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SUMMARY PLAN DESCRIPTION

This Summary Plan Description provides detailed information about your group health plan. Please review the booklet thoroughly to become familiar with the coverage available under this plan. Keep this booklet with your important documents for future reference.

If you require information about Plan coverage of a specific benefit, (a particular drug, treatment or test, etc.), additional information may be obtained by contacting your Human Resources Department, or Consolidated Health Plan’s Customer Service Department at the numbers noted below.

Consolidated Health Plans
(413) 733-4540 or (800) 633-7867

Name of Plan:
Pinsly Railroad Company Health Benefits Plan

Name, Address and Phone Number of Employer/Plan Sponsor:
Pinsly Railroad Company
53 Southampton Road
Westfield, MA 01085
(413) 568-6426

Employer Identification Number:
04-2507678

Plan Number:
501

Group Number:
EPRC306

Type of Plan:
Group Health Plan: medical, dental, and prescription drug benefits

Type of Administration:
Contract administration: The processing of claims for benefits under the terms of the Plan is provided through a company contracted by the employer and shall hereinafter be referred to as the claims processor.

Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:
Pinsly Railroad Company
53 Southampton Road
Westfield, MA 01085
(413) 568-6426

Legal process may be served upon the plan administrator.
Name, Address and Phone Number of Designated Claims Processor:

Consolidated Health Plans
2077 Roosevelt Avenue
Springfield, MA 01104
1-413-733-4540 or 1-800-633-7867

Eligibility Requirements:

For detailed information regarding a person's eligibility to participate in the Plan, refer to the following sections:
   Eligibility
   Enrollment
   Effective Date of Coverage

For detailed information regarding a person being ineligible for benefits through reaching maximum benefit levels, pre-existing conditions, termination of coverage or Plan Exclusions, refer to the following sections:
   Schedule of Benefits
   Effective Date of Coverage, Pre-existing Conditions
   Termination of Coverage
   Plan Exclusions

For detailed information regarding a person's benefits being offset, reduced or recovered (by exercise of subrogation or reimbursement rights), refer to the following sections:
   Coordination of Benefits
   Subrogation/Reimbursement

Source of Plan Contributions:

Contributions for Plan expenses are obtained from the employer and from the covered employees. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees.

Funding Method:

The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.

Ending Date of Plan Year:

February 28

Procedures for Filing Claims:

For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled:
   Claim Filing Procedures.

The designated claims processor is:
   Consolidated Health Plans
Statement of ERISA Rights:

Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

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

3. Receive a summary of the Plan's annual financial report. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

4. Continue health care coverage for the participant, the participant's spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. The participant or dependent may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for preexisting conditions under the Plan, if the participant or dependent has creditable coverage from another plan. The participant or dependent should be provided a certificate of creditable coverage, free of charge from the group health plan or health insurance issuer when coverage under the plan is lost, when the participant or dependent becomes entitled to elect COBRA continuation coverage; when COBRA coverage ceases; if a certificate is requested before losing coverage; or if a certificate is requested within twenty-four (24) months after losing coverage. The participant or dependent may be subject to preexisting condition exclusion for twelve (12) months after the enrollment date for coverage.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants.

No one, including the employer, a union, or any other person, may fire an employee or discriminate against an employee to prevent the employee from obtaining any benefit under the Plan or exercising the rights under ERISA.

If claims for benefits under the Plan are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the Plan review and reconsider the claim.

Under ERISA, there are steps participants can take to enforce the rights. For instance, if material is requested from the Plan and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the plan administrator. If a claim for benefits is denied or ignored in whole or in part, the participant may file suit in a state or federal court.
If it should happen that Plan fiduciaries misuse the Plan's money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.

Participants should contact the plan administrator for questions about the Plan. For questions about this statement or about rights under ERISA, participants should contact the nearest 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, N.W., Washington, D.C. 20210.
SCHEDULE OF BENEFITS

The following Schedule of Benefits is designed as a quick reference. For complete provisions of the Plan's benefits, refer to the following sections: Claim Filing Procedure/Pre-Service Claims Procedure, Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Plan Exclusions, and Preferred Provider Organization.

MEDICAL BENEFITS

<table>
<thead>
<tr>
<th>Maximum Benefit Per covered Person While Covered By This Plan For:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Hospice Care</td>
<td>$10,000</td>
</tr>
<tr>
<td>Infertility Testing and Treatment</td>
<td>$2,000</td>
</tr>
<tr>
<td>Temporomandibular Joint Dysfunctions (TMJ)</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Maximum Benefit Per Covered Person Per Procedure:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Procedures</td>
<td>See Appendix “A”</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Maximum Benefit Per Covered Person Per Calendar Year For:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Health Care ($110 maximum allowable charge per visit)</td>
<td>90 visits</td>
</tr>
<tr>
<td>Chiropractic Care (Limited to preferred providers)</td>
<td>12 visits</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>$2,000</td>
</tr>
<tr>
<td>Extended Care Facility (Non-preferred providers limited to $250 maximum allowable charge per day)</td>
<td>90 days</td>
</tr>
<tr>
<td>Mental and Nervous Disorders (Inpatient and Partial Confinement)</td>
<td>Two days of Partial Confinement shall equal one day of Inpatient Care</td>
</tr>
<tr>
<td>Chemical Dependency (Inpatient and Partial Confinement)</td>
<td>Two days of Partial Confinement shall equal one day of Inpatient Care</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>DEDUCTIBLE, PER CALENDAR YEAR (Applies only to non-preferred providers):</th>
<th>Preferred Provider</th>
<th>Non-preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Deductible (Per Person)</td>
<td></td>
<td>$500</td>
</tr>
<tr>
<td>Family Deductible (Aggregate)</td>
<td></td>
<td>$1,500</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Per Occurrence Deductibles: (Applies to preferred and non-preferred providers, Refer to Medical Expense Benefit, Deductibles for additional information)</th>
<th>Preferred Provider</th>
<th>Non-preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ambulance Services Deductible</td>
<td></td>
<td>$50</td>
</tr>
<tr>
<td>Inpatient Admission Deductible (applied to 1st inpatient admission per calendar year)</td>
<td></td>
<td>$250</td>
</tr>
<tr>
<td>Outpatient Surgery Deductible (applied to 1st outpatient surgery per calendar year)</td>
<td></td>
<td>$250</td>
</tr>
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<tr>
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<th>Non-preferred Provider</th>
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<tr>
<td>Office Service Copay</td>
<td>$20</td>
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<tr>
<td>Well Child Care Copay</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Routine Adult Wellness Copay</td>
<td>$0</td>
<td></td>
</tr>
<tr>
<td>Imaging Tests (MRI, CT Scans)</td>
<td>$100</td>
<td></td>
</tr>
<tr>
<td>Emergency Room Copay (facility)</td>
<td></td>
<td>$100</td>
</tr>
</tbody>
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### Out-of-Pocket Expense Limit Per Calendar Year: (excludes deductible)

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<tr>
<th></th>
<th>Preferred Provider</th>
<th>Non-preferred Provider</th>
</tr>
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<tbody>
<tr>
<td>Individual (Per Person)</td>
<td>$4,000</td>
<td>$8,000</td>
</tr>
<tr>
<td>Family (Aggregate)</td>
<td>$8,000</td>
<td>$16,000</td>
</tr>
</tbody>
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Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit. If both Preferred Providers and Non-preferred Providers are used in a calendar year, the Out-of-Pocket Maximums will offset each other. Any partial Out-of-Pocket Maximums will also be offset.

### COINSURANCE:

The Plan pays the percentage listed on the following pages for Preferred Provider covered expenses incurred by a covered person during a calendar year without application of a calendar year deductible, until the individual or family Preferred Provider out-of-pocket expense limit has been reached. The Plan pays the percentage listed on the following pages for Non-preferred Provider covered expenses incurred by a covered person during a calendar after the individual or family Non-preferred Provider deductible has been satisfied and until the individual or family Non-preferred Provider out-of-pocket expense limit has been reached. Thereafter, the Plan pays one hundred percent (100%) of covered expenses for the remainder of the calendar year plan year or until the maximum benefit has been reached. Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.

**Preferred Provider**  - % of a negotiated rate, if applicable, otherwise it is a % of customary and reasonable amount

**Non-Preferred Provider**  - % of customary and reasonable amount

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<th>Benefit Description</th>
<th>Preferred Provider</th>
<th>Non-preferred Provider</th>
</tr>
</thead>
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<tr>
<td>Inpatient Hospital (Hospital Admission deductible applied to 1st admission each calendar year.)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient Hospital</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Outpatient Surgery/Ambulatory Surgical Center (Outpatient Surgery Deductible applies to 1st surgery each calendar year.)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Emergency Room Services (facility charges)</td>
<td>$100 Copay, then 100%</td>
<td>100% Copay, then 100% (Deductible waived)</td>
</tr>
<tr>
<td>Non-Emergency Use of the Emergency Room</td>
<td>0%</td>
<td>0%</td>
</tr>
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**Physician Services**

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<th>Service Description</th>
<th>Preferred Provider</th>
<th>Non-preferred Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office Services (Copay applies to all services billed by physician on same day, including allergy shots, excluding office surgery)</td>
<td>$20 Copay, then 100%</td>
<td>60%</td>
</tr>
<tr>
<td>Home and Inpatient Visits</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Surgery – Inpatient or Physician’s Office</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Surgery – Outpatient Hospital or Ambulatory Surgical Facility (Outpatient Surgery Deductible applies to 1st surgery each calendar year.)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Pathology</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Radiology</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Diagnostic X-ray and Lab (inpatient or outpatient)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Imaging Tests (MRI, CT Scans)</td>
<td>$100 Copay, then 80%</td>
<td>60%</td>
</tr>
<tr>
<td>Extended Care Facility (Hospital Admission deductible applies to 1st admission each calendar year.) Limited to 90days maximum benefit per calendar year</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Home Health Care ($110 maximum allowable charge per visit. Limited to 90 visits per calendar year.)</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Benefit Description</td>
<td>Preferred Provider</td>
<td>Non-preferred Provider</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td><strong>Well Child Care &amp; Immunizations (through age 16)</strong></td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td>Includes Office services and Other Covered Expenses.</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Well Adult Care</strong></td>
<td>100%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Ambulance Services</strong></td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>(Ambulance Services Deductible applies)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Therapy Services (PT, ST, OT, etc.)</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Limited to 12 visits maximum per calendar year.</td>
<td>$20 Copay, then 100%</td>
<td>0%</td>
</tr>
<tr>
<td><strong>Infertility Testing and Treatment</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Limited to $2,000 maximum per lifetime (includes prescription drugs)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Marital and Family Counseling</strong></td>
<td>$20 Copay, then 100%</td>
<td>60%</td>
</tr>
<tr>
<td>Limited to 24 visits maximum per calendar year</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nutritional Counseling (Visits 1-3)</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Nutritional Counseling (Visits 4+)</strong></td>
<td>$20 Copay, then 100%</td>
<td>$20 Copay, then 100%</td>
</tr>
<tr>
<td><strong>Mental &amp; Nervous Disorders</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient and Partial Confinement Services</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospital Admission deductible applies to 1st admission each calendar year. (2 days of Partial equals 1 day of Inpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>$20 Copay, then 100%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Chemical Dependency</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Inpatient and Partial Confinement Services</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td>Hospital Admission deductible applies to 1st admission each calendar year. (2 days of Partial equals 1 day of Inpatient)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient Services</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
<tr>
<td><strong>Injury/Illness Arising Out of Employment</strong></td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>(Applies to FELA Employees Only)</td>
<td></td>
<td>Deductible Waived</td>
</tr>
<tr>
<td><strong>Organ Transplants</strong></td>
<td>See Appendix A for Benefits</td>
<td>See Appendix A for Benefits</td>
</tr>
<tr>
<td><strong>All Other Covered Expenses</strong></td>
<td>80%</td>
<td>60%</td>
</tr>
</tbody>
</table>
**PRESCRIPTION DRUG PROGRAM**

**Pharmacy Option**

Prescription Drug Card 100% after copay;
Copay
Generic: $10 copay
Preferred Brand Name: $20 copay
Non-preferred Brand Name: 50% copay

**Limitation:** 30 day supply

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the cost of the *generic* drug and the brand name requested, plus the usual *copay*.

**Mail Order Option**

Mail Order Prescriptions 100% after copay;
Copay
Generic: $20 per prescription
Preferred Brand Name: $40 per prescription
Non-preferred Brand Name: 50% copay

**Limitation:** 90 day supply

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the cost of the *generic* drug and the brand name requested, plus the usual *copay*.

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**DENTAL BENEFITS**

**Calendar Year Deductible:**

Individual $50
Family (Aggregate) $100

The Deductible is waived for diagnostic & preventive dental services. Calendar year deductible applies to all other services, including orthodontic care.

**Maximum Benefit Per Covered Person:**

Preventive, Basic and Major services per calendar year (other than Orthodontics) $1,500
Orthodontic services while covered by this *Plan* $1,500

**Percentage of Customary and Reasonable Amount Payable For:**

- Diagnostic & Preventive Dental Services 100%
- Basic Dental Services 80%
- Major Dental Services 50%
- Orthodontic Services 50%

* Calendar Year Deductible Waived

Refer to *Dental Expense Benefit* for complete details, including late entrant limitations.
PREFERRED PROVIDER OR NON-PREFERRED PROVIDER

Covered persons have the choice of using either a preferred provider or a non-preferred provider.

PREFERRED PROVIDERS

Your Preferred Provider is Cigna. A preferred provider is a physician, hospital or ancillary service provider which has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to covered persons. This is known as the negotiated rate. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate. Listings of preferred provider are furnished automatically, without charge, to each participant, as a separate document. You may locate a preferred provider at www.mycignaforhealth.com.

NON-PREFERRED PROVIDERS

A non-preferred provider does not have an agreement in effect with the Preferred Provider Organization. This Plan will allow only the customary and reasonable amount as a covered expense. The Plan will pay its percentage of the customary and reasonable amount for the non-preferred provider services, supplies and treatment. The covered person is responsible for the remaining balance. This results in greater out-of-pocket expenses to the covered person.

EXCEPTIONS

The following listing of exceptions represents services, supplies or treatments rendered by a non-preferred provider where covered expenses shall be payable at the preferred provider level of benefits:

1. Emergency treatment is rendered at a non-preferred facility.

2. Non-preferred anesthesiologist and/or assistant surgeon if the operating surgeon is a preferred provider and when the facility rendering such services is a preferred provider.

3. Radiologist or pathologist services for interpretation of x-rays and diagnostic laboratory and surgical pathology tests rendered by a non-preferred provider when the facility rendering such services is a preferred provider.

4. Diagnostic laboratory and surgical pathology tests referred to a non-preferred provider by a preferred provider.

5. While confined to a preferred provider hospital, the preferred provider physician requests a consultation from a non-preferred provider.

6. Medically necessary services, supplies and treatment not available through a preferred provider within a forty (40) mile radius of the covered person’s place of residence.

7. Ambulance Transport.
MEDICAL EXPENSE BENEFIT

This section describes the **covered expenses** of the **Plan**. All **covered expenses** are subject to applicable **Plan** provisions including, but not limited to: deductibles, **copay**, **coinsurance** and **maximum benefit** provisions as shown on the **Schedule of Benefits**, unless otherwise indicated. Any portion of an expense **incurred** by the **covered person** for services, supplies or treatment, that is greater than the customary and reasonable amount for **non-preferred providers** or **negotiated rate** for **preferred providers** will not be considered a **covered expense** by this **Plan**. Specified preventive care expenses will be considered to be **covered expenses**.

COPAY

The **copay** is the amount payable by the **covered person** for certain services, supplies or treatment rendered by a **preferred provider**. The service and applicable **copay** are shown on the **Schedule of Benefits**. The **covered person** selects a **preferred provider** and pays the **preferred provider** the **copay**. The **Plan** pays the remaining **covered expenses** at the **negotiated rate**. The **copay** must be paid each time a treatment or service is rendered. The **copay** will not be applied toward the following:

1. The calendar year deductible.
2. The deductible carry-over.
3. The common accident deductible.

DEDUCTIBLES

**Inpatient Admission Deductible**

For the first **inpatient hospital confinement** each calendar year, the **covered person** is responsible for an additional inpatient admission deductible as specified on the **Schedule of Benefits**. Not more than one (1) inpatient admission deductible will be applied per calendar year. The **hospital** deductible shall be applied to the facility charges. Any applicable calendar year deductible shall also be applied.

