

**PLAN DOCUMENT AND
SUMMARY PLAN DESCRIPTION**

FOR

**HUNTINGTON
UNIVERSITY**

GROUP MEDICAL PLAN



AMENDED AND RESTATED AS OF

February 1, 2005



IMPORTANT PLAN INFORMATION

<u>Plan Name</u>	Huntington University Group Medical Plan
<u>Plan Number</u>	501
<u>Plan Year</u>	The Plan Year is the twelve- (12) month period beginning on February 1 st and ending on January 31 st .
<u>Restatement Effective Date</u>	February 1, 2005
<u>Employer Name and Address</u>	Huntington University 2303 University Ave. Huntington, IN 46750
<u>Employer Tax ID Number</u>	35-0868101
<u>Plan Administrator</u>	Huntington University
<u>Plan Fiduciary</u>	same as Plan Administrator
<u>Plan Supervisor</u>	Unified Group Services, Inc. P.O. Box 10 Pendleton, IN 46064 (800) 291-5837
<u>Utilization Review Company</u>	Individualized Care Management, Inc.
<u>Type of Plan and Administration</u>	The Plan is a self-funded employee welfare plan that provides health benefits for Eligible Employees and their Dependents. A third party administrator (the Plan Supervisor) provides the administration.
<u>Role of Insurance Company</u>	Stop-loss insurance has been obtained for indemnification against major losses from the self-funded nature of the Plan. However, benefits under the Plan in no way shall be guaranteed by any such insurance, and the issuer of any such insurance does not provide any administrative services to the Plan. Covered Persons have no right to or legal interest in the proceeds of any such insurance.

Certain information is required by law to be specifically provided to Plan participants. To help you find this information, listed below is each type of information and where you can find it in the rest of this Summary Plan Description.

PLEASE NOTE: Pre-admission certification is required for all Hospital admissions. Further, it is recommended to certify in advance any Durable Medical Equipment (including all Prosthetic, Orthotic or Orthopedic Devices), Home Health Care, Home IV Therapy and First Trimester Maternity. The pre-admission certification is designed to confirm Medical Necessity; appropriateness of requested length of stay and appropriateness of proposed location of care.
See pages 33-34 for important details. The Plan also uses case management to limit costs.

Eligibility The Plan's requirements respecting eligibility for participation and for benefits are set forth in the Section *Eligibility, Enrollment and Termination of Coverage*.

<u>QMCSO</u>	Participants and beneficiaries in the Plan can obtain, without charge, a copy of procedures governing qualified medical child support order (QMCSO) determinations from the Plan Supervisor.
<u>Description of Benefits</u>	A description of benefits under the Plan is set forth in the Sections <i>Benefit and Information Grid, Medical Benefits, Covered Services, Services Not Covered, Organ and Tissue Transplant</i> and <i>Prescription Drug Benefits</i> ,
<u>Preventive Services</u>	The extent to which preventive services are covered under this Plan is described in Sections <i>Benefit and Information Grid, Covered Services, Services Not Covered</i> and <i>Prescription Drug Benefits</i>
<u>Specific Medical Benefits</u>	Provisions regarding whether, and under what circumstances, coverage is provided under the Plan for medical tests, devices, and procedures are set forth in Sections <i>Benefit and Information Grid, Covered Services, Services Not Covered</i> and <i>Organ and Tissue Transplants</i> ,
<u>PPO Network</u>	Provisions governing the use of network providers, which providers are in network, and whether and under what circumstances coverage is provided under the Plan for out-of-network services are set forth in Sections <i>PPO Network Benefits</i> and <i>Benefit and Information Grid</i> . Access to a detailed list of network providers will be made available upon request, without charge.
<u>Prescription Drug Benefits</u>	Provisions regarding whether, and under what circumstances, existing and new drugs are covered under this Plan are set forth in Sections <i>Benefit and Information Grid, Covered Services, Services Not Covered, Organ and Tissue Transplant</i> and <i>Prescription Drug Benefits</i> .
<u>Childbirth Benefits</u>	Employee Benefit Plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a vaginal delivery, or less than ninety-six (96) hours following a caesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours as applicable). This Plan's coverage of childbirth is described in the Section <i>Covered Services</i> .
<u>Emergency Care</u>	Conditions or limits applicable to obtaining emergency medical care are set forth in Sections <i>Benefit and Information Grid, Covered Services</i> and <i>Services Not Covered</i> .
<u>Caps/Maximums</u>	Annual and lifetime caps or maximums and other limits on benefits under the Plan are set forth in the Sections <i>Benefit and Information Grid, Medical Benefits, Covered Services, Services Not Covered, Organ and Tissue Transplant</i> and <i>Prescription Drug Benefits</i> .
<u>Cost of Plan Benefits</u>	Provisions regarding premiums, Deductibles, Coinsurance, and Copayment amounts for which the Covered Person will be responsible are set forth in the Sections <i>Medical Benefits, Benefit and Information Grid</i> , and <i>Funding</i> .
<u>Loss of Benefits</u>	Circumstances which may result in disqualification, ineligibility, or denial, loss, forfeiture or suspension of any benefits that a Covered Person might otherwise reasonably expect the Plan to provide are described in Sections <i>Eligibility, Enrollment, and Termination of Coverage</i> .
<u>Continuation Coverage</u>	The rights and obligations of Covered Persons with respect to continuation coverage are set forth in Section <i>Eligibility, Enrollment and Termination of Coverage</i> and <i>Continuation of Coverage</i> .
<u>Claim Procedures</u>	Procedures governing claims for benefits, applicable time limits, and remedies available to resolve claims that are denied in whole or in part are set forth in Section <i>Case Management, Cost Containment for Hospital & Surgical Services</i> , and <i>Administration of the Plan</i> .

ERISA Rights

A statement about certain legal rights of participants and beneficiaries is set forth in the Section *Rights Under ERISA*.

Termination/
Amendment of Plan

Provisions governing the authority of the Employer or others to terminate the Plan or amend or eliminate benefits under the Plan and the circumstances under which the Plan may be terminated or benefits may be amended or eliminated are set forth in Sections *Entry and Withdrawal of Employers* and *Amendment and Termination of Plan*. Provisions governing the benefits, rights, and obligations of participants and beneficiaries under the Plan upon termination of the Plan or amendment or elimination of benefits under the Plan are set forth in Section *Amendment and Termination of Plan*. If the Plan is amended in any material respect or terminated, you will be notified in writing.

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PREAMBLE

Huntington University (the “Company”) provides several fringe benefits to its Eligible Employees. These benefits include health and prescription drug.

As of the Effective Date, the Company hereby establishes the Huntington University Group Medical Plan (the “Plan”) for the benefit of Covered Persons (as defined below). This Plan is a continuation of several welfare benefit arrangements maintained by the Company. The Company hereby amends and restates the Plan as of February 1, 2005. This Plan is not in lieu of and does not affect any requirements for coverage under Worker’s Compensation laws of any state.

ELIGIBILITY, ENROLLMENT, AND TERMINATION OF COVERAGE

Each Eligible Employee or Dependent shall become covered under this Plan in accordance with the following rules:

Eligible Employees. An employee of the Employer is eligible for coverage under this Plan if he or she:

- (1) is regularly scheduled to work not less than thirty-two (32) hours per week (referred to as the "Hours of Service requirement").
- (2) Coverage begins the first day of Full-Time employment. Completion of an enrollment form is also a Plan requirement.
- (3) Eligible Employees on approved Leave of Absence, Sabbatical or Phased Retirement.

Dependents. A family member of an Eligible Employee will become eligible for coverage under this Plan as a Dependent on the first day that the Eligible Employee is eligible for coverage under this Plan and the family member satisfies the following requirements:

- (1) **Spouse.** An individual is eligible for coverage under this Plan as a Dependent if he or she is legally recognized as the marital partner of a Covered Eligible Employee. The Plan Administrator may require documentation proving a legal marital relationship for verification of eligibility at any time.
- (2) **Child.** An individual is initially eligible for coverage under this Plan as a Dependent if he or she is an unmarried child (biological child, adopted child, child placed for adoption, step-child, or child under legal guardianship) of an Eligible Employee for whom the Eligible Employee has more than one-half of their annual support financial responsibility for medical expenses as the result of a legal decree.* The child must also be dependent upon the Eligible Employee for more than one-half of their annual support.* A child of an Eligible Employee remains eligible as a Dependent until the date in which he or she reaches age nineteen (19), unless the child is a Full-Time Student, in which case the child remains eligible as a Dependent until the earlier of the date in which he or she attains the age of twenty-six (26)** or the date on which the child loses status as a Full-Time Student. These age limits do not apply to a child who has a mental or physical disability and depends on the Eligible Employee for support as long as the debilitating condition existed before coverage otherwise would have ended. For a Dependent child with a disability, the Plan Administrator must be furnished with proof satisfactory to it as to the Dependent child's disability within one hundred twenty (120) days after the later of the date the Dependent child is first eligible for coverage under this Plan or the date the Dependent child reaches the otherwise disqualifying age, and as may be requested by the Plan Administrator from time to time.

* Please Note: The support requirement as it pertains to a child, is waived if the Eligible Employee is required to provide coverage due to court order, divorce decree, a Qualified Medical Child Support Order or any other legal decree.

** Please Note: Full-time Students covered under this Plan beyond his or her twenty-fourth (24th) birthday, who are employed and earn more than \$3,200 during the year, could experience tax consequences.

Child Support Order. A child may become eligible for coverage as a Dependent under this Plan as set forth in a qualified medical child support order. The Plan Administrator will establish written procedures for determining (and shall have sole discretion to determine) whether a medical child support order is qualified under Section 609 of ERISA and for administering the provision of benefits under the Plan pursuant to a qualified medical child support order. The Plan Administrator may seek clarification and modification of the order, up to and including the right to seek a hearing before the court or agency which issued the order.

- (3) **Exceptions.** The following individuals are excluded as eligible for Dependent coverage: an individual who lives in the Covered Eligible Employee's home but who is not eligible as previously described; the legally separated or divorced former spouse of the Eligible Employee; any person who is on active duty in any military service of any country; or any person who is eligible for coverage under the Plan as an Eligible Employee.

Multiple Family Members Eligibility. An individual cannot be covered as both an Eligible Employee and a Dependent under the Plan. The following rules govern the coordination of the eligibility rules for multiple family member Eligible Employees:

- (1) **Married Eligible Employees**
 - (a) If both married Eligible Employees are eligible for coverage under the Plan, the Eligible Employees may choose which Eligible Employee shall be deemed the Employee for purposes of Plan eligibility. The covered Eligible Employee's spouse and any eligible children would then be deemed eligible Dependents.
 - (b) In the event of a dispute, the Eligible Employee who has been in the Plan the longest assumes status as the covered Eligible Employee under the Plan.
 - (c) If the coverage is terminated, COBRA (as defined in Section *Continuation of Coverage*) will not be offered to the extent coverage is available through the spouse by means of the spouse's employment at the Company. The spouse would automatically assume status as the covered Eligible Employee, and the individual whose coverage was terminated will become an eligible dependent under the Plan.
- (2) **Employment of a Dependent.** When a child of a covered Eligible Employee becomes eligible for coverage as an Eligible Employee, he or she is no longer covered as a Dependent under this Plan.

Automatic Enrollment. An Eligible Employee or Dependent who was covered under one of the several welfare benefit arrangements in existence as of the day preceding this Plan's Effective Date remains covered under this Plan as of the Effective Date without the need for separate enrollment in this Plan.

Regular Enrollment. An individual who is not automatically enrolled in the Plan as described above may enroll in the Plan within thirty (30) days of the date he or she first becomes eligible for coverage. Coverage for a Regular Enrollee becomes effective immediately on the first day of Full-Time employment. Submission of a completed and signed enrollment form is also required.

Special Enrollment. If an Eligible Employee or Dependent declined coverage hereunder at the time of initial eligibility (and, if required, stated in writing at that time that coverage was declined because of alternative health coverage) but subsequently loses coverage under the other health plan and applies for coverage under this Plan within thirty (30) days of the loss, such individual shall be a Special Enrollee provided such person: (1) was under a COBRA continuation provision and the coverage was exhausted; or (2) was not under such a provision and either the coverage was terminated as a result of loss or eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment, or reduction in the number of hours of employer) or employer contributions toward such coverage were terminated. Individuals who lose other coverage due to non-payment of premiums or for cause (e.g., filing fraudulent claims) may not be Special Enrollees hereunder.

An Eligible Employee or Dependent who seeks to enroll in the Plan as a result of the acquisition of a Dependent through marriage, birth, adoption, or placement of adoption shall be a Special Enrollee hereunder if enrolled within thirty (30) days of the acquisition of the Dependent. Coverage for a newborn or newly adopted Special Enrollee becomes effective as of the date of the adoption, birth, or placement for adoption. Coverage for a Special Enrollee other than a newborn or newly adopted child becomes effective the concurrent with the qualifying event date.

Late Enrollment. Notwithstanding anything in the above Subsections to the contrary, if an Eligible Employee or Dependent completes and returns the required enrollment form (and agrees to make the required contribution) more than thirty (30) days after the date on which he or she otherwise satisfies all other requirements for regular or special enrollment for coverage under the Plan, he or she shall be considered a Late Enrollee. Late Enrollees may enroll for coverage under the Plan if they experience a Special Enrollment qualifying event (*as explained above or during an Open Enrollment Period*).

Open Enrollment. Late enrollees may enroll for coverage during an enrollment period specified by the employer. A Late Enrollee could be subject to additional Preexisting condition exclusion time.

Re-Enrollment after Termination of Coverage. In the event an Eligible Employee is covered under the Plan, voluntarily chooses to terminate such coverage (for himself or herself or for a covered Dependent), does not terminate employment with the Company, and thereafter desires to be covered (or to have a previously-covered Dependent covered) again under the Plan, the Employee or Dependent may do so only as a Late Enrollee as described above.

Continuation During Periods of Employer-Certified Disability. An Eligible Employee may remain eligible for a limited time if full-time work ceases due to disability. This continuance will end as follows:

- (a) the date this Plan terminates;
- (b) the date of termination of employment;
- (c) the date the Eligible Employee becomes eligible for Medicare;
- (d) upon eligibility for coverage in any other Employee Benefit Plan that does not limit coverage for the disabling condition;
- (e) the date the Lifetime Maximum Benefits under this Plan have been paid on the person's behalf;
- (f) the date the Eligible Employee is no longer considered Disabled;
- (g) the end of the six (6) month period (*plus any available paid leave time*) immediately following the last day of active work; and
- (h) as detailed below in the next following four (4) subsections.

Coverage during Layoff. Coverage ends the date of the layoff and the Eligible Employee becomes COBRA eligible.

Unpaid Leave of Absence for Full-time and Academic Year Employees. (Refer to Employee Handbook) Full-time and Academic Year employees may request an unpaid leave of absence after three (3) months of service beyond the completion of the introductory period. Such leaves are available to employees who need to be away from work for personal or family reasons, which may not qualify them for long-term disability benefits including leaves under the Family Medical Leave Act (FMLA). The University requires an employee to use any available paid medical leave time, paid personal time, paid academic break days, and 50% of any paid vacation time before the beginning of an unpaid leave of absence. During an unpaid leave of absence, paid medical leave time does not accrue. Leaves of absence are granted on the assumption that the employee will return to work following the leave of absence period.

A written request outlining the reasons for the leave and pertinent details must be submitted to the director of human resources who will, in consultation with the vice president for business & finance, decide whether to grant an unpaid leave of absence. An employee is expected to provide at least thirty (30) days advance notice of the need for such a leave when the leave is foreseeable. If an employee has already used leave for a non-FMLA reason, he/she may still use up to twelve (12) weeks for a FMLA reason per rolling twelve (12) month period measured backward from the date he/she begins to use FMLA leave.

An unpaid leave of absence due to a serious health condition that makes the employee unable to perform the functions of his/her job may normally be requested for a period of up to six (6) months. A physician's statement regarding the nature and expected duration of the health condition must be submitted to the director of human resources before a leave can be granted. An extension of an additional three (3) to six (6) months may be granted to an eligible employee having at least five (5) years of full-time service. A physician's statement is necessary for consideration of an extension, noting progress as well as the expected duration of the health condition. A physician's statement certifying the employee's ability to return to work and perform his/her full duties must be submitted to the director of human resources prior to an employee returning to work.

An unpaid leave of absence due to reasons other than a health condition of the employee may be requested for a period of up to six (6) months; extensions are not normally available. Reasons for granting such requests might include: death of a family member; care for the employee's child after birth, or placement for adoption or foster care; or care for the employee's spouse, dependent child, or parent, who has a serious health condition.

An unpaid leave of absence may follow an unpaid maternity leave; however, the period of the maternity leave will be considered as part of the unpaid leave of absence period. If an unpaid leave of absence is granted to care for the employee's child after birth or placement for adoption or to care for the employee's spouse, dependent child, or parent, who has a serious health condition and both the employee and his/her spouse are employed by the University, the period of the leave of absence will be reduced by any leave previously granted to the spouse and/or will reduce any future leave granted to the spouse for the same reason.

During an unpaid leave of absence, the employee may continue his/her group health insurance coverage provided that advance arrangements are made with the Business Office to pay any necessary premium payments prior to their due date as determined by the University. The University will continue to pay its share of the premium for group health insurance, group term life insurance, and long-term disability insurance for the first twelve (12) weeks of an unpaid leave of absence; thereafter, the full premiums must be paid by the employee for continued coverage.

The University will reserve the employee's existing position or an equivalent position during the unpaid leave of absence. However, if the employee secures employment with another employer while on leave, the leave will automatically be rescinded and employment with the University will be terminated. If an employee's leave of absence expires and he/she fails to return immediately to work, then his/her employment status with the University may be terminated.

Unpaid Leave of Absence for Other than Full-time/Academic Year Employees. Unpaid leaves of absence under the Family Medical Leave Act (FMLA) are available to other than Full-time and Academic Year employees who have been

employed for at least twelve (12) months and who have worked at least 1250 hours in the previous twelve (12) months. Leaves of absence are granted on the assumption that the employee will return to work following the leave of absence period.

A written request outlining the reasons for the leave and pertinent details must be submitted to the director of human resources who will, in consultation with the vice president for business & finance, decide whether to grant an unpaid leave of absence. An employee is expected to provide at least thirty (30) days advance notice of the need for such a leave when the leave is foreseeable.

An unpaid leave of absence may be granted for the following reasons: care for the employee's child after birth, or placement for adoption or foster care; care for the employee's spouse, dependent child, or parent, who has a serious health condition; or a serious health condition that makes the employee unable to perform the functions of his/her job. An employee is eligible for twelve (12) weeks of FMLA leave per rolling twelve (12) month period measured backward from the date he/she uses FMLA leave.

In the case of an employee's serious health condition, a physician's statement regarding the nature and expected duration of the health condition must be submitted to the vice president for business & finance before a leave can be granted. A physician's statement certifying the employee's ability to return to work and perform his/her full duties must be submitted to the director of human resources prior to an employee returning to work.

If an unpaid leave of absence is granted to care for the employee's child after birth or placement for adoption or to care for the employee's spouse, dependent child, or parent, who has a serious health condition and both the employee and his/her spouse are employed by the University, the period of the leave of absence will be reduced by any leave previously granted to the spouse and/or will reduce any future leave granted to the spouse for the same reason.

