Amendment #1
Effective September 1, 2008
ANCIRA ENTERPRISES INC
Plan Year 06-01-2008 to 06-01-2009

The Health Benefit Summary Plan Description is hereby amended as follows:

1. **The following underlined portion(s) of the BENEFIT CLASS DESCRIPTION is hereby added to the Summary Plan Description.**

Class	Class Description	Benefit Plan
A04	ALL ACTIVE EMPLOYEES WITH ENTRY PPO PLAN PARTICIPATING IN TEXAS TRUE CHOICE (TTC) WITH PHCS HD TRAVEL/FIRST HEALTH/BEECHSTREET/TC3	004
C04	ALL COBRA PARTICIPANTS WITH ENTRY PPO PLAN PARTICIPATING IN TEXAS TRUE CHOICE (TTC) WITH PHCS HD TRAVEL/FIRST HEALTH/BEECHSTREET/TC3	004

2. **The SCHEDULE OF BENEFITS, Benefit Plan(s) 004, is hereby added to the Summary Plan Description.**

MEDICAL SCHEDULE OF BENEFITS

Benefit Plan(s) UMR 004 – Entry Plan

All health benefits shown on this Schedule of Benefits are subject to the following: Lifetime and annual maximums, Deductibles, Co-pays, Plan Participation rates, and out-of-pocket maximums, if any. Refer to the Out-of-Pocket Expenses section of this SPD for more details.

Benefits are subject to all provisions of this Plan including any benefit determination based on an evaluation of medical facts and Covered Benefits. Refer to the Covered Medical Benefits and General Exclusions sections of this SPD for more details.

Note: Notification may be required before benefits will be considered for payment. Failure to obtain notification may result in a penalty or increased out-of-pocket costs. Refer to the Utilization Management section of this SPD for a description of these services and notification procedures.

Note: Refer to the Provider Network section for clarifications and possible exceptions.

Note: If a benefit maximum is listed in the middle of a column on the Schedule of Benefits, that means that it is a combined Maximum Benefit for services that Covered Person receives from all In-Network and Out-of-Network providers and facilities.

	IN-NETWORK	OUT-OF-NETWORK
Individual Maximum Benefit Excluding Prescription Benefits Per Calendar Year	$25,000	
Annual Deductible Per Calendar Year Excluding The Prescription Benefit Deductible:		
• Per Person	$1,000	$2,000
• Per Family	$3,000	$6,000
Plan Participation Rate, Unless Otherwise Stated Below:		
• Paid By Plan After Satisfaction Of Deductible	70%	50%
Annual Out-Of-Pocket Maximum:		
• Per Person	$4,500	$10,000
• Per Family	$13,500	$30,000
Ambulance Transportation:		
• Paid By Plan After In-Network Deductible	70%	70%
Contraceptives:		
Devices:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Injectable Contraceptives:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Durable Medical Equipment:		
• Paid By Plan After Deductible	70%	50%
Emergency Services / Treatment:		
Urgent Care:		
• Co-pay Per Visit	$35	$35
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
True Emergency Room / Emergency Physicians:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$50	$50
• Paid By Plan	70% (Deductible Waived)	70% (Deductible Waived)
Non-True Emergency Room / Emergency Physicians:		
• Co-pay Per Visit (Waived If Admitted As Inpatient Within 24 Hours)	$50	$50
• Paid By Plan After In-Network Deductible	70%	70%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Sub-Acute Facility:		
• Maximum Benefit Per Calendar Year	$10,000	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	IN-NETWORK	OUT-OF-NETWORK
Hearing Deficit Services:		
Exams, Tests:		
• Paid By Plan After Deductible	70%	50%
Hearing Aids:		
• Maximum Benefit Every 36 Months	$1,000	
• Paid By Plan After Deductible	70%	50%
Implantable Hearing Devices:		
• Maximum Benefit Per Lifetime	$10,000	
• Paid By Plan After Deductible	70%	50%
Home Health Care Benefits:		
• Maximum Benefit Per Calendar Year	$10,000	
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.		
Hospice Care Benefits:		
Hospice Services:		
• Maximum Benefit Per Lifetime	$20,000	
• Paid By Plan After Deductible	100%	50%
Respite Care:		
• Paid By Plan After Deductible	70%	50%
Hospital Services - Except For Mental Health And Substance Abuse And Chemical Dependency:		
Pre-Admission Testing:		
• Paid By Plan After Deductible	70%	50%
Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-Private Room Rate Or Negotiated Room Rate:		
• Co-pay Per Admission	$250	
• Paid By Plan After Deductible	70%	50%
Outpatient Services / Outpatient Physician Charges:		
• Paid By Plan After Deductible	70%	50%
Outpatient Lab And X-ray Charges:		
• Paid By Plan After Deductible	70%	50%
Outpatient Surgery / Surgeon Charges:		
• Paid By Plan After Deductible	70%	50%