**Outpatient Surgery Deductible**

For the first outpatient surgery at a hospital or ambulatory surgical facility each calendar year, the **covered person** is responsible for an additional outpatient surgery deductible as specified on the **Schedule of Benefits**. The outpatient surgery deductible shall be applied to the surgeon's charges. Any applicable calendar year deductible shall also be applied.

**Ambulance Services Deductible**

For each ambulance service, the **covered person** is responsible for an additional ambulance services deductible as specified on the **Schedule of Benefits**. The ambulance services deductible shall be applied first, then any applicable calendar year deductible shall be applied.

**Individual Deductible**

The individual deductible is the dollar amount of **covered expense** which each **covered person** must have incurred during each calendar year before the **Plan** pays applicable benefits. The individual deductible amount is shown on the **Schedule of Benefits**.

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Family Deductible

If, in any calendar year, covered members of a family incur covered expenses that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The Plan pays a specified percentage of covered expenses at the customary and reasonable amount for non-preferred providers, or the percentage of the negotiated rate for preferred providers. That percentage is specified on the Schedule of Benefits. For non-preferred providers, the covered person is responsible for the difference between the percentage the Plan paid and 100% of the billed amount. The covered person's portion of the coinsurance represents the out-of-pocket expense limit.

OUT-OF-POCKET EXPENSE LIMIT

After the covered person has incurred an amount equal to the out-of-pocket expense limit listed on the Schedule of Benefits for covered expenses (after satisfaction of any applicable deductibles), the Plan will begin to pay 100% for covered expenses for the remainder of the calendar year.

After a covered family has incurred a combined amount equal to the family out-of-pocket expense limit shown on the Schedule of Benefits, the Plan will pay 100% of covered expenses for all covered family members for the remainder of the calendar year.

Out-of-Pocket Expense Limit Exclusions

The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:

1. Expenses for services, supplies and treatments not covered by this Plan, to include charges in excess of the customary and reasonable amount.
2. Deductible(s).
3. Expenses incurred as a result of failure to obtain pre-certification.
5. Prescription co-pays.
6. Dental expenses.

MAXIMUM BENEFIT

The maximum benefit payable on behalf of a covered person is shown on the Schedule of Benefits. The maximum benefit applies to the entire time the covered person is covered under the Plan, either as an employee, dependent, alternate recipient or under COBRA. If the covered person’s coverage under the Plan terminates and at a later date he again becomes covered under the Plan, the maximum benefit will include all benefits paid by the Plan for the covered person during any period of coverage.

The Schedule of Benefits contains separate maximum benefit limitations for specified conditions. Any separate maximum benefit will include all such benefits paid by the Plan for the covered person during any and all periods of coverage under this Plan. All separate maximum benefits are part of, and not in addition to, the maximum benefit. No more than the maximum benefit will be paid for any covered person while covered by this Plan.
HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient or partial confinement admissions are subject to pre-certification. Failure to obtain pre-certification will result in a reduction of benefits (refer to Claim Filing Procedure/Pre-Service Claims Procedure).

Covered expenses shall include:

1. Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar medically necessary accommodations. Covered expenses for room and board shall be limited to the hospital's semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount for non-preferred providers and the percentage of the negotiated rate for preferred providers. A full private room rate is covered when the facility only offers private rooms or if the private room is necessary for isolation purposes and is not for the convenience of the covered person.

2. Miscellaneous hospital services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the hospital for rendering services, supplies and treatments;
   b. Use of operating, treatment or delivery rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the hospital;
   d. Medical and surgical dressings and supplies, casts and splints;
   e. Blood transfusions, including the cost of whole blood, the administration of blood, blood processing and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   f. Drugs and medicines (except drugs not used or consumed in the hospital);
   g. X-ray and diagnostic laboratory procedures and services;
   h. Oxygen and other gas therapy and the administration thereof;
   i. Therapy services.

3. Services, supplies and treatments described above furnished by an ambulatory surgical facility, including follow-up care provided within seventy-two (72) hours of a procedure.

4. Charges for preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a hospital admission which are related to the condition which is necessitating the confinement. Such tests shall be payable even if they result in additional medical treatment prior to confinement or if they show that hospital confinement is not medically necessary. Such tests shall not be payable if the same tests are performed again after the covered person has been admitted.

FACILITY PROVIDERS

Services of facility providers if such services would have been covered if performed in a hospital or ambulatory surgical facility.

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

Covered expenses shall include:

1. Ambulance services for air or ground transportation for the covered person from the place of injury or serious medical incident to the nearest hospital where treatment can be given.
2. Ambulance service is covered in a non-emergency situation only to transport the covered person to or from a hospital or between hospitals for required treatment when such treatment is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.

3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

Benefits for ambulance service are subject to a per occurrence deductible as specified on the Schedule of Benefits.

**EMERGENCY SERVICES/EMERGENCY ROOM**

Coverage for emergency room treatment (facility charges) are subject to copay per occurrence as described on the Schedule of Benefits, provided the condition meets the definition of emergency herein. If emergency room services are used for treatment of a non-emergency medical condition, the facility charges for such treatment shall not be considered a covered expense. Physician charges are subject to the benefits noted in the Benefit Description.

**PHYSICIAN SERVICES**

Covered expenses shall include:

1. Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, home visits.

2. Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.

   For related operations or procedures performed through the same incision or in the same operative field, covered expenses shall include the surgical allowance for the highest paying procedure, plus fifty (50) percent of the surgical allowance for each additional procedure.

   When two (2) or more unrelated operations or procedures are performed at the same operative session, covered expenses shall include the surgical allowance for each procedure.

3. Surgical assistance provided by a physician if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance.

4. Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.

5. Consultations requested by the attending physician during a hospital confinement. Consultations do not include staff consultations, which are required by a hospital's rules and regulations.

6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.

7. Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

8. Allergy testing consisting of percutaneous, intracutaneous and patch tests.
SECOND SURGICAL OPINION

1. Benefits for a second surgical opinion will be payable according to the Schedule of Benefits if an elective surgical procedure (non-emergency surgery) is recommended by the physician.

2. The physician rendering the second opinion regarding the medical necessity of such surgery must be a board certified specialist in the treatment of the covered person's illness or injury and must not be affiliated in any way with the physician who will be performing the actual surgery.

3. In the event of conflicting opinions, a request for a third opinion may be obtained. The Plan will consider payment for a third opinion the same as a second surgical opinion.

4. The second surgical benefit includes physician services only. Any diagnostic services will be payable under the standard provisions of the Plan.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, and x-ray.

IMAGING SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for Magnetic Resonance Imaging (MRI) and Computed Tomography (CT scan).

ORGAN TRANSPLANT PROGRAM

Refer to Appendix A for information about transplant coverage.

PREGNANCY

Covered expenses for pregnancy or complications of pregnancy shall be provided for a covered female employee or a covered female spouse of a covered employee.

The Plan shall cover services, supplies and treatments for medically necessary abortions when the life of the mother would be endangered by continuation of the pregnancy, or when the fetus has a known condition incompatible with life or when the pregnancy is the result of rape or incest.

Complications from an abortion for the covered female employee or a covered female spouse of an employee shall be a covered expense whether or not the abortion is a covered expense.

BIRTHING CENTER

Covered expenses shall include services, supplies and treatments rendered at a birthing center provided the physician in charge is acting within the scope of his license and the birthing center meets all legal requirements. Services of a midwife acting within the scope of his license or registration are a covered expense provided that the state in which such service is performed has legally recognized midwife delivery.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered employee or covered spouse. Reversal of sterilization is not a covered expense.
FAMILY PLANNING

Covered expenses shall include family planning expenses for infertility testing, and infertility treatment for employees and their covered spouse. Covered expenses for infertility testing and treatment include the actual testing for a diagnosis of infertility, treatment (including prescription drugs) and outside intervention procedures (e.g. artificial insemination, invitro fertilization).

Treatment of infertility shall be subject to the maximum benefit as shown on the Schedule of Benefits.

WELL NEWBORN CARE

The Plan shall cover well newborn care. Such care shall include, but is not limited to:

1. Physician services.
2. Hospital services.
3. Circumcision.

WELL CHILD CARE (birth through age 16)

Covered expenses for well childcare are available for all covered dependent children from birth through age 16. Covered expenses include well baby/well child check-up examinations, routine laboratory, x-rays, immunizations and vaccines (including the HPV vaccine for females ages 9-16) and other services as required under the Patient Protection Affordable Care Act (PPACA), which is subject to change.

ROUTINE ADULT WELLNESS BENEFITS

Routine adult wellness benefits (provided to all covered person age seventeen (17) or older) include routine examinations services such as physical check-up; gynecological examination, Papanicolaou test (Pap Smear); screening mammograms; prostate examination; routine laboratory tests, x-rays, immunizations, HPV vaccine for females ages 17-26 and other services as required under the Patient Protection Affordable Care Act (PPACA), which is subject to change, including coverage for tobacco use counseling and evidence-based tobacco cessation interventions; and expanded Women’s Preventive Care Services which will include:

Well-woman visits: This would include an annual well-woman preventive care visit for adult women to obtain the recommended preventive services, and additional visits if women and their health care providers determine they are necessary.

Gestational diabetes screening: This screening is for women 24 to 28 weeks pregnant, and those at high risk of developing gestational diabetes.

HPV DNA testing: Women who are 30 or older will have access to high-risk human papillomavirus (HPV) DNA testing every three years, regardless of Pap smear results.

STI counseling: Sexually-active women will have access to annual counseling on sexually transmitted infections (STIs).

HIV screening and counseling: Sexually-active women will have access to annual counseling on HIV.

Contraception and contraceptive counseling: Women will have access to all Food and Drug Administration-approved contraceptive methods, sterilization procedures, and patient education and counseling.

Breastfeeding support, supplies, and counseling: Pregnant and postpartum women will have access to comprehensive lactation support and counseling from trained providers, as well as breastfeeding equipment.

Interpersonal and domestic violence screening and counseling: Screening and counseling for interpersonal and domestic violence should be provided for all adolescent and adult women.

OUTPATIENT THERAPY SERVICES

Outpatient therapy services are subject to pre-certification and must be ordered by a physician to aid restoration of normal function lost due to illness or injury, for congenital anomaly, or for prevention of continued deterioration of function. Covered expenses shall include:
1. Services of a professional provider for physical therapy.

2. Services of a professional provider for Occupational therapy.

3. Services of a professional provider for Speech therapy. Therapy must be ordered by a physician and follow either:
   a. surgery for correction of a congenital anomaly of the oral cavity, throat or nasal complex (other than a frenectomy);
   b. an injury; or
   c. an illness other than a learning, mental, or functional nervous disorder.

4. Respiratory therapy.

5. Radiation therapy and chemotherapy.
7. Infusion Therapy.

EXTENDED CARE FACILITY

Extended care facility confinement is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits. Extended care facility benefits are limited as shown the Schedule of Benefits.

Extended care facility services, supplies and treatments shall be a covered expense provided:

1. The attending physician recommends extended care confinement for a convalescence from a condition which caused that hospital confinement, or a related condition; and

2. The covered person is under a physician's continuous care and the physician certifies that the covered person must have twenty-four (24) hours-per-day nursing care.

Covered expenses shall include:

1. Room and board (including regular daily services, supplies and treatments furnished by the extended care facility) limited to the facility's average semiprivate room rate; and

2. Other services, supplies and treatment ordered by a physician and furnished by the extended care facility for inpatient medical care.

HOME HEALTH CARE

Home health care is subject to pre-certification. Failure to obtain pre-certification shall result in a reduction of benefits.

Home health care enables the covered person to receive treatment in his home for an illness or injury instead of being confined in a hospital or extended care facility. Covered expenses shall include:

1. Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;

2. Physical, respiratory, occupational or speech therapy;

3. Part-time or intermittent home health aide services for a covered person who is receiving covered nursing or therapy services;

4. Medical social service consultations;

5. Nutritional guidance by a registered dietitian and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.

The requirement that these services must follow or be in lieu of a hospital admission will not apply if the service is a medically appropriate treatment for a covered condition that does not require an acute care hospital admission.

Covered expenses shall be subject to the maximum benefit specified on the Schedule of Benefits. A visit by a member of a home health care team will be considered one (1) home health care visit.

No home health care benefits will be provided for homemaker services (except as may be specifically provided herein), maintenance therapy, dialysis treatment, food or home delivered meals, rental or purchase of durable medical equipment, prescriptions or non-prescription drugs, or biologicals.
**HOSPICE CARE**

*Hospice* care is subject to pre-certification. **Failure to obtain pre-certification shall result in a reduction of benefits.**

*Hospice* care is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in facility settings for a **covered person** suffering from a condition that has a terminal prognosis.

*Hospice* benefits will be covered only if the **covered person's** attending **physician** certifies that:

1. The **covered person** is terminally ill, and
2. The **covered person** has a life expectancy of six (6) months or less.

**Covered expenses** shall include:

1. **Confinement** in a hospice to include ancillary charges and room and board.
2. Services, supplies and treatment provided by a hospice to a **covered person** in a home setting.
3. **Physician** services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.
4. Physical therapy, occupational therapy, speech therapy or respiratory therapy.
5. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be **medically necessary**.
6. Counseling services provided through the hospice.

*Hospice* benefits are limited to the **maximum benefit** as stated on the *Schedule of Benefits*.

Charges **incurred** during periods of remission are not eligible under this provision of the **Plan**. Any **covered expense** paid under hospice benefits will not be considered a **covered expense** under any other provision of this **Plan**.

**DURABLE MEDICAL EQUIPMENT**

Rental or purchase, whichever is less costly, of **medically necessary durable medical equipment** which is prescribed by a **physician** and required for therapeutic use by the **covered person** shall be a **covered expense**. Repair or replacement of purchased **durable medical equipment** which is **medically necessary** due to normal use or growth of a child will be considered a **covered expense**. Maintenance contracts for purchased equipment will be considered a **covered expense**.

Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the **covered person's** condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the **covered person's** medical needs.
**PROSTHESSES**

The initial purchase of a prosthesis (other than dental) provided for functional reasons when replacing all or part of a missing body part (including contiguous tissue) or to replace all or part of the function of a permanently inoperative or malfunctioning body organ shall be a **covered expense**. Repair or replacement of a prosthesis, which is **medically necessary**, due to normal use or growth of a child will be considered a **covered expense**. Maintenance contracts for purchased prosthetics will be considered a **covered expense**.

**ORTHOTICS**

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall be a **covered expense**. Orthopedic shoes or corrective shoes, unless they are an integral part of a leg brace, and other supportive devices for the feet shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless growth and development of a child necessitates earlier replacement.

**DENTAL SERVICES**

**Covered expenses** shall include repair of sound natural teeth or surrounding tissue provided it is the result of an **injury**. Treatment must made within twelve (12) months of the date of such **injury**. Damage to the teeth as a result of chewing or biting shall not be considered an **injury** under this benefit. **Covered expenses** shall also include hospital charges **incurred** if the **covered person** receives covered dental treatment in a **hospital** setting due to **medical necessity**.

**TEMPOROMANDIBULAR JOINT DYSFUNCTION**

Surgical and nonsurgical treatment of temporomandibular joint (TMJ), myofascial pain syndrome or orthognathic treatment shall be a **covered expense**. This benefit will include orthodontia or prosthetic devices prescribed by a **physician** or dentist.

If a **physician** or **dentist** recommends a course of treatment for or in connection with TMJ, myofascial pain syndrome or orthognathic treatment, a **covered person** may submit the treatment plan, including x-rays and study models, for predetermination of benefits under the **Plan**. A written predetermination of benefits is suggested before any course of treatment is started to ensure the proposed treatments will be considered **medically necessary covered expenses**. Oral surgery will only be approved after a demonstrated course of conservative treatment has been attempted.

When a written predetermination of benefits is requested by the **covered person**, the **claims processor** will determine if the treatment is a **covered expense** and will notify the **covered person** in writing.

Benefits for treatment of temporomandibular joint (TMJ), myofascial pain syndrome or orthognathic treatment are limited to the **maximum benefit** as stated on the **Schedule of Benefits**.

**SPECIAL EQUIPMENT AND SUPPLIES**

**Covered expenses** shall include **medically necessary** special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; diabetic blood sugar measurement devices; allergy serums; crutches; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of **illness** or **injury** of the eye; support stockings, such as Jobst stockings, surgical dressings and other medical supplies ordered by a **professional provider** in connection with medical treatment, but not common first aid supplies.
COSMETIC SURGERY

Cosmetic surgery or reconstructive surgery shall be a covered expense provided:

1. A covered person receives an injury as a result of an accident and as a result requires surgery. Cosmetic or reconstructive surgery and treatment must be for the purpose of restoring the covered person to his normal function immediately prior to the accident.