The University will reserve the employee's existing position or an equivalent position for up to twelve (12) weeks while he/she is on an unpaid leave of absence. However, if the employee secures employment with another employer while on leave, the leave will automatically be rescinded and employment with the University will be terminated. If an employee's leave of absence expires and he/she fails to return immediately to work, then his/her employment status with the University may be terminated.

Military Leave. Notwithstanding anything in this Plan to the contrary, with respect to any Eligible Employee or Dependent who loses coverage under this Plan during the Eligible Employee's absence from employment by reason of military service, any applicable Waiting Period and Pre-Existing Condition limitation described herein shall not be imposed upon the reinstatement of such Eligible Employee's or Dependent's coverage upon reemployment of the Eligible Employee unless such Waiting Period or Pre-Existing Condition limitation would apply to such Eligible Employee or Dependent had the Eligible Employee or Dependent not been on military leave of absence.

Termination of Coverage. Except as described in the Section *Continuation of Coverage*, the coverage of any Covered Person under the Plan shall terminate on the earliest of the following dates.

- (1) The date this Plan is terminated;
- (2) With respect to an Eligible Employee, the date that he or she ceases to be classified in an Eligible Class of Eligible Employees, whether by a change in job classification, a change in the definition of Eligible Employee, or some other modification of the Plan.
- (3) With respect to an Eligible Employee, the Eligible Employee's Employment Termination Date or, if later, the date on which the Eligible Employee's coverage ceases as a result of termination of employment with an Employer;
- (4) With respect to a Dependent, the date that he or she ceases to be a Dependent, whether by a change in status, a change in the definition of Dependent, or some other modification of the Plan;
- (5) With respect to a Dependent child, the date the related Eligible Employee's coverage terminates;
- (6) With respect to a Dependent spouse, the date the coverage of the related Eligible Employee terminates;
- (7) With respect to any Covered Person, the date that he or she becomes a full-time member of the Armed Forces of any country; or
- (8) With respect to any Covered Person, the date that he or she fails to pay the required contribution, if any, to the Plan.

Full-Time Student Provisions. In addition to any other termination of coverage provisions, a student will terminate on the earlier of the dates described as follows:

- (1) The date any of the dependent criteria are no longer satisfied;
- (2) the date enrollment as a Full-time Student ends;

- (3) September 1, annually, if enrolled as a Full-Time Student on the last day of the prior spring term, unless the Plan Administrator receives satisfactory confirmation that the dependent will continue studies as a Full-time Student; or
- (4) the date of class graduation following completion of high school, under-graduate or post-graduate study unless the Plan Administrator receives satisfactory confirmation that the dependent will continue studies as a Full-Time Student.

Further, if a Full-Time Student still under the age requirement of this Plan, has a gap in attendance, not to exceed one calendar year, at an accredited College, University or Trade School and then returns to Full-Time Student status, coverage will begin the first day of school and the pre-existing condition limitation provisions will be waived.

Change in Status. Each Eligible Employee must notify the Company of any change of address, entrance or the entrance of a Dependent into the military, loss or acquisition of a Dependent, a child ceasing to be a Dependent under the terms of the Plan, the Eligible Employee's or a Dependent's eligibility for or entitlement to Medicare, or any other change in status which might affect coverage for the Eligible Employee and/or the Eligible Employee's Dependents under the Plan. Notice must be given within thirty (30) days of the change in status, or as soon as reasonably possible whenever a change in such status occurs, except as otherwise required under Section *Continuation of Coverage*. However, the failure to provide notice to the Plan Administrator shall not permit the Eligible Employee and/or Dependent to continue coverage if otherwise ineligible.

Family and Medical Leave Act (FMLA). An Eligible 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.

During this leave, the Employer will continue to pay the same portion of the Eligible Employee's contribution for the Plan. The Eligible Employee shall be responsible to continue payment for Eligible Dependent's coverage and any remaining Employee contributions. If the covered Eligible 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.

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

PPO Requirements. Subject to this Section's provisions, an Eligible Employee's eligibility under a PPO Option shall be governed by the applicable contract entered into by the Company and the applicable preferred provider organization.

MEDICAL BENEFITS

General. Subject to the provisions and limitations of the Plan, a Covered Person shall be reimbursed for Covered Charges (other than a Copayment, Deductible or Coinsurance amount for which the Covered Person is financially responsible) resulting from an Injury or Illness Incurred by that Covered Person; provided, however, that no Covered Charges shall be reimbursed, nor other medical benefits paid, with respect to a Covered Person to the extent such Covered Charges, when added to Covered Charges previously reimbursed to that Covered Person, exceed the Maximum Lifetime Limit as set forth in this Section.

Excess Charges. Neither the Plan Administrator nor the applicable Plan Supervisor shall be liable for the payment of any benefit in excess of the Usual & Customary Charge. If requested by a Covered Person, the applicable Plan Supervisor shall review its initial determination with respect to a Usual & Customary Charge under this Plan and may attempt to reach an agreement with the applicable service provider in order to compromise, settle or otherwise reduce the charges incurred by the Covered Person; provided, however, that the Covered Person shall remain financially responsible with respect to such charges incurred and for all other matters that may exist between the Covered Person and the service provider.

Offset of Benefits. If any payment is erroneously made (either with respect to the amount, identity of the payee or the fact of payment) under this Plan, this Plan may recover that erroneous payment, whether it was made as the result of the Plan Administrator's or applicable Plan Supervisor's own error, from the person to whom it was made or from any other appropriate party. If any such erroneous payment is made directly to a Covered Person, this Plan may offset future payments made directly to that Covered Person by the amount of such erroneous payment.

Request for Additional Claim Information. The Plan Supervisor may need to request additional information from the Covered Person before a claim for benefits can be adjudicated. A request for additional information may occur:

1. when necessary information is missing from the claim (i.e. birth date, date of service, diagnosis etc.);
2. when coordination of benefits information is needed;
3. (if applicable) when a pre-existing condition determination is in progress; or
4. when the claim appears to be related to an accident (see Section *Subrogation Rights*).

The Plan Supervisor will send written correspondence (letter or Explanation of Benefits (EOB)) to the Covered Person and the provider of services (if applicable) detailing the information needed. If related claims are received, an Explanation of Benefits (EOB) will again be sent to the Covered Person and Provider (if applicable) explaining the claim (s) in question will be closed until the requested information is received from the Covered Person. When the claim information is received, the Plan Supervisor will reopen and adjudicate the claim (s) by the terms as set forth in this Plan.

Pre-Existing Condition Limitation. Covered Charges Incurred for a Pre-Existing Condition (as described in the Section *Definitions*) of a Covered Person are not payable under this Plan if Incurred during the twelve (12) month period after the Covered Person's Enrollment Date if the Covered Person is a Regular or Special Enrollee and are not payable under this Plan if Incurred during the eighteen (18) month period after the covered Person's Enrollment Date if the covered Person is a Late Enrollee. However, a Covered Person otherwise subject to the Pre-Existing Condition limitation as described shall have the applicable twelve (12) or eighteen (18) month period reduced for his or her past Creditable Coverage, if any. The Pre-Existing Condition limitation shall not apply at all to the condition of pregnancy or to a newborn or newly adopted child who becomes covered under the Plan as of the date of birth, adoption or placement for adoption.

Deductibles and Coinsurance. All Covered Charges are subject to Usual & Customary allowances. All charges applied to a Deductible are not applied toward the 100% maximum out-of-pocket payment.

Calendar Year Deductible. Covered Persons must pay an annual Deductible as outlined below prior to Coinsurance payment for all benefits received from non-network providers or any benefits where it is specifically stated in the Plan that Deductible is applicable.

	<u>In-Network</u>	<u>Out-of-Network</u>
Per Covered Person	\$ 500	\$ 500
Per Family Unit	\$1,000	\$1,000

Deductible Three-Month Carryover. Covered expenses incurred in, and applied toward the Deductible in October, November, and December will be applied toward the Deductible in the next Calendar Year.

Calendar Year Maximum Out-Of-Pocket Limits. Covered Persons must pay an annual Out-Of-Pocket Maximum as outlined below for any non-network benefits or for benefits specifically stating a Coinsurance limit is applicable. The amounts below do not include annual Deductibles.



	<u>In-Network</u>	<u>Out-of-Network</u>
Per Covered Person	\$1,000	\$1,500
Per Family Unit	\$2,000	\$3,000

Maximum Lifetime Limit. The Maximum Lifetime Limit shall be \$2,000,000 for all Injuries and Illnesses combined for each Covered Person.

Secondary Payor Rules. When this Plan is secondary and its benefits are determined after those of an Other Plan, the amount of Covered Charges for which a Covered Person shall be reimbursed in a Claim Determination Period shall be reduced to an amount equal to: (a) the Covered Charges that would otherwise be payable under this Plan in the absence of Article VI with respect to an Allowable Expense incurred by the Covered Person during the Claim Determination Period; minus (b) the actual benefits payable by the Other Plan with respect to that Allowable Expense incurred by the Covered Person during the Claim Determination Period.

Charges Never Paid at 100%. The charges for the following do not apply to the 100% benefit limit and are never paid at 100%.

1. Deductible(s)
2. Precertification penalties
3. Copayment (s) (if applicable)
4. Outpatient Mental/Nervous and Substance Abuse charges

PPO NETWORK BENEFITS

Definitions. For purposes of this Section, the terms listed here shall have the following meanings:

Ancillary charges - Charges for additional services related to treatment that is not included in facility charges. Examples of ancillary charges include a radiologist or pathologist services and anesthesiology services.

Annual out-of-pocket maximum - The maximum yearly amount of Covered Charges (excluding Deductibles, Copayments, Cost Containment Penalties, over Usual & Customary Amounts, and non-covered services) that a Covered Person will pay through Coinsurance. Once this maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year.

Elective treatment – A treatment or procedure not requiring immediate attention and therefore planned for the patient’s convenience.

Emergency – Any urgent condition perceived by the patient as requiring immediate medical evaluation or treatment.

In-Network - Services provided by Physicians or Hospitals that are members of the PPO Network.

Out-of-Network - Services provided by Physicians or Hospitals that are not affiliated with the PPO Network.

Recertification - An administrative procedure whereby a provider explains via telephone a treatment plan to a third party for review before the treatment plan is initiated.

Preferred Provider Organization (PPO Network) - A group or network of Physicians and Hospitals (providers) that contracts with employer to provide comprehensive medical service. Provider’s exchange discounted service for increased volume. A Covered Person’s out-of-pocket costs are usually lower than they would be under a traditional, fee-for-service plan.

Eligibility. Eligibility for the Plan is outlined in Section *Eligibility, Enrollment, and Termination of Coverage* and applies to Covered Persons at all Company locations.

Effective Date. Plan is restated effective as of **February 1, 2005.**

Other Network-Related Plan Provisions

Eligible Employees who reside over (fifty (50) miles) from a Network Provider. Any Eligible Employee (including any covered Dependents) residing over fifty (50) miles from a Network Provider will receive the In-Network level of benefits.

Procedure for seeking Elective treatment outside the PPO Network area. A Covered Person who seeks Elective medical assistance while traveling outside the Network may see any physician. Out-of-Network percentages will apply.

Procedure for seeking Emergency treatment outside the PPO Network area. A Covered Person who requires emergency medical assistance or after-hours care when traveling outside the Network area may obtain the necessary care. Emergency care outside of the PPO Network area will be payable at the In-Network level.

Referrals to Specialists. If a Network Physician refers a Covered Person to a specialist, it is the responsibility of the Covered Person to verify, by consulting the PPO Network directory, that the specialist is a Network participant. If the specialist is not in the Network, benefits will be paid at the lower Out-of-Network rate unless the necessary treatment is unavailable from a Network Provider or Facility.


Ancillary Services. When utilizing a PPO Network provider, the following out-of-network services will be paid at the In-Network level: Radiologist or Pathologist services, consultation from an out-of-network provider or ER Physician. Also, if the operating surgeon (inpatient or outpatient) is in the PPO Network and the anesthesiologist is not, the anesthesiologist will be paid at the In-Network level. Please Note: If the hospital is Out-of-Network the charges will

be considered Out-of-Network, unless due to an Emergency or if the required services are unavailable at an In-Network facility.

Network Unavailable. Medically Necessary services and supplies that are unavailable from a network facility or provider will be considered at the In-Network level.

HUNTINGTON UNIVERSITY

BENEFIT SUMMARY

	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT	APPLY TO OUT-OF- POCKET MAXIMUM	PRECERT REQUIRED
Calendar Year Deductible	\$500 per Covered Person \$1,000 per Family Unit	\$500 per Covered Person \$1,000 per Family Unit		
Annual Out-of-Pocket Maximum <i>(Does not include deductible)</i>	\$1,000 per Covered Person \$2,000 per Family Unit	\$1,500 per Covered Person \$3,000 per Family Unit		
Coinsurance	80% - unless otherwise noted	70% - unless otherwise noted		
For those Covered Persons who qualify and register as residing outside the PPO service area	80%			
Lifetime Plan Maximum per Covered Person	\$2,000,000			
HOSPITAL SERVICES				
Hospital Admission <i>(including Intensive Care Unit)</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	YES
Hospital Outpatient and Related Charges	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
PRECERTIFICATION <i>(see pages 33-34)</i>				
Precertification Services	<p style="text-align: center;"><i>Precertify all inpatient admissions to avoid penalties. Further, it is recommended to certify in advance any Durable Medical Equipment (including all Prosthetic, Orthotic or Orthopedic Devices), Home Health Care, Home IV Therapy and First Trimester Maternity.</i></p> <p style="text-align: center;">Call (800) 728-0327</p>			
Authorization Penalties	\$500			
PHYSICIAN SERVICES				
Outpatient Physician charges	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
Outpatient Surgery Physician charges <i>(including anesthesia)</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO

	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT	APPLY TO OUT-OF- POCKET MAXIMUM	PRECERT REQUIRED
Inpatient Physician Charges <i>(including surgery, anesthesia, radiology & pathology charges)</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
EMERGENCY SERVICES				
Emergency Room	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	YES, if admitted
Supplemental Accident Benefit	1 st \$500 at 100% then after Deductible, 80% paid by Plan	1 st \$500 at 100%, then after Deductible, 70% of Usual & Customary paid by Plan	YES, after 1 st \$500	NO, unless admitted
Ambulance <i>\$10,000 per air trip maximum</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
PREVENTIVE/WELLNESS CARE				
Wellness/Routine Care Adult Includes <i>only</i> the following: Routine Mammogram Routine Prostate (PSA) Routine Colon testing <i>when Physician prescribed</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	NO	NO
OTHER MEDICAL SERVICES				
Maternity Services	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	Recommended
Durable Medical Equipment <i>\$25,000 Lifetime Maximum</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	Recommended
Prosthetic/ Orthotic/ Orthopedic Devices	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	Recommended
Extended Care Facility Combined with Skilled Nursing Facility <i>90 day Calendar Year Maximum</i>	No Deductible, 100% paid by Plan.	No Deductible, 70% of Usual & Customary paid by Plan.	YES	YES

	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT	APPLY TO OUT-OF- POCKET MAXIMUM	PRECERT REQUIRED
Hospice with 6 month life expectancy	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	Recommended
Home Health Care	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	Recommended
Rehabilitation Facility	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	Recommended
Physical, Occupational and Speech Therapy	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
Other Therapy Services	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
Organ and Tissue Transplants	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	YES
Chiropractic Care \$500 Calendar Year Maximum	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO
TMJ/Jaw Joint	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	NO, unless inpatient
PRE-EXISTING CONDITIONS LIMITATIONS				
<p>Permissible only if the limitation relates to a physical or mental condition for which medical advice, diagnosis, care or treatment was recommended or received within the six (6) month period before the plan participation started. The pre-existing condition limitation will no longer apply if:</p> <ul style="list-style-type: none"> The person is covered under the Plan for a period of time equal to twelve (12) consecutive (18 in the case of a Late Enrollee) months minus the covered person's period of Creditable Coverage. 				
MENTAL HEALTH AND SUBSTANCE ABUSE				
Please Note: Partial Hospitalization will be considered first as inpatient and then as outpatient. Two (2) days of partial hospitalization equal one (1) day of inpatient.				
Mental Health Inpatient 30 day Calendar Year Maximum	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	YES

	IN-NETWORK BENEFIT	OUT-OF-NETWORK BENEFIT	APPLY TO OUT-OF- POCKET MAXIMUM	PRECERT REQUIRED
Mental Health Outpatient <i>52 visits per Calendar Year</i>	After Deductible, 50% paid by Plan.	After Deductible, 50% of Usual & Customary paid by Plan.	NO	NO
Substance Abuse Inpatient <i>30 day Calendar Year Maximum</i>	After Deductible, 80% paid by Plan.	After Deductible, 70% of Usual & Customary paid by Plan.	YES	YES
PLEASE NOTE: <i>Substance Abuse inpatient and outpatient treatment has a combined Lifetime Maximum of \$25,000 per Covered Person. Further, the maximum allowable charge for substance abuse professional fees is \$80, limit one (1) per day.</i>				
Substance Abuse Outpatient <i>52 visits per Calendar Year</i>	After Deductible, 50% paid by Plan.	After Deductible, 50% of Usual & Customary paid by Plan.	NO	NO
PRESCRIPTION DRUGS <i>Please Note: Prescription Drug Coinsurance/Copayments do not apply to the medical out-of-pocket maximum. However, generic and brand Coinsurance/Copayments have a combined out-of-pocket maximum per Covered Person, per Calendar Year of \$1,000.</i>				
Prescription Drugs <i>(1 month supply)</i>	Generic – 25% (Coinsurance) Copayment Brand – 25% (Coinsurance) Copayment			
Prescription Drugs Mail Order Service <i>(3-month supply)</i>	Generic – \$15 Copayment Brand – \$30 Copayment			

This benefit and information grid is a summary of the plan benefits. For more complete information, please see sections *Covered Services, Prescription Drug Benefits and Services Not Covered.*

COVERED SERVICES

Subject to any limitations described elsewhere herein, the Plan shall cover the following services and supplies:

Hospital Services

- (1) **Inpatient Hospital** room and board services not to exceed the cost of a semi-private room. However, private room and board expenses will be considered if Medically Necessary.
- (2) After **23 observation hours**, a confinement will be considered an inpatient confinement.
- (3) **Hospital ancillary and professional services** including:
 - (a) Operating and treatment room and delivery room service;
 - (b) Anesthesia and administration thereof;
 - (c) Oxygen and other gas therapy, and its administration;
 - (d) X-ray and diagnostic laboratory procedures and services;
 - (e) Medical and surgical supplies;
 - (f) Drugs and medicines approved by the FDA;
 - (g) Respiratory/inhalation therapy, speech therapy and physical or occupational therapy;
 - (h) Pathological and laboratory services;
 - (i) Electrocardiograms;
 - (j) Basal metabolism tests;
 - (k) Pneumoencephalograms;
 - (l) Blood transfusions, including the cost of blood and blood plasma expander.
- (4) **Private room** accommodations in a Hospital if confinement is Medically Necessary for treatment, such as a contagious disease requiring gown, glove and/or mask isolation.
- (5) **Hospital rooms** required for the treatment of a condition or to provide Medically Necessary care and treatment including, but not limited to, intensive care rooms, coronary care, progressive care rooms, and burn units.
- (6) **Outpatient Hospital** services.
- (7) **Hospital** confinement expenses for dental services.

