discontinue or terminate the Plan in whole or in part at any time for any and all participants of the Plan by formal action taken by the Board of Directors, or by the execution of a written amendment by the Plan Sponsor. If the Plan is amended, modified, suspended, withdrawn, discontinued or terminated, covered Members and covered dependents will be entitled to benefits for claims incurred prior to the date of such action as if such change had not been made. Such changes may include, but are not limited to, the right to (1) Change or eliminate benefits, (2) Increase or decrease participant contributions, (3) Increase or decrease deductibles and/or copayments, and (4) Change the class(es) of member or dependent covered by the Plan.

Medical Care Decision – The benefits under the Plan provide solely for the payment of certain health care expenses. All decisions regarding health care are solely the responsibility of each Covered Person in consultation with the health care providers selected. The Plan contains rules for determining the percentage of allowable health care expenses that will be reimbursed, and whether particular treatments or health care expenses are eligible for reimbursement. The Covered Person in accordance with the Plan’s appeal procedures may dispute any decision with respect to the level of health care reimbursements, or the coverage of a particular health care expense. Each Covered Person may use any source of care for health treatment and health coverage as selected, and neither the Plan nor the employer shall have any obligation for the cost or legal liability for the outcome of such care, or as a result of a decision by a Covered Person not to seek or obtain such care, other than the liability of the Plan for the payments of benefits as outlined herein.

Subrogation, Reimbursement & Third Party Recovery – The Covered Person may incur medical, dental or other charges due to injuries, which may be caused by the act or omission of another person, or a third party may be responsible for payment. In such circumstances, the covered person may have a claim against any person, third party, corporation or other entity, including but not limited to any liability insurance, no-fault coverage, homeowner’s plan, renter’s plan, uninsured or underinsured motorist and medical payment provision or other

insurance policy or funds. The benefits advanced, or to be advanced by this medical plan will be paid only if the covered person fully cooperates with the terms and conditions of the Plan. When the Plan advances benefits for accidental injury or illness or other loss for the benefit of a covered person, the Plan shall be subrogated to all rights of recovery that the person, his heirs, guardians, executors, agents or other representatives may have as a result of the loss.

The covered person under the Plan, who claims and receives an advance of benefits on account of an injury caused by the act or omission of another person or a third party, must execute a reimbursement agreement at the time the first claim is submitted. The signed reimbursement agreement indicates that the covered person agrees to promptly reimburse the Plan for benefits advanced, out of any monies recovered against the person causing the injury or any other source as the result of judgment, award, settlement or otherwise.

Accepting advanced benefits under this Plan for incurred medical, dental or other expenses automatically assigns to the Plan any rights the covered person may have to recover payments from any party or insurer. This subrogation right allows the Plan to pursue any claim, which the covered person has against any party, or insurer, whether or not the covered person chooses to pursue that claim. The Plan may make a claim directly against any party or insurer, but in any event, the Plan has a lien on any amount recovered by the covered person whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan is repaid in full.

The Covered Person agrees to recognize the Plan's right to subrogation and reimbursement from the first dollars recovered. The Plan specifically states that it has priority over **any and all** funds paid by any party to a covered person relative to the injury or sickness, including a priority over any claim for non-medical or dental charges, attorney fees, other costs or expenses, whether or not the covered person is made whole. If the Covered Person fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any recovery or reimbursement received, the covered person will be liable for any and all expenses (whether fees or costs) associated with the Plans attempt to recover such money from the covered person. The Plan may not pay for any additional care or treatment for the covered person, whether anticipated or unanticipated, until the Plan is reimbursed in accordance with the Plan terms.

If the injured person is a minor, any amount recovered by the minor, the minor's trustee, guardian, parent, or other representative, shall be subject to this provision regardless of state law and/or whether the minor's representative has access or control of any recovery funds. If the injury or condition giving rise to subrogation involves wrongful death of a Plan participant, this provision applies to the parent, guardian or the executor, agent or other personal representative of the estate.

When a right of recovery exists, the covered person will execute and deliver all required instruments and papers as well as doing whatever else is needed to secure the Plan's right of subrogation as a condition to having the Plan advance benefits. Failure or refusal to execute such agreements or furnish information does not preclude the Plan from exercising its right to subrogation or obtaining full reimbursement. In addition, the covered person will do nothing to prejudice the right of the Plan to subrogate. Any settlement or recovery received shall first be deemed for reimbursement of medical expenses paid by the Plan.

The Plan shall have no obligation to share the costs of, or pay any part of, the covered person's attorney's fees and costs incurred in obtaining any recovery. The Plan Administrator retains sole and final discretion for interpreting the terms and conditions of this Plan Document. Please refer to the Defined Terms Section for definitions of Subrogation, Recovery and Reimbursement.