2. It is required to correct a congenital anomaly, for example, a birth defect.

MASTECTOMY (WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998)

This Plan intends to comply with the provisions of the federal law known as the Women's Health and Cancer Rights Act of 1998.

Covered expenses will include eligible charges related to medically necessary mastectomy.

For a covered person who elects breast reconstruction in connection with such mastectomy, covered expenses will include:

1. reconstruction of a surgically removed breast; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance.
3. Prostheses (and medically necessary replacements) and physical complications from all stages of mastectomy, including lymphedemas will also be considered covered expenses following all medically necessary mastectomies.

MENTAL AND NERVOUS DISORDERS

Inpatient or Partial Confinement

Subject to the pre-certification provisions of the Plan, the Plan will pay the applicable coinsurance, as shown on the Schedule of Benefits, for confinement or partial confinement in a hospital or treatment center for services, supplies and treatment related to the treatment of mental and nervous disorders. Two days of partial confinement will be considered as one day of inpatient confinement.

Covered expenses shall include:

1. Inpatient hospital confinement;
2. Individual psychotherapy;
3. Group psychotherapy;
4. Psychological testing; and
5. Electro-Convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional provider.

Outpatient

The Plan will pay the applicable coinsurance, as shown on the Schedule of Benefits, for outpatient services, supplies and treatment related to the treatment of mental and nervous disorders.
CHEMICAL DEPENDENCY

The Plan will pay for the treatment of chemical dependency as shown on the Schedule of Benefits, subject to the noted benefit limitations. Benefits shall be payable for inpatient or outpatient treatment in a hospital or treatment center by a physician or professional provider. Inpatient or partial confinement care is subject to pre-certification requirements of the plan. Two days of partial confinement will be considered as one day of inpatient confinement.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or debridement of infected toenails, surgical removal of nail root, and treatment of fractures or dislocations of bones of the foot.

CHIROPRACTIC CARE

Covered expenses include initial consultation, x-rays and treatment (but not maintenance care), subject to the maximum benefit shown on the Schedule of Benefits.

PATIENT EDUCATION

Covered expenses shall include medically necessary patient education programs including, but not limited to diabetic education and ostomy care.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a professional provider; physician; hospital; facility or any other health care provider shall be a covered expense under the terms of the Plan.

OUTPATIENT CARDIAC/PULMONARY REHABILITATION PROGRAMS

Covered expenses shall include charges for medically necessary outpatient cardiac/pulmonary rehabilitation programs.

INJURY OR ILLNESS ARISING OUT OF EMPLOYMENT (FELA EMPLOYEES ONLY)

Covered expenses include charges incurred due to injury or illness arising out of employment for employees governed by the Federal Employers Liability Act (FELA). This coverage does not apply to persons enrolled as Non-FELA employees or to dependents of any employee covered under this Plan.
**MEDICAL EXCLUSIONS**

In addition to *Plan Exclusions*, no benefit will be provided under this *Plan* for medical expenses for the following:

1. Charges for *pre-existing conditions* as specified in *Pre-existing Conditions* and *Certificates of Coverage*.
2. Charges for services, supplies or treatment for the reversal of sterilization procedures.
3. Charges for services, supplies or treatment related to infertility testing, treatment or artificial reproductive procedures in excess of the *maximum benefit* noted on the *Schedule of Benefits*.
4. Charges for services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
5. Charges for treatment or surgery for sexual dysfunction.
6. Charges for *hospital* admission on Friday, Saturday or Sunday unless the admission is an *emergency* situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, *hospital* expenses will be payable commencing on the date of actual surgery.
7. Charges for *inpatient room and board* in connection with a *hospital confinement* primarily for diagnostic tests, unless it is determined by the *Plan* that *inpatient* care is *medically necessary*.
8. Charges for services, supplies or treatment for behavior or conduct disorders, development delay, hyperactivity, learning disorders, mental retardation, autistic disease, or senile deterioration. However, the initial examination, office visit and diagnostic testing to determine the *illness* shall be a *covered expense*.
9. Charges for biofeedback therapy.
10. Charges for services, supplies or treatments which are primarily educational in nature; except as specified in *Medical Expense Benefit, Patient Education*; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
11. Charges for marital counseling in excess of the maximum number of visits noted on the *Schedule of Benefits*.
12. Except as specifically stated in *Medical Expense Benefit, Dental Services* or *Temporomandibular Joint Dysfunction*, charges for or in connection with: treatment of *injury* or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.
13. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under *Medical Expense Benefit, Special Equipment and Supplies*; dispensing optician's services.
14. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as nearsightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.
15. Except as *medically necessary* for the treatment of metabolic or peripheral-vascular *illness*, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat,
strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.

16. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a physician, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages, non-hospital adjustable beds, exercise equipment.

17. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.

18. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost is included in the orthotist's charge).

19. Expenses for a cosmetic surgery or procedure and all related services, except as specifically stated in Medical Expense Benefit, Cosmetic Surgery.

20. Charges incurred as a result of, or in connection with, any procedure or treatment excluded by this Plan which has resulted in medical complications.

21. Charges incurred as a result of, or in connection with, the pregnancy of a dependent child.

22. Charges for services provided to a covered person for an elective abortion (See Pregnancy for specifics regarding the coverage of abortions). However, complications from such procedure shall be a covered expense for a covered female employee or the covered female spouse of an employee.

23. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and hospital confinements for weight reduction programs.

24. Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity.

25. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid.


27. Charges for custodial care, domiciliary care or rest cures.

28. Charges for travel or accommodations, whether or not recommended by a physician, except as specifically provided herein.

29. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise - used to eliminate baldness or stimulate hair growth.

30. Charges for expenses related to hypnosis.

31. Charges for prescription drugs that are covered under the Prescription Drug Program or for the Prescription Drug copay applicable thereto. Outpatient prescription drugs are paid under the Prescription Drug Program and under no other provision of this Plan.

32. Charges for professional services billed by a physician or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a hospital or any other facility and who is paid by the hospital or other facility for the service provided.

33. Charges for environmental change including hospital or physician charges connected with prescribing an environmental change.
34. Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example.)

35. Charges for any services, supplies or treatment not specifically provided herein.

36. Charges for hospital emergency room care when the emergency room is used in a non-emergency situation.

37. Charges for private duty nursing.
**PRESCRIPTION DRUG PROGRAM**

**PHARMACY OPTION**

*Participating pharmacies* have contracted with the *Plan* to charge *covered persons* reduced fees for covered prescription drugs.

**Copay**

The *copay* is applied to each covered pharmacy drug charge and is shown on the *Schedule of Benefits*. The *copay* amount is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to a thirty (30) day supply.

If a drug is purchased from a *participating pharmacy* when the *covered person*’s ID card is not used, the *covered person* must pay the entire cost of the prescription, including *copay*, and then submit the receipt to the prescription drug card vendor for reimbursement. If a drug is purchased from a *nonparticipating pharmacy*, the *covered person* is responsible for the entire cost of the prescription. The Plan will not reimburse *nonparticipating pharmacy* charges under the Prescription Drug Plan, nor under the Medical Expense Benefit.

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the *generic drug* and the brand name requested, plus the usual *copay*.

**MAIL ORDER OPTION**

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.).

If the *covered person* purchases a brand name drug when the *physician* has indicated a *generic drug* can be dispensed, the *covered person* will be required to pay the difference between the *generic drug* and the brand name requested, plus the usual *copay*.

**Copay**

The *copay* is applied to each covered mail order prescription charge and is shown on the *Schedule of Benefits*. It is not a *covered expense* under the *Medical Expense Benefit*. Any one prescription is limited to a ninety (90) day supply.

**COVERED PRESCRIPTION DRUGS**

1. Drugs prescribed by a *physician* that require a prescription either by federal or state law, except injectables (other than insulin) and drugs excluded by the *Plan*.

2. Compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.

3. Insulin, insulin needles and syringes and diabetic supplies.
LIMITS TO THIS BENEFIT

This benefit applies only when a *covered person incurs* a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

1. Refills only up to the number of times specified by a *physician*.
2. Refills up to one year from the date of order by a *physician*.

EXPENSES NOT COVERED

1. A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin.
2. Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
3. Immunization agents or biological sera, blood or blood plasma.
4. A drug or medicine labeled: “Caution - limited by federal law to investigational use.”
5. Experimental drugs and medicines, even though a charge is made to the *covered person*, including DESI drugs (drugs determined by the FDA as lacking substantial evidence of effectiveness).
6. Any charge for the administration of a covered prescription drug.
7. Any drug or medicine that is consumed or administered at the place where it is dispensed.
8. A drug or medicine that is to be taken by the *covered person*, in whole or in part, while *hospital confined*. This includes being confined in any institution that has a facility for dispensing drugs.
9. A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
10. A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin).
11. A charge for infertility medication. Refer to *Medical Expense Benefit, Family Planning*, for information about coverage of infertility medications.
12. A charge for legend vitamins, except pre-natal legend vitamins.
15. A charge for minoxidil.
19. A charge for weight loss drugs.

20. A charge for Tretinoin, all dosage forms, when used for cosmetic purposes.

21. A charge for non-legend drugs, other than as specifically listed herein.

22. A charge for Levonorgestrel (Norplant implants).

23. A charge for Hematinics.

24. Impotence medication.

Note that drugs which are currently excluded under the Plan due to experimental/investigational status will be considered eligible expenses if and when the drug receives approval for general use by the Food and Drug Administration (FDA), subject to general Plan provisions and limitations.

NOTICE OF AUTHORIZED REPRESENTATIVE

The covered person may provide the plan administrator or their designee with a written authorization for an authorized representative to represent and act on behalf of a covered person and consent to release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

APPEALING A DENIED PRESCRIPTION DRUG CLAIM

The “named fiduciary” for purposes of an appeal of a denied Prescription Drug Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

A covered person, or the covered person’s authorized representative, may request a review of a denied claim by making written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered person feels the claim should not have been denied.

The following describes the review process and rights of the covered person:

1. The covered person has a right to submit documents, information and comments.

2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.

3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.

4. The review by the named fiduciary will not afford deference to the original denial.

5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.

6. If original denial was, in whole or in part, based on medical judgment:
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The professional provider utilized by the named fiduciary will be neither:
i. An individual who was consulted in connection with the original denial of the claim, nor
ii. A subordinate of any other professional provider who was consulted in connection with the
original denial.

7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in
connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION ON APPEAL

The plan administrator or their designee shall provide the covered person (or authorized representative) with a written
notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.

2. Reference to specific Plan provisions on which the denial is based.

3. A statement that the covered person has the right to access, free of charge, relevant information to the
claim for benefits.

4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil

5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal
Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

6. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or
limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant’s
medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
DENTAL EXPENSE BENEFIT

Subject to all the terms of the Plan, the Plan will pay a dental benefit for covered dental expenses. The dental benefit is a percentage of the customary and reasonable amount for covered dental expenses, as shown on the Schedule of Benefits.

LATE ENROLLMENT

Coverage for dental expense benefits will be subject to this late enrollment provision if the employee fails to enroll himself and/or his eligible dependents within thirty-one (31) days of becoming eligible for coverage or during a Special Enrollment period.

Late enrollment shall result in dental coverage being limited as follows:

1. Basic and Major dental services will not be covered during the first twelve (12) months of coverage under the Plan. Coverage for basic and major dental expenses shall commence on the first day of the month following completion of twelve (12) months of coverage for preventive dental expenses.

2. Orthodontic care will not be covered for the first twenty-four (24) months of coverage under the Plan. Coverage for orthodontic expenses shall commence on the first day of the month following completion of twenty-four (24) months of coverage for preventive dental expenses and twelve (12) months of coverage for basic and major dental expenses.

However, the late enrollment provision will not apply if the employee enrolls an eligible dependent for coverage within thirty-one (31) days of termination of dental coverage under another employer sponsored dental plan because the dependent is no longer eligible for coverage under that plan.

DEDUCTIBLE

Individual Deductible

The individual deductible is the dollar amount of covered expense which each covered person must incur during each calendar year before the Plan pays applicable benefits. The individual deductible amount is shown on the Schedule of Benefits.

Family Deductible

If, in any calendar year, covered members of a family incur covered expenses that are subject to the deductible that are equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, then the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The Plan pays a specified percentage of the customary and reasonable amount for covered expenses. That percentage is listed on the Schedule of Benefits. The covered person is responsible for the difference.
**MAXIMUM BENEFIT**

The maximum calendar year benefit payable on behalf of a **covered person** for covered dental expense is stated on the *Schedule of Benefits*. If the **covered person**'s coverage under the **Plan** terminates and he subsequently returns to coverage under the **Plan** during the calendar year, the maximum benefit will be calculated on the sum of benefits paid by the **Plan**.

The **maximum benefit** for orthodontic treatment while a **covered person** is covered by this **Plan** is also shown on the *Schedule of Benefits*. If the **covered person** receives more than one course of orthodontic treatment while covered by this **Plan** and if it can be clearly shown that any later course of treatment is not a part of a previous course of treatment, then the **covered person** will be entitled to a separate **maximum benefit** for each course of treatment.

**ALTERNATIVE TREATMENT**

In the event the **dentist** recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the **covered person's** choice to obtain the higher-cost treatment will be the **covered person's** responsibility.

**DENTAL INCURRED DATE**

A dental procedure will be deemed to have commenced on the date the covered dental expense is **incurred**, except as follows:

1. For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
2. For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
3. For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the **claims processor** will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be **incurred** as each visit or treatment is completed.

**COVERED DENTAL EXPENSES**

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

**Class I Diagnostic and Preventive Dental Services**

1. Routine oral examination: Initial or periodic, limited to twice per calendar year.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per calendar year.
3. Dental x-rays as follows:
   a. Supplementary bite-wing x-rays, limited to twice per calendar year.
   b. Panorex or full mouth series limited to once every thirty-six (36) months.
   c. Other dental x-rays necessary for the diagnosis of a specific condition requiring treatment.
4. Topical application of fluoride for dependent children through the age of seventeen (17), limited to two treatments per calendar year.

5. Topical application of sealant to permanent posterior teeth, for dependent children through the age of seventeen (17), limited to one treatment per tooth every thirty-six (36) months.

Class II Basic Dental Services

1. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited to dependent children through the age of seventeen (17). This does not include space maintainers used in orthodontics to create a space between teeth.

2. Emergency palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

3. Sedative fillings covered as a separate procedure only if no other service (except x-rays) is rendered during the visit.

4. Restorations (fillings) to restore teeth to normal function, using amalgam, silicate, acrylic, synthetic, and composite filling materials to restore teeth broken down by decay or injury. Composite fillings are covered only for teeth in front of the first bicuspid.

5. Periodontics, including but not limited to the following:
   a. Gingivectomy/gingivoplasty, gingival curettage, gingival flap procedure or mucogingival surgery
   b. Scaling and root planing limited to twice per quadrant in any calendar year.
   c. Pedicle and free soft tissue grafts, and vestibuloplasty.
   d. Occlusal adjustment, excluding charges for TMJ. Refer to Medical Expense Benefits, Temporomandibular Joint Dysfunction for information about coverage of TMJ.
   e. Excision of pericoronal gingiva.
   f. Periodontal prophylaxis, limited to twice per calendar year with proof of previous periodontal treatment.
   g. Osseous surgery.

6. Endodontics including but not limited to the following:
   b. Pulpotomy.
   c. Root canal therapy.
   d. Apicoectomy.
   e. Hemisection.
   f. Retrograde fillings.

7. Oral surgery (including customary postoperative treatment furnished in connection with oral surgery), including but not limited to the following:
   a. Simple extraction of one or more teeth.
   b. Surgical extraction of erupted teeth and of soft tissue, partially bony, and completely bony impacted teeth.
   c. Extraction of tooth root.
   d. Incision and drainage of a tumor or a cyst.
   e. Alveolectomy, alveoloplasty, and frenectomy.
   f. Exostosis or hyperplastic tissue and excision of oral tissue for biopsy.
   g. Re-implantation or transplantation of a natural tooth.
   h. General anesthesia, only when provided in conjunction with a surgical procedure.
8. Bacteriologic cultures in connection with a covered dental service.
9. Therapeutic injections of antibiotics administered by a dentist.
10. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined during the past twelve (12) months.
11. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased during the past thirty-six (36) months.
12. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the initial insertion of the denture.
13. Specialist consultations and specialty examinations provided the covered person has been referred by a general dentist. These consultations and examinations are not restricted to the limitations for routine oral exams.