Hospital Room Limitation - Charges for a Hospital room shall be limited to the semi-private room charge in the Hospital where the Covered Person is confined; provided, however, that, if the Hospital in which the Covered Person is confined does not have semi-private rooms, charges shall be limited to the lowest private room rate in that Hospital; provided, further, that if a private or specialty care room (intensive care, coronary care, etc.) is Medically Necessary, charges for that room shall be covered at the standard rate for that room in the Hospital where the Covered Person is confined.

Specialized Treatment Facilities

- (1) Charges made by a **Ambulatory Surgical Facility, Rehabilitation Facility, or Birthing Center** for services and supplies furnished as deemed Medically Necessary.
- (2) Charges made by a **Home Health Care Agency** for services and supplies furnished to a covered individual in his home are considered Covered Charges. The attending Physician must furnish a written program of health care and certification that proper treatment of the Illness or Injury would require hospitalization if services and supplies were not otherwise available under a Home Health Care program.

Covered expenses include:

- (a) Part-time or intermittent nursing care (up to four (4) hours per visit) by a Registered Nurse or Licensed Practical Nurse;
- (b) Part-time or intermittent home health aide services which consist primarily of caring for the individual;

- (c) Physical, occupational or speech therapy; and
- (d) Medical supplies, drugs, and medicines prescribed by a Physician and laboratory services provided by or on behalf of a Hospital, but only to the extent that they would have been covered under this Plan if the individual had remained in the Hospital.

For purposes of this provision, see Section *Definitions*, “Home Health Care” and “Home Health Care Agency”.

Home Health Care Agency Limitation - Charges for Home Health Care services and supplies are covered only for care and treatment of an Injury or Illness when Hospital or Skilled Nursing Facility confinement would otherwise be required. The diagnosis, care and treatment must be certified by the attending Physician and be contained in a Home Health Care Plan. A Home Health Care visit will be considered a periodic visit by either a nurse or therapist, as the case may be, or four (4) hours of Home Health aide services.

- (3) **Extended Care Facility and Skilled Nursing Facility.** Covered Charges include Inpatient convalescent home care for the following services and supplies furnished while the patient is in an Extended Care Facility or Skilled Nursing Facility, is under the continuous care of the attending Physician and requires twenty-four (24) hour care:
 - (a) Room and Board and other services and supplies furnished by the facility for necessary care (other than personal items);
 - (b) Professional services;
 - (c) Use of special treatment rooms;
 - (d) X-ray and laboratory examinations;
 - (e) Physical, occupational and speech therapy;
 - (f) Oxygen and other respiratory therapy;

For purposes of this provision, see Section *Definitions*, “Extended Care Facility” and “Skilled Nursing Facility”.

Extended Care/Skilled Nursing Facility Limitation - The room and board and nursing care furnished by an Extended Care/Skilled Nursing facility will be payable if and when:

- (a) the patient is confined as a bed patient in the facility;
- (b) the confinement starts within fourteen (14) days of a Hospital confinement;
- (c) the attending Physician certifies that the confinement is needed for further care of the condition that caused the Hospital confinement; and
- (d) the attending Physician completes a treatment plan, which includes a diagnosis, the proposed course of treatment and the projected date of discharge from the Skilled Nursing Facility.

Two or more periods of convalescent care facility confinement will be considered one if the later confinement results from causes that are related to those of the previous one and in the meantime the Eligible Employee does not return to the Full-time duties of a regular job for at least two consecutive weeks.

- (4) **Hospice care.** For purposes of this provision, see Section *Definitions*, “Hospice”. Benefits. Benefits are subject to the maximums and limitations set forth in Section *Benefit and Information Grid*.
 - (a) Hospice Care Services and Supplies are covered only when the attending Physician has diagnosed the Covered Person’s condition as being terminal and determined that the person is not expected to live more than six (6) months. Benefits are payable subject to limits for all Illness.
 - (b) Room and board and services and supplies while confined in a Hospice or Hospice setting.
 - (c) Part-time nursing care by or under the supervision of a registered nurse (RN).
 - (d) Home health aide services.
 - (e) Nutrition services and special meals.

Surgical Services

- (1) When **more than one surgical procedure** is performed during an operation, 100% of the Usual & Customary Charge for the primary procedure, 50% of the Usual & Customary Charge for second and for any additional incisions and procedure types payable under this Plan. The following situations are exceptions:
 - (a) Fractures: When reductions (or treatment) of one or more separate and distinct fractures take place, 100% of the Usual & Customary charge of each procedure is allowable.
 - (b) More than One Surgeon: When the skills of two or more physicians are required and each surgeon performs separate operations, the allowance is 100% of Usual & Customary for each procedure, provided each of the doctor's bills separately for the procedure he/she performed. This applies even though both procedures were performed at the same operative session
- (2) Charges for a **second and third surgical opinions** which are provided to determine the medical necessity of an elective operation (one that is not of an emergency or life-threatening nature) and which is rendered by a Physician who is neither the operating surgeon nor associated with the Physician who recommended the surgery. Payment is subject to the benefits listed in Section *Benefit and Information Grid*.
- (3) Technical assistance by a **Physician or Certified Surgical Assistant (CSA)** in the performance of a **surgical procedure** provided that the surgical procedure necessitates the use of an **assistant** not to exceed 25% of the primary surgeon's charge. Charges for a Physician's Assistant (PA) may be further reduced.
- (4) **Anesthetic services**, when performed by a licensed anesthesiologist or certified registered nurse anesthetist in connection with a surgical procedure.
- (5) **Circumcision** for newborns and when Medically Necessary.
- (6) Surgical treatment of **Temporomandibular Joint Dysfunction (TMJ)** subject to the limitations set forth in section *Benefit and Information Grid*.
- (7) **Outpatient surgery**.
- (8) **Orthognathic surgery with Medical Necessity**.
- (9) **Podiatry surgery**.
- (10) **Sterilization** (for Covered Employees and Spouses) including:
 - (a) Vasectomy;
 - (b) Tubal ligation (when elective procedure)
- (11) **Reconstructive surgery** when needed to correct damage caused by a birth defect resulting in the malformation or absence of a body part, an accidental injury or for breast reconstruction following a total or partial mastectomy. **Further, regarding breast reconstruction after a total or partial mastectomy the following are covered expenses:**
 - (a) reconstruction of the breast on which the mastectomy has been performed;
 - (b) reconstruction of the other breast to produce symmetrical appearance; and
 - (c) coverage for prostheses and physical complications of all stages of mastectomy, including lymph edemas; in a manner determined in consultation with the attending physician and the patient.
- (12) **Nasal surgery** when Medically Necessary.

SURGICAL SERVICES FOR TREATMENT OF MORBID OBESITY

I. QUALIFYING CRITERIA FOR SURGICAL SERVICES FOR THE TREATMENT OF OBESITY (TO INCLUDE GASTRIC BYPASS AND/OR BARIATRIC SURGERY/SERVICES) AS COVERED UNDER THE PLAN:

- A. Subject to review and must be approved by the Plan's contracted Utilization Review Company.
- B. The Plan's contracted Utilization Review Company must determine that the surgical services or the treatment of obesity are medically necessary.
- C. Employees/dependents must be pre-certified and meet the following criteria to qualify for coverage of surgical services or treatment of obesity:
 - 1. Must be at least 100 pounds overweight or have a Body Mass Index (BMI) greater than or equal to 40 in conjunction with co-morbidities such as diabetes, hypertension, coronary artery disease, obstructive sleep apnea, or unremitting lower extremity arthritis. Shortness of breath when walking up stairs, knee pain, gastric reflux and general body aches would not be considered co-morbidities.
 - 2. Have an authorized statement from a physician that:
 - a. Bariatric surgery is medically necessary; and
 - b. The patient has documented morbid obesity for five (5) years or more; and
 - c. The patient has/is participating in a least 18 months of documented physician directed weight loss program. (Actively participate is defined as compliant participation within the plan described by the physician); and
 - d. The patient must undergo a consultation with a dietary professional. All of the life-style eating changes must be explained to and understood by the patient.
 - e. The patient must undergo an independent psychological evaluation prior to the procedure to ensure he/she can understand, tolerate and comply with all phases of care.

II. THE FOLLOWING GASTROINTESTINAL SURGERIES FOR THOSE MEETING THE QUALIFICATIONS IN ITEM I ARE COVERED (if all the above guidelines are met):

- A. Vertical-banded gastroplasty (gastric stapling);
- B. Gastric bypass using Roux-en-Y anastomosis (short limit (less than 100 cm));
- C. Vertical Banded Gastroplasty and Laproscopic Adjustable Silicone Banded Gastroplasty
 - 1. is considered MN for those who meet the surgical criteria and who are at increase risk for adverse consequences from Roux-en-Y Gastric Bypass due to presence of any of the following co morbid conditions:
 - a. Hepatic cirrhosis with elevated liver function tests; or
 - b. Inflammatory bowel disease; or
 - c. Radiation enteritis; or
 - d. Demonstrated complications from extensive adhesions involving intestines from major abdominal surgery, or multiple minor surgeries or major trauma; or
 - e. Poorly controlled systemic diseases
- D. Other gastrointestinal procedures only when significant documentation exists that the procedure has been scientifically proven to result in an improved net health outcome for obese patients;
- E. Any related complications; and
- F. After a covered procedure, Panniculectomy (removal of excess skin from abdominal region) when Medically Necessary.

III. EXCLUSIONS:

- A. Jejunioileal bypass;
- B. Biliopancreatic bypass such as the Scopinaro procedure;
- C. Long limb gastric bypass (long limb Roux-en-Y, greater than 100cm);
- D. Horizontal gastric partitioning/gastroplasty;
- E. Gastric wrapping;
- F. Gastric bypass using Billroth II type anastomosis (the "mini-gastric bypass);
- G. Garren-Edwards gastric bubbles;
- H. Any existing or new procedure that has not been scientifically proven to result in an improved net health outcome for obese patients;
- I. Any complications related to a non-covered procedure; and
- J. Also **excluded**, all health club memberships, weight control/loss programs, exercise programs, appetite suppressants, medications/supplements, dietary regimens, food supplements and liposuction.

Diagnostic Services

- (1) Diagnostic charges for **X-rays**.
- (1) **Radiology**, ultrasound and nuclear medicine.

- (3) **Pre-admission testing (PAT).**
- (4) **Laboratory and pathology.**
- (5) **EKG, EEG and other electronic diagnostic medical tests.**
- (6) **Amniocentesis.**
- (7) **Psychological testing** (*payable at the applicable Mental Health/Substance Abuse benefit percentage*).
- (8) **Neuropsychological testing** (*payable at the applicable Mental Health/Substance Abuse benefit percentage*).
- (9) **Allergy testing.**
- (10) **Magnetic Resonance Imaging (MRI).**

Emergency Services

- (1) Professional local **ambulance service** provided by a Hospital or by a government certified ambulance service to or from the Hospital, including both air and ground ambulance services, when such service is deemed by the Physician as Medically Necessary to safeguard the health of the Covered Person.
- (2) Treatment in a hospital **emergency room** or other emergency care facility for a condition that can be classified as an Emergency (*see Definitions page 59*).
- (3) **Physician services**, and the treatment of an Injury or Illness which is the result of an Emergency.

Ambulance/Emergency Service Limitation – To be treated as a Covered Charge, Emergency transportation must be:

- (a) Medically Necessary;
- (b) within or between the United States, Canada and Puerto Rico;
- (c) by a licensed professional ambulance service, regularly scheduled airline, air ambulance or railroad; and
- (d) to the nearest facility where Emergency care or treatment is rendered;
- (e) from a facility to home, only when Medically Necessary.

Dental Services

- (1) Services performed by a **Dentist or an oral surgeon** when required for:
 - (a) Accidental Injury to natural teeth and jaw within twelve (12) months after an Accident.
 - (b) Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
 - (c) Surgery needed to correct accidental injuries to the jaws, cheeks, lips, tongue, floor and roof of the mouth when the Injuries occurred while covered under this Plan.
 - (d) Excision of benign bony growths of the jaw and hard palate.
 - (e) External incision and drainage of cellulitis.
 - (f) Incision of sensory sinuses, salivary glands or ducts.
 - (g) Surgical removal of bone or tissue impacted teeth.

Provider Services

- (1) **Services of a Physician**, while the Covered Person is an **Inpatient**, including surgical procedures, administration of anesthesia by a second Physician during surgery, treatments and other Physician's services received in a Hospital, excluding routine services or other care not connected with treatment of an Illness or Injury unless otherwise stated herein.
- (2) **Physician services**, and the cost of the use of facilities, including surgical procedures and other Physician's services received in a Physician's office, the Covered Person's home, the Outpatient department of a Hospital, an Ambulatory Surgical Center, an urgent or immediate care center or a Hospital for inpatient

services. Regarding outpatient office visit charges, one office charge per visit is payable under this Plan; extended office visits charges will be paid as appropriate.

- (3) **Services of chiropractors** acting within the scope of their licenses, subject to any limitations set forth herein.
- (4) Services of actively practicing **nurses** (other than persons who reside in the Covered Person's home or who are a member of the Covered Person's Immediate Family) as follows:
 - (a) In a Hospital, services of a Registered Professional Nurse (R.N.) or services of a Licensed Practical Nurse (L.P.N.);
 - (b) Other than in a Hospital, services of a Registered Professional Nurse (R.N.), a visiting nurses association, where available, or a Licensed Practical Nurse (L.P.N.)
- (5) The **Private Duty Nursing** care by a licensed nurse (R.N., L.P.N. or L.V.N.). Covered charges for this service will be included to the extent of: a) *Inpatient Nursing Care* – Charges are covered only when care is Medically Necessary or not Custodial in nature and the Hospital's Intensive Care Unit is filled or the Hospital has no Intensive Care Unit. b) *Outpatient Nursing Care*. Outpatient nursing care is subject to the Home Health Care limitations and maximums. Outpatient private duty nursing care on a shift-basis is not covered.
- (6) **Midwife** delivery services, provided:
 - (a) The state in which such services are performed has officially recognized midwife delivery; and
 - (b) The person or persons performing such midwife delivery and the facility available for these services are properly licensed by the state at the time the delivery is performed.
- (7) The charges of a legally qualified **physical, speech, occupational or orthopedic therapist**, if prescribed by a Physician. Therapy is covered only for purposes of restoring speech ability or improving a bodily Injury or Illness and only if the therapy is expected to result in significant improvement of the specific defects.

Spinal Manipulation/Chiropractic Services

- (1) Chiropractic or Chiropractic Services means the diagnosis and analysis of any interference with normal nerve transmission and expression, the procedure preparatory to and complementary to the correction thereof by an adjustment of the articulations of the vertebral column, its immediate articulation, and includes other incidental means of adjustments of the spinal column and practice of drugless therapeutics. However, chiropractic does not include any of the following:
 - a) Prescription or administration of legend drugs or other controlled substances;
 - b) Performing of incisive surgery or internal or external cauterization;
 - c) Penetration of the skin with a needle or other instrument for any purpose except for the purpose of blood analysis;
 - d) Use of colonic irrigations, plasmatics, ionizing radionics;
 - e) Conducting invasive diagnostic tests or analysis of body fluids except for urinalysis;
 - f) The taking of x-rays of an organ other than the vertebral column and extremities; and
 - g) The treatment or attempt to treat infectious diseases, endocrine disorders, or atypical or abnormal histology.

Mental Health and Substance Abuse Services

- (1) **Physician services** and the cost for the use of facilities, for **Inpatient** treatment of **mental and nervous conditions**, not to exceed any Inpatient mental or nervous limitation specified herein.
- (2) **Physician services** and the cost for the use of facilities, for **Outpatient** treatment of **mental and nervous conditions**, not to exceed any Outpatient mental or nervous limitation specified herein.
- (3) **Physician services** and the cost for the use of facilities, for **Inpatient** treatment of **substance abuse**, not to exceed the Inpatient substance abuse limitation specified herein.

- (4) **Physician services** and the cost for the use of facilities, for **Outpatient** treatment of **substance abuse**, not to exceed the amount of the Outpatient substance abuse limitation specified herein
- (5) Professional services provided by a **Psychologist or mental health therapist** licensed by the state where practicing and acting within the scope of such license.
- (6) **Non-Residential** treatment facility services as specified herein.
- (7) **Intensive Outpatient** treatment services, as specified herein.
- (8) **Psychiatric Day Hospital** treatment services, as specified herein.
- (9) **Partial Hospitalization** treatment services, as specified herein.
- (10) Treatment for **Eating Disorders**.
- (11) **Psychological testing** (*payable at the applicable Mental Health/Substance Abuse benefit percentage*).

Mental Health and Substance Abuse Services - Covered Charges for Physician services and the use of facilities for treatment of **Mental Health and Substance Abuse conditions treatment shall be subject to Plan Lifetime Maximum of \$2,000,000 and the limitations detailed in Section *Benefit and Information Grid***.

Inpatient mental health treatment will be considered at the appropriate Coinsurance level after satisfaction of the Calendar Year Deductible where applicable.

Note: Two (2) days of treatment in a day treatment program will be considered as one (1) day of inpatient treatment when the day treatment program is approved by the utilization review administrator. "Day Treatment" means treatment of a mental illness in an intensive outpatient program primarily used to assist patients during an acute crisis. A day treatment program will be considered inpatient first and then as outpatient.

Outpatient Mental/Nervous treatment Services – Charges will be considered at the appropriate Coinsurance level after satisfaction of the Deductible or Copayment where applicable.

Substance Abuse Limitation – Covered Charges for Physician services and the use of facilities for treatment of substance abuse conditions on an **inpatient basis** will be considered at the appropriate Coinsurance level after satisfaction of the Calendar Year Deductible or Copayment where applicable.

Note: Two (2) days of treatment in an Intensive Outpatient Program or Partial Hospitalization will be considered as one (1) day of inpatient treatment when the treatment is approved by the utilization review administrator. Intensive Outpatient or partial hospitalization will be considered as inpatient first and outpatient secondarily.

Outpatient substance abuse treatment Services – Charges will be considered at the appropriate Coinsurance level after satisfaction of the Deductible or Copayment where applicable.

This Plan will pay for treatment rendered in accordance with generally accepted standards of medical practice of Mental Health and Substance Abuse Disorders. Covered Services include:

- (a) diagnostic and psychological testing;
- (b) charges for room and board, services and supplies while confined as an inpatient;
- (c) individual and group therapy; and
- (d) electroshock therapy.

Therapy Services Therapy services include, but are not limited to:

- (1) **Radiation** therapy through treatment of disease by X-ray, radium or radioactive isotopes.