No Liability of SBOA for Insufficiency of Assets and Acts or Omissions of Providers – No person shall have any claim, right, or cause of action against the SBOA or its officers or members on account of the insufficiency of the Trust to pay or provide benefits under the Plan, or any act of commission or omission, whether negligent, willful or otherwise, on the part of any institution or person rendering services or furnishing material or on account of any failure or inability for any reason of a covered person to obtain admission to any hospital or other facility provider or to obtain from an physician or other provider any other services, care, treatment, or supplies for which benefits are payable under this Plan. Nothing in this Plan shall be construed as obligated the SBOA to provide services, equipment, material, or facilities to any provider of services in order to enable the provider to furnish services, care, treatment, or supplies for which benefits are provided under this Plan.

RIGHTS AND PROTECTIONS

As a Plan participant, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all covered persons shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.
- Obtain copies of all plan documents such as the form 5500, insurance contracts, collective bargaining agreements, updated summary plan descriptions, and other plan information upon written request to the Plan Administrator. The Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report, if requested.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date.

In addition to creating rights for covered persons, ERISA imposes duties upon the people who are responsible for the operation of this plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and the other covered persons and beneficiaries.

No one, including your employer or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If a claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps a Covered Person can take to enforce the above rights. For instance, if a Covered Person requests information from the Plan and does not receive it within 30 days, they may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay up to \$110 a day until the Covered Person receives the materials, unless the materials were not sent because of reasons beyond the control of the administrators. If anyone has a claim for benefits which is denied or ignored, in whole or in part, they may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in a federal court. If it should happen that plan fiduciaries misuse the Plan's money, or if anyone is discriminated against for asserting their rights, they may seek assistance from the U.S. Department of Labor, or file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful, the court may order the persons sued to pay these costs and fees. If the individual loses, the court may order that person to pay these costs and fees, for example, if it finds the claim is frivolous.

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

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to maintain the privacy of your protected health information (PHI). We are obligated to provide you with a copy of this Notice of our legal duties and of our privacy practices with respect to PHI and we must abide by the terms of this Notice. We reserve the right to change the provisions of our Notice and make the new provisions effective for all PHI we maintain. If we make a material change to our Notice, we will mail a revised Notice to the address that we have on record for the policyholder.

If you have any questions or want additional information about this Notice or the policies and procedures described in this Notice, please contact the Plan Administrator.

Effective Date: This Notice of Privacy Practices becomes effective on April 14, 2004.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Payment: We may use or disclose your PHI to pay claims for services provided to you and to fulfill our responsibilities for plan coverage and providing plan benefits. For example, we may disclose your PHI when a provider (doctor, Hospital, clinic, etc.) requests information regarding your eligibility for coverage under our health plan, or we may use your information to determine if a treatment that you received was medically necessary.

Health Care Operations: We may use or disclose your PHI to support our business functions. These functions include, but are not limited to: medical care, quality assessment and improvement, stop-loss insurance underwriting, business planning, and business development. For example, we may use or disclose your PHI: (i) To provide you with information about one of our health management programs; (ii) To respond to a customer service inquiry from you; or (iii) In connection with fraud and abuse detection and compliance programs.

Business Associates: We contract with individuals and entities (Business Associates) to perform various functions on our behalf or to provide certain types of services. To perform these functions or to provide their services, our Business Associates will receive, create, maintain, use, or disclose PHI, but only after we require the Business Associates to agree in writing to contract terms designed to appropriately safeguard your information. For example, we may disclose your PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation, or pharmacy benefit management.

Other Covered Entities: We may use or disclose your PHI to assist other covered entities in connection with payment activities and certain health care operations. For example, we may disclose or share your PHI with other insurance carriers in order to coordinate benefits, if you or your family members have coverage through another carrier.

PERMITTED USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Personal Representatives: We may disclose PHI to the patient or the patient's personal representative. A personal representative is a legal guardian, or a person designated by you to act on your behalf in making decisions related to your health care.

Public Health Activities: We may disclose PHI to report health information to public health authorities for the purpose of preventing or controlling disease, injury or disability.

Abuse or Neglect: If we believe you are the victim of abuse or neglect, we may disclose PHI to a government authority such as social services or protective services agency.

Health Oversight Activities: We may disclose PHI to a health oversight agency that oversees the health care system and is charged with responsibility for ensuring compliance.

Legal Proceedings: We may disclose PHI in the course of a judicial or administrative proceeding in response to legal order or other lawful process.

Law Enforcement Officials: We may disclose PHI to the police or other officials in compliance with a court order or subpoena.

Organ & Tissue Procurement: We may disclose PHI to organizations that facilitate organ, eye or tissue procurement, banking or transplantation.

Coroners: We may disclose PHI to a medical examiner as authorized by law.