Class III Major Dental Expenses
1. Repairs and adjustments to full or partial dentures.
2. Repair or recementing of crowns, inlays, onlays or bridgework.
3. Post and core on permanent teeth only.
4. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement.
5. Porcelain Restorations: Covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement.
6. Crowns: Covered only when the tooth cannot be restored by an basic restoration, and then only if at least five (5) consecutive years have lapsed since the last placement. Crowns used to treat temporomandibular joint dysfunction will not be covered.
7. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth that have been extracted.
8. Removable bridge, partial or complete dentures to replace one (1) or more natural teeth that have been extracted.
9. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth. However, only replacement or additions that meet the "Prosthesis Replacement Rule" below will be covered.
10. Complete dentures.
Prosthesis Replacement Rule

The Prosthesis Replacement Rule requires that replacements or additions to existing dentures or bridgework will be covered only if satisfactory evidence is furnished that one of the following services applies:

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed.
2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

Covered expenses for a both a temporary and permanent prosthesis will be limited to the charge for the permanent prosthesis.

Class IV Orthodontic Services (for Dependent Children age 6 through age 18 only)

1. Active appliances. Includes diagnostic services, the treatment plan, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
3. Fixed or cemented appliance to control harmful habits.

The following provisions apply to Class IV Orthodontic Services:

1. The plan's obligation to make monthly or other periodic payments for an orthodontia treatment plan begun prior to the covered person's effective date of coverage begins with the first payment due after the covered person has been enrolled in the plan for one month. The maximum amount payable by the plan for orthodontia will apply fully to this and subsequent payments.
2. The plan's obligation to make monthly or other periodic payments for an orthodontia treatment plan stops on the payment due date next following the earlier of: termination of treatment for any reason prior to completion of the case; the date the covered person is no longer eligible for plan coverage; or the termination date of the plan.
3. X-rays and extraction procedures incidental to orthodontia are not covered under the Class IV Orthodontic Services benefit but may be covered under Class I or Class II Dental services, or as a medical expense if applicable.
4. Plan benefits are payable over a period not to exceed the length of the approved treatment plan. The initial payment will be equal to no more than 35% of the total benefit payable by the plan. The remaining 65% of the benefit will be payable in equal monthly installments during the period covered by the approved treatment plan and while the covered person's coverage is in effect. If the treatment plan is satisfactorily completed in less than the period specified in the approved treatment plan, the remaining benefit will be paid after the appropriate notification from the orthodontist.
5. Predetermination of benefits is required for all orthodontic services.
**DENTAL EXCLUSIONS**

In addition to the *Plan Exclusions*, no benefit will be provided under this *Plan* for dental expenses *incurred* by a *covered person* for the following:

1. Replacement of duplicate, lost, missing or stolen appliances or prosthetic devices;
2. Charges for all services, supplies and treatment related to dental implants
3. Any procedure not listed under *Covered Dental Expense*.
4. Any procedure which began before the date the *covered person's* dental coverage started, to include a service which is:
   a. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
   b. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
   c. Root canal therapy, for which the pulp chamber was opened before such person became covered.

X-rays and prophylaxis shall not be deemed to start a dental procedure.

5. Services, supplies or treatment that are cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.

6. Surgical services with respect to congenital or developmental malformations that do not interfere with function. These conditions include: cleft palate, mandibular prognathism, enamel hypoplasia, fluorosis, and anodontia.

7. Appliances, restoration or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, except as provided under *Orthodontic Services*.

8. A service not furnished by a *dentist*, except:
   a. Services performed by a licensed dental hygienist under a *dentist's* supervision;
   b. X-rays ordered by a *dentist*; and
   c. Denturist.

9. Replacement of a prosthetic which in the dentist's opinion can be repaired or does not need replacement.

10. A posterior fixed prosthetic appliance when done in connection with a removable appliance in the same arch.

11. Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.

12. Charges resulting from changing from one dentist to another while receiving treatment, or resulting from receiving care from more than one dentist for one dental procedure, to the extent that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.

13. Charges for precision attachments, semi-precision attachments, instruction in dental plaque control, dental hygienics, or nutritional counseling.
14. Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called. Refer to *Medical Expense Benefits, Temporomandibular Joint Dysfunction* for information about coverage of TMJ.

15. Charges for adjustments of new dentures within six (6) months of installation.

16. Charges for failure to keep a scheduled visit with a *dentist*. 
PLA N EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.

2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.

3. Charges for services, treatment or supplies for treatment of illness or injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.

4. Charges incurred by a non-FELA employee, or a dependent of any employee covered under this Plan, as a result of any condition for which benefits of any nature are payable or are found to be eligible, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the non-FELA employee, or covered dependent, fails to claim rights to such benefits or fails to enroll or purchase such coverage. This exclusion does not apply to charges incurred by a FELA employee covered under the plan.

5. Charges incurred by a non-FELA employee, or a dependent of any employee covered under this Plan, in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment. This exclusion does not apply to charges incurred by an FELA employee covered under the plan.

6. Charges made for services, supplies and treatment which are not medically necessary for the treatment of illness or injury, or which are not recommended and approved by the attending physician, except as specifically stated herein, or to the extent that the charges exceed customary and reasonable amount or exceed the negotiated rate as applicable.

7. Charges for treatment of any intentionally self-inflicted illness or injury, unless the injury or illness results from a medical condition (physical or mental).

8. Charges in connection with any illness or injury of the covered person resulting from or occurring during commission or attempted commission of a criminal battery or felony by the covered person if the covered person is charged with such crime.

9. To the extent that payment under this Plan is prohibited by any law of any jurisdiction in which the covered person resides at the time the expense is incurred.

10. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a person's coverage.

11. Any services, supplies or treatment for which the covered person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.

12. Charges for services, supplies or treatment that are considered experimental/investigational.
13. Charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

14. Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person.

15. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.

16. Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in Subrogation.

17. Claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.

18. Charges for telephone consultations, completion of claim forms, charges associated with missed appointments.

19. This Plan will not pay for any charge which has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.

20. Benefits which are payable under any one section of this Plan shall not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical Expense Benefit section and the Dental Expense Benefit section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Dental Expense Benefit.
ELIGIBILITY, ENROLLMENT AND EFFECTIVE DATE

This section identifies the Plan's requirements for a person to participate in the Plan.

EMPLOYEE ELIGIBILITY

All full-time employees regularly scheduled to work at least thirty-two (32) hours per work week shall be eligible to enroll for coverage under this Plan. This does not include temporary or seasonal employees.

Note that employees governed by the Federal Employers Liability Act (FELA employees) are treated as active, full-time employees, for up to 36 months, during a period of disability resulting from an injury or illness incurred in the course of employment.

EMPLOYEE ENROLLMENT

An employee must file a written application with the employer for coverage hereunder for himself within thirty-one (31) days of becoming eligible for coverage. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

EMPLOYEE(S) EFFECTIVE DATE

Eligible employees, as described in Eligibility, are covered under the Plan as follows:

1. FELA Employees - Employees governed by the Federal Employers Liability Act (FELA) are covered under the Plan of the first day of full-time employment. For the purpose of this Plan, these employees will be referred to as FELA employees.

2. Non-FELA Employees - Employees that are not governed by the Federal Employers Liability Act (FELA) are covered under the Plan of the first day of the month coincident with or following completion of sixty (60) days of full-time employment. For the purpose of this Plan, these employees will be referred to as non-FELA employees.

DEPENDENT(S) ELIGIBILITY

The following describes dependent eligibility requirements. The employer will require proof of dependent status.

A Dependent is any one of the following persons:

1. A covered Employee’s Spouse.
2. Children from birth to the limiting age of 26 years.

The term "Spouse" means the spouse of the employee under a legally valid existing marriage between two person’s unless court ordered separation exists. The Plan Administrator may require documentation proving a legal marital relationship.

The term "Children" shall include natural children, adopted children, Foster children or children placed with a covered Employee in anticipation of adoption. Step-children who reside in the Employee’s household may also be included as long as a natural parent remains married to the Employee and also resides in the Employee’s household. An Employee’s Child will be an eligible Dependent until reaching the limiting age of 26, without regard to student status, marital status, financial dependency or residency status with the Employee or any other person. When the child reaches the applicable limiting age, coverage will end on the child’s birthday.
3. An eligible child shall also include any other child of an employee or their spouse who is recognized in a qualified medical child support order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the employee's household. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage regardless of whether the employee elects coverage for himself. An application for enrollment must be submitted to the employer for coverage under this Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is a QMCSO and for administering the provision of benefits under the Plan pursuant to a valid QMCSO. The employer/plan administrator reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.

4. A child who is unmarried, incapable of self-sustaining employment, and dependent upon the employee for support due to a mental and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or due to other loss of dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost.

Proof of incapacitation must be provided within thirty-one (31) days of the child's loss of eligibility and thereafter as requested by the employer or claims processor, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:

a. Cessation of the mental and/or physical disability;

b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

Every eligible employee may enroll eligible dependents. However, if both the husband and wife are employees, each individual will be covered as an employee. An employee cannot be covered as an employee and a dependent. Eligible children may be enrolled as dependents of one spouse, but not both.

**DEPENDENT ENROLLMENT**

An employee must file a written application with the employer for coverage hereunder for his eligible dependents within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

**DEPENDENT(S) EFFECTIVE DATE**

Eligible dependent(s), as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty-one (31) days of meeting the Plan's eligibility requirements.

1. The first of the month coincident with or following the employee's completion of sixty (60) days of fulltime employment. Note that the sixty (60) day eligibility waiting period applies to dependents of all employees (FELA and non-FELA employees).

2. The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty-one (31) days of the date acquired.

3. Newborn children will be considered a dependent under this Plan for thirty (30) days immediately following birth. For coverage under the Plan for the newborn beyond that date, the employee must submit an application for enrollment within thirty-one (31) days of birth.

4. Coverage for a newly or to be adopted child shall be effective on the date the child is placed for adoption.
**SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)**

An employee or dependent who did not enroll for coverage under this Plan because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

1. Termination of the other coverage (including exhaustion of COBRA benefits)
2. Cessation of employer contributions toward the other coverage
3. Legal separation or divorce
4. Termination of other employment or reduction in number of hours of other employment
5. Death of dependent or spouse.

The end of any extended benefits period which has been provided due to any of the above will also be considered a loss of eligibility.

However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis or termination of coverage for cause (such as making a fraudulent claim or an intentional misrepresentation of a material fact in connection with the other coverage.)

The employee or dependent must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the plan administrator's receipt of the completed enrollment form.

**SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)**

An employee who is not covered under the Plan, but who acquires a new dependent may request a special enrollment period. For the purposes of this provision, the acquisition of a new dependent includes:

1. Marriage.
2. Birth of a dependent child.
3. Adoption or placement for adoption of a dependent child.

In these circumstances, the newly eligible dependent(s) (and if not already enrolled the employee) are given the opportunity to enroll in the Plan. In the case of birth, adoption or placement for adoption, the spouse of the employee may also enroll if not already covered under the Plan.

The employee must request the special enrollment within thirty-one (31) days of the acquisition of the dependent. The effective date of coverage as the result of a special enrollment shall be:

1. in the case of marriage, the first day of the first calendar month following the plan administrator's receipt of the completed enrollment form;
2. in the case of a dependent's birth, the date of such birth;
3. in the case of adoption or placement for adoption, the date of such adoption or placement for adoption.
OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may change benefit elections, or enroll himself and his eligible dependents in the Plan if he did not do so when first eligible or does not qualify for a special enrollment period. An open enrollment will be permitted from January 15th thru February 15th each calendar year. A covered employee who fails to make an election or to change enrollment during the open enrollment period will automatically retain his or her present coverage.

The effective date of coverage as the result of an open enrollment period will be March 1.

Any person enrolling in this Plan for the first time at open enrollment will be treated as a late enrollee. Late enrollees are subject to restrictions on dental coverage during the first 24 months of coverage. Refer to the Dental Expense Benefit, Late Enrollment provision and Definitions section (enrollment date and late enrollee definitions) for additional information.

Except for a status change listed below, the open enrollment period is the only time an employee may change benefit options or modify enrollment. Status changes include:

1. Change in family status. A change in family status shall include only:
   a. Change in employee's legal marital status;
   b. Change in number of dependents;
   c. Termination or commencement of employment by the employee, spouse or dependent;
   e. Change in work schedule;
   f. Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
   g. Change in residence or worksite of employee, spouse or dependent.

2. Change in the cost of coverage under the employer's group medical plan.

3. Cessation of required contributions.

4. Taking or returning from a leave of absence under the Family and Medical Leave Act.

5. Significant change in the health coverage of the employee or spouse attributable to the spouse's employment.

6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act.

7. A court order, judgment or decree.

8. Entitlement to Medicare or Medicaid.

9. A COBRA qualifying event.
PRE-EXISTING CONDITIONS

A *pre-existing condition* is an *illness* or *injury* which existed within six (6) months before the *covered person's enrollment date* for coverage under this *Plan*. An *illness* or *injury* is considered to have existed when the *covered person*:

1. Sought or received professional advice for that *illness* or *injury*, or
2. Received medical care or treatment for that *illness* or *injury*, or
3. Received medical supplies, drugs, or medicines for that *illness* or *injury*.

Benefits will be provided for *pre-existing conditions* after the completion of a period of twelve (12) months from the *covered person's enrollment date* for coverage under this *Plan*. Refer to Definitions, for a definition of *enrollment date*.

This *pre-existing condition* limitation shall not apply to any member under the age of 19.

Pre-certification from the *Health Care Management Organization* does not constitute *Plan* liability for any *pre-existing condition* charges during this waiting period.

The *covered person* has a right to appeal the determination of coverage for *pre-existing conditions*. See *Claim Filing Procedures*.

For the purpose of determining whether this *pre-existing condition* provision of the *Plan* will be applied to claims for any individual, the *plan administrator* will look not only to the period of time the individual has been covered under this *Plan*, but also to any period of previous creditable coverage the individual has earned. Creditable coverage shall include, but is not limited to, coverage the individual may have had under a prior employer's benefit plan or COBRA, individual or group insurance, Medicare or Medicaid, a state risk pool, or CHAMPUS. Other types of coverage may also be considered creditable coverage. However, creditable coverage will only be applied to this *Plan's pre-existing condition* time periods if there has been no break in coverage of the individual for more than sixty-three days. If there has been a break in coverage of more than sixty-three days, the *plan administrator* will not apply previous coverage towards this *Plan's pre-existing condition* limitation. Waiting periods for coverage do not count as a break in coverage.

It is the *employee's* responsibility to provide the *plan administrator* with evidence of creditable coverage. Such evidence may be in the form of a Certificate of Coverage or in any other form acceptable to the *plan administrator*. 
TERMINATION OF COVERAGE

Except as provided in the Plan’s Continuation of Coverage (COBRA) provision, coverage will terminate on the earliest of the following dates:

TERMINATION OF EMPLOYEE COVERAGE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee ceases to meet the eligibility requirements of the Plan.
3. The date employment terminates, as defined by the employer's personnel policies.
4. The date the employee becomes a full-time, active member of the armed forces of any country.
5. The date the employee ceases to make any required contributions.

TERMINATION OF DEPENDENT(S) COVERAGE

1. The date the employer terminates the Plan and offers no other group health plan.
2. The date the employee's coverage terminates. However, if the employee remains eligible for the Plan, but elects to discontinue coverage, coverage may be extended for alternate recipients.
3. The date such person ceases to meet the eligibility requirements of the Plan.
4. The date the employee ceases to make any required contributions on the dependent's behalf.
5. The date the dependent reaches the limiting age of 26.
6. The date the dependent becomes a full-time, active member of the armed forces of any country.
7. The date the Plan discontinues dependent coverage for any and all dependents.
8. The date the dependent becomes eligible as an employee.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer. In no event will coverage continue for more than three (3) months after the employee's active service ends.
FAMILY AND MEDICAL LEAVE ACT (FMLA)

Eligible Leave

An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.

Contributions

During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employer shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.

Reinstatement

If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty (30) days of his return to active work.

Repayment Requirement

The employer may require employees who fail to return from a leave under FMLA to repay any contributions paid by the employer on the employee's behalf during an unpaid leave. This repayment will be required only if the employee's failure to return from such leave is not related to a "serious health condition," as defined in FMLA, or events beyond the employee's control.

EMPLOYEE REINSTATEMENT

Employees and eligible dependents who lost coverage due to a layoff from the employer are eligible for reinstatement of coverage as follows:

1. Reinstatement of coverage is available to employees and dependents who were previously covered under the Plan.
2. Return to active status must occur within six (6) months of the layoff.
3. The employee must submit the completed application for enrollment to the employer within thirty-one (31) days of return to active service.
4. Coverage shall be effective from the date of rehire. Prior benefits and limitations, such as deductible, maximum benefit, pre-existing condition waiting period, shall be applied with no break in coverage.