- (2) **Chemotherapy** by way of treatment of disease by chemical or biological antineoplastic agents.
- (3) **Dialysis** for the treatment of acute renal failure or chronic irreversible renal insufficiency for removal of waste materials from the body, including hemodialysis and peritoneal dialysis.
- (4) **Respiratory/inhalation** therapy.
- (5) **Occupational** therapy from a qualified practitioner. The therapy must be ordered by a Physician, result from an Injury or Sickness that occurred while covered under the Plan and improve a body function. Covered expenses do not include recreational programs or maintenance therapy.
- (6) **Speech** therapy from a qualified practitioner to restore speech loss due to an illness, injury or surgical procedure. Therapy must be ordered by a Physician and follow either:
 - (a) surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than frenectomy) of a person born while covered under the Plan;
 - (b) an Injury; and
 - (c) a Sickness that is other than a learning or Mental Disorder.
- (7) **Physical** therapy by a qualified practitioner. Therapy must be in accord with a Physician's exact orders as to type, frequency and duration, and to improve a body function.
- (8) **Human Growth Hormone** therapy with Medical Necessity and periodic submission of growth charts.
- (9) **Cardiac rehabilitation** as deemed Medically Necessary provided services are rendered:
 - (a) under the supervision of a Physician;
 - (b) in connection with a myocardial infarction, coronary occlusion or coronary bypass surgery or recurrent symptoms;
 - (c) initiated within 12 weeks after other treatment for the medical condition ends; and
 - (d) in a Medical Care Facility as defined by this Plan.
- (10) **Home (IV) Therapy.**

Medical Equipment and Prosthetic Devices

- (1) Rental of **Durable Medical Equipment** that is appropriate for the home use and is made mainly to treat the ill or injured, or other durable equipment required for temporary therapeutic use, or the purchase of such medical equipment and its repair and replacement if economically justified, whichever is less. Routine maintenance is not covered and charges for deluxe items are limited to the cost of features considered basic and necessary to the intended function of the device.
- (2) **Orthotic devices** including initial purchase, fitting and repair of braces, splints and other appliances used to stabilize or immobilize a body part, prevent deformity, protect against injury, or assist with functions.
- (3) **Orthopedic/Prosthetic devices** (except as stated as not covered in Section *Not Covered Services*) including crutches and prosthetic devices and appliances. Orthopedic shoes are covered only if attached to a Medically Necessary brace. Non-prescription devices to be attached to or placed in shoes are not covered. Covered services also include the purchase, fitting, repair and initial placement of fitted devices which replace body parts or perform body functions, such as artificial limbs and eyes necessary for the alleviation of or correction of conditions arising out of Accidental Injury or Illness.

Other Medical and Related Supplies

Including, but not limited to, the following:

- (1) Initial **contact lenses or glasses** required following cataract surgery.
- (2) **Surgical dressings, osmotic supplies, electronic heart pacemaker, casts, splints and trusses.**
- (3) Administration of **blood and blood plasma, blood transfusions**, including the cost of blood and blood plasma expander.

- (4) **Oxygen** and rental of equipment required for its use, not to exceed the purchase price of such equipment.
- (5) **Occupational** therapy supplies.
- (6) Sterile **surgical supplies** after surgery.
- (7) **Diabetic** supplies, including glucose monitors.
- (8) **Corrective shoes** when physician prescribed.

Pregnancy

- (1) Services provided for any condition of pregnancy and the resulting childbirth or miscarriage, including any complications therefrom **for all Covered Persons.**
- (2) Hospital charges Incurred by a newborn during the initial period of Hospital Confinement, or within the first seven (7) days after live birth, will be covered as charges of the mother. **However, the newborn child must be added to the Eligible Employees coverage (per the terms set forth in section *Enrollment, Eligibility, and Termination of Coverage*) for the newborn charges to be considered under this Plan.** In addition, the following services will be covered during the same time period: (a) professional services; (b) nursery care; (c) circumcision; and (d) required general care and treatment. Please Note: Regarding pregnancy of a dependent child, only charges incurred by the mother are covered expenses.

The Plan will provide coverage for Hospital care, including room and board and pediatric visits, for a newborn infant and the mother during the first forty-eight (48) hours after a normal vaginal delivery and during the first ninety-six (96) hours after a caesarean section. This coverage is subject to the satisfaction of the mother's Coinsurance Deductible or Copayments where applicable and then is paid at the appropriate level of benefits subject to case management and accessing the PPO network. In the event of an early discharge, the Plan will cover two (2) R.N. home visits.

- (3) Pre-admission certification for the condition of pregnancy is not required for hospital confinements which do not exceed the minimum required periods stated above. However, pre-admission certification is required for labor induction and days beyond the above time periods.

Prescription Drugs and Medicines

- (1) **Drugs and medicines** which require the written prescription of a Physician which are purchased from a licensed pharmacist or from a Physician who is licensed to dispense drugs unless specifically stated as not covered herein. All prescription drugs are subject to the limitations specified in Sections *Benefit and Information Grid* and *Prescription Drug Benefits*.
- (2) **Injectable drugs** and the charge for administration when in lieu of an office visit charge .
- (3) **Allergy serum** and the physician charge for the injection (when in lieu of an office visit charge).

Temporomandibular Joint Syndrome (TMJ)

- (1) Reimbursements shall be limited to the applicable Copayment or Coinsurance percentage after application of the Deductible. Please Note: Orthodontia services are covered under this benefit.

Routine/Wellness Services for Adults. Includes only the following services, as recommended by a Physician:

Routine Mammogram – A routine mammogram and the related charges will be covered one (1) time per year subject to the limitations listed in Section *Benefit and Information Grid*.

Routine Prostate (PSA) – The Plan will reimburse expenses for a routine prostate exam and related charges one (1) time per year subject to the limitations listed in Section *Benefit and Information Grid*.

Routine Colon testing – The Plan will reimburse expenses for routine occult blood screenings and (for those age 50 and beyond) routine colonoscopies when Physician prescribed.

Organ and Tissue Transplants

- (1) **Organ and tissue transplants** as set forth in Section *Organ and Tissue Transplants*.

Other

- (1) Medically Necessary treatment of the **feet**.
- (2) Covered charges include any **taxes or surcharges** imposed by a governmental entity based on the value or volume of Covered Services provided to Covered Persons, or amount imposed or assessed against the Plan or the Employer in lieu of such taxes or surcharges. Taxes or surcharges are not subject to Deductible or Coinsurance and are payable at 100%.
- (3) Treatment of or related to **sleep disorders** when Medically Necessary.
- (4) Services or supplies related to **Acupuncture** when in lieu of anesthesia or for pain management shall be a covered expense.
- (5) **Medically Necessary patient education programs** including, but not limited to, diabetic education and ostomy care education covered one (1) time initially with follow-up as directed by a Physician.

Services listed as a covered expenses in this section that are not listed in Section Benefit and Information Grid are payable at the applicable Coinsurance level, after satisfaction of Deductible (if applicable), subject to access of the PPO Network and the precertification requirements of this Plan.

ORGAN AND TISSUE TRANSPLANTS

Covered Charges for organ and tissue transplant surgeries and related expenses shall be subject to the Plan Maximum Lifetime limit of \$2,000,000 per Covered Person and Coinsurance and Deductible amounts otherwise applicable under this Plan.

Covered Services for Organ and Tissue Transplants

The following services are Covered Services:

- (1) Inpatient and Outpatient Hospital services;
- (2) services of a Physician for diagnosis, treatment, and surgery for a covered transplant procedure;
- (3) diagnostic services;
- (4) services provided to a living donor of an organ or tissue, as specified in more detail below;
- (5) procurement of an organ or tissue, including services provided by a living donor of an organ or tissue for procurement of an organ or tissue. Covered Services are limited to the actual procurement expenses and benefits are subject to the maximums stated in this section of the Plan;
- (6) reasonable and necessary transportation costs for travel (including meals and lodging) to and from the site of the surgery for a covered transplant procedure for the transplant recipient and one companion (two if the recipient is a minor), per covered transplant procedure. Itemized receipts in a form satisfactory to the Employer must be submitted for reimbursement.
- (7) private duty nursing by a registered nurse or a licensed practical nurse when recommended by a Physician. The nurse cannot be a family member of the recipient or normally live in the recipient's home. Inpatient private duty nursing is a covered service only if the Hospital's regular staff cannot provide the care needed due to the recipient's condition;
- (8) rental or Durable Medical Equipment for use outside the Hospital. Covered charges are limited to the purchase price of the same equipment;
- (9) prescription drugs, including immunosuppressive drugs;
- (10) oxygen;
- (11) speech therapy, autotherapy, visual therapy, occupational therapy, physical therapy, and chemotherapy, as defined in herein. Speech therapy for voice training or to correct a lisp is not a covered service;
- (12) services and supplies for high dose chemotherapy when provided as part of the treatment plan which includes stem cell transplantation;
- (13) surgical dressings and supplies; and
- (14) Home Health Care.

Donor Coverage

Charges for obtaining donor organs are covered charges under the Plan when the recipient is a Covered Person. When the donor has medical coverage, his or her plan will pay first. The benefits under this Plan will be reduced by that payable under the donor's plan. If the organ donor is a Covered Person and the recipient is not, the Plan will not cover charges incurred for obtaining donor organs from the Covered Person

- (1) evaluating the organ;
- (2) removing the organ from the donor;
- (3) transportation of the organ from within the United States and Canada to the place where the transplant is to take place;

- (4) transportation of the patient and a companion (two companions if the patient is a minor) to and from the site of the transplant including the cost of meals and necessary lodging;
- (5) private nursing care by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) for any transplant procedure; and
- (6) procurement of donor organ or tissue.

Limitations

Transplant limitations include the following:

- (1) If a covered transplant procedure is not performed as scheduled due to the intended recipient's medical condition or death, benefit will be paid for transplant services until the earlier of a) the recipient's death; or b) the date the decision is made by the recipient's Physician not to perform the transplant.

Exclusions

In addition to the exclusions stated in Section *Services Not Covered*, no benefits are provided for:

- (1) services and supplies for a transplant which is Experimental and/or Investigational;
- (2) services and supplies which are eligible to be repaid under any private or public research fund, whether or not such funding was applied for or received; or
- (3) services and supplies of any provider located outside the United States of America, except for procurement services. The maximums for procurement services will apply to procurement services provided by a provider located outside of the United States of America.

PRESCRIPTION DRUG BENEFITS

Participating Pharmacy Discount

Prescription drugs that require a physician's prescription and that are dispensed by a Pharmacist are covered under the Medical Plan. This benefit is not subject to the Pre-Existing Conditions Limitation. 100% will be payable after satisfaction of the appropriate Copayment. Discounts are acquired through participating pharmacies of the chosen pharmacy network. Any one prescription is limited to the greater of a 34-day supply or a 100-unit dose, unless the medication is a maintenance drug (those medications that are taken for long periods of time such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc). Maintenance medications will be defined as any prescription drug taken more than thirty-one (31) days.

Pharmacy Prescription Benefits

25% Coinsurance/Copayment	Generic Drugs
25% Coinsurance/Copayment	Brand Drugs

Please Note: The out-of-pocket maximum per Covered Person, per Calendar Year is \$1,000 for generic and brand drugs combined.

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.
- (3) Any one-prescription drug is limited to the greater of a thirty-four (34) day supply or 100-unit dose through a local pharmacy or, if purchasing a maintenance medication, the greater of a ninety (90) day supply or 310-unit dose which is available through the mail order drug benefit option.

Mail Order Drug Benefit Option

The mail order drug benefit option is available for maintenance medications (those medications that are taken for long periods of time such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc). Because of volume buying, the pharmacy network is able to offer significant savings on prescription drugs. Maintenance medications will be defined as any prescription drug taken more than thirty-one (31) days.

Mail Order Benefit

\$15 Copayment	Generic 90-day Supply
\$30 Copayment	Brand 90-day Supply

Maintenance legend drugs may be dispensed in maximum quantities of 90-day supply. These may be filled only through the Mail Order Pharmacy and will be payable at the Copayment specified in this section and in Section *Benefit and Information Grid*.

Non-Pharmacy Network Benefit

Submit to the pharmacy network for reimbursement of the discounted drug amount less the appropriate Copayment

PLEASE NOTE: Prior Authorization

Some prescription drugs may be covered only if approved by Prior Authorization. If you find your prescription requires Prior Authorization, please place a telephone call to your claims account manager at Unified Group Services, Inc. so he/she may assist you with this process.

Expenses Not Covered

This benefit (*specifically the prescription drug card program*) will not cover a charge for any of the following:

- (1) A charge excluded under Medical Plan Exclusions.

- (2) A drug or medicine that can legally be bought without a written prescription. This does not apply to injectable insulin.
- (3) 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.
- (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.
- (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 the dispensing of drugs and medicines on its premises.
- (9) A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.
- (10) A charge for fertility medication.
- (11) Immunization agents or biological sera.
- (12) Amphetamines and appetite suppressants.
- (13) A charge for vitamins, except for Pre-natal vitamins.
- (14) Human Growth Hormones. (*Human Growth Hormones are covered under the Medical portion of this Plan*).
- (15) Contraceptive injectables, devices or implants. (*Contraceptive injectables, devices or implants are covered under the Medical portion of this Plan*).
- (16) Cosmetic drugs.
- (17) Vitamin A derivatives for dermatological/cosmetic treatment over age 26.
- (18) Anti-hyperkinesis over age 14.
- (19) Betaseron. (*Betaseron is covered under the Medical portion of this Plan*).
- (20) Hair loss products.
- (21) Transdermal and other smoking cessation products.

SERVICES NOT COVERED

The Plan does not cover charges for any of the following services:

Note: A comprehensive list of all exclusions related to Organ and Tissue Transplants is shown in the Section *Organ and Tissue Transplants*.

Note: A comprehensive list of all exclusions related to Prescription Drugs is shown in the Section *Prescription Drug Benefits*.

- (1) Services and supplies rendered for any condition, disability, or expense resulting from Injury or Illness caused by **war**, declared or undeclared, or any act of war or by participating in **civil insurrection or a riot**. An act of terrorism will not be considered an act of war, declared or not declared.
- (2) Services and supplies in a Hospital owned or operated by **the United States government or any government outside the United States** in which the Covered Person is entitled to receive benefits, except for Usual & Customary Charges for services, and supplies which are billed, pursuant to federal law, by the Veterans Administration or the Department of Defense of the United States, for services and supplies which are covered herein and which are not Incurred during or as a result of service in the Armed Forces of the United States.
- (3) Services and supplies rendered while a member of the **armed forces** of any state or country.
- (4) Services, medicines or supplies paid or payable under any **Other Plan**, except as provided herein under Section *Coordination with Other Plans and Benefits*, of the Plan. This exclusion shall apply, regardless of whether the person covered under this Plan is covered under such Other Plan, or is merely the spouse or dependent of such person.
- (5) Services and supplies provided to the extent that the Covered Person is reimbursed, entitled to reimbursement, or in any way indemnified for these expenses by or through any **public plan**, including Medicare, in accordance with applicable laws.
- (6) Services provided for which payment or reimbursement is received by or for the account of the Covered Person as the result of a **legal action or settlement**.
- (7) To the extent permitted by applicable law, services and supplies rendered for any condition, Disability or expense resulting from or sustained as a result of being engaged in an **illegal occupation**, commission of or attempted commission of an assault or a **felonious act** unless resulting from a physical or mental medical condition as would be prohibited under the Health Insurance Portability and Accountability Act of 1996.
- (8) Services or supplies that are **prohibited by any law** of the jurisdiction in which the Covered Person resides at the time the charge is Incurred.
- (9) Services and supplies rendered as a result of a voluntary **self-inflicted Injury or attempted suicide** unless resulting from a physical or mental medical condition as would be prohibited under the Health Insurance Portability and Accountability Act of 1996.
- (10) Services, medicines or supplies for any Injury received in an **Accident** (except for Covered Charges not payable by any other policy).
- (11) Services or supplies rendered for an Illness or Injury that is an **occupational Illness or an occupational Injury which are payable by another Plan or policy**.
- (12) Services or supplies for any **occupational condition**, Accident, disease, ailment, Illness or Injury arising out of and in the course of employment which are or could have been available under Worker's Compensation laws, or services, medicines or supplies which are furnished without cost to a Covered Person under the laws of the United States or any other country or of any state or political subdivision thereof.
- (13) Services and supplies rendered to an individual prior to the **Effective Date** of the Plan or the Covered Persons effective date of coverage.

- (14) Services and supplies provided for any operation, procedure, treatment, facility, drug, device or supply **not** generally accepted as **standard medical treatment** under the professional standards of medical practice for the condition being treated at the time Incurred for the geographic location of the principal office of the Company, or any items requiring United States federal or other United States governmental agency approval which approval has not been granted as of the time services are provided.
- (15) Care and treatment that is either **Experimental/Investigational**.
- (16) Services and supplies which are **not Medically Necessary** for the diagnosis or treatment of Illness or Injury.
- (17) **No Physician or Provider recommendation.** Care, treatment, services or supplies not recommended and approved by a Physician or Provider; or treatment, services or supplies when the Covered Person is not under the regular care of a Physician or Provider. Regular care means ongoing medical supervision or treatment, which is appropriate care for the Injury or Sickness.
- (18) Any **limitation** as defined under the Section *Covered Services*.
- (19) **Expenses used to satisfy Plan Deductibles or Copayments (if applicable).**
- (20) Services for which charges are made which are in excess of the **Usual & Customary Charges**.
- (21) Services and supplies **not specifically listed** as Covered Services in this Plan.
- (22) **Complications of non-covered treatments.** Care, services or treatment required as a result of or complications from a treatment not covered under this Plan, unless otherwise required by law.
- (23) **Room and board** charge for days in which the Covered Person is permitted to leave a health care facility (a weekend pass, for example).
- (24) **Organ transplant** expenses as defined in non-covered expenses in the Section *Organ and Tissue Transplants*.
- (25) Services rendered or performed or supplies ordered by anyone **other than a Physician or Dentist or other provider** as defined herein.
- (26) **Professional services** performed by a person who ordinarily resides in the Covered Person's home or is related to the Covered Person's Immediate Family, whether the relationship is by blood or exist by law.
- (27) Professional services billed by a **Physician or nurse** who is an Eligible Employee of a Hospital or Skilled Nursing Facility and paid by the Hospital or facility for the service.
- (28) Standby charges of a **Physician**.
- (29) Any **chiropractic services** in excess of the amount shown in the covered benefits for Chiropractor/Spinal Manipulation Limitations.
- (30) **Laboratory testing** in connection with services performed by a licensed **chiropractor**.
- (31) **Pre-marital laboratory testing.**
- (32) **Genetic testing and counseling** that is without Medical Necessity.
- (33) **Radial keratotomy** or other **eye** surgery to correct near-sightedness. **Eye examinations** for the diagnosis or treatment of a refractive error, including the fitting of eyeglasses or lenses or supplies, unless such treatment is due to a covered Illness or accidental Injury or is otherwise covered as specified herein. This exclusion does not apply to aphasic patients and soft lenses or sclera shells intended for use as corneal bandages.