	IN-NETWORK	OUT-OF-NETWORK
Physician Office Services:		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Office Surgery:		
• Paid By Plan After Deductible	70%	50%
Allergy Injections:		
• Co-pay Per Visit	$5	$5
• Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Allergy Testing:		
• Paid By Plan After Deductible	70%	50%
Allergy Serum:		
• Paid By Plan After Deductible	70%	50%
Prescription Benefits:		
• Maximum Benefit Per Calendar Year	$5,000	
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include:		
From Age 6		
• Maximum Benefit Per Calendar Year	Not Applicable	$500
Preventive / Routine Physical Exams:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Immunizations Including Flumist Vaccine:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Diagnostic Tests, Lab And X-rays:		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Mammograms And Breast Exams:		
Included In Maximum		
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Pelvic Exams And Pap Test:		
Included In Maximum		
• Maximum Exams Per Calendar Year	1 Exam	
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Fecal Blood Culture:		
Included In Maximum		
• Maximum Exams Per Calendar Year	1 Exam	
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine PSA Test and Prostate Exams:		
Included In Maximum		
From Age 40		
• Maximum Exams Per Calendar Year	1 Exam	
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Colonoscopy, Sigmoidoscopy And Similar Routine Surgical Procedures Done For Preventive Reasons:		
Included In Maximum		
From Age 50		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Hearing Exams:		
Included In Maximum		
• Maximum Exams Every 2 Years	1 Exam	
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%
Preventive / Routine Eye Exam And Glaucoma Testing (Discounts Are Offered At Pearl Vision And Eyemasters At Ancira.com):		
Included In Maximum		
• Co-pay Per Visit	$35	Not Applicable
• Paid By Plan After Deductible	100% (Deductible Waived)	50%

	IN-NETWORK	OUT-OF-NETWORK
Preventive / Routine Care Benefits For Children Include: To Age 6 • Maximum Benefit Per Calendar Year	Not Applicable	$500
Preventive / Routine Physical Exams: Included In Maximum • Co-pay Per Visit • Paid By Plan After Deductible	$35 100% (Deductible Waived)	Not Applicable 50%
Immunizations Including Flumist Vaccine: • Paid By Plan	100% (Deductible Waived)	100% (Deductible Waived)
Preventive / Routine Diagnostic Tests, Lab And X-rays: Included In Maximum • Co-pay Per Visit • Paid By Plan After Deductible	$35 100% (Deductible Waived)	Not Applicable 50%
Preventive / Routine Hearing Exam: Included In Maximum • Co-pay Per Visit • Paid By Plan After Deductible	$35 100% (Deductible Waived)	Not Applicable 50%
Preventive / Routine Eye Exam And Glaucoma Testing (Discounts Are Offered At Pearl Vision And Eyemasters At Ancira.com): Included In Maximum • Paid By Plan After Deductible	100% (Deductible Waived)	50%
Private Duty Nursing (When Meets Clinical Eligibility For Coverage): • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$10,000 70%	 50%
Sleep Studies: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	$2,500 70%	 50%
Temporomandibular Joint Disorder Benefits: • Maximum Benefit Per Calendar Year • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	$1,000 $5,000 70%	 50%

	IN-NETWORK	OUT-OF-NETWORK
Therapy Services: • Maximum Benefit Per Calendar Year	$2,500	
Occupational / Physical / Speech Outpatient Hospital Therapy: Included In Maximum • Paid By Plan After Deductible	70%	50%
Occupational / Physical / Speech Office Therapy: Included In Maximum • Co-pay Per Visit • Paid By Plan After Deductible	$35 70% (Deductible Waived)	Not Applicable 50%
Aquatic Therapy: Included In Maximum • Paid By Plan After Deductible	70%	50%
Massage Therapy: Included In Maximum • Paid By Plan After Deductible	70%	50%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment For Alopecia Areata: • Maximum Benefit Per Lifetime • Paid By Plan	$500 100% (Deductible Waived)	 100% (Deductible Waived)
All Other Covered Expenses: • Paid By Plan After Deductible	70%	50%

3. **The following underlined portion(s) of the OUT-OF-POCKET EXPENSES AND MAXIMUMS is hereby changed in the Summary Plan Description.**

DEDUCTIBLES

(Applies to Benefit Plan(s) 001 and 004) All Covered Expenses incurred during the last three months of a Plan Year and applied toward satisfaction of the individual and family Deductible for that year, will also be applied toward the individual and family Deductible requirement for the next Plan Year.

4. **The following underlined portion(s) of the ELIGIBILITY AND ENROLLMENT is hereby added to the Summary Plan Description.**

- **ELIGIBILITY REQUIREMENTS**

Employees hired 02-01-2008 and later are eligible for coverage in UMR - Plan 004. As a condition of employment, participation is required without proof of medical coverage elsewhere.

Eligibility for UMR Plan 001, 002 - 003 is dependent upon satisfying the following requirements:

- 12-months minimum enrollment in the Entry Plan 004
- two years consecutive full time, active employment
- qualified participants who satisfy the eligibility conditions will be allowed to transfer into Plan 001, 002-003 each June 1 (policy year start) following conclusion of the required Waiting Period.

5. **The following underlined portion(s) of the PROVIDER NETWORK is hereby changed in the Summary Plan Description.**

EXCEPTIONS TO THE PROVIDER NETWORK RATES

a. The In-Network level of benefits may be applied when an Out-of-Network provider is used during a true Emergency, provided the Out-of-Network provider is the closest medically-appropriate provider and a transfer to an In-Network provider occurs as soon as medically appropriate. **(Applies to Benefit Plan(s) 001 and 004).**

6. **The following underlined portion(s) of the COORDINATION OF BENEFITS is hereby changed in the Summary Plan Description.**

(Applies to Benefit Plan(s) 001 and 004) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.

MEDICARE

(Applies to Benefit Plan(s) 001 and 004) The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim, and will reduce the benefits it pays so that the total payment between the Primary Plan and Secondary Plan does not exceed the Covered Expenses Incurred. Up to 100% of charges Incurred may be paid between both plans.