If the provisions of (1) through (3) above are not met, the Plan's provisions for eligibility and application for enrollment shall apply.

An employee who returns to work more than six (6) months after a layoff, or who returns to eligible status after any other separation of service will be considered a new employee for purposes of eligibility and will be subject to all eligibility requirements, including all requirements relating to the effective date of coverage and the pre-existing condition limitations.
CERTIFICATES OF COVERAGE

The *plan administrator* shall provide each terminating *covered person* with a Certificate of Coverage, certifying the period of time the individual was covered under this *Plan*. For *employees* with *dependent* coverage, the certificate provided may include information on all covered *dependents*. This *Plan* intends to at all times comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.
CONTINUATION OF COVERAGE

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

The coverage which may be continued under this provision consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug and dental benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan, even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan or cause an increase in required contributions, even if such loss of coverage or increase in required contributions does not take effect immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

1. Death of the employee.
2. The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan. This event is referred to below as an "18-Month Qualifying Event."
3. Divorce or legal separation from the employee.
4. The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
5. A dependent child no longer meets the eligibility requirements of the Plan.
6. The last day of leave under the Family and Medical Leave Act of 1993, or an earlier date on which the employee informs the employer that he or she will not be returning to work.
7. The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

1. When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must submit a completed Qualifying Event Notification form to the plan administrator or its designee within sixty (60) days of the latest of:
   a. The date of the event;
   b. The date on which coverage under this Plan is or would be lost as a result of that event; or
   c. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.
A copy of the Qualifying Event Notification form is available from the plan administrator (or its designee). In addition, the employee or dependent may be required to promptly provide any supporting documentation as may be reasonably requested for purposes of verification. Failure to provide such notice and any requested supporting documentation will result in the person forfeiting their rights to continuation of coverage under this provision.

Within fourteen (14) days of the receipt of a properly completed Qualifying Event Notification, the plan administrator (or its designee) will notify the employee or dependent of his rights to continuation of coverage, and what process is required to elect continuation of coverage. This notice is referred to below as "Election Notice."

2. When eligibility for continuation coverage results from any qualifying event under this Plan other than the ones described in Paragraph 1 above, the employer must notify the plan administrator (or its designee) not later than thirty (30) days after the date on which the employee or dependent loses coverage under the Plan due to the qualifying event. Within fourteen (14) days of the receipt of the notice of the qualifying event, the plan administrator (or its designee) will furnish the Election Notice to the employee or dependent.

3. In the event it is determined that an individual seeking continuation coverage (or extension of continuation coverage) is not entitled to such coverage, the plan administrator (or its designee) will provide to such individual an explanation as to why the individual is not entitled to continuation coverage. This notice is referred to here as the "Non-Eligibility Notice." The Non-Eligibility Notice will be furnished in accordance with the same time frame as applicable to the furnishing of the Election Notice.

4. In the event an Election Notice is furnished, the eligible employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who is described in the Election Notice and was covered under the Plan on the day before the qualifying event has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continuation coverage, he must advise the plan administrator (or its designee) of this choice by returning to the plan administrator (or its designee) a properly completed Election Notice not later than the last day of the sixty (60) day period. If the Election Notice is mailed to the plan administrator (or its designee), it must be postmarked on or before the last day of the sixty (60) day period. This sixty (60) day period begins on the later of the following:

a. The date coverage under the Plan would otherwise end; or
b. The date the person receives the Election Notice from the plan administrator (or its designee).

5. Within forty-five (45) days after the date the person notifies the plan administrator (or its designee) that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the original date continued benefits begins, through the same day of the following month. Thereafter, payments for the continuation coverage are to be made monthly, and are due in advance.

COST OF COVERAGE

1. The Plan requires that covered persons pay the entire costs of their continuation coverage, plus a two percent (2%) administrative fee. Except for the initial payment (see above), payments must be remitted to the plan administrator (or its designee) by or before the first day of each month during the continuation period. The payment must be remitted on a timely basis in order to maintain the coverage in force.

2. For a person originally covered as an employee or as a spouse, the cost of coverage is the amount applicable to an employee if coverage is continued for himself alone. For a person originally covered as a child and continuing coverage independent of the family unit, the cost of coverage is the amount applicable to an employee.
WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the initial payment is made within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

EXTENSION OF CONTINUATION COVERAGE

1. In the event any of the following events occur during the period continuation coverage resulting from an 18-Month Qualifying Event, it is possible for a dependent's continuation coverage to be extended:
   a. Death of the employee.
   b. Divorce or legal separation from the employee.
   c. The child's loss of dependent status.

   Written notice of such event must be provided by submitting a completed Additional Extension Event Notification form to the plan administrator (or its designee) within sixty (60) days of the latest of:
   i. The date of that event;
   ii. The date on which coverage under this Plan would be lost as a result of that event if the first qualifying event had not occurred; or
   iii. The date on which the employee or dependent is furnished with a copy of this Plan Document and Summary Plan Description.

   A copy of the Additional Extension Event Notification form is available from the plan administrator. In addition, the dependent may be required to promptly provide any supporting documentation as may be reasonably required for purposes of verification. Failure to properly provide the Additional Extension Event Notification and any requested supporting documentation will result in the person forfeiting their rights to extend continuation coverage under this provision. In no event will any extension of continuation coverage extend beyond thirty-six (36) months from the later of the date of the first qualifying event or the date as of which continuation coverage began.

   Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA coverage may be eligible to continue coverage through an extension of continuation coverage as described above. Any other dependent acquired during continuation coverage is not eligible to extend continuation coverage as described above.

2. A person who loses coverage on account of an 18-Month Qualifying Event may extend the maximum period of continuation coverage from eighteen (18) months to up to twenty-nine (29) months in the event both of the following occur:
   a. That person (or another person who is entitled to continuation coverage on account of the same 18-Month Qualifying Event) is determined by the Social Security Administration, under Title II or
Title XVI of the Social Security Act, to have been disabled before the sixtieth (60th) day of continuation coverage; and
b. The disability status, as determined by the Social Security Administration, lasts at least until the end of the initial eighteen (18) month period of continuation coverage.

The disabled person (or his representative) must submit written proof of the Social Security Administration's disability determination to the plan administrator (or its designee) within the initial eighteen (18) month period of continuation coverage and no later than sixty (60) days after the latest of:

i. The date of the disability determination by the Social Security Administration;
ii. The date of the 18-Month Qualifying Event;
iii. The date on which the person loses (or would lose) coverage under this Plan as a result of the 18-Month Qualifying Event; or
iv. The date on which the person is furnished with a copy of this Plan Document and Summary Plan Description.

Should the disabled person fail to notify the plan administrator (or its designee) in writing within the time frame described above, the disabled person (and others entitled to disability extension on account of that person) will then be entitled to whatever period of continuation he or they would otherwise be entitled to, if any. The Plan may require that the individual pay one hundred and fifty percent (150%) of the cost of continuation coverage during the additional eleven (11) months of continuation coverage. In the event the Social Security Administration makes a final determination that the individual is no longer disabled, the individual must provide notice of that final determination no later than thirty (30) days after the later of:

a. The date of the final determination by the Social Security Administration; or
b. The date on which the individual is furnished with a copy of this Plan Document and Summary Plan Description.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

1. Eighteen (18) months [or twenty-nine (29) months if continuation coverage is extended due to certain disability status as describe above] from the date continuation began because of an 18-Month Qualifying Event, or because of the call-up to military duty or the last day of leave under the Family and Medical Leave Act of 1993.

2. Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.

3. The end of the period for which contributions are paid if the covered person fails to make a payment by the date specified by the plan administrator (or its designee). In the event continuation coverage is terminated for this reason, the individual will receive a notice describing the reason for the termination of coverage, the effective date of termination, and any rights the individual may have under this Plan or under applicable law to elect an alternative group or individual coverage, such as a conversion right. This notice is referred to below as an "Early Termination Notice."

4. The date coverage under this Plan ends and the employer offers no other group health benefit plan. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

5. The date the covered person first becomes entitled, after the date of the covered person's original election of continuation coverage, to Medicare benefits under Title XVIII of the Social Security Act. In the event continuation coverage is terminated for this reason, the individual will receive and Early Termination Notice.
6. The date the covered person first becomes covered under any other employer’s group health plan after the original date of the covered person’s election of continuation coverage, but only if such group health plan does not have any exclusion or limitation that affects coverage of the covered person’s pre-existing condition. In the event continuation coverage is terminated for this reason, the individual will receive an Early Termination Notice.

7. For the spouse or dependent child of a covered employee who becomes entitled to Medicare prior to the spouse’s or dependent’s election for continuation coverage, thirty-six (36) months from the date the covered employee becomes entitled to Medicare.

SPECIAL RULES REGARDING NOTICES

1. Any notice required in connection with continuation coverage under this Plan must, at minimum, contain sufficient information so that the plan administrator (or its designee) is able to determine from such notice the employee and dependent(s) (if any), the qualifying event or disability, and the date on which the qualifying event occurred.

2. In connection with continuation coverage under this Plan, any notice required to be provided by any individual who is either the employee or a dependent with respect to the qualifying event may be provided by a representative acting on behalf of the employee or the dependent, and the provision of the notice by one individual shall satisfy any responsibility to provide notice on behalf of all related eligible individuals with respect to the qualifying event.

3. As to an Election Notice, Non-Eligibility Notice or Early Termination Notice:
   a. A single notice addressed to both the employee and the spouse will be sufficient as to both individuals if, on the basis of the most recent information available to the Plan, the spouse resides at the same location as the employee; and
   b. A single notice to the employee or the spouse will be sufficient as to each dependent child of the employee if, on the basis of the most recent information available to the Plan, the dependent child resides at the same location as the individual to whom such notice is provided.

PRE-EXISTING CONDITIONS

In the event that a covered person becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an applicable exclusion or limitation regarding coverage of the covered person’s pre-existing condition, the covered person’s continuation coverage under the Plan will not be affected by enrollment under that other group health plan. This Plan shall be primary payer for the covered expenses that are excluded or limited under the other employer sponsored group health plan and secondary payer for all other expenses.

MILITARY MOBILIZATION

If an employee or an employee’s dependent is called for active duty by the United States Armed Services (including the Coast Guard, the National Guard or the Public Health Service), the employee or the employee’s dependent may continue their health coverage, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

When the leave is less than thirty-one (31) days, the employee or employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is thirty-one (31) days or longer,
then the *plan administrator* (or its designee) may require the *employee* or *employee's dependent* to pay no more than one hundred and two percent (102%) of the full contribution.

The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:

1. Twenty-four (24) months beginning on the day that the leave commences, or
2. A period beginning on the day that the leave began and ending on the day after the *employee* fails to return to employment within the time allowed.

The period of continuation coverage under USERRA will be counted toward any continuation coverage period concurrently available under COBRA. Upon return from active duty, the *employee* or the *employee's dependent* will be reinstated without *pre-existing conditions* exclusions or a waiting period, regardless of their election of COBRA continuation coverage.

**PLAN CONTACT INFORMATION**

Questions concerning this *Plan*, including any available continuation coverage, can be obtained from the *plan administrator*

**ADDRESS CHANGES**

In order to help ensure the appropriate protection of rights and benefits under this *Plan*, *covered persons* should keep the *plan administrator* informed of any changes to their current addresses.
MEDICAL/DENTAL CLAIM FILING PROCEDURE

A “Pre-service claim” is a claim for a Plan benefit that is subject to the prior certification, as described in the section below, Pre-service Claim Procedure. All other claims for Plan benefits are “Post-Service Claims” and are subject to the rules described in Post-Service Claim Procedure.

POST-SERVICE CLAIMS PROCEDURE

FILING A CLAIM

1. Claims should be submitted to the claims processor at the address noted below:

   Consolidated Health Plans
   2077 Roosevelt Avenue
   Springfield, MA 01104
   1-413-733-4540 or 1-800-633-7867

   The date of receipt will be the date the claim is received by the claims processor.

2. All claims submitted for benefits must contain all of the following:
   a. Name of patient
   b. Patient’s date of birth.
   c. Name of employee.
   d. Address of employee.
   e. Name of employer and group number.
   f. Name, address and tax identification number of provider.
   g. Employee Social Security Number.
   h. Date of service.
   i. Diagnosis (applies to medical claims ONLY)
   j. Description of service and procedure number.
   k. Charge for service.
   l. The nature of the accident, injury or illness being treated.

3. Properly completed claims not submitted within twelve (12) months from the date the services were rendered will not be a covered expense and will be denied.

The covered person may ask the health care provider to submit the claim directly to the claims processor, or the covered person may submit the bill with a claim form. However, it is ultimately the covered person’s responsibility to make sure the claim for benefits has been filed.
**NOTICE OF AUTHORIZED REPRESENTATIVE**

The *covered person* may provide the *plan administrator* or their designee with a written authorization for an authorized representative to represent and act on behalf of a *covered person* and consent to the release of information related to the *covered person* to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from Consolidated Health Plans.

**NOTICE OF CLAIM**

A claim for benefits should be submitted to the *claims processor* within ninety (90) calendar days after the occurrence or commencement of any services by the *Plan*, or as soon thereafter as reasonably possible.

Failure to file a claim within the time provided shall not invalidate or reduce a claim for benefits if: (1) it was not reasonably possible to file a claim within that time; and (2) that such claim was furnished as soon as possible, but no later than one (1) year after the loss occurs or commences, unless the claimant is legally incapacitated.

Notice given by or on behalf of a *covered person* or his beneficiary, if any, to the *plan administrator* or to any authorized agent of the *Plan*, with information sufficient to identify the *covered person*, shall be deemed notice of claim.

**TIME FRAME FOR BENEFIT DETERMINATION**

After a completed claim has been submitted to the *claims processor*, and no additional information is required, the *claims processor* will generally complete its determination of the claim within thirty (30) calendar days of receipt of the completed claim unless an extension is necessary due to circumstances beyond the *Plan’s* control.

After a completed claim has been submitted to the *claims processor*, and if additional information is needed for determination of the claim, the *claims processor* will provide the *covered person* (or authorized representative) with a notice detailing information needed. The notice will be provided within thirty (30) calendar days of receipt of the completed claim and will state the date as of which the *Plan* expects to make a decision. The *covered person* will have forty-five (45) calendar days to provide the information requested, and the *Plan* will complete its determination of the claim within fifteen (15) calendar days of receipt by the *claims processor* of the requested information. Failure to respond in a timely and complete manner will result in the denial of benefit payment.

**NOTICE OF BENEFIT DENIAL**

If the claim for benefits is denied, the *plan administrator* or their designee shall provide the *covered person* or authorized representative with a written Notice of Benefit Denial within the time frames described immediately above.

The Notice of Benefit Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the *Plan* provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the *Plan’s* claim review procedure and applicable time limits.
5. A statement that if the covered person’s appeal (Refer to Appealing a Denied Claim below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.

6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.

7. If denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

**APPEALING A DENIED CLAIM**

The “named fiduciary” for purposes of an appeal of a Post-Service Claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

A covered person, or the covered person’s authorized representative, may request a review of a denied claim by making written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered person feels the claim should not have been denied.

The following describes the review process and rights of the covered person:

1. The covered person has a right to submit documents, information and comments
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits
3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
4. The review by the named fiduciary will not afford deference to the original denial.
5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment,
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment; and
   b. The professional provider utilized by the named fiduciary will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other professional provider who was consulted in connection with the original denial.
7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.
NOTICE OF BENEFIT DETERMINATION ON APPEAL

The **plan administrator** or their designee shall provide the **covered person** (or authorized representative) with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the Decision, including:

1. The specific reasons for the denial.
2. Reference to specific **Plan** provisions on which the denial is based.
3. A statement that the **covered person** has the right to access, free of charge, **relevant information** to the claim for benefits.
4. A statement that if the **covered person**’s appeal is denied, the **covered person** has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
6. If the denial was based on **medical necessity**, **experimental/investigational** treatment or similar exclusion or limit, the **Plan** will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the **Plan** to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

FOREIGN CLAIMS

In the event a **covered person** incurs a **covered expense** in a foreign country, the **covered person** shall be responsible for providing the following information to the **claims processor** before payment of any benefits due are payable.

1. The claim form, provider invoice and any documentation required to process the claim must be submitted in the English language.
2. The charges for services must be converted into U.S. dollars.
3. A current published conversion chart, validating the conversion from the foreign country’s currency into U.S. dollars, must be submitted with the claim.
PRE-SERVICE CLAIMS PROCEDURE

HEALTH CARE MANAGEMENT

Health care management is the process of evaluating whether proposed services, supplies or treatments are medically necessary and appropriate to help ensure quality, cost-effective care.

Certification of medical necessity and appropriateness by the Health Care Management Organization does not establish eligibility under the Plan nor guarantee benefits. It is the covered person’s responsibility to contact CHP to establish whether the services are covered and whether or not the provider is in-network.

FILING A PRE-CERTIFICATION CLAIM

All inpatient admissions, partial hospitalizations and home health care (excluding supplies and durable medical equipment) are to be certified by the Health Care Management Organization. All organ and tissue transplants (except cornea transplants) are to be certified in advance of the proposed confinement (precertification). Refer to Appendix A for important information concerning special requirements for precertification of transplants. For non-urgent care, the covered person or their authorized representative must call the Health Care Management Organization at least fifteen (15) calendar days prior to initiation of services. If the Health Care Management Organization is not called at least fifteen (15) calendar days prior to initiation of services for non-urgent care, benefits may be reduced. For urgent care, the covered person or their authorized representative must call the Health Care Management Organization within forty-eight (48) hours or the next business day after the initiation of services.

Covered persons shall contact the Health Care Management Organization by calling the 800 number on the I.D. card:

When a covered person (or authorized representative) calls the Health Care Management Organization, he or she should be prepared to provide all of the following information:

1. Employee’s name, address, phone number and Social Security Number.
2. Employer’s name.
3. If not the employee, the patient’s name, address, phone number.
4. Admitting physician’s name and phone number.
5. Name of facility, home health care agency or hospice.
6. Date of admission or proposed date of admission.
7. Condition for which patient is being admitted.

Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (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 forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law, require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

However, hospital maternity stays in excess of forty-eight (48) or ninety-six (96) hours as specified above must be precertified.
If the covered person (or authorized representative) fails to contact the Health Care Management Organization prior to the hospitalization or home health care services, and within the timelines detailed above, covered expenses for the hospital confinement (facility charges) or home health care services shall be reduced by $250 for the purpose of determining benefits payable. If the Health Care Management Organization declines to grant the full pre-certification requested, charges for inpatient days or any services that are not certified as medically necessary will be denied. (Refer to Post-Service Claims discussion above.)

NOTICE OF AUTHORIZED REPRESENTATIVE

The covered person may provide the plan administrator or their designee with a written authorization for an authorized representative to represent and act on behalf of a covered person and consent to release of information related to the covered person to the authorized representative with respect to a claim for benefits or an appeal. Authorization forms may be obtained from the Human Resource Department.

TIME FRAME FOR PRE-SERVICE CLAIM DETERMINATION

1. In the event the Plan receives from the covered person (or authorized representative) a communication that fails to follow the pre-certification procedure as described above but communicates at least the name of the covered person, a specific medical condition or symptom, and a specific treatment, service or product for which prior approval is requested, the covered person (or the authorized representative) will be orally notified (and in writing if requested), within five (5) calendar days of the failure of the proper procedure to be followed.

2. After a completed pre-certification request for non-urgent care has been submitted to the Plan, and if no additional information is required, the Plan will generally complete its determination of the claim within a reasonable period of time, but no later than fifteen (15) calendar days from receipt of the request.

3. After a pre-certification request for non-urgent care has been submitted to the Plan, and if an extension of time to make a decision is necessary due to circumstances beyond the control of the Plan, the Plan will, within fifteen (15) calendar days from receipt of the request, provide the covered person (or authorized representative) with a notice detailing the circumstances and the date by which the Plan expects to render a decision. If the circumstances include a failure to submit necessary information, the notice will specifically describe the needed information. The covered person will have forty-five (45) calendar days to provide the information requested, and the Plan will complete its determination of the claim no later than fifteen (15) calendar days after receipt by the Plan of the requested information. Failure to respond in a timely and complete manner will result in a denial.

CONCURRENT CARE CLAIMS

If an extension beyond the original certification is required, the covered person (or authorized representative) shall call the Health Care Management Organization for continuation of certification.

1. If a covered person (or authorized representative) requests to extend a previously approved hospitalization or an ongoing course of treatment, and;
   a. The request involves non-urgent care, then the extension request must be processed within fifteen (15) calendar days after the request was received.
   b. The inpatient admission or ongoing course of treatment involves urgent care, and
      i. The request is received at least twenty-four (24) hours before the scheduled end of a hospitalization or course of treatment, then the request must be ruled upon and the covered person (or authorized representative) notified as soon as possible but no later than twenty-four (24) hours after the request was received; or
ii. The request is received less than twenty-four (24) hours before the scheduled end of the hospitalization or course of treatment, then the request must be ruled upon and the covered person (or authorized representative) notified no later than seventy-two (72) hours after the request was received.

If the Health Care Management Organization determines that the hospital stay or course of treatment should be shortened or terminated before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved, then the Health Care Management Organization shall:

1. Notify the covered person of the proposed change, and
2. Allow the covered person to file an appeal and obtain a decision, before the end of the fixed number of days and/or treatments, or the fixed time period that was previously approved.

If, at the end of a previously approved hospitalization or course of treatment, the Health Care Management Organization determines that continued confinement is no longer medically necessary, additional days will not be certified. (Refer to Appealing a Denied Pre-Service Claim discussion below.)

**NOTICE OF PRE-SERVICE CLAIM DENIAL**

If a pre-certification request is denied in whole or in part, the plan administrator or their designee shall provide the covered person (or authorized representative) with a written Notice of Pre-Service Denial within the time frames above.

The Notice of Pre-Service Denial shall include an explanation of the denial, including:

1. The specific reasons for the denial.
2. Reference to the Plan provisions on which the denial is based.
3. A description of any additional material or information needed and an explanation of why such material or information is necessary.
4. A description of the Plan’s claim review procedure and applicable time limits.
5. A statement that if the covered person’s appeal (Refer to Appealing a Denied Pre-Service Claim below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Benefit Denial will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.
APPEALING A DENIED PRE-SERVICE CLAIM

The named fiduciary for purposes of an appeal of a Pre-service claim, as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000), is the claims processor.

A covered person (or authorized representative) may request a review of a denied claim by making a written request to the named fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial and stating the reasons the covered person feels the claim should not have been denied. If the covered person (or authorized representative) wishes to appeal the denial when the services in question have already been rendered, such an appeal will be considered as a separate Post-Service Claim. (Refer to Post-Service Claims Procedure discussion above.)

The following describes the review process and rights of the covered person:

1. The covered person has a right to submit documents, information and comments.
2. The covered person has the right to access, free of charge, relevant information to the claim for benefits.
3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
4. The review by the named fiduciary will not afford deference to the original denial.
5. The named fiduciary will not be:
   a. The individual who originally denied the claim, nor
   b. Subordinate to the individual who originally denied the claim.
6. If original denial was, in whole or in part, based on medical judgment,
   a. The named fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
   b. The professional provider utilized by the named fiduciary will be neither:
      i. An individual who was consulted in connection with the original denial of the claim, nor
      ii. A subordinate of any other professional provider who was consulted in connection with the original denial.
7. If requested, the named fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.
NOTICE OF PRE-SERVICE DETERMINATION ON APPEAL

The plan administrator or their designee shall provide the covered person (or authorized representative) with a written Notice of Appeal Decision as soon as possible, but not later than thirty (30) calendar days from receipt of the appeal.

If the appeal is denied, the Notice of Appeal Decision will contain an explanation of the decision, including:

1. The specific reasons for the denial.
2. Reference to specific Plan provisions on which the denial is based.
3. A statement that the covered person has the right to access, free of charge, relevant information to the claim for benefits.
4. A statement that if the covered person’s appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
5. A statement that the covered person has the right to access, free of charge, information about the voluntary appeal process.
6. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice of Appeal Decision will contain either:
   a. A copy of that criterion, or
   b. A statement that such criterion was relied upon and will be supplied free of charge, upon request.
7. If the denial was based on medical necessity, experimental/investigational treatment or similar exclusion or limit, the Plan will supply either:
   a. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the claimant’s medical circumstances, or
   b. A statement that such explanation will be supplied free of charge, upon request.

SECOND LEVEL VOLUNTARY APPEAL

The Health Care Management Organization, upon request by the covered person (or authorized representative) following a pre-service determination on appeal, will conduct a second level voluntary appeal. This appeal is comprised of a panel of three professional providers that were not consulted in connection with the original pre-service denial. The covered person’s decision as to whether to submit a previously denied appeal to the voluntary appeal process will have no effect on the covered person’s rights to any other benefits under the Plan. There are no fees or costs imposed as a condition to use of the voluntary appeal process.

Upon receipt of the request to conduct a voluntary appeal, a determination will be made within thirty (30) business days. Notification of the outcome of the review will be communicated verbally and in writing.

With respect to pre-service claims, the Plan agrees not to later assert a defense of failure to exhaust available administrative remedies against a covered person who chooses not to make use of the voluntary appeal process.

With respect to pre-service claims, the Plan agrees that any statute of limitations or other defense based on timelines is tolled while the dispute is under submission to the voluntary appeal process.

Upon written request, more information about the voluntary appeal process is available, free of charge, from the Health Care Management Organization.
CASE MANAGEMENT

In cases where the covered person's condition is expected to be or is of a serious nature, the Health Care Management Organization may arrange for review and/or case management services from a professional qualified to perform such services. The plan administrator shall have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost effective result without a sacrifice to the quality of care.

In addition, the Health Care Management Organization may recommend (or change) alternative methods of medical care or treatment, equipment or supplies that:

1. Are not covered expenses under this Plan; or
2. Are covered expenses under this Plan but on a basis that differs from the alternative recommended by the Health Care Management Organization.

The recommended alternatives will be considered as covered expenses under the Plan provided the expenses can be shown to be viable, medically necessary, and are included in a written case management report or treatment plan proposed by the Health Care Management Organization.

Case management will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that covered person or any other covered person.
COORDINATION OF BENEFITS

The *Coordination of Benefits* provision is intended to prevent duplication of benefits. It applies when the *covered person* is also covered by any Other Plan(s). When more than one coverage exists, one plan normally pays its benefits in full, referred to as the primary plan. The Other Plan(s), referred to as secondary plan, pays a reduced benefit. When coordination of benefits occurs, the total benefit payable by all plans will not exceed 100% of "allowable expenses." Only the amount paid by this Plan will be charged against the maximum benefit.

The *Coordination of Benefits* provision applies whether or not a claim is filed under the Other Plan(s). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

**DEFINITIONS APPLICABLE TO THIS PROVISION**

"Allowable Expenses" means any reasonable, necessary, and customary expenses incurred while covered under this Plan, part or all of which would be covered under this Plan. Allowable Expenses do not include expenses contained in the "Exclusions" sections of this Plan.

When this Plan is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).

When this Plan is secondary, "Allowable Expense" shall not include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the covered person for the difference between the provider's contracted amount and the provider's regular billed charge.

"Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision care. Such Other Plan(s) may include, without limitation:

1. Group insurance or any other arrangement for coverage for *covered persons* in a group, whether on an insured or uninsured basis, including, but not limited to, hospital indemnity benefits and hospital reimbursement-type plans;

2. Hospital or medical service organization on a group basis, group practice, and other group prepayment plans or on an individual basis having a provision similar in effect to this provision;

3. A licensed Health Maintenance Organization (HMO);

4. Any coverage under a government program and any coverage required or provided by any statute;

5. Any plan or policies funded in whole or in part by an *employer*, or deductions made by an *employer* from a person's compensation or retirement benefits;

6. Labor/management trustees, union welfare, employer organization, or employee benefit organization plans.

"This Plan” shall mean that portion of the *employer's Plan* which provides benefits that are subject to this provision.

"Claim Determination Period" means a calendar year or that portion of a calendar year during which the *covered person* for whom a claim is made has been covered under this Plan.
EFFECT ON BENEFITS

This provision shall apply in determining the benefits for a covered person for each claim determination period for the Allowable Expenses. If this Plan is secondary, the benefits paid under this Plan may be reduced so that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

If the rules set forth below would require this Plan to determine its benefits before such Other Plan, then the benefits of such Other Plan will be ignored for the purposes of determining the benefits under this Plan.

ORDER OF BENEFIT DETERMINATION

Each plan will make its claim payment according to the following order of benefit determination:

1. No Coordination of Benefits Provision
   If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).

2. Member/Dependent
   The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining covered expenses are paid under a plan which covers the claimant as a dependent.

3. Dependent Children of Parents not Separated or Divorced
   The plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's year of birth is not relevant in applying this rule.

4. Dependent Children of Separated or Divorced Parents
   When parents are separated or divorced, the birthday rule does not apply, instead:
   a. If a court decree has given one parent financial responsibility for the child's health care, the plan of that parent pays first. The plan of the stepparent married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
   b. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.

5. Active/Inactive
   The plan covering a person as an active (not laid off or retired) employee, or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.

6. Limited Continuation of Coverage
   If a person is covered under another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for pre-existing conditions or exclusions, the Other Plan shall be primary.

7. Longer/Shorter Length of Coverage
   If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.
**COORDINATION WITH MEDICARE**

Individuals may be eligible for Medicare Part A at no cost if they: (i) are age 65 or older, (ii) have been determined by the Social Security Administration to be disabled, or (iii) have end stage renal disease. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an employee becomes entitled to Medicare coverage (due to age or disability) and is still actively at work, the employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

2. When a dependent becomes entitled to Medicare coverage (due to age or disability) and the employee is still actively at work, the dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.

3. If the employee and/or dependent is also enrolled in Medicare (due to age or disability), this Plan shall pay as the primary plan. If, however, the Medicare enrollment is due to end stage renal disease, the Plan’s primary payment obligation will end at the end of the thirty (30) month “coordination period” as provided in Medicare law and regulations.

4. Notwithstanding Paragraphs 1 to 3 above, if the employer (including certain affiliated entities that are considered the same employer for this purpose) has fewer than one hundred (100) employees, when a covered dependent becomes entitled to Medicare coverage due to total disability, as determined by the Social Security Administration, and the employee is actively-at-work, Medicare will pay as the primary payer for claims of the dependent and this Plan will pay secondary.

5. If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

**LIMITATIONS ON PAYMENTS**

In no event shall the covered person recover under this Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by this Plan and the Other Plan(s). Nothing contained in this section shall entitle the covered person to benefits in excess of the total maximum benefits of this Plan during the claim determination period. The covered person shall refund to the employer any excess it may have paid.

**RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION**

For the purposes of determining the applicability of and implementing the terms of this Coordination of Benefits provision, the Plan may, without the consent of or notice to any person, release to or obtain from any insurance company or any other organization any information with respect to any covered person. Any person claiming benefits under this Plan shall furnish to the employer such information as may be necessary to implement the Coordination of Benefits provision.

**FACILITY OF BENEFIT PAYMENT**

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plan, the employer shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision. Amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the employer shall be fully discharged from liability.
SUBROGATION/REIMBURSEMENT

The Plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the Plan may pay covered expenses that may be or become the responsibility of another person, provided that the Plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the Plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

Assignment of Rights (Subrogation)

The covered person automatically assigns to the Plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program (except flexible spending accounts, health reimbursement accounts and health savings accounts), but limited to the amount of Reimbursable Payments made by the Plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds actually or allegedly paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the Plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the Plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

Equitable Lien and other Equitable Remedies

The Plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the Plan. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the Plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person’s attorney, and/or a trust) as a result of an exercise of the covered person’s rights of recovery (sometimes referred to as “proceeds”). The Plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the plan administrator, the Plan may reduce any future covered expenses otherwise available to the covered person under the Plan by an amount up to the total amount of Reimbursable Payments made by the Plan that is subject to the equitable lien.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court’s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.
Assisting in Plan’s Reimbursement Activities

The covered person has an obligation to assist the Plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the Plan with any information concerning the covered person’s other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity [including their insurer(s)] that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the Plan’s (or any Plan fiduciary’s) enforcement of the terms of the Plan, including the exercise of the Plan’s right to subrogation and reimbursement, whether against the covered person or any third party, (b) not do anything to prejudice those enforcement efforts or rights (such as settling a claim against another party without including the Plan as a co-payee for the amount of the Reimbursable Payments and notifying the Plan), (c) sign any document deemed by the plan administrator to be relevant to protecting the Plan’s subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the plan administrator or claims processor to enforce the Plan’s rights.

The plan administrator has delegated to the claims processor the right to perform ministerial functions required to assert the Plan’s rights; however, the plan administrator shall retain discretionary authority with regard to asserting the Plan’s recovery rights.
GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Human Resources Department of the employer. The employer is the plan administrator. The plan administrator shall have full charge of the operation and management of the Plan. The employer has retained the services of an independent claims processor experienced in claims review.