- (34) **Orthopedics/Orthotics/Prosthetics**, replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the Covered Person's physical condition to make the original device no longer functional or unless growth and development of a child necessitates replacement.
- (35) Services and supplies for the **removal of bunions (except by capsular or bone surgery), toe nails (except for surgery for ingrown nails), corns or calluses or the trimming of toenails**, unless needed in treatment of a metabolic or peripheral-vascular disease.
- (36) **Orthopedic** shoes, orthopedic **non**-prescription devices to be attached to or placed in shoes; treatment of weak, strained, flat, unstable or unbalanced feet.
- (37) **Speech therapy** for behavioral or learning disabilities unless specifically stated otherwise elsewhere in this document.
- (38) **Marriage counseling, family, child, career, social adjustment, pastoral or financial counseling.**
- (39) **Infertility treatment.** For the diagnosis or treatment of, including, but not limited to, **in vitro fertilization, artificial insemination, embryo implantation, gamete intra fallopian transfer (GIFT)**, and any related expenses, medications, or testing beyond the period to diagnose the condition.
- (40) **Reversal of voluntary or elective sterilization** and the use of a **surrogate mother** for Covered Persons or non-Covered Persons and any related expenses.
- (41) **Services, supplies or treatment for transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.**
- (42) Cosmetic surgery or related **Hospital admissions unless Medically Necessary for:**
- (a) Correction of congenital deformity resulting from disease, birth defects or previous medical treatment while less than twelve (12) years of age, provided that it is not Medically Necessary to delay the procedure, for conditions resulting from injuries or traumatic scars; or
- (b) Reconstructive surgery as Medically Necessary for the treatment of a diseased condition, functional disorder, Accidental Injury or to restore bodily function (*see page 16*).
- (43) Any services performed in connection with the enlargement, reduction or change in **appearance of a portion of the body**, including, but not limited to the breasts, lips, jaw, chin, nose or ears unless Medically Necessary.
- (44) **Surgical excision or reformation** of any sagging skin of or on any part of the body, including, but not limited to the eyelids, face, neck, abdomen, arms, legs or buttocks unless Medical Necessary.
- (45) Care and treatment for **hair loss** including hair transplantation, wigs or any drug that promises hair growth, unless Medically Necessary and prescribed by a Physician (*other than one (1) wig following chemotherapy*).
- (46) **Chemical face peels or abrasion** of the skin.
- (47) **Electrolysis.**
- (48) **Personal hygiene and convenience items**, such as air conditioners, humidifiers, hot tubs, whirlpools, swimming pools or physical exercise equipment, even if such items are prescribed by a Physician.
- (49) Hospitalization for environmental change or Physician charges connected with prescribing an **environmental change.**
- (50) **Exercise programs.** Exercise programs for treatment of any condition, except for Physician-supervised cardiac rehabilitation, occupational or physical therapy covered by this Plan.
- (51) Hospital and surgical services rendered for the treatment of **obesity and/or weight control unless Medically Necessary due to Morbid Obesity.** (*see Section Covered Services under Surgical Services*).

- (52) **Weight control** programs, amphetamines and appetite suppressants regardless of diagnosis.
- (53) **Fluoroscopy** without films.
- (54) Charges for **Laetrile** and its administration.
- (56) Vitamins, aspirin, nutritional supplements and other substances **not requiring a prescription by federal law**.
- (57) Any drug which is consumed at the time and place of the **prescription** order.
- (58) Any **drug or medicine** which is not required in and for the treatment of bodily Injury or Illness (including, but not limited to, fertility drugs) *unless stated otherwise elsewhere in this document*.
- (59) **Drugs, medicines** or injectable insulin dispensed in a quantity or an amount, which is in excess of that quantity or amount specified by the prescribing Physician.
- (60) **Drugs, medicines** or injectable insulin, which are not approved under the United States Food and Drug Act, or its successor.
- (61) **Illegal use** of narcotics or use of hallucinogens in any form (unless prescribed by a Physician).
- (62) **Drugs, medicines** or injectable insulin for an occupational Injury or Illness.
- (63) **Drugs, medicines** or injectable insulin to the extent that benefits are payable for the same Covered Service under the provisions of another section of this Plan.
- (64) **Drugs, medicines** or injectable insulin which are obtained for any condition, disease, ailment or Accidental Injury for which coverage is available in whole or in part under any Worker's Compensation laws or similar legislation.
- (65) **Prescription Drugs**, as defined in non-covered expenses in the Section *Prescription Drug Benefits*.
- (66) Care and treatment for **smoking cessation** programs, or related to nicotine addiction, including smoking deterrent patches.
- (67) **Hypnosis or Biofeedback**.
- (68) **Hearing aids** and exams for their fitting or related supplies unless loss of hearing is due to a covered Illness or accidental Injury.
- (69) **Custodial care**, which is care whose primary purpose is to meet personal rather than medical needs and which can be provided by a person with no special medical skill or training.
- (70) **Telephone consultations, charges for the completion of claim forms or charges for failure to keep scheduled appointments. Radio, television, telephone, and guest meals.**
- (71) **Travel expenses** for a Covered Person, whether or not recommended by a Physician, or for a Physician.
- (72) Charges for **self-help training** or other forms of non-medical self-care other than specifically listed in the Plan.
- (73) Treatment of **sleep disorders** that is **not** Medically Necessary.
- (74) Charges for which the Plan has **no legal obligation to pay**.
- (75) Care and treatment for which **there would not have been a charge if no coverage had been in force**.

- (76) 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 Section Subrogation.**
- (77) Claims **not submitted within the Plan's filing limitation** as specified in Section *Administration of the Plan*.
- (78) Charges for services rendered **outside the United States** *if* the Covered Person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.
- (79) Charges or disabilities for or in connection with an injury arising out of or in the course of any **employment for wage or profit.**
- (80) **Recreational or diversional therapy.**
- (81) **Court ordered Substance Abuse treatment** lacking a collaborating diagnosis from a Physician.
- (82) Expenses **covered by medical coverage provided through "no fault" auto coverage.**
- (83) **Military service related illnesses or injuries** are not payable under this Plan.
- (84) Services or treatment related to **sexual dysfunction** unless due to a covered illness.
- (85) **Abortions.**

COST CONTAINMENT FOR HOSPITAL & SURGICAL SERVICES

The Company shall designate an entity or individual to perform utilization review services. In addition to the general precertification requirements described in the *Case Management* Section, Covered Persons are required to take the following steps with respect to review of proposed medical care:

Pre-Admission Certification. Pre-admission certification is **required** for all Hospital admissions. Further, it is **recommended** to certify in advance any Durable Medical Equipment (including all Prosthetic, Orthotic or Orthopedic Devices), Home Health Care, First Trimester Maternity and Home IV Therapy. The pre-admission certification is designed to confirm Medical Necessity; appropriateness of requested length of stay and appropriateness of proposed location of care.

Certification does not guarantee coverage and/or payment for respective Hospital admission or related charges. Eligibility, as well as any applicable limitations or exclusions on coverage are determined by Plan benefits. This process should be completed seven (7) days in advance of the planned procedure, but not less than one (1) day prior to the planned admission. For Emergency admissions, certification is required within forty-eight (48) hours (or the next business day). **Failure to precertify an inpatient admission will result in a:**

\$500 reduction in payment

PLEASE NOTE: Pre-admission certification for the condition of pregnancy is not required for hospital confinements which do not exceed the minimum required periods of forty-eight (48) hours for a normal delivery and ninety-six (96) hours for a caesarean section. However, pre-admission certification is required for labor induction and days beyond the above time periods.

Concurrent Stay Review/Discharge Planning. Concurrent stay review and discharge planning are parts of the utilization review program. The utilization review administrator will monitor the Covered Person's Hospital stay and coordinate with the attending Physician, Hospital, and Covered Person. If the attending physician feels that it is Medically Necessary for a Covered Person to stay in the Hospital for a greater length of time than has been precertified, the attending physician must request the additional days.

Large Case Management. When a catastrophic condition, such as a spinal cord Injury, a degenerative Illness, or a neurological paralytic disease occurs, a person will require long-term, perhaps lifetime care. After the person's condition is stabilized in the Hospital, he or she might be able to move to another type of care setting or to the person's home.

Sometimes specialized care or adaptations to the home are required, but are not covered under the Plan. The Large Case Management program was initiated for those situations in which there would be a large cash outlay for non-Covered Expenses for catastrophic conditions. It is a way in which these non-Covered Expenses can be paid by the Plan. However, the Plan Administrator, attending Physician, patient, and patient's family must all agree to the alternate treatment plan. Once agreement has been reached, the Plan Administrator will direct the Plan to reimburse for expenses as stated in the treatment plan, even if these expenses normally would not be paid by the Plan.

Cost Containment Services Phone Number. (800) 728-0327

The patient or family member must call this number to receive certification of the above listed cost management services. This call must be made at least one (1) day in advance of a non-emergency Hospitalization or within two (2) business days after an emergency Hospitalization. Any reduced reimbursement due to failure to follow cost management procedures will not accrue toward the 100% maximum out-of-pocket payment.

The following information will be expected at time of Pre-certification:

- (1) the name of the patient and relationship to the Covered Eligible Employee;
- (2) the name, Social Security number and address of the Covered Eligible Employee;
- (3) the name of the Employer;
- (4) the name and telephone number of the attending physician;
- (5) the name of the Hospital and proposed date of admission;
- (6) the diagnosis and/or type of surgery and;
- (7) the proposed length of Hospital stay.

CASE MANAGEMENT

The purpose of this Case Management Section is to protect the financial integrity of the Plan by limiting coverage, in those instances in which there are alternative courses of medical treatment, to services and supplies Incurred in connection with the most cost effective course of medical treatment.

Case Management. “Case Management” means with respect to a Covered Person:

- (1) the review by the Plan Supervisor or Case Manager of the course of medical treatment proposed with respect to that Covered Person;
- (2) consideration of available alternative courses of medical treatment; and
- (3) the determination of the extent to which:
 - (a) services and supplies that would otherwise be Covered Services shall be limited because there is a more cost effective course of medical treatment; and
 - (b) services and supplies Incurred with respect to an alternative course of medical treatment should be covered under this Plan in lieu of those services and supplies Incurred with respect to the proposed course of medical treatment.

Case Manager. “Case Manager” means the individual or entity appointed by the Plan Supervisor to provide Case Management services. The appointment of a Case Manager shall be evidenced by a written agreement between the Case Manager and this Plan.

Applicability. Case Management shall apply with respect to services or supplies rendered to any Covered Person to the extent that the Plan Supervisor or Case Manager, in its sole discretion, determines that the cost to the Plan of reimbursing such Covered Person for Covered Charges may be reduced as a result of the application of Case Management.

Effect of Case Management. Notwithstanding anything in this Plan to the contrary, with respect to any Covered Person to whom Case Management applies, Covered Services shall be limited to those services and supplies approved in advance by the Plan Supervisor or Case Manager. In addition, services and supplies that are not otherwise described in Section *Covered Services* (or that are described in Section *Services Not Covered*) shall be treated as Covered Services if such services and supplies are Incurred with respect to a course of medical treatment that, in the sole discretion of the Plan Supervisor or Case Manager, is more cost effective than the other available alternative courses of medical treatment.

No Liability. Each Covered Person shall be responsible for all decisions relating to his medical care, and nothing in this Plan (including this Case Management Section) shall be construed to restrict or prohibit a Covered Person from choosing a particular course of medical treatment. No Case Management decision made by the Plan Supervisor or Case Manager shall be deemed to be the rendering of medical advice or the prescribing of a course of medical treatment.

CONTINUATION OF COVERAGE.

In order to comply with the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, this Plan allows for continuation of coverage for certain individuals whose coverage otherwise would terminate.

Qualifying Events. The right to elect continuation of coverage is triggered by the occurrence of one of the following “Qualifying Events” which otherwise would cause a Covered Person to lose coverage under the Plan:

1. Death of the Eligible Employee;
2. The Eligible Employee’s termination of employment (for a reason other than gross misconduct) or reduction in hours to less than the minimum required for eligibility;
3. Divorce or legal separation of the Eligible Employee from the Eligible Employee’s spouse;
4. The Eligible Employee becoming entitled to Medicare benefits;
5. A dependent ceasing to be an Eligible Dependent Child as described in the Section Eligibility, Enrollment, and Termination of Coverage;
6. The end of a leave of absence by the Eligible Employee under the Family and Medical Leave Act of 1993; or
7. The beginning of a military leave of absence by the Eligible Employee.

Notification Requirements / Election. The Eligible Employee or Dependent must notify the Company of a divorce, legal separation, or loss of Eligible Dependent Child status within sixty (60) days of the Qualifying Event. This notice must be provided in writing to the Human Resource Department, 2303 College Ave., Huntington, IN 46750 and must be accompanied by written documentation proving that such an event has occurred. Failure to provide such notice to the Company will result in a forfeiture of rights to continuation of coverage under this Section.

Within fourteen (14) days of a Qualifying Event (or of receiving notice of a Qualifying Event), the affected Covered Persons will be notified of their rights to continuation of coverage and the process required to elect continuation of coverage. The affected Covered Persons will have sixty (60) days from the date coverage under the Plan otherwise would terminate or the date the notification is received, whichever is later, to decide whether to elect continuation of coverage. Such an election must be received or postmarked on or before the last day of the sixty (60) day period.

For families that would lose coverage without an election, each family member separately can elect continuation of coverage. However, unless otherwise specified in the election, an employee’s election to continue coverage will be deemed to include an election of continuation for the employee’s spouse and dependent children. Similarly, a spouse’s election to continue coverage will be deemed to include an election of continuation for any dependent children covered by the Plan. Such an election on behalf of a family member is binding on that family member. Although an employee and spouse can elect by default to continue coverage on behalf of other family members, they cannot elect by default to decline coverage on behalf of other family members. For example, if an employee declines continuation coverage but does not address coverage for a spouse and dependent children, the spouse and dependent children still can elect to continue their coverage.

Cost. Except as provided below in the Subsection Extension for Disability, anyone who elects continuation of coverage must pay the entire cost of the coverage plus a two percent (2%) administrative fee. For purposes of determining such costs, a person originally covered as an employee or as a spouse must pay only the rate applicable to an employee if coverage is continued for only that one person. Similarly, each child continuing coverage independent of a family unit must pay only the rate applicable to a single employee.

The first payment is due within forty-five (45) days after the election for continued coverage, and will apply from the date continued coverage begins through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are due monthly by the first day of each month.

Effective Date. When continued coverage is elected and the costs paid within the required time limit, the continued coverage becomes effective retroactively to the date of the loss of normal coverage so that no break in coverage occurs.

Family Members Acquired During Continuation. A spouse or Eligible Dependent Child newly acquired during continuation coverage may be enrolled as a dependent. The standard enrollment provisions of the Plan apply during the period of continuation coverage.

Length of Continuation Period. Upon election and subsequent payment of premiums, continuation coverage may be continued on a monthly basis for up to thirty-six (36) months unless normal coverage under the Plan was lost because of termination of employment or reduction in hours. In that case, continuation coverage may be continued for up to eighteen (18) months. If,

during that eighteen (18) months, another Qualifying Event occurs, coverage may be continued up to another eighteen (18) months. In no case may the total period of continued coverage be more than thirty-six (36) months total.

When the Qualifying Event is the termination of employment or reduction of the employee's hours of employment, and the Eligible Employee became entitled to Medicare benefits less than 18 months before the Qualifying Event, continuation coverage for persons who lose coverage other than the Eligible Employee lasts until 36 months after the date of Medicare entitlement. For example, if an Eligible Employee becomes entitled to Medicare 8 months before the date on which his employment terminates, continuation coverage for his spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Extension for Disability. Coverage may be extended beyond an initial eighteen (18) months based on disability. If the initial Qualifying Event was termination of employment or reduction of hours, and a person who has elected continuation coverage is determined – within the first eighteen (18) months of continuation coverage – to have been disabled under Social Security rules at any time during the first sixty (60) days of continuation coverage, that person and covered family members may obtain an additional eleven (11) months of coverage, at one hundred fifty per cent (150%) of the regular cost of coverage. The Plan Administrator must be notified within 60 days of the disability determination. This notice must be provided in writing to the Human Resource Department, 2303 College Ave., Huntington, IN 46750 and must be accompanied by written documentation proving that such an event has occurred and must be accompanied by the written determination of the Social Security Administration. If the disabled person is determined thereafter to be no longer disabled, the Plan Administrator must be notified within thirty (30) days, and the additional period of coverage will end.

End of Continuation Coverage. Continuation of coverage will end upon the earliest of the following dates:

1. The end of the applicable 18-month, 29-month, or 36-month period;
2. If the Qualifying Event was a military leave of absence, the day after the date on which the Eligible Employee fails to apply for or return to a position of employment with the Company.
3. The end of the period for which premiums have been paid if a subsequent premium is not paid;
4. The date the Company no longer sponsors this Plan or another Employee Benefit Plan;
5. The date the Covered Person first becomes entitled to Medicare benefits; or
6. The date the Covered Person first becomes covered under any other Employee Benefit Plan which does not have an exclusion or limitation on a Pre-Existing Condition of the Covered Person.

COORDINATION WITH MEDICARE

Secondary Coverage to Medicare. To the greatest extent allowable under applicable law, coverage under the Plan for a Covered Person who is also covered under Medicare shall be secondary to coverage of such Covered Person under Medicare. If a Covered Person's coverage under this Plan is secondary to his or her coverage under Medicare, the benefits payable under this Plan shall be reduced in the manner described in Section *Coordination with other Plans and Benefits*, Subsection *Effect on the Benefits of this Plan* (applying that Section by treating Medicare as an "Other Plan").

Primary Coverage to Medicare. If, in accordance with the above Subsection *Secondary Coverage to Medicare*, a Covered Person's coverage under this Plan is not permitted to be secondary to his or her coverage under Medicare, that Covered Person shall be reimbursed for Covered Charges in accordance with Section *Medical Benefits* of this Plan without regard to that Covered Person's coverage under Medicare.

Medicare Coverage Election. Notwithstanding any provision in this Section to the contrary, if a Covered Person is covered by Medicare and chooses not to be covered by this Plan, coverage under this Plan shall terminate.

Eligibility for Medicare. A Covered Person is considered covered under Medicare for the purposes of the Plan during any period such Covered Person has actual coverage under Medicare or, while otherwise qualifying for actual coverage under Medicare, does not have such coverage solely because he or she has refused or failed to make any necessary application for Medicare coverage.

COORDINATION WITH OTHER PLANS AND BENEFITS

Definitions. For purposes of this Section, the following terms shall have the following respective meanings:

- (1) “Allowable Expense” means a necessary, reasonable, and customary item of expense for health care, which is covered (without regard to any applicable deductible or Coinsurance limit) at least in part by one or more plans covering the person for whom the claim is made.
- (2) “Other Plan” means any of the plans, programs or policies listed below that provides benefits or services with respect to medical, dental, vision, prescription drug treatment, supplementary accident or weekly income:
 - (a) Group insurance or group-type coverage, whether insured or uninsured, including prepayment, group practice or individual practice coverage, but excluding school Accident-type coverage;
 - (b) Coverage under a governmental plan, required or provided by law, excluding any state plan under Medicaid (Title XIX, Grants to States for Medical Assistance Programs, of the United States Social Security Act, as amended from time to time) and any plan when, by law, its benefits are excess to those of any private insurance program or other non-governmental program; and
 - (c) Coverage under any other individual insurance policy or arrangement that provides payment or reimbursement for medical, dental, vision, prescription drug supplementary accident, or weekly income expenses, including but not limited to, coverage under any automobile liability insurance policy (including no-fault coverage), any homeowners insurance policy, or any individual health insurance policy (including any policy issued by or through a state risk pool or similar arrangement).

Each contract or other arrangement for coverage under paragraphs (a), (b), or (c) shall be a separate Other Plan. If only part of a contract or other arrangement is subject to coordination of benefit rules, that part of such contract or other arrangement that is subject to coordination of benefit rules shall be treated as one Other Plan and the remainder of such contract or other arrangement shall be treated as a separate Other Plan.

- (3) “Claim Determination Period” means, with respect to each person subject to this Section, a calendar year; provided, however, that a Claim Determination Period shall not include any part of a calendar year during which such person has no coverage under this Plan or any part of a calendar year before the date this Section or a similar coordination of benefits provision is effective with respect to such person.

Order of Benefit Determination Rules. With respect to a Covered Person who is covered under this Plan and an Other Plan described in the above Subsection *Definitions* (2)(c), this Plan shall be, in all instances, a secondary plan that has its benefits determined after those of the Other Plan. With respect to a Covered Person who is covered under this Plan and an Other Plan described in the above Subsection, *Definitions* (2)(a) or (b), this Plan shall be a secondary plan that has its benefits determined after those of the Other Plan, unless the Other Plan has rules coordinating its benefits with those of this Plan and both those rules and this Subsection, *Order of Benefit Determination Rules*, require that this Plan’s benefits be determined before those of the Other Plan. For purposes of the preceding sentence, this Plan shall determine its order of benefits using the first of the following rules that applies:

- (1) Eligible Employee/Dependent. The plan that covers the person as an Eligible Employee shall be primary and its benefits shall be determined before those of the plan that covers the person as a Dependent.
- (2) Dependent Child/Parents Not Separated or Divorced. Except as otherwise provided in Subsection (c) below, when this Plan covers a child as the Dependent of one natural parent and an Other Plan covers the same child as a dependent of another natural parent:
 - (a) the plan covering the parent whose birthday falls earlier in a year shall be primary and its benefits shall be determined before those of the plan covering the parent whose birthday falls later in that year; provided, however, that
 - (b) if both parents have the same birthday, the Plan that covered a parent for a longer period of time shall be primary and its benefits shall be determined before those of the plan that covered the other parent for the shorter period of time; provided, further, that
 - (c) if the Other Plan does not apply the rule described in paragraphs (a) and (b) and instead applies the rule commonly known as the “gender rule,” the rule of the plan that has covered a parent for the longer period of time shall be applied to determine the order of benefits.

- (3) Dependent Child/Separated or Divorced Parents. If two or more plans cover as a dependent the natural child of divorced or separated parents, benefits for that child shall be determined in the following order:
- (a) First, the plan covering the parent with custody of the child;
 - (b) Second, the plan covering the spouse of the parent with custody of the child;
 - (c) Third, the plan covering the parent not having custody of the child; and
 - (d) Fourth, the plan covering the spouse of the parent not having custody of the child;
 - (e) Fifth, if joint custody,
 - (i) the plan covering the parent whose birthday falls earlier in a year; or
 - (ii) if both parents have the same birthday, the Plan that covered a parent for a longer period of time; or
 - (iii) if the Other Plan does not apply, the rule described in (i) and (ii) and instead applies the rule commonly known as the “gender rule,” the rule of the plan that has covered a parent for the longer period of time shall be applied to determine the order of benefits.

provided, however, that, if a court order or court-approved settlement specifically provides that one of the parents is responsible for the health care expenses of the child and that parent’s plan (or the plan administrator, trustee, or agent, Eligible Employee or designee of either) has actual knowledge of that court order or court-approved settlement, the benefits of the plan covering that parent shall be determined first; provided, further, that any benefits that are actually paid or provided before such plan (or the plan administrator, trustee, or agent, Eligible Employee or designee of either) has actual knowledge of that court order or court-approved settlement shall not be retroactively adjusted to reflect the preceding provision.

- (1) Active/Inactive Eligible Employee. A plan that covers a person as an active Eligible Employee (or as that active Eligible Employee’s dependent) shall be primary and its benefits shall be determined before those of a plan that covers that person as an inactive or retired Eligible Employee (or as that inactive or retired Eligible Employee’s dependent). If an Other Plan does not apply the rule of this Subsection, and if, as a result, this Plan and that Other Plan do not agree on the order of benefits, this Subsection shall be ignored.
- (5) Coordination with COBRA. The plan covering the individual as an Eligible Employee, or retiree, or as a dependent of an Eligible Employee will be primary, and the plan providing continuation coverage will be secondary. If the two plans do not have this rule and the plan COB rules disagree on the order of benefits, this rule would not apply.
- (6) Longer/Shorter Length of Coverage. If none of the above Subsections of this Subsection, *Order of Benefit Determination Rules*, determines the order of benefits, the plan that covered a person for a longer period of time shall be primary and its benefits shall be determined before benefits are determined under the plan that covered that person for the shorter period of time.

Effect on the Benefits of this Plan. If, after application of the above Subsection *Order of Benefit Determination Rules*, this Plan is a secondary plan with respect to (and its benefits are determined after those of) one or more Other Plans, reimbursements for Covered Charges under this Plan shall be payable only in accordance with the formula set forth under the caption “Secondary Payor Rules” in Section *Medical Benefits*. For purposes of applying such formula, when an Other Plan provides benefits in the form of services, the reasonable cash value of each service rendered shall be considered both an Allowable Expense and a benefit payable. When Covered Charges of this Plan are reduced in accordance with the preceding sentence, each separate Covered Charge shall be reduced in the same proportion and then charged against any applicable benefit limit of this Plan.

Right to Obtain and Provide Information. The applicable Plan Supervisor may obtain or provide (without the prior consent of, or notice to, any party) information that the applicable Plan Supervisor, in its sole discretion, determines if necessary or helpful with respect to the application of this Section. As a necessary condition to receiving benefits under this Plan, each Covered Person shall provide to the applicable Plan Supervisor any information the applicable Plan Supervisor requests.

Payment of Coordinated Benefits. If payment made under an Other Plan includes an amount that should have been paid under this Plan, the applicable Plan Supervisor may pay that amount directly to that Other Plan. Any amount paid under the preceding sentence shall be treated as a Covered Charge paid under this Plan, and such amount shall not be paid again. With respect to benefits provided in the form of services, the amount of a “payment made” shall equal the reasonable cash value of the benefits provided in the form of services.

Right of Recovery. If the amount of any payment made by the Plan is more than should have paid under the coordination of benefit rules of this Section, the Plan may recover the excess from:

- (1) the Covered Person to whom, or on whose behalf, payment was made;
- (2) any insurance company that should have made such payment;
- (3) any Other Plan that should have made such payment;

- (4) any service provider to whom such payment was erroneously made; or
- (5) any other individual or entity which should have made such payment or which received the benefit of such erroneous payments.

With respect to benefits provided in the form of services, the amount of payments made shall equal the reasonable cash value of any benefits provided in the form of services.

FUNDING

Employer Contributions. This Plan shall share the cost of Eligible Employee and Dependent coverage under this Plan with the Eligible Employees.

Employee Contributions. The Plan Administrator sets the level of any Employee contributions. The required amount of contributions, if any, shall be communicated by the Company to the Eligible Employees and their Dependents. The Company hereby reserves the right to increase or decrease Eligible Employee or Dependent contributions from time to time. In the event that an Eligible Employee makes an overpayment of contributions due to a mistake in determining the eligibility of one or more of his family members, the Plan Administrator, in its sole discretion, shall determine whether a refund is appropriate and, if appropriate, the amount of the refund. For Eligible Employees and their Dependents, the enrollment application for coverage may include a payroll deduction authorization, if applicable. This authorization must be filled out, signed and returned with enrollment application.

Funding Mechanism. Benefits under this Plan will be paid from the Employer's general assets unless the Employer determines that the Employer and Eligible Employee contributions should be held in a trust, in which case the benefits will be paid from such trust.

ADMINISTRATION OF THE PLAN

Plan Administrator. Except as otherwise specifically provided in the Plan, in any insurance contract or in any trust document pursuant to which Plan benefits are funded, the Plan Administrator shall have the full, discretionary, and exclusive authority to control and manage the operation and administration of the Plan and shall be the named fiduciary of the Plan for purposes of the Act. The Plan Administrator shall have all power necessary or convenient to enable it to exercise such authority. In connection therewith, the Plan Administrator may provide rules and regulations, not inconsistent with the provisions hereof, for the operation and management of the Plan, and may from time to time amend or rescind such rules or regulations. The Plan Administrator may accept service of legal process for the Plan and shall have full discretionary power to take all actions necessary or proper to carry out the duties required under the Act, including, but not limited to, the power:

- (1) To employ one (1) or more persons or entities to render advice with respect to any responsibility the Plan Administrator has under this Plan;
- (2) To construe and interpret this Plan;
- (3) To adopt such rules, regulations, forms and procedures as from time to time it deems advisable or appropriate in the proper administration of this Plan;
- (4) To decide all questions of eligibility and to determine the amount, manner and time of payment of any benefits hereunder;
- (5) To prescribe procedures to be followed by any person in applying for any benefits under this Plan and to designate the forms, documents, evidence or such other information as the Plan Administrator may reasonably deem necessary to support an application for any benefits under this Plan;
- (6) To authorize, in its discretion, payments of benefits properly payable pursuant to the provisions of this Plan;
- (7) To prepare and to distribute, in such manner as it deems appropriate, information explaining this Plan;
- (8) To apply consistently and uniformly its rules, regulations, determinations and decisions to all Covered Persons in similar circumstances;
- (9) To prepare and file such reports and to complete and to distribute such other documents as may be required to comply fully with the provisions of the Act, and of all regulations promulgated there under; and
- (10) To retain counsel (who may, but need not, be counsel to the Company), to employ agents and to provide for such clerical, medical, accounting, auditing and other services as it may require in carrying out the provisions of this Plan.

Benefits under this Plan shall only be paid if the Plan Administrator decides, in its discretion, that the applicant (Covered Person) is entitled to them.

Delegation of Responsibility. The Plan Administrator may delegate duties involved in the administration of this Plan to such person or persons whose services are deemed necessary or convenient. However, both the ultimate responsibility for the administration of this Plan and the authority to interpret this Plan shall remain with the Plan Administrator. The Company shall indemnify any Eligible Employee to whom duties are delegated by the Plan Administrator pursuant to this Subsection from and against any liability that such Eligible Employee may incur in the administration of this Plan, except for liabilities arising from the recklessness or willful misconduct of such Eligible Employee.

Plan Supervisor. The Plan Administrator, in its sole discretion, may from time to time appoint one or more Plan Supervisors to provide consulting services to the Company and the Plan Administrator in connection with the operation of the Plan and to perform such other functions and services (including the processing and payment of claims) as may be delegated to it by the Plan Administrator. Any Plan Supervisor shall be entitled to reasonable compensation for its services.

The duties and responsibilities delegated to the Plan Supervisors shall be reflected in the separate written agreements between the Plan Administrator and the Plan Supervisors. The Plan Administrator may remove a Plan Supervisor, subject to any notice or other requirements set forth in such separate written agreement. Upon its removal, a Plan Supervisor shall transfer to any successor Plan Supervisor (or to the Plan Administrator, in the absence of a successor Plan Supervisor) all Plan records or other documents in its possession, as requested by the Plan Administrator. A Plan Supervisor shall be entitled to reimbursement of all reasonable expenses (including copying charges) incurred in connection with the transfer of Plan records or other documents to a successor Plan Supervisor (or to the Plan Administrator, in the absence of a successor Plan Supervisor).

Claims Procedure. Upon receipt of proof satisfactory to the Plan Supervisor that a Covered Person has Incurred Covered Charges for which he is entitled to reimbursement covered under this Plan, the Plan shall reimburse such Covered Person for such Covered Charges pursuant to the claims review and appeals procedure set forth below.

- (1) All claims for benefits under this Plan shall be submitted to the Plan Supervisor on forms furnished for that purpose, or otherwise approved, by the Plan Supervisor. **Such claim form, along with a billing statement or invoice of the Covered Charges must be submitted within twelve (12) months from the date of**

service. Failure to submit written proof of loss with respect to a claim for Covered Charges before the deadline for submission of claims shall invalidate that claim, unless the affected Covered Person demonstrates to the satisfaction of the Plan Administrator that it was not reasonably possible to furnish such proof within the required time and that proof was furnished as soon as was reasonably possible

- (2) The Plan Supervisor may select a Physician to examine any Covered Person whose Injury or Illness is the basis of a claim. The costs of any medical examination required under this provision shall be paid by the Plan. The Plan Supervisor may also question the health care provider or other professional person who performs services or provides supplies that are the basis of a claim for reimbursement of Covered Charges.

Foreign Claims. In the event a Covered Person incurs an expense in a foreign country, the Covered Person shall be responsible for providing the following to the Plan Administrator before payment of any benefits due are payable:

- (1) The claim form, provider invoice and any other documentation required to process the claim must be submitted in the English language.
- (2) The charges for services rendered must be converted into dollars.
- (3) A current conversion chart validating the conversion from the foreign country's currency into dollars.

Deadlines for Processing Claims. The Plan Administrator shall notify a claimant of the Plan's benefit determination in accordance with the following rules.

- (a) **Urgent care claims.** In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claim by the Plan, unless the claimant fails to provide sufficient information to determine whether, or to what extent, benefits are covered or payable under the Plan. In the case of such a failure, the Plan Administrator shall notify the claimant as soon as possible, but not later than 24 hours after receipt of the claim by the Plan, of the specific information necessary to complete the claim. The claimant shall be afforded a reasonable amount of time, taking into account the circumstances, but not less than 48 hours, to provide the specified information. The Plan Administrator shall notify the claimant of the Plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of: (1) the Plan's receipt of the specified information, or (2) the end of the period afforded the claimant to provide the specified additional information. Notification of any adverse benefit determination pursuant to this paragraph shall be made in accordance with Form of Claim Denial Section.
- (b) **Concurrent Care Decisions.** If this Plan has approved an ongoing course of treatment to be provided over a period of time or number of treatments --
 - (1) Any reduction or termination by the Plan of such course of treatment (other than by Plan amendment or termination) before the end of such period of time or number of treatments shall constitute an adverse benefit determination. The Plan Administrator shall notify the claimant, in accordance with Form of Claim Denial Section, of the adverse benefit determination at a time sufficiently in advance of the reduction or termination to allow the claimant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated.
 - (2) Any request by a claimant to extend the course of treatment beyond the period of time or number of treatments that is a claim involving urgent care shall be decided as soon as possible, taking into account the medical exigencies, and the Plan Administrator shall notify the claimant of the benefit determination, whether adverse or not, within 24 hours after receipt of the claim by the Plan, provided that any such claim is made to the Plan at least 24 hours prior to the expiration of the prescribed period of time or number of treatments. Notification of any adverse benefit determination concerning a request to extend the course of treatment, whether involving urgent care or not, shall be made in accordance with Form of Claim Denial and appeal shall be governed by Appeal of Claim Denials.
- (c) **Other Claims.** In the case of a claim not described in subsections (a) or (b) of this Section, the Plan Administrator shall notify the claimant of the Plan's benefit determination in accordance with the following rules.

- (1) **Pre-Service Claims.** In the case of a pre-service claim, the Plan Administrator shall notify the claimant of the Plan's benefit determination (whether adverse or not) within a reasonable period of time appropriate to the medical circumstances, but not later than 15 days after receipt of the claim by the Plan. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 15-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information. Notification of any adverse benefit determination pursuant to this paragraph (1) shall be made in accordance with Form of Claim Denial.
- (2) **Post-Service Claims.** In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Claim Denial, of the Plan's adverse benefit determination, within a reasonable period of time, but not later than 30 days after receipt of the claim. This period may be extended one time by the Plan for up to 15 days, provided that the Plan Administrator both determines that such an extension is necessary due to matters beyond the control of the Plan and notifies the claimant, prior to the expiration of the initial 30-day period, of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision. If such an extension is necessary due to a failure of the claimant to submit the information necessary to decide the claim, the notice of extension shall specifically describe the required information, and the claimant shall be afforded at least 45 days from receipt of the notice within which to provide the specified information.

Form of Claim Denials. Except as otherwise provided in this Section, the Plan Administrator shall provide a claimant with written or electronic notification of any adverse benefit determination. The notification shall be set forth, in a manner calculated to be understood by the claimant –

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the determination is based;
- (c) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary;
- (d) A description of the Plan's review procedures and the time limits applicable to such procedures, including a statement of the claimant's right to bring a civil action under section 502(a) of the Act following an adverse benefit determination on review;
- (e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request;
- (f) If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; or
- (g) In the case of an adverse benefit determination concerning a claim involving urgent care, a description of the expedited review process applicable to such claims.

In the case of an adverse benefit determination concerning a claim involving urgent care, the information described in this section may be provided to the claimant orally within the prescribed time frame, provided that a written or electronic notification in accordance with this section is furnished to the claimant not later than 3 days after the oral notification.

Appeal of Claim Denials. Each claimant shall be provided a reasonable opportunity for a full and fair review of a claim and adverse benefit determination in accordance with the following procedures –

- (a) Claimants shall have 180 days following receipt of a notification of an adverse benefit determination within which to appeal the determination;
- (b) Claimants shall have the opportunity to submit written comments, documents, records, and other information relating to the claim for benefit;
- (c) Each claimant shall be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- (d) Any review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination;
- (e) Any review shall not afford deference to the initial adverse benefit determination and shall be conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- (f) In deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment;
- (g) The Plan Administrator shall identify medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination;
- (h) The health care professional engaged for purposes of a consultation under subsection (f) shall be an individual who is neither an individual who has consulted in connection with the adverse benefit determination that is the subject of the appeal, nor the subordinate of any such individual; and
- (i) In the case of a claim involving urgent care, there shall be an expedited review process pursuant to which –
 - (1) A request for an expedited appeal of an adverse benefit determination may be submitted orally or in writing by the claimant; and
 - (2) All necessary information, including the Plan's benefit determination on review, shall be transmitted between the Plan and the claimant by telephone, facsimile, or other available similarly expeditious method.

Time Deadlines for Determinations on Appeal. The Plan Administrator shall notify a claimant of the Plan's benefit determination on review in accordance with the following rules.

- (a) **Urgent Care Claims.** In the case of a claim involving urgent care, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal, of the Plan's benefit determination on review as soon as possible, taking into account the medical exigencies, but not later than 72 hours after receipt of the claimant's request for review of an adverse benefit determination by the Plan.
- (b) **Pre-Service Claims.** In the case of a pre-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal Section, of the Plan's benefit determination on review within a reasonable period of time appropriate to the medical circumstances. Such notification shall be provided not later than 15 days after receipt by the Plan of the claimant's request for review of the adverse determination.
- (c) **Post-Service Claims.** In the case of a post-service claim, the Plan Administrator shall notify the claimant, in accordance with Form of Notice of Determination on Appeal, of the Plan's benefit determination on review within a reasonable period of time. Such notification shall be provided not later than 30 days after receipt of the Plan of the Claimant's request for review of the adverse determination.

Form of Notice of Determination on Appeal. The Plan Administrator shall provide a claimant with written or electronic notification of a Plan's benefit determination on review. In the case of an adverse benefit determination, the notification shall set forth, in a manner calculated to be understood by the claimant –

- (a) The specific reason or reasons for the adverse determination;
- (b) Reference to the specific Plan provisions on which the benefit determination is based;
- (c) A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claimant's claim for benefits;
- (d) A statement describing any voluntary appeal procedures offered by the Plan and the claimant's right to obtain the information about such procedures and a statement of the claimant's right to bring an action under section 502(a) of the Act.;
- (e) If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, either the specific rule, guideline, protocol, or other similar criterion; or a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination and that a copy of the rule, guideline, protocol, or their similar criterion will be provided free of charge to the claimant upon request;
- (f) If the adverse benefit determination is based on a medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, or a statement that such explanation will be provided free of charge upon request; and
- (g) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

Additional Rules. In the case of a failure by a claimant or his authorized representative to follow the Plan's procedures for filing a "pre-service claim," the claimant or his representative shall be notified of the failure and the proper procedures to be followed in filing a claim for benefits. This notification shall be provided to the claimant or authorized representative, as appropriate, as soon as possible, but not later than 5 days (24 hours in the case of a failure to file a "claim involving urgent care") following the failure. Notification may be oral, unless written notification is requested by the claimant or authorized representative.

This Section shall apply only in the case of a failure that

- (a) Is a communication by a claimant or an authorized representative of a claimant that is received by a person or organizational unit customarily responsible for handling benefit matters; and
- (b) Is a communication that names a specific claimant; a specific medical condition or symptom; and a specific treatment, service, or product for which approval is requested.

Calculation of Time Limits. For purposes of this section, the period of time within which a benefit determination or review of a benefit determination is required to be made shall begin at the time a claim (or appeal, as the case may be) is filed in accordance with this Plan's procedures, without a regard to whether all the information necessary to make benefit determination (or review of a benefit determination) accompanies the filing. In the event that a period of time is extended as permitted under the Plan due to a claimant's failure to submit information necessary to decide a claim (or appeal), the period for making the benefit determination (or review of a benefit determination) shall be tolled from the date on which the notification of the extension is sent to the claimant until the date on which the claimant responds to the request for additional information.

Definitions. The following terms shall have the following meaning whenever used in the context of the claims review and appeal procedures in this Plan:

- (a) A “claim involving urgent care” is any claim for medical care or treatment with respect to which the application of the time periods for making non-urgent care determinations –
- (1) Could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
 - (2) In the opinion of a physician with knowledge of the claimant’s medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Except as provided in the following sentence, whether a claim is a “claim involving urgent care” within the meaning of paragraph (1) is to be determined by an individual acting on behalf of the Plan applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Any claim that a physician with knowledge of the claimant’s medical condition determines is a “claim involving urgent care” within the meaning of this subsection (a) shall be treated as a “claim involving urgent care.”

- (b) The term “pre-service claim” means any claim for a benefit with respect to which the terms of the Plan condition receipt of the benefit, in whole or in part, on approval of the benefit in advance of obtaining medical care.
- (c) The term “post-service claim” means any claim for a benefit that is not a pre-service claim.
- (d) The term “adverse benefit determination” means any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of an individual’s eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.
- (e) The term “health care professional” means a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with State law.
- (f) A document, record, or other information shall be considered “relevant” to a claimant’s claim if such document, record, or other information
- (1) was relied upon in making the benefit determination;
 - (2) was submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record or other information was relied upon in making the benefit determination;
 - (3) demonstrates that the Plan provisions have been consistently and uniformly applied with respect to similarly situated claimants; or
 - (4) constitutes a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for the claimant’s diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Actions. No person may bring any action at law or in equity to recover benefits under the Plan:

- (1) prior to a final determination under the claims review procedures,
- (2) after the expiration on one (1) year from the date of the final determination.

Any determination made or action taken by the Plan Administrator pursuant to this Section shall be deemed to be conclusive with respect to any Covered Person or other individual to whom that determination or action relates, any such determination or action may be reversed by a court of competent jurisdiction only upon a finding by the court that such determination or action was arbitrary and capricious.

ENTRY AND WITHDRAWAL OF EMPLOYERS

Entry Into Plan. With the consent of a duly authorized officer of the Company, any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Code shall become an Employer as of that date approved by the Executive Director, or other duly authorized officer of the Company, and shall be subject to the terms and provisions of this Plan as then in effect and thereafter amended.

Withdrawal from the Plan. An Employer may withdraw from the Plan by delivering to the applicable Plan Supervisor written notice of its withdrawal no later than thirty (30) days prior to the date withdrawal is to be effective.

Addition or Deletion of Employers Upon the addition or deletion of Employers, the Plan Administrator shall instruct the applicable Plan Supervisor to make appropriate modifications to this Plan (including a statement as to the effective date of such addition or deletion) without the need for a Plan amendment.

RIGHTS UNDER ERISA

As a Covered Person in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that you shall be entitled to:

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all 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.

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 Administrator may make a reasonable charge for the copies.

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

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

Have exclusionary periods of coverage for Pre-Existing Conditions reduced or eliminated under your Employee Benefit Plan, if you have Creditable Coverage from another plan. You should be provided a certificate of Creditable Coverage, free of charge, from your Employee Benefit Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of Creditable Coverage, you may be subject to a Pre-Existing Condition exclusion for 12 months (18 months for late enrollees) after your Enrollment Date in your coverage.

In addition to creating rights for Covered Persons under the Plan, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

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

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you 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.

SUBROGATION RIGHTS

This Plan reserves the right to full subrogation and recovery of any and all amounts paid on behalf of a Covered Person from any judgment, settlement or other arrangement in which the Covered Person is paid damages or benefits by another party, and shall have a lien against and shall be reimbursed to the extent of such payment. In the event of any payment for services under this Plan, the Plan shall, to the extent of such payment, be subrogated to all rights of the Covered Person to receive or claim such indemnification, damages or other payment arising out of any claim or cause of action that may accrue. Each Covered Person, by accepting the benefits of coverage under this Plan, agrees to: (a) as soon as he or she first becomes aware that another party may be liable for the Covered Person's Injury or Illness, notify the Plan of the identity of the other party and the nature of the other party's inability; (b) reimburse the Plan for any benefit paid to him or on his behalf, from any monies recovered from a third party as a result of a judgment, settlement or otherwise; and (c) take such action, to furnish such information and assistance, and to execute and deliver all necessary instruments as the applicable Plan Supervisor may require to facilitate the enforcement of these rights. A Covered Person shall not release a third party from its liability or obligation or take any other action after an Injury or Illness occurs that could prejudice the Plan's recovery under this Section. The Plan's exercise of its rights to take whatever legal action it deems necessary or advisable against a third party shall not affect the Covered Person's right to pursue other forms of recovery, unless the Covered Person or his legal representative consents to the Plan's actions.

If a Covered Person or the legal representative of the Covered Person does not take such action as may be required to result in a judgment, settlement or other recovery, the Plan Administrator, upon giving thirty (30) days written notice to the Covered Person or the legal representative of the Covered Person, shall have the right to take such action at law as deemed by the Plan Administrator or applicable Plan Supervisor to be necessary or appropriate to recover an amount the Plan Administrator believes may be recovered under this Section; provided, however, that such action without the consent of the Covered Person or legal representative shall be without prejudice to such Covered Person or legal representative.

The Covered Person agrees to execute or secure the execution of such instruments as the applicable Plan Supervisor may require to enforce its rights hereunder, including but not limited to, the execution of a subrogation agreement prior to payments of claims that the applicable Plan Supervisor believes may be covered by this Section. The full amount to which the Plan is entitled under this Section shall be due from any payment made to, or on behalf of, a Covered Person or his legal representative under any judgment, settlement or otherwise, even though such payment does not fully satisfy the judgment, settlement or underlying claim for damages or fully reimburse the injured party (or parties) for his or her loss or injury. An amount recovered by, or on behalf of, a Covered Person pursuant to a settlement of litigation, to the extent it does not exceed the amount of Covered Charges Incurred by or on behalf of that Covered Person, shall be subject to subrogation under this Section regardless of whether that amount is denominated in the settlement as damages or otherwise. The expenses of recovery, including reasonable attorneys' fees, shall be paid by all persons and entities receiving payment or reimbursement in proportion to the amounts said persons and entities actually recover. The amount of attorneys' fees payable by this Plan shall not exceed 25% of the amount recovered on behalf of the Plan.

In addition to, or in lieu of, its rights of subrogation, the Plan shall also be entitled to take the following action with respect to benefits paid or Covered Charges Incurred under this Plan to the extent another party may be liable under this Section:

- (1) With respect to benefits that have been paid to or on behalf of a Covered Person, the Plan may offset future benefits payable to or on behalf of that Covered Person to the extent the Plan's subrogation rights under this Section have not been fully satisfied.
- (2) To the extent a Covered Person fails to comply with this Section, or if the Plan Administrator, exercising reasonable diligence, believes there is a substantial risk a Covered Person will fail to comply with this Section, or that the Plan will be unable to fully exercise its subrogation rights, the Plan Administrator may suspend the processing of claims by or on behalf of that Covered Person until the Covered Person complies fully with this Section (or until the Covered Person provides reasonable assurances, satisfactory in the judgment of the Plan Administrator, that he or she will comply with this Section or that the Plan will be able to fully exercise its subrogation rights).

HIPAA PRIVACY & SECURITY REGULATIONS

As of the date set forth herein this Section, the Employer amends the Plan to comply with the requirements of HIPAA (as defined below).

Effective Date

This Amendment shall apply with respect to the use of Protected Health Information by the Plan or disclosure of Protected Health Information to the Employer on and after **April 14, 2004**.

Use and Disclosure of Protected Health Information

Except as provided under Section 2(b) or (c) of this Amendment or as otherwise authorized under a valid Authorization, this Plan, in order to disclose Protected Health Information to the Employer or to provide for or permit the disclosure of Protected Health Information to the Employer by a health insurance issuer or HMO with respect to the Plan, shall restrict uses and disclosures of such information by the Employer consistent with the requirements set forth in this Amendment.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose Summary Health Information to the Employer, if the Employer requests the Summary Health Information for the purpose of:

- obtaining premium bids from health plans for providing health insurance coverage under the Plan; or
- modifying, amending, or terminating the Plan.

The Plan, or a health insurance issuer or HMO with respect to the Plan, may disclose to the Employer information on whether an individual is participating in the Plan, or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan.

This Plan may:

- disclose Protected Health Information to the Employer to carry out Plan Administration Functions that the Employer performs only to the extent consistent with the provisions of this Amendment;
- not permit a health insurance issuer or HMO with respect to the Plan to disclose Protected Health Information to the Employer except as permitted by this Amendment;
- not disclose and may not permit a health insurance issuer or HMO to disclose Protected Health Information to the Employer as otherwise permitted by this Amendment unless a statement to that effect is included in the appropriate notice of privacy practices; and
- not disclose Protected Health Information to the Employer for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Employer.

Employer Certification

This Plan will disclose Protected Health Information to the Employer only upon receipt of a certification by the Employer that the Plan documents have been amended to incorporate the provisions of this Section. With respect to Protected Health Information disclosed to the Employer by the Plan, the Employer agrees to:

- not use or further disclose the information other than as permitted to required by the Plan documents or as required by law;
- ensure that 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 Employer with respect to such information;
- not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer.
- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- make available Protected Health Information in accordance with 45 CFR § 164.524;

make available Protected Health Information for amendment and incorporate any amendments to Protected Health Information in accordance with 45 CFR §164.526;

make available the information required to provide an accounting of disclosures in accordance with 45 CFR § 164.528;

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 Health and Human Services for purposes of determining compliance by the Plan with this Amendment;

if feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, 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; and

ensure that the adequate separation required in Section 4 of this Amendment is established.

Separation Between Plan and Employer

A list of those employees or classes of employees or other persons under the control of the Employer who are permitted to have access to the Protected Health Information to be disclosed is made available on the Company web site and will be updated as necessary. Any employee or person who receives Protected Health Information relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business shall be deemed to have been included in such list.

access to and use by such employees and other persons described in Section 4(a) of this Amendment shall be restricted to the Plan Administration Functions that the Employer performs for the Plan.

The Plan Administrator shall investigate any allegations by a participant, beneficiary or other person of a breach of the Employer's or Plan's obligations under this Amendment. If the Plan Administrator determines there has been such a breach, the Plan Administrator shall provide a summary report of such breach, identifying the person responsible for such breach, to the Employer. If the person responsible for the breach is an employee of the Employer, the Employer shall take such disciplinary action against that person as required under the Employer's employment policies and practices.

Definitions

For purposes of this Amendment, the following capitalized terms shall have the following meanings:

"Authorization" means an authorization by an individual that permits the Plan to use or disclose Protected Health Information that complies with the requirements of 45 CFR §164.508(c).

"HIPAA" means the security and privacy requirements applicable to health plans as reflected in 42 U.S.C. 1320d *et seq.* and such regulations as may be promulgated thereunder from time to time (currently, 45 CFR §164.102 through §164.534).

"Plan Administration Functions" means administration functions performed by the Employer on behalf of the Plan and excludes functions performed by the Employer in connection with any of its other benefits or benefit plans.

"Protected Health Information" means individually identifiable health information of the Plan that is (i) transmitted by electronic media, (ii) maintained in any medium described as electronic media, or (iii) transmitted or maintained in any other form or medium. "Protected Health Information" does not include individually identifiable health information in: (i) education records covered by the Family Educational Right and Privacy Act (20 U.S.C. section 1232g(a)(4)(B)(iv)), or (ii) records described at 20 U.S.C. section 1232g(a)(4)(B)(iv).

"Summary Health Information" means information, that may be individually identifiable health information, and:

that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom the Employer has provided health benefits under this Plan; and

from which the following information has been deleted:

names;

all geographic subdivisions smaller than a State, including street address, city, county precinct, zip code, and their equivalent geocodes, except for the initial five digits of a zip code if, according to the current publicly available data from the Bureau of the Census:

- (1) The geographic unit formed by combining all zip codes with the same five initial digits contains more than 20,000 people; and
- (2) The initial five digits of a zip code for all such geographic units containing 20,000 or fewer people is changed to 000.

all elements of dates (except year) for dates directly related to an individual, including birth date, admission date, discharge date, date of death; and all ages over 89 and all elements of dates (including year) indicative of such age, except that such ages and elements may be aggregated into a single category of age 90 or older;

telephone numbers;

fax numbers;

electronic mail addresses;

social security numbers;

medical record numbers;

health plan beneficiary numbers;

account numbers;

certificate/license numbers;

vehicle identifiers and serial numbers, including license plate number;

device identifiers and serial numbers;

Web Universal Resource Locators (URLs);

Internet Protocol (IP) address numbers;

biometric identifiers, including finger and voice prints;

full face photographic images and any comparable images; and

any other unique identifying number, characteristic, or code, except a code or other means of de-identifying and re-identifying information permitted under HIPAA.

AMENDMENT AND TERMINATION OF PLAN

Plan Amendment. A duly authorized officer of the Company shall have the right, in his or her sole discretion, to amend or modify the Plan at any time and from time to time and to any extent deemed advisable, subject to the terms and conditions of any applicable collective bargaining agreement. Such modification or amendment shall be in writing and shall be effective as of the date indicated in such written amendment or modification.

Plan Termination. All or any part of this Plan may be terminated at any time by the Executive Director (or any duly authorized officer) of the Company, except to the extent otherwise prohibited under the terms of a collective bargaining agreement. In the event of such termination, the Employers' sole obligation under the Plan shall be to pay the Covered Charges Incurred (even though later filed) and expenses of the Plan accrued through the date of termination. To the extent allowed by the Act, any such termination may be effective retroactively. Subrogation rights (as described in Section *Subrogation Rights*) shall also apply through the date of termination and applicable run-out payment periods.

MISCELLANEOUS PROVISIONS

Non-Alienation and Assignment. The Plan shall not be liable for any debt, liability, contract or tort of any Eligible Employee or Covered Person. The Plan shall pay all benefits due and payable for Covered Charges directly to the Covered Person who incurred the Covered Charges, and no Plan benefits shall be subject to anticipation, sale, assignment, transfer, encumbrance, pledge, charge, attachment, garnishment, execution, alienation or any other voluntary or involuntary alienation or other legal or equitable process not transferable by operation of law; provided, however, that a Covered Person to whom benefits are otherwise payable may assign benefits to a Hospital, Physician or other service provider; provided, further, that any such assignment of benefits by a Covered Person to a Hospital, Physician or other service provider shall be binding on the Plan only if:

- (1) the Plan Administrator or applicable Plan Supervisor is notified of such assignment prior to payment of benefits;
- (2) the assignment is made on a form provided by, or approved by, the applicable Plan Supervisor; and
- (3) the assignment contains such additional terms and conditions as may be required from time to time by the Plan Administrator or applicable Plan Supervisor.

Fiduciary Responsibilities. No fiduciary of the Plan shall be liable for any act or omission in carrying out his or its responsibilities under the Plan, except as may be provided under the Act.

Allocation of Fiduciary Responsibilities. Each fiduciary under the Plan shall be responsible only for the specific duties assigned to it, him, or her under the Plan and shall not be directly or indirectly responsible for the duties assigned to another fiduciary, except as may be otherwise provided in the Act.

Headings. Any headings or subheadings in the Plan are for convenience and shall be ignored in the construction of any provisions of the Plan.

Choice of Law. The Plan shall be construed, enforced and administered in accordance with the laws of the State of Indiana or any other state in which this Plan shall be enforced, to the extent such laws are not preempted by the Act.

Limitation of Rights and Obligations. Neither the establishment, nor the maintenance of this Plan, nor any amendment thereof, nor the purchase of any insurance contract, nor any act or omission under this Plan or resulting from the operation of the Plan shall be construed:

- (1) As conferring upon any Eligible Employee, beneficiary or any other person, a right or claim against an Employer or the Plan Administrator, except to the extent that such right of claim shall be specifically expressed and provided in the Plan;
- (2) As creating any responsibility or liability of the Plan Administrator for the validity or effect of the Plan; or
- (3) As a contract or agreement between any Employer and any Eligible Employee or to be consideration for, or as affecting in any manner or to any extent whatsoever, the rights or obligations of an Employer or any Eligible Employee to continue or terminate the employment relationship at any time. Nothing in the Plan shall be deemed to give any Eligible Employee the right to be retained in the service of any Employer, or to interfere with the right of any Employer to discharge any Eligible Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements between any Employer and the bargaining representatives of any Eligible Employee.

Facility of Payment. If, in the opinion of the applicable Plan Supervisor, a valid release cannot be obtained from a Covered Person with respect to the payment of any Plan benefit, such payment may be made directly to a Hospital, Physician or other service provider; the Covered Person's guardian, conservator or estate; the parents of a minor child or an individual or individuals who have custody or provide care and principal support of the Covered Person. Any payment made by the applicable Plan Supervisor in good faith pursuant to this Subsection shall fully discharge all Plan liability to the extent of such payment.

Employment of Consultants. The Plan Administrator, or a fiduciary named by the Plan Administrator pursuant to the Plan, may employ one or more persons to render advice with regard to its respective responsibilities under the Plan.

Notice. Any notice given under this Plan shall be sufficient if:

- (1) to the Plan Administrator when addressed to it at its office;
- (2) to the applicable Plan Supervisor when addressed to it at its office or;

- (3) to a Covered Person when addressed to the Covered Person at his or her address as it appears on the records of the applicable Plan Supervisor.

Misrepresentation. Any material misrepresentation on the part of the Covered Person in applying for coverage, in applying for a reclassification to an Eligible Class or in filing a claim for benefits shall render the Covered Person's coverage null and void.

Disclaimer of Liability. Nothing contained herein shall confer upon a Covered Person any claim, right or cause of action, either at law or at equity, against the Plan, Plan Administrator, applicable Plan Supervisor, Company or any Employer for the acts or omissions of any health care provider from whom a Covered Person receives care, or for the acts or omissions of any Physician from whom the Covered Person receives service under this Plan, or for any acts or omissions of any provider of services or supplies under this Plan.

Certification of Prior Health Care Coverage. The Plan Administrator, or its designee, will provide to Covered Persons certification of their coverage under this Plan as required by the Health Insurance Portability and Accountability Act of 1996.

Entire Plan. This Plan Document and Summary Plan Description shall constitute the only legally governing document for the Plan. All statements made by the Company, Plan Administrator or applicable Plan Supervisor shall be deemed representations and not warranties. No such statement shall void or reduce coverage under this Plan or be used in defense to a claim unless in writing signed by the Plan Administrator or applicable Plan Supervisor.

Construction. In the construction of this Plan, the masculine includes the feminine, the feminine includes the masculine, and the singular includes the plural where appropriate.

DEFINITIONS

Accident. The term “Accident” means a sudden, unforeseen and unintended event arising from an external cause.

Act. The term “Act” means the Employee Retirement Income Security Act of 1974, as amended from time to time.

Actively at Work or Active Work. The term “Actively at Work” or “Active Work” means, that, on the day that coverage’s under the Plan would begin, an Eligible Employee is not absent from work due to an unapproved absence, which is not related to the health of the Eligible Employee.

Ambulatory Surgical Center. The term “Ambulatory Surgical Center” means a freestanding surgical facility licensed as an ambulatory surgical center under the laws of the state at the time and place Covered Charges are Incurred.

Ancillary Charges. Charges for Hospital services that are exclusive of such routine services as room and board and nursing. Examples of Ancillary Charges include X-rays and laboratory charges.

Annual Out-of-Pocket Maximum. The Maximum yearly amount of Covered Charges (excluding Copayments, Cost Containment Penalties and Deductibles) that a Covered Person will pay through Coinsurance. Once this Maximum is met, the Plan will pay 100% of Covered Charges for the remainder of the year.

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

The Birthing Center must provide facilities for obstetrical delivery and short-term recovery after delivery; provide care under the full-time supervision of a Physician and either a registered nurse (R.N.) or a licensed nurse-midwife; and have a written agreement with a Hospital in the same locality for immediate acceptance of patients who develop complications or require pre- or post-delivery confinement.

Calendar Year. The term “Calendar Year” means January 1st through December 31st of the same year.

COBRA. The term “COBRA” means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

Code. The term “Code” means the Internal Revenue Code of 1986, as amended from time to time.

Coinsurance. The term “Coinsurance” means with respect to a Covered Person the percentage of Covered Charges for which he or she is financially responsible and which shall not otherwise be payable under the terms of the Plan; provided, however, any such Coinsurance shall be determined after any Deductible amount is applied. The Coinsurance percentage is specified in the *Benefit and Information Grid* Section.

Copayment. An amount of money that is paid each time a particular service is used. Copayments do not accrue towards the Out-of-Pocket Maximum.

Cosmetic Surgery. The term “Cosmetic Surgery” means medically unnecessary surgical procedures, usually, but not limited to, plastic surgery directed toward preserving beauty or correcting scars, burns or disfigurements.

Covered Charges. The term “Covered Charges” means with respect to a Covered Person the Usual & Customary Charges for those Covered Services that are:

- (1) specified in Section *Covered Services*;
- (2) Medically Necessary for the care and treatment of an Injury or Illness and recommended by a Physician;
- (3) incurred while that Covered Person is covered under this Plan; and
- (4) covered charges include any taxes or surcharges imposed by a governmental entity based on the value or volume of Covered Services provided to Covered Persons, or amount imposed or assessed against the Plan or the Employer in lieu of such taxes or surcharges.

Covered Person. The term “Covered Person” means each Eligible Employee or Dependent who is covered under the Plan as set forth in Section *Eligibility, Enrollment, and Termination of Coverage*.

Creditable Coverage. The term “Creditable Coverage” means those periods of coverage required to be included as such under 701(c) of ERISA and shall exclude those periods of coverage permitted to be excluded under Section 701(c) of ERISA. Solely

for purposes of illustration and not in limitation of the foregoing, Creditable Coverage generally includes periods of coverage under an individual or Employee Benefit Plan (including Medicare, Medicaid, governmental, and church plans) that are not followed by a period of at least 63 days without coverage (not including any applicable waiting period), and Creditable Coverage generally excludes periods of coverage for liability, limited scope dental or vision benefits, specific disease and/or other supplemental-type benefits.

Custodial Care. The term “Custodial Care” means personal care that does not require the continuing attention of trained medical or paramedical personnel and that serves to assist an individual in the activities of daily living. Custodial Care includes, but shall not be limited to, assistance in walking, getting in and out of bed, bathing, dressing, feeding, using the toilet, preparation of special diets, and supervision of medication that can usually be self-administered.

Deductible. The term “Deductible” means with respect to a Covered Person the amount of Covered Charges for which he or she is financially responsible each calendar year before benefits are payable under this Plan. The amount of the Deductible for each Covered Person is specified in the *Benefit and Information Grid* Section.

Dentist. The term “Dentist” is a person who is properly trained and licensed to practice dentistry and who is practicing within the scope of such license.

Dependent. The term “Dependent” means the spouse of an Eligible Employee (other than a spouse who is legally separated from the Eligible Employee under state law) and each child of an Eligible Employee who is described in Section *Eligibility, Enrollment, and Termination of Coverage* under the Subsection *Eligible Dependent Children*; provided, however, that no person who is a full-time member of the armed forces shall be considered a Dependent.

In determining whether an individual is a Dependent, in the case of a child who would otherwise be a Dependent under this Plan and whose parents agree, pursuant to a court order or divorce decree, which parent is responsible for the medical care of such child, such child shall be a Dependent only if the agreed upon responsible parent is an Eligible Employee; provided, however, that a child shall also be a Dependent of an Eligible Employee, regardless of agreement of the parents, to the extent provided by a qualified medical child support order issued under Section 609 of the Act.

Effective Date. The term “Effective Date” most often means the date coverage becomes effective for the Eligible Employee. It also can mean the date this restatement is effective which is February 1, 2005.

Eligible Class. The term “Eligible Class” means each employment classification of Eligible Employees eligible to participate in the Plan as set forth in Section *Eligibility, Enrollment, and Termination of Coverage*.

Eligible Employee. The term “Eligible Employee” means an Eligible Employee of the Employer who is meets the requirements listed in Section *Eligibility, Enrollment, and Termination of Coverage*.

Emergency. The term “Emergency” means the following:

- 1) **Accident:** A sudden and unforeseen event which includes all of the following:
 - a) causes injury to the physical structure of the body;
 - b) results from an external agent or trauma;
 - c) is definite as to time and place; and
 - d) happens involuntarily, or if it is the result of a voluntary act, entails unforeseen consequences.
- 2) **Emergency Illness:** A medical condition that is not accident related and that is characterized by the sudden onset of acute symptoms of sufficient severity that the absence of immediate medical attention could reasonably result in any of the following:
 - a) permanently placing the participant’s health in jeopardy;
 - b) causing other serious medical consequences;
 - c) causing serious impairment of bodily function; or
 - d) causing serious and permanent dysfunction of any bodily organ or part.

Employer. The term “Employer” means the Company and any entity that is affiliated with the Company within the meaning of Section 414(b), (c) or (m) of the Code, that adopts this Plan for the benefit of its Eligible Employees, whose participation in the Plan is approved by the Executive Director (or any other duly authorized officer) of the Company.

Employment Termination Date. The term “Employment Termination Date” means, with respect to a particular Eligible Employee, the date that Eligible Employee’s employment with an Employer is voluntarily or involuntarily terminated.

Enrollment Date. The term “Enrollment Date” means the date on which a Covered Person becomes covered under the Plan or, if earlier and applicable, the first day of the Waiting Period.

ERISA. The term “ERISA” is the Eligible Employee Retirement Income Security Act of 1974 as amended.

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

- (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 the drug or device will be considered Experimental; or
- (2) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility’s Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval the drug, device, medical treatment or procedure will be considered Investigational; 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 the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis the drug, device, medical treatment or procedure will be considered Experimental; or
- (4) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis the drug device, medical treatment or procedure will be considered Experimental.

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. The term “Extended Care Facility” means an institution, or a distinct part of an institution, which is licensed to provide Inpatient care to persons convalescing from Injury or Illness including, but not limited to:

- (1) Professional nursing services rendered by a Registered Nurse (RN) or by a Licensed Practical Nurse (LPN);
- (2) Physical restoration services assisting patients in reaching a degree of bodily function permitting self-care in essential daily living activities;
- (3) Providing 24 hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; or
- (4) Maintaining a complete medical record on each patient.

The term Extended Care Facility shall not include a place that provides, other than incidentally, for: rest, the aged, drug addicts, alcoholics, mentally handicapped, custodial or educational care, or care of mental disorders.

Family Unit. The term “Family Unit” means an Eligible Employee and his or her Dependents.

Full-Time Eligible Employees. The term “Full-Time Eligible Employees” is defined as Eligible Employees hired to work at least thirty-two (32) hours per week that are in an eligible class.

Full-Time Student. The term “Full-Time Student” means a child who is enrolled at an accredited College, University or Trade School for at least the minimum number of credit hours required by the institution to maintain full-time student status; provided, however, that in the event the child is absent from the educational institution for reasons due to injury or illness, the child’s status as a full-time student shall continue only to the extent determined by this Plan.

Generic Drug. The term “Generic Drug” means a Prescription Drug, which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic Drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

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

Home Health Care. The term “Home Health Care: means services and supplies provided to a Covered Person in his home by a Home Health Care Agency as an alternative to Hospital Confinement, provided that such services and supplies are recommended by a Physician.

Home Health Care Agency. The term “Home Health Care Agency” means an institution which is operated primarily for the purpose of providing skilled nursing care and therapeutic services in a person’s home, provided that the Home Health Care Agency is approved and licensed by a state licensing agency and meets the requirements of the Social Security Amendments of 1965, as amended.

Hospice. The term “Hospice” means a free-standing or Hospital affiliated facility which provides short periods of stay for the terminally ill (i.e., individuals with life expectancies of less than six (6) months) in a home-like setting for either direct care or respite. The facility must operate as an integral part of a formal Hospice Care Program directed by a Physician for the purpose of caring for a terminally ill person. The Hospice Care Program must meet the standards set by the National Hospice Organization and be approved by the Plan Supervisor. If the Hospice Care Program is required by a state to be licensed, certified or registered, the Program must also meet that requirement to be considered an eligible Hospice Care Program.

Hospital. The term “Hospital” means an institution that is licensed as a hospital under the laws of the state at the time and place Covered Charges are Incurred; and is accredited by the Joint Commission on Accreditation of Hospitals or by the American Osteopathic Association; provided, however, that the term “Hospital” shall not include an institution that is primarily a nursing home or a place for rest for the aged, drug addicts, alcoholics, treatment of tuberculosis or mental disorders.

Hospital Confinement. The term “Hospital Confinement” means the period of time during which a person is an inpatient at a Hospital.

Human Growth Hormone. The term “Human Growth Hormone” means an adenohipophyseal hormone that promotes growth and also has direct influence on the metabolism of carbohydrates, fats, and proteins.

Illness. The term “Illness” means a sickness or disease that requires treatment by a Physician, is sustained by a Covered Person while covered under this Plan and is not due to an Injury.

Immediate Family. The term “Immediate Family” is defined as parents, step-parents, siblings, spouse, children, step-children, foster children, in-laws, grandparents, great grandparents, step-grandparents, step-great grandparents, grandchildren, step-grandchildren, aunts, uncles, nieces and nephews.

Incurred. The term “Incurred” means the date on which a service or supply was rendered or furnished, without regard to when a Covered Person is formally billed or charged, or pays for, the service or supply. In the absence of due proof to the contrary, when a single charge is made for a series of identical services, each service shall be considered to bear a pro rata share of the charge.

Injury. The term “Injury” means a physical or mental condition that is the direct or indirect result of an Accident (other than an occupational Accident) sustained by a Covered Person while covered under this Plan.

Inpatient. The term “Inpatient” means a Covered Person who is admitted and registered to an inpatient bed in a Hospital and for whom a room and board charge is Incurred.

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

accredited by the Joint Commission on Accreditation of Health Care Organizations and shall be licensed to provide partial hospitalization services, if required by the state in which the facility is providing these services. Treatment lasts less than 24 hours, but more than four hours a day and no charge is made for room and board.

Pharmacy. The term “Pharmacy” means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician. The term “Physician” means a doctor of medicine or doctor of osteopathy who is legally qualified and licensed to practice medicine, surgery or obstetrics at the time and place a service is Incurred with respect to a Covered Person, other than an individual who ordinarily resides in that Covered Person’s home, or who is a member of the Immediate Family.

Plan. The term “Plan” means the plan as embodied herein, including all Sections attached hereto, as amended from time to time.

Plan Administrator. The term “Plan Administrator” means the Company. The Plan Administrator shall be the named fiduciary under the Plan.

Plan Supervisor. The term “Plan Supervisor” means Unified Group Services, Inc., the applicable third party administrator of any benefits provided under this Plan, or any successor as may be appointed from time to time by the Plan Administrator under Section *Administration of the Plan*, Subsection *Plan Supervisor* of this Plan.

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

Pre-Existing Condition. The term “Pre-Existing Condition” means a physical or mental condition of a Covered Person, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six (6) month period ending on the Enrollment Date. Genetic status information is not treated as a Pre-Existing Condition in the absence of a diagnosis of a condition related to such information. Pregnancy shall not be treated as a Pre-Existing Condition under the Plan. The length of a Pre-Existing Conditions Limitation may be reduced or eliminated if an eligible person has creditable coverage from another health plan.

Pregnancy. The term “Pregnancy” is childbirth and conditions associated with Pregnancy, including complications.

Prescription Drug. The term “Prescription Drug” means any of the following: a drug or medicine which, under federal law, is required to bear the legend: “Caution: federal law prohibits dispensing without prescription”; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription.

Primary Care Physician. The term “Primary Care Physician” means any Physician of medicine who is legally qualified to practice medicine at the time and place a service is Incurred with respect to a Covered Person, other than an individual who ordinarily resides in the Covered Person’s home, or who is the spouse, child or parent of that Covered Person, and is a General Practitioner, Family Practitioner, Pediatrician, or a General Internist whose practice is at least % General Medicine. Covered Persons are strongly encouraged to select and utilize a Primary Care Physician but no penalty applies if this guideline is not followed.

Prosthetic Device. The term “Prosthetic Device” means any device used to replace missing or non-functional body parts.

Psychiatric Day Treatment Facility. The term “Psychiatric Day Treatment Facility” means a public or private facility, licensed and operated according to the law, which provides: treatment for all its patients for not more than eight (8) hours in any 24-hour period; a structured psychiatric program based on an individualized treatment plan that includes specific attainable goals and objectives appropriate for the patient; and supervision by a physician certified in psychiatry by the American Board of Psychiatry and Neurology. The facility must be accredited by the Program for Psychiatric Facilities or the Joint Commission on Accreditation of Hospitals.

Psychiatrist. The term “Psychiatrist” means a person who is legally qualified and licensed to practice psychiatry at the time and place services are rendered to a Covered Person, other than an individual who ordinarily resides in that Covered Person’s home, or who is a member of the Immediate Family.

Psychologist. The term “Psychologist” means a person who is legally qualified and licensed to practice psychology at the time and place services are rendered to a Covered Person, other than an individual who ordinarily resides in that Covered Person’s home, or who is a member of the Immediate Family.

Reconstructive Surgery. The term “Reconstructive Surgery” is a procedure performed to restore the anatomy and/or functions of the body, which are lost or impaired due to an Injury or Illness.

Regular Enrollee. The term “Regular Enrollee” means an Eligible Employee or Dependent who enrolls in the Plan other than through special or late enrollment as described in Section *Eligibility, Enrollment, and Termination Coverage*, Subsection *Individual Enrollment and Effective Dates*.

Regularly Scheduled Hours. The term “Regularly Scheduled Hours” is defined as the normal scheduled hours of the location, at which the Eligible Employee works and is not based on the department or position in which the Eligible Employee works.

Rehabilitation Facility. The term “Rehabilitation Facility” means a legally operating institution or distinct part of an institution which has a transfer agreement with one or more hospitals, and which is primarily engaged in providing comprehensive multi-disciplinary physical restorative services, post-acute hospital and rehabilitative inpatient care and is duly licensed by the appropriate government agency to provide such services.

It does not include institutions which provide only minimal care, custodial care, ambulatory or part-time care services, or an institution which primarily provides treatment of mental/nervous disorders, substance abuse or tuberculosis, except if such facility is licensed, certified or approved as a rehabilitation facility for the treatment of mental/nervous conditions or substance abuse in the jurisdiction where it is located, or is accredited as such a facility by the Joint Commission for the Accreditation of Health Care Organizations or the Commission for the Accreditation of Rehabilitation Facilities.

Residential Treatment Facility. The term “Residential Treatment Facility” means a child-care institution that provides residential care and treatment for emotionally disturbed children and adolescents. The facility must be accredited as a residential treatment facility by the Council on Accreditation, the Joint Commission on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Sickness. The term “Sickness” is a person’s illness, disease or Pregnancy (including complications).

Skilled Nursing Facility. The term “Skilled Nursing Facility” means an institution, or distinct part of an institution, which

- (1) is primarily engaged in providing to residents
 - (a) skilled nursing care and related services for residents who require medical or nursing care, or
 - (b) rehabilitation services for the rehabilitation of injured, disabled, or ill persons, and is not primarily for the care and treatment of mental diseases;
- (2) has in effect a transfer agreement with at least one (1) Hospital; and
- (3) meets the requirements for a Skilled Nursing Facility as described in Title XVIII of the Social Security Act, as amended.

Special Enrollee. The term “Special Enrollee” means an Eligible Employee or Dependent who is entitled to and does request special enrollment as described in Section *Eligibility, Enrollment, and Termination of Coverage*, Subsection *Individual Enrollment and Effect Dates* within thirty (30) days of losing other health coverage or, for a newly acquired Dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption.

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

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

Summary Plan Description. (SPD) The term “Summary Plan Description” shall also mean the Plan as defined in the above Subsection *Plan*.

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

Total Disability (Totally Disabled). The term “Total Disability” means in the case of an Active Eligible Employee, the complete inability to perform any and every duty of his or her occupation or of a similar occupation for which the person is reasonably capable due to education and training, as a result of Injury or Illness.

Usual & Customary Charge. The term “Usual & Customary Charge” means the charge made by a Physician or supplier of services or supplies to the extent such charge does not exceed the general level of charges made by others rendering or furnishing such services or supplies within the same area in which the charge is Incurred for Illnesses or Injuries comparable in nature and severity to the Illness or Injury being treated. The term “area” as it applies to any particular service or supply means a county or such greater area as is necessary to obtain a representative cross section of charges. If the Usual & Customary Charge for a service or supply cannot be easily determined because of the unusual nature of the service or supply, the determination shall be made by the applicable Plan Supervisor based on information it deems pertinent.

Waiting Period. The term “Waiting Period” means the period of time that the Eligible Employee must be employed prior to becoming eligible (and having any Dependents become eligible) for coverage under the Plan. The Waiting Period is counted in the Pre-existing Conditions exclusion time.



Huntington University has adopted this Huntington University Group Medical Plan as of the first day of February, 2005. I have read the document herein and certify that the contents reflect the terms and conditions of the Employee welfare benefit plan as established by Huntington University.

Executed on this _____ day of _____, 2005.

Huntington University
"The Company"

By: _____

Printed Name: _____

Title: _____

Attested by:

