

BUTLER HEALTH PLAN

BASIC PLAN

This booklet describes the Basic Plan Medical and Prescription Drug benefits for Eligible Employees of Butler Health Plan.

Information Applicable to Plan 501

Employer Identification Number
31-1151537

**The Benefits In This Booklet Are Effective
January 1, 2011**

TABLE OF CONTENTS

KEY INFORMATION	5
ELIGIBILITY:	5
WORKING SPOUSE COVERAGE:.....	6
ENROLLMENT:	6
OPEN ENROLLMENT PERIOD:.....	6
TERMINATION OF COVERAGE:	6
PRE EXISTING CONDITION LIMITATION(S):.....	7
PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):	7
PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS	8
MEDICAL DEDUCTIBLES, OUT OF POCKET MAXIMUMS AND COST CONTAINMENT PENALTIES	8
PRESCRIPTION DRUGS (UTILIZING PLAN’S CONTRACTED PHARMACY VENDOR FOR RETAIL/MAIL ORDER DRUGS)	9
WELLNESS CARE	9
PHYSICIAN SERVICES	10
FACILITY SERVICES	11
MENTAL HEALTH SERVICES	11
OTHER SERVICES	12
PRE-CERTIFICATION PROGRAM	14
PENALTY FOR NON-COMPLIANCE:.....	15
PRESCRIPTION DRUG BENEFIT	16
COVERED PRESCRIPTION DRUGS:	16
MAIL ORDER DRUG BENEFIT	17
SPECIALTY DRUG PHARMACY BENEFIT	17
TRANSPLANTS	18
PREFERRED TRANSPLANT NETWORK FACILITY:.....	18
TRANSPLANT EXPENSES.....	18
COVERED TRANSPLANT EXPENSES.....	18
WHAT IS NOT COVERED	21
DEFINITIONS	26
ELIGIBILITY	36
WHO IS ELIGIBLE	36
NON-DISCRIMINATION	36
STANDARD EMPLOYEE COVERAGE	36
STANDARD DEPENDENT COVERAGE.....	36
STANDARD INDIVIDUAL EFFECTIVE DATE.....	36
OPEN ENROLLMENT	37
SPECIAL ENROLLMENT	37
TERMINATION OF COVERAGE.....	38
PERSONNEL POLICIES	38
PRE-EXISTING CONDITIONS LIMITATION	38
NETWORK BENEFITS	40
PROCEDURES FOR FILING CLAIMS	41
KEY POINTS TO REMEMBER	41
FILING A HOSPITAL CLAIM.....	41
MISCELLANEOUS CLAIMS FILING CONSIDERATIONS	41
IF YOU FIND BILLING ERRORS	42
THIS PLAN AND MEDICARE	43
GENERAL PROVISIONS	44
ADMINISTRATION OF THE PLAN.....	44

APPEALING A CLAIM	44
ASSIGNMENT OF BENEFITS	50
CLAIM AUDIT	50
COMPLIANCE	50
CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS	50
CONTRIBUTIONS	50
ERISA AMENDMENTS	50
FUNDING	51
LIENS	51
NO WAIVER	51
PLAN IS NOT A CONTRACT	51
PLAN AMENDMENT, MODIFICATION OR TERMINATION	51
PROHIBITION ON RESCISSION	51
REIMBURSEMENT AND SUBROGATION PROVISIONS	51
SUBROGATION	52
RIGHT OF REIMBURSEMENT	53
SEPARATION OF FUNDS	53
RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION	55
RIGHTS OF RECOVERY	55
SEVERABILITY	55
SUBMISSION OF CLAIM	55
SUMMARY OF MATERIAL MODIFICATIONS	55
SUMMARY PLAN DESCRIPTION	55
SYSTEM FOR PROCESSING CLAIMS	56
TYPE OF ADMINISTRATION	56
COORDINATION OF BENEFITS (COB)	57
COMPLIANCE REGULATIONS	58
STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT	58
SOURCE OF INJURY RESTRICTIONS	58
WELLNESS VS. RISK FACTORS	58
FAMILY MEDICAL LEAVE ACT (FMLA)	59
MILITARY LEAVES	59
GENETIC INFORMATION	59
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA	61
ERISA RIGHTS SECTION	66
STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "PRIVACY STANDARDS")	68
NOTICE OF PRIVACY PRACTICES	70
STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE "SECURITY STANDARDS")	79
IMPORTANT POINTS	80

KEY INFORMATION

IMPORTANT NETWORK CONTACT INFORMATION:

Function	Network Name	Claims Filing Information	Phone Number	URL
PPO Network	Health Span Preferred	Allied Benefit Systems, Inc. PO Box 909786-60690 Chicago, IL 60690	888-914-7726	www.butlerhealthplan.org
Prescription Benefit Manager	Express Scripts	N/A	866-275-0044	express-scripts.com
Utilization Review/Pre-certification Firm	Health Span Preferred	N/A	513-551-1420	N/A

ELIGIBILITY:

- Employees: You are eligible to enroll in the Plan if you work for a Participating Employer and you are a member of a group of Employees designated by your Participating Employer as eligible to participate, or if you are a full-time Employee of the Butler Health Plan.
- Retirees: This Plan does not cover Retirees or their Dependents.
- Dependents Including:
 - Dependent Children: Child(ren) up to age 26 consisting of natural children, stepchildren, foster children, adopted children, and children placed for adoption.
 - Spouse: This Plan defines “marriage” consistent with the federal Defense of Marriage Act, in which the word “marriage” means only a legal union between one man and one woman as husband and wife, and the word “spouse” refers only to a person of the opposite sex who is a husband or a wife.
 - Spouses of deceased retired Employees are not eligible for coverage under this Plan.
 - Domestic Partners: This Plan does not cover Domestic Partners.

WORKING SPOUSE COVERAGE:

- If the spouse of an eligible Employee is eligible for coverage through his employer, and works more than 20 hours per week and is not required to pay more than 50% of the premium for coverage:
 - When the Spouse has enrolled in a plan maintained by his/her Employer, coverage for the Spouse under this Plan will then be secondary to the coverage provided by the Spouse's Employer's plan. (See "Coordination of Benefits"). The Employee will provide all information required to administer this provision through the initial enrollment form or through the COB Questionnaire form. Until the Claim Administrator has received all required documentation, any claims for the Spouse will be denied or returned to the sender.
 - If a Spouse has coverage available through his/her employment but fails to enroll for such coverage, Spouse benefits paid by the Plan retroactive to the date on which the Spouse became eligible for coverage through his/her employment will be recovered up to a maximum of \$5,000 per calendar year. Upon administrative notice of non-compliance, the Spouse is no longer eligible for primary coverage under this Plan and must be enrolled and covered under his/her Employer's plan.

ENROLLMENT:

Enrollment Waiting Period:

- All Employees shall be eligible to enroll on the Employee's starting date or on another beginning date, as determined by the Employer.

Open Enrollment Period:

- Each year, a period of time may be designated as an Open Enrollment period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will become effective on the date specified by your Employer.

TERMINATION OF COVERAGE:

Employee: The coverage of any Employee covered under this Plan shall terminate on the earliest of the following:

- The date the Employee ceases to be eligible for coverage under the Plan; or
- The date of termination of the Plan.

Dependent: The coverage of any Dependent covered under this Plan shall terminate on the earliest of the following:

- The date such individual ceases to be an eligible Dependent under the Plan; or
- The date the Employee's coverage terminates under the Plan.

PRE EXISTING CONDITION LIMITATION(S):

- A Pre-Existing Condition Limitation applies to Employees and Dependents age 19 and over.
- If you have a pre-existing condition when you enroll in the Plan, Plan payment of charges for treatment of that condition will be limited to 50% of In-Network charges, up to a maximum payment of \$5,000 during your first 12 consecutive months of Plan coverage. You will be responsible for paying the other 50% of these charges, as well as all charges over the Plan's \$5,000 payment. Amounts you pay for treatment of a pre-existing condition will not count toward your Out-of-Pocket Maximum. Any Deductible requirement will be applied prior to consideration of any payment at 50%

Pre-Existing Condition Look Back Period:

- The 3-month period prior to the Enrollment Date that is used to determine if You or Your eligible Dependents has a Pre-Existing Condition (i.e., when the individual sought medical advice, diagnosis, or care, had treatment recommended or received treatment from a licensed or authorized person during this time).

Pre-Existing Condition Look Forward Period:

- The 12-month (18-month for late Enrollments if applicable) period following the Enrollment Date, which is the time period during which the Plan will apply a Pre-