The employer is named fiduciary of the Plan except as noted herein. The claims processor is the named fiduciary of the Plan for pre-service and post service claim appeals. As the named fiduciary for appeals, the claims processor maintains discretionary authority to review all denied claims under appeal for benefits under the Plan. The employer maintains discretionary authority to interpret the terms of the Plan, including but not limited to, determination of eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan; any interpretation or determination made pursuant to such discretionary authority shall be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT

The Plan will pay benefits under this Plan to the employee unless payment has been assigned to a hospital, physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment of benefits shall be binding on the Plan unless the claims processor is notified in writing of such assignment prior to payment hereunder.

Preferred providers normally bill the Plan directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The covered person's portion of the negotiated rate, after the Plan's payment, will then be billed to the covered person by the preferred provider.

This Plan will pay benefits to the responsible party of an alternate recipient as designated in a qualified medical child support order.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, no person other than an eligible covered person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

CLERICAL ERROR

No clerical error on the part of the employer or claims processor shall operate to defeat any of the rights, privileges, services, or benefits of any employee or any dependent(s) hereunder, nor create or continue coverage which would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

Any provision of the Plan which is in conflict with statutes which are applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).
EFFECTIVE DATE OF THE PLAN

The original effective date of this Plan was March 1, 2002. The effective date of the modifications contained herein is March 1, 2011.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restrict or interfere with the right of any person entitled to benefits hereunder to select a hospital or to make a free choice of the attending physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the covered person will have higher out-of-pocket expenses if the covered person uses the services of a non-preferred provider.

INCAPACITY

If, in the opinion of the employer, a covered person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan’s obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the employer or by the employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and signed by the employer or by the covered person, as the case may be. A statement made shall not be used in any legal contest unless a copy of the instrument containing the statement is or has been furnished to the other party to such a contest.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of two (2) years from the date the expense was incurred, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the covered person incurred in excess thereof. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the plan administrator is unable to locate the covered person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits within the time prescribed in Claim Filing Procedure.
**MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS**

The Plan will not take into account whether an individual is eligible for, or is currently receiving, medical assistance under a State plan for medical assistance as provided under Title XIX of the Social Security Act ("State Medicaid Plan") either in enrolling that individual as a covered person or in determining or making any payment of benefits to that individual. The Plan will pay benefits with respect to such individual in accordance with any assignment of rights made by or on behalf of such individual as required under a State Medicaid plan pursuant to § 1912(a)(1)(A) of the Social Security Act. To the extent payment has been made to such individual under a State Medicaid Plan and this Plan has a legal liability to make payments for the same services, supplies or treatment, payment under the Plan will be made in accordance with any State law which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

**MISREPRESENTATION**

If the covered person or anyone acting on behalf of a covered person makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the covered person, or from any other person responsible for misleading the Plan, and from the person for whom the benefits were provided. Any material misrepresentation on the part of the covered person in making application for coverage, or any application for reclassification thereof, or for service thereunder shall render the coverage under this Plan null and void.

**PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN**

The Plan, at its own expense, shall have the right to require an examination of a person covered under this Plan when and as often as it may reasonably require during the pendency of a claim.

**PLAN IS NOT A CONTRACT**

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

**PLAN MODIFICATION AND AMENDMENT**

The employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications which affect covered persons will be communicated to the covered persons. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the employer's designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to covered persons shall be timely made by the employer.

**PLAN TERMINATION**

The employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the covered persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the covered persons.
PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

PRIOR PLAN COVERAGE

Employees and dependents who are covered under the employer's prior plan as of the day immediately prior to the effective date of this Plan shall be covered hereunder, provided they have elected coverage under this Plan. Employees who have not satisfied the prior plan's waiting period shall become effective under this Plan upon completing the waiting period of the prior plan.

Prior plan benefits and limitations shall be applied to this Plan. For example, satisfaction of the prior plan's calendar year deductible shall satisfy this Plan's calendar year deductible requirement; time applied toward satisfaction of the pre-existing condition limitation under the prior plan shall be credited under this Plan; benefits paid under the prior plan shall be applied toward the maximum benefits limitations of this Plan.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an employee or dependent has a status change while covered under this Plan (i.e. dependent to employee, COBRA to Active) and no interruption in coverage has occurred, the Plan will provide continuance of coverage with respect to any pre-existing condition limitation, deductible(s), coinsurance and maximum benefit.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the plan administrator.
HIPAA PRIVACY

The following provisions are intended to comply with applicable plan amendment requirements under Federal regulation implementing Section 264 of the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and shall be construed as a part of the Plan document, effective April 14, 2004.

DISCLOSURE BY PLAN TO PLAN SPONSOR

The Plan may take the following actions only upon receipt of a plan amendment certification:

1. Disclose protected health information to the plan sponsor.

2. Provide for or permit the disclosure of protected health information to the plan sponsor by a health insurance issuer or HMO with respect to the Plan.

USE AND DISCLOSURE BY PLAN SPONSOR

The plan sponsor may use or disclose protected health information received from the Plan to the extent not inconsistent with the provisions of this HIPAA PRIVACY Section or the privacy rule.

OBLIGATIONS OF PLAN SPONSOR

The plan sponsor shall have the following obligations:

1. Ensure that:
   a. Any agents (including a subcontractor) to whom it provides protected health information received from the Plan agree to the same restrictions and conditions that apply to the plan sponsor with respect to such information; and
   b. Adequate separation between the Plan and the plan sponsor is established as provided below in Access to Protected Health Information.

2. Not use or further disclose protected health information received from the Plan, other than as permitted or required by the Plan documents or as required by law.

3. Not use or disclose protected health information received from the Plan:
   a. For employment-related actions and decisions; or
   b. In connection with any other benefit or employee benefit plan of the plan sponsor.

4. Report to the plan any use or disclosure of the protected health information received from the Plan that is inconsistent with the use or disclosure provided for of which it becomes aware.

5. Make available protected health information received from the Plan, as and to the extent required by the privacy rule:
   a. For access to the individual;
   b. For amendment and incorporate any amendments to protected health information received from the Plan; and
   c. To provide an accounting of disclosures.
6. Make its internal practices, books, and records relating to the use and disclosure of protected health information received from the Plan available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the Plan with the privacy rule.

7. Return or destroy all protected health information received from the Plan that the plan sponsor still maintains in any form and retain no copies when no longer needed for the purpose for which the disclosure by the Plan was made, but if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible.

8. Provide protected health information only to those individuals, under the control of the plan sponsor who perform administrative functions for the Plan; (i.e. eligibility, enrollment, payroll deduction, benefit determination, claim reconciliation assistance), and to make clear to such individuals that they are not to use protected health information for any reason other than for Plan administrative functions nor to release protected health information to an unauthorized individual.

9. Provide protected health information only to those entities required to receive the information in order to maintain the plan (i.e. claim administrator, case management vendor, pharmacy benefit manager, claim subrogation, vendor, claim auditor, network manager, stop-loss insurance carrier, insurance broker/consultant, and any other entity subcontracted to assist in administering the plan.

10. Provide an effective mechanism for resolving issues of noncompliance with regard to the items mentioned in this provision.

11. Effective April 20, 2006, reasonably and appropriately safeguard electronic protected health information created, received, maintained, or transmitted to or by the plan sponsor on behalf of the Plan. Specifically, such safeguarding entails an obligation to:

   a. Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that the plan sponsor creates, receives, maintains, or transmits on behalf of the Plan;

   b. Ensure that the adequate separation as required by 45 C.F.R. 164.504(f)(2)(iii) is supported by reasonable and appropriate security measures;

   c. Ensure that any agent, including a subcontractor, to whom it provides this information agrees to implement reasonable and appropriate security measures to protect the information; and

   d. Report to the Plan any security incident of which it becomes aware.

EXCEPTIONS

Notwithstanding any other provision of this HIPAA PRIVACY Section, the Plan (or a health insurance issuer or HMO with respect to the Plan) may:

1. Disclose summary health information to the plan sponsor:

   a. If the plan sponsor requests it for the purpose of:

      i. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

      ii. Modifying, amending, or terminating the Plan;

2. Disclose to the plan sponsor information on whether the individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan;
3. Use or disclose protected health information:

a. With (and consistent with) a valid authorization obtained in accordance with the privacy rule;
b. To carry out treatment, payment, or health care operations in accordance with the privacy rule; or
c. As otherwise permitted or required by the privacy rule.
DEFINITIONS

Certain words and terms used herein shall be defined as follows and are shown in \textit{bold and italics} throughout the document:

\textit{Accident}

An unforeseen event resulting in \textit{injury}.

\textit{Active Service}

An \textit{employee} performing all of the regular duties of his job while in \textit{active service} with the \textit{employer}. On any day, an \textit{employee} will be considered in \textit{active service} if the \textit{employee} performed the regular duties of his job on the last scheduled work day.

\textit{Actively at Work; Active Work}

The expenditure of time and energy in the service of the \textit{employer}, except that an \textit{employee} shall be deemed \textit{actively at work} on each day of regular paid vacation, or on a regular non-working day, on which he is not disabled, provided he was \textit{actively at work} on the last preceding regular working day.

\textit{Alternate Recipient}

Any child of an \textit{employee} or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this \textit{Plan}.

\textit{Ambulatory Surgical Facility}

A \textit{facility} provider with an organized staff of \textit{physicians} which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc., which:

1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an \textit{outpatient} basis;

2. Provides treatment by or under the supervision of \textit{physicians} and nursing services whenever the \textit{covered person} is in the \textit{ambulatory surgical facility};

3. Does not provide \textit{inpatient} accommodations; and

4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a \textit{physician}.

\textit{Birthing Center}

A \textit{facility} that meets professionally recognized standards and complies with all licensing and other legal requirements that apply.

\textit{Chemical Dependency}

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern of pathological use to the extent the user exhibits a loss of self-
control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially impaired or endangered or his social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria.

**Chiropractic Care**

Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.

**Claims Processor**

Refer to the Summary Plan Description section of this Plan Document.

**Close Relative**

The employee’s spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee's spouse.

**Coinsurance**

The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.

**Complications of Pregnancy**

A disease, disorder or condition which is diagnosed as distinct from pregnancy, but is adversely affected by or caused by pregnancy. Some examples are:

1. Intra-abdominal surgery (but not elective Cesarean Section).
2. Ectopic pregnancy.
3. Toxemia with convulsions (Eclampsia).
4. Pernicious vomiting (hyperemesis gravidarum).
5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during pregnancy even if prescribed by a physician; morning sickness; or like conditions that are not medically termed as complications of pregnancy.

**Concurrent Care**

A request by a covered person or their authorized representative to the Health Care Management Organization prior to the expiration of a covered person’s current course of treatment to extend such treatment; or a determination by the Health Care Management Organization to reduce or terminate an ongoing course of treatment.
Confinement

A continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center due to an illness or injury diagnosed by a physician.

Cosmetic Surgery

Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.

Covered Expenses

Medically necessary services, supplies or treatments that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and that are not specifically excluded from coverage herein. Covered expenses shall include specified preventive care services.

Covered Person

A person who is eligible for coverage under this Plan, or becomes eligible at a later date, and for whom the coverage provided by this Plan is in effect.

Custodial Care

Care provided primarily for maintenance of the covered person or which is designed essentially to assist the covered person in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness or injury. Custodial care includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered custodial care without regard to the provider by whom or by which they are prescribed, recommended or performed.

Room and board and skilled nursing services are not, however, considered custodial care (1) if provided during confinement in an institution for which coverage is available under this Plan, and (2) if combined with other medically necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the covered person's medical condition.

Customary and Reasonable Amount

The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is incurred and is comparable in severity and nature to the illness or injury. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The customary and reasonable amount is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.

The customary and reasonable amount applicable to this Plan is based on the 90th percentile.

Dentist

A Doctor of Dental Medicine (D.M.D.), a Doctor of Dental Surgery (D.D.S.), a Doctor of Medicine (M.D.), or a Doctor of Osteopathy (D.O.), other than a close relative of the covered person, who is practicing within the scope of his license.

Dependent

Refer to Eligibility, Dependent Eligibility, for information regarding dependent eligibility requirements.
**Durable Medical Equipment**

Medical equipment which:

1. Can withstand repeated use;
2. Is primarily and customarily used to serve a medical purpose;
3. Is generally not used in the absence of an **illness** or **injury**;
4. Is appropriate for use in the home.

All provisions of this definition must be met before an item can be considered *durable medical equipment*. *Durable medical equipment* includes, but is not limited to: crutches, wheel chairs, *hospital* beds, etc.

**Effective Date**

The date of this *Plan* or the date on which the **covered person's** coverage commences, whichever occurs later.

**Emergency**

An accidental **injury**, or the sudden onset of an **illness** where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:

1. Placing the **covered person's** life in jeopardy, or
2. Causing other serious medical consequences, or
3. Causing serious impairment to bodily functions, or
4. Causing serious dysfunction of any bodily organ or part.

**Employee**

A person directly involved in the regular business of and compensated for services, as reported on the individual's annual W-2 form, by the **employer**, who is regularly scheduled to work not less than thirty-two (32) hours per work week on a **full-time** status basis.

**Employer**

The **employer** is Pinsky Railroad Company.

**Enrollment Date**

The **covered person's enrollment date** is the first day of any applicable service waiting period or the date of hire.

**Experimental/Investigational**

Services, supplies, drugs and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.
The claims processor, named fiduciary for post-service claims, named fiduciary for pre-service claims, employer/plan administrator, or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor, named fiduciary for post-service claims, named fiduciary for pre-service claims, employer/plan administrator or their designee shall be guided by a reasonable interpretation of Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, named fiduciary for post-service claims, named fiduciary for pre-service claims, employer/plan administrator or their designee will be guided by the following examples of experimental services and supplies:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

2. If the drug, device, medical treatment or procedure, was not 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; or

3. If “reliable evidence” shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in 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 as compared with a standard means of treatment or diagnosis; or

4. If “reliable evidence” shows that 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, or its efficacy as compared with 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.

Extended Care Facility

An institution, or distinct part thereof, operated pursuant to law and one which meets all of the following conditions:

1. It is licensed to provide, and is engaged in providing, on an inpatient basis, for persons convalescing from illness or injury, professional nursing services, and physical restoration services to assist covered persons to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.

2. Its services are provided for compensation from its covered persons and under the full-time supervision of a physician or Registered Nurse.

3. It provides twenty-four (24) hour-a-day nursing services.

4. It maintains a complete medical record on each covered person.

5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for custodial or educational care, or a place for the care of mental and nervous disorders.

6. It is approved and licensed by Medicare.
This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

**Facility**

A healthcare institution which meets all applicable state or local licensure requirements.

**Full-time**

*Employees* who are regularly scheduled to work not less than thirty-two (32) hours per work week.

**Generic Drug**

A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or physician and must be clearly designated by the pharmacist or physician as generic.

**Genetic Information**

Means information about the genetic tests of an individual or his or her family members, and information about the manifestations of disease or disorder in family members of the individual. A “genetic test” means analysis of human DNA, RNA, chromosomes, proteins or metabolites, which detects genotypes, mutations or chromosomal changes. It does not mean an analysis of proteins or metabolites that is directly related to a manifested disease, disorder or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved. Genetic information does not include information about the age or gender of an individual.

**Health Care Management**

A process of evaluating if services, supplies or treatment are medically necessary and appropriate to help ensure cost-effective care.

**Health Care Management Organization**

The individual or organization designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary.

**Home Health Aide Services**

Services which may be provided by a person, other than a Registered Nurse, which are medically necessary for the proper care and treatment of a person.

**Home Health Care**

Includes the following services: hospice, skilled nursing visits and IV Infusion therapy for the purposes of pre-service claims only.
**Home Health Care Agency**

An agency or organization which meets fully every one of the following requirements:

1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide skilled nursing and other therapeutic services.

2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one **physician** and at least one Registered Nurse. It must provide for full-time supervision of such services by a **physician** or Registered Nurse.

3. It maintains a complete medical record on each **covered person**.

4. It has a full-time administrator.

5. It qualifies as a reimbursable service under Medicare.

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**Hospice**

An agency that provides counseling and medical services and may provide **room and board** to a terminally ill **covered person** and which meets all of the following tests:

1. It has obtained any required state or governmental Certificate of Need approval.

2. It provides service twenty-four (24) hours-per-day, seven (7) days a week.

3. It is under the direct supervision of a **physician**.

4. It has a Nurse coordinator who is a Registered Nurse.

5. It has a social service coordinator who is licensed.

6. It is an agency that has as its primary purpose the provision of **hospice** services.

7. It has a full-time administrator.

8. It maintains written records of services provided to the **covered person**.

9. It is licensed, if licensing is required.

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**Hospital**

An institution that meets the following conditions:

1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which pertain to **hospitals**.

2. It is engaged primarily in providing medical care and treatment to **ill** and **injured** persons on an **inpatient** basis at the **covered person**'s expense.

3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an **illness** or **injury**; and such treatment is provided by or under the supervision of a **physician** with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
4. It qualifies as a hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

5. It must be approved by Medicare.

Under no circumstances will a hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home.

Hospital shall include a facility designed exclusively for physical rehabilitative services where the covered person received treatment as a result of an illness or injury.

The term hospital, when used in conjunction with inpatient confinement for mental and nervous conditions or chemical dependency, will be deemed to include an institution which is licensed as a mental hospital or chemical dependency rehabilitation and/or detoxification facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.

Illness

A bodily disorder, disease, or physical sickness. Pregnancy of a covered employee or their covered spouse shall be considered an illness.

Incurred or Incurred Date

With respect to a covered expense, the date the services, supplies or treatment are provided.

Injury

A physical harm or disability which is the result of a specific incident caused by external means. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include illness or infection of a cut or wound.

Inpatient

A confinement of a covered person in a hospital, hospice, or extended care facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for room and board.

Intensive Care

A service which is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance which is prescribed by the attending physician.

Intensive Care Unit

A separate, clearly designated service area which is maintained within a hospital solely for the provision of intensive care. It must meet the following conditions:

1. Facilities for special nursing care not available in regular rooms and wards of the hospital;
2. Special life saving equipment which is immediately available at all times;
3. At least two beds for the accommodation of the critically ill; and
4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.
This term does not include care in a surgical recovery room, but does include cardiac care unit or any such other similar designation.

**Late Enrollee**

A *covered person* who did not enroll in the *Plan* when first eligible or as the result of a special enrollment period.

**Layoff**

A period of time during which the *employee*, at the *employer's* request, does not work for the *employer*, but which is of a stated or limited duration and after which time the *employee* is expected to return to *full-time, active work*. Layoffs will otherwise be in accordance with the *employer's* standard personnel practices and policies.

**Leave of Absence**

A period of time during which the *employee* does not work, but which is of stated duration after which time the *employee* is expected to return to active work.

**Maximum Benefit**

Any one of the following, or any combination of the following:

1. The maximum amount paid by this *Plan* for any one *covered person* during the entire time he is covered by this *Plan*.

2. The maximum amount paid by this *Plan* for any one *covered person* for a particular *covered expense*. The maximum amount can be for:
   a. The entire time the *covered person* is covered under this *Plan*, or
   b. A specified period of time, such as a calendar year.

3. The maximum number as outlined in the *Plan* as a *covered expense*. The maximum number relates to the number of:
   a. Treatments during a specified period of time, or
   b. Days of *confinement*, or
   c. Visits by a *home health care agency*.

**Medically Necessary (or Medical Necessity)**

Service, supply or treatment which is determined by the *claims processor, named fiduciary for post-service claims*, *named fiduciary for pre-service claims*, *employer/plan administrator* or their designee to be:

1. Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the *covered person’s illness* or *injury* and which could not have been omitted without adversely affecting the *covered person’s* condition or the quality of the care rendered; and

2. Supplied or performed in accordance with current standards of medical practice within the United States; and

3. Not primarily for the convenience of the *covered person* or the *covered person’s* family or *professional provider*; and

4. Is an appropriate supply or level of service that safely can be provided; and

5. Is recommended or approved by the attending *professional provider*. 
The fact that a **professional provider** may prescribe, order, recommend, perform or approve a service, supply or treatment does not, in and of itself, make the service, supply or treatment **medically necessary** and the **claims processor, named fiduciary for post-service claims, named fiduciary for pre-service claims, employer/plan administrator** or its designee, may request and rely upon the opinion of a **physician** or **physicians**. The determination of the **claims processor, named fiduciary for post-service claims, named fiduciary for pre-service claims, employer/plan administrator** or its designee shall be final and binding.

**Mental and Nervous Disorder**

An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.

**Named Fiduciary for Post-Service Claim Appeals**

Refer to the **Summary Plan Description** section of this Plan Document.

**Named Fiduciary for Pre-Service Claim Appeals**

Refer to the **Summary Plan Description** section of this Plan Document.

**Negotiated Rate**

The rate the **preferred providers** have contracted to accept as payment in full for **covered expenses** of the **Plan**.

**Nonparticipating Pharmacy**

Any pharmacy, including a **hospital** pharmacy, **physician** or other organization, licensed to dispense prescription drugs which does not fall within the definition of a **participating pharmacy**.

**Non-preferred Provider**

A **physician**, **hospital**, or other health care provider which does not have an agreement in effect with the **Preferred Provider Organization** at the time services are rendered.

**Nurse**

A licensed person holding the degree Registered Nurse (R.N.), Licensed Practical Nurse (L.P.N.) or Licensed Vocational Nurse (L.V.N.) who is practicing within the scope of the license.

**Outpatient**

A **covered person** shall be considered to be an **outpatient** if he is treated at:

1. A **hospital** as other than an **inpatient**;
2. A **physician's** office, laboratory or x-ray **facility**; or
3. An **ambulatory surgical facility**; and the stay is less than twenty-three (23) consecutive hours.
**Partial Confinement**

A period of less than twenty-four (24) hours of active treatment in a *facility* licensed or certified by the state in which treatment is received to provide one or more of the following:

1. Psychiatric services.
2. Treatment of *mental and nervous disorders*.

It may include day, early evening, evening, night care, or a combination of these four.

**Participating Pharmacy**

Any pharmacy licensed to dispense prescription drugs that is contracted within the pharmacy organization.

**Pharmacy Organization**

The *Pharmacy Organization* is noted on the *employee's* benefit identification card.

**Physician**

A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.), other than a *close relative* of the *covered person* who is practicing within the scope of his license.

**Placed For Adoption**

The date the *employee* assumes legal obligation for the total or partial financial support of a child during the adoption process.

**Plan**

"*Plan*" refers to the benefits and provisions for payment of same as described herein.

**Plan Administrator**

The *plan administrator* is responsible for the day-to-day functions and management of the *Plan*. The *plan administrator* is the *employer*.

**Plan Sponsor**

The *Plan sponsor* is the *employer*.

**Plan Year End**

The plan year end is December 31.
Pre-existing Conditions

An illness or injury which existed within six (6) months before the covered person's enrollment date for coverage under this Plan. An illness or injury is considered to have existed when the covered person:

1. Sought or received professional advice for that illness or injury, or
2. Received medical care or treatment for that illness or injury, or
3. Received medical supplies, drugs, or medicines for that illness or injury.

Preferred Provider

A physician, hospital or other health care facility who has an agreement in effect with the Preferred Provider Organization at the time services are rendered. Preferred providers agree to accept the negotiated rate as payment in full.

Preferred Provider Organization

An organization who selects and contracts with certain hospitals, physicians, and other health care providers to provide services, supplies and treatment to covered persons at a negotiated rate.

Pregnancy

The physical state which results in childbirth or miscarriage.

Prior Plan

Any plan of group accident and health benefits provided by the employer (or its predecessor) for an employee group which has been replaced by coverage under this Plan.

Professional Provider

A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers include, but are not limited to:

Certified Addictions Counselor
Certified Registered Nurse Anesthetist
Certified Registered Nurse Practitioner
Chiropractor
Christian Science Practitioner
Clinical Laboratory
Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.)
Dental Hygienist
Dentist
Dietitian
Dispensing optician
Midwife
Nurse (R.N., L.P.N., L.V.N.)
Nurse Practitioner
Occupational Therapist
Ophthalmologist
Optician Optometrist
Physical Therapist
Physician
Physician's Assistant
Podiatrist
Psychologist
Respiratory Therapist
Speech Therapist

Qualified Prescriber

A physician, dentist or other health care practitioner who may, in the legal scope of the license, prescribe drugs or medicines.

Reconstructive Surgery

Surgical repair of abnormal structures of the body, caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease.

Relevant Information

Relevant Information when used in connection with a claim for benefits or a claim appeal, means any document, record or other information:

1. Relied on in making the benefit determination; or
2. That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
3. That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or
4. That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person’s diagnosis, even if not relied upon.

Room and Board

Room and linen service, dietary service, including meals, special diets and nourishments, and general nursing service. Room and board does not include personal items.

Routine Examination

A comprehensive history and physical examination which would include services as defined in Medical Expense Benefit, Routine Examination/Wellness Benefit.

Semiprivate

The daily room and board charge which a facility applies to the greatest number of beds in its semiprivate rooms containing two (2) or more beds.
**Total Disability or Totally Disabled**

The *employee* is prevented from engaging in his regular, customary occupation or from an occupation for which he or she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit; or a *dependent* is prevented from engaging in all of the normal activities of a person of like age and sex who is in good health.

**Treatment Center**

1. An institution which does not qualify as a *hospital*, but which does provide a program of effective medical and therapeutic treatment for *chemical dependency*, and

2. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law, or

3. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by the *physician*.
   c. It has or maintains a written, specific, and detailed regimen requiring full-time residence and full-time participation by the *covered person*.
   d. It provides at least the following basic services:
      1. Room and board
      2. Evaluation and diagnosis
      3. Counseling
      4. Referral and orientation to specialized community resources.

**Urgent Care**

An *emergency* or an onset of severe pain that cannot be managed without immediate treatment.

**Well Child Care**

Preventive care rendered to *dependent* children through the age of sixteen (16).
APPENDIX “A” - COVERAGE FOR ORGAN AND/OR TISSUE TRANSPLANTS

Pre-Authorization Requirement for Organ Transplant

Expenses incurred in connection with any organ or tissue transplant listed in this provision will be covered subject to referral to and pre-authorization. Cornea transplants are not subject to the pre-authorization provision, but will be considered on the same basis as any other medical expense coverage under this Plan. Transplant coverage is offered under this Plan through a transplant network of specialized professionals and facilities. Coverage is also provided for transplant services obtained outside of the transplant network, at a reduced benefit level.

Coverage will be provided for covered expenses incurred in conjunction with medically necessary, non-experimental/investigational organ transplants in accordance with all of the terms and exclusions of the Plan. All organ transplants must be coordinated through the Health Care Management Organization and the Claims Processor to be eligible for benefits under this Plan. As soon as reasonably possible, but in no event more than ten (10) days after a covered person’s attending physician has indicated that the covered person is a potential candidate for a transplant, the covered person or his physician should contact the Health Care Management Organization. The Health Care Management Organization will provide the covered person with a list of transplant network facilities and will help to coordinate referral into the network if the covered person chooses one of the transplant network facilities.

A comprehensive treatment plan must be developed for the plan’s medical review, and must include such information as diagnosis, the nature of the transplant, the setting of the procedure, (i.e. name and address of the hospital), any secondary medical complications, a five year prognosis, two (2) qualified opinions confirming the need for the procedure, as well as a description and the estimated cost of the proposed treatment (One or both confirming second opinions may be waived by the plan’s medical review specialist). Additional attending physician's statements may also be required. The covered person may provide a comprehensive treatment plan independent of the transplant network, but this will be subject to medical appropriateness review and may result in non-transplant network benefit coverage.

All potential transplant cases will be assessed for their appropriateness for Large Case Management.

NOTE: Failure to pre-authorize a transplant procedure will result in the application of a $5,000 deductible to all covered expenses incurred as a result of the transplant. This deductible is in addition to any other plan deductible and co-payment requirements that would normally be applicable to the transplant procedure.

Organ Transplant Network

As a result of the pre-authorization review the Covered Person will be asked to consider obtaining transplant services from a participating Center of Excellence facility arranged by the Plan Administrator. The purpose of designating Centers of Excellence networks is to perform necessary transplants in the most appropriate setting for the procedure, to improve the quality and probability of a successful outcome, and reduce the average cost of the procedures.

There is no obligation for the patient to use a participating transplant network facility. However, benefits for the transplant and its related expenses may vary depending on whether services are provided in or out of the transplant network. If services are provided out of the transplant network, then out of transplant network benefits will apply.

Transplant Benefit Period

Covered transplant expenses will accumulate during a Transplant Benefit Period, and will be charged toward the transplant benefit period maximums, if any, shown in the Transplant Schedule of Benefits. The term “Transplant Benefit Period” means the period beginning on the date of the initial evaluation and ending on the date twelve consecutive months following the date of the transplant. (If the transplant is a bone marrow transplant, the date the marrow is re-infused is considered the date of the transplant.)
Covered Transplant Expenses

The term "covered expenses" with respect to transplants includes the reasonable and customary expenses for services and supplies which are covered under this plan (or which are specifically identified as covered only under this provision) and which are medically necessary and appropriate to the transplant, including:

1. Charges incurred in the evaluation, screening, and candidacy determination process.
2. Charges incurred for organ transplantation.
3. Charges for organ procurement, including donor expenses not covered under the donor's plan of benefits.
   
   Coverage for organ procurement from a non-living donor will be provided for costs involved in removing, preserving and transporting the organ.

   Coverage for organ procurement from a living donor will be provided for the costs involved in screening the potential donor, transporting the donor to and from the site of the transplant, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow up care.

   If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or the donor's marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, and treatment and storage cost of the marrow, up to the time of reinfusion. (The harvesting of the marrow need not be performed within the transplant benefit period.)

4. Charges incurred for follow up care, including immuno-suppressant therapy.

5. Charges for transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the transplant benefit period will be covered up to a maximum of $10,000 per transplant period.

Re-transplantation

Re-transplantation will be covered for up to two re-transplants, for a total of three transplants per person, per lifetime. Each transplant will be subject to the Pre-Authorization Requirement for Organ Transplant. Each transplant and re-transplant will have a new benefit period and a new maximum benefit, subject to the plan's overall per-person maximum lifetime benefit.

Accumulation of Expenses

Expenses incurred during any transplant period for the recipient and for the donor will accumulate towards the recipient's benefit and will be included in the plan's overall per-person maximum lifetime benefit.

Donor Expenses

Medical expenses of the donor will be covered under this provision to the extent that they are not covered elsewhere under this plan or any other benefit plan covering the donor. In addition, medical expense benefits for a donor who is not a participant under this plan are limited to a maximum of $10,000 per transplant benefit period when the transplant services are provided out of the transplant network. This does not include the donor's transportation and lodging expenses.

Pre-Existing Conditions Limitation

Transplant charges will be subject to this plan's pre-existing conditions limitation.
**Extended Benefits in the Event of Termination**

In the event of termination of the *plan*, or of the recipient's termination of membership in an eligible class, if a transplant treatment program had commenced while coverage was in force and benefits had not been exhausted, then benefits will be paid for expenses related to the same organ transplant which are incurred during the lesser of a) the remainder of that transplant benefit period or b) one month after termination of the *plan* or membership, as though coverage had not ended.

**Organ Transplant Schedule of Benefits**

<table>
<thead>
<tr>
<th>Transplant Procedure</th>
<th>Transplant Network</th>
<th>Preferred Provider*</th>
<th>Non-Preferred Provider Facility**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>100%</td>
<td>80% up to an overall maximum of $110,000 including a physician’s maximum of $20,000</td>
<td>60% up to an overall maximum of $110,000 including a physician’s maximum of $20,000</td>
</tr>
<tr>
<td>Lung</td>
<td>100%</td>
<td>80% up to an overall maximum of $155,000 including a physician’s maximum of $20,000</td>
<td>60% up to an overall maximum of $155,000 including a physician’s maximum of $20,000</td>
</tr>
<tr>
<td>Bone Marrow or Liver</td>
<td>100%</td>
<td>80% up to an overall maximum of $130,000 including a physician’s maximum of $20,000</td>
<td>60% up to an overall maximum of $130,000 including a physician’s maximum of $20,000</td>
</tr>
<tr>
<td>Pancreas</td>
<td>100%</td>
<td>80% up to an overall maximum of $70,000 including a physician’s maximum of $20,000</td>
<td>60% up to an overall maximum of $70,000 including a physician’s maximum of $20,000</td>
</tr>
<tr>
<td>Kidney</td>
<td>100%</td>
<td>80% up to an overall maximum of $55,000 including a physician’s maximum of $20,000</td>
<td>60% up to an overall maximum of $55,000 including a physician’s maximum of $20,000</td>
</tr>
</tbody>
</table>

*Calendar Year deductible waived

**Calendar Year deductible applies
BROKER INFORMATION

Plan Arranged By:

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