Specialized Government Functions: We may use and disclose PHI to units of the government with special functions such as the U.S. military or the U.S. Department of State.

Workers' Compensation: We may disclose PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

Health & Safety: We may use and disclose PHI, if in good faith, we believe it is necessary to prevent or lessen a serious and imminent threat to the health & safety of a person or the public.

As Required by Law: We may use and disclose PHI when required to do so by any other law not already referred to in the preceding categories.

To the Plan Sponsor: We may disclose your PHI to the plan sponsors of the group health plan for purposes of plan administration.

Others Involved in Your Care: We may disclose your PHI known to a family member, relative or close personal friend that you identify. Such a use will be based on how involved the person is in your care. If you are not present or able to agree to these disclosures of your PHI, then, using our professional judgment, we may determine whether the disclosure is in your best interest.

YOUR RIGHTS

Right to Request a Restriction: You have the right to request a restriction on the PHI we use or disclose about you for claim payment or healthcare operations. We are not required to agree to any restriction that you may request. If we do agree to the restriction, we will comply with the restriction unless the information is needed to provide emergency treatment to you.

Right to Request Confidential Communications: If you believe that a disclosure of your PHI may endanger you, you may request that we communicate with you regarding your information in an alternative manner or at an alternative location. For example, you may ask that we only contact you at your work address or via your work e-mail.

Right to Inspect and Copy: You have the right to inspect and copy your PHI that is contained in a “designated record set.” A “designated record set” contains your medical and billing records, as well as other records that are used to make decisions about your health care benefits. However, you may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

Right to Amend: If you believe that your PHI is incorrect or incomplete, you may request that we amend your information. In certain cases, we may deny your request for an amendment. For example, we may deny your request if the information you want to amend is not maintained by us, but by another entity.

Right of an Accounting: You have a right to an accounting of certain disclosures of your PHI that are made for reasons other than claim payment or health care operations. No accounting of disclosures is required for disclosures you authorized. You should know that most disclosures of your PHI will be for purposes of claim payment or health care operations, and, therefore, will not be subject to your right to an accounting.

Right to a Paper Copy of this Notice: You have the right to a paper copy of this Notice, even if you may have agreed to accept this Notice electronically.

COMPLAINTS

You may complain to us if you believe that we have violated your privacy rights. You may file a complaint with us by contacting the Privacy Officer.

You also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. You may submit this complaint to:

Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201

We will not penalize or in any other way retaliate against you for filing a complaint with the Secretary or with us.

HIPAA SECURITY REGULATIONS

We are required to:

- Implement administrative, physical, and technical standards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI;
- Ensure that the firewall required by the HIPAA privacy rule is supported by reasonable and appropriate security measures;
- Ensure that any agent or subcontractor to whom the Plan Sponsor provides electronic PHI agrees to implement reasonable and appropriate security measures; and
- Report to the Plan any security incident of which the Plan Sponsor becomes aware.

NO VERBAL MODIFICATIONS

The Covered Person shall not rely on any oral statement from any employee of The Loomis Company which modifies or otherwise affects the benefits, general limitations and exclusions, or other provisions of this Plan and increases, reduces, waives or voids any coverage or benefits under this Plan.

In addition, such oral statement shall not be used in the prosecution or defense of a claim under this Plan.

Any written or oral verification received from Standardbred Breeders and Owners Association is based upon eligibility information and Plan benefits, which are subject to change. Therefore, any verification should not be interpreted as a guarantee of coverage or payment for any services rendered or otherwise provided to a participant.

MISSTATEMENTS

In the event of any misstatement of any fact(s) affecting coverage under the Plan, the true facts will be used to determine the proper coverage. Coverage means eligibility as well as the amount of any benefits herein.

This booklet is not a contract. It explains in non-technical language the essential features of your Member Benefit Program. Contact the Human Resources Department if there are any questions concerning coverage.

**ACCEPTANCE
SUMMARY PLAN DESCRIPTION
EXECUTION**

It is agreed that the provisions set forth in this document and properly executed amendments will be the basis for the administration of Standardbred Breeders and Owners Association Group Health Plan effective January 1, 2011.

PLAN SPONSORS' CERTIFICATION OF COMPLIANCE

Standardbred Breeders and Owners Association Group Insurance Plan – the Sponsor of Group Health Plan hereby certifies that:

The plan documents have been amended to establish the permitted and required uses and disclosures of Protected Health Information (PHI) by the group health plan consistent with 45 C.F.R. § 164.504(f)(2) of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The plan sponsor agrees to comply with the plan provisions as set forth by this amendment; and

The plan documents have been amended to provide that the group health plan will disclose PHI to the plan sponsor only upon receipt of this certification signed on behalf of the plan sponsor.

On Behalf of Standardbred Breeders and Owners Association

Name and Title

Date

Medical Version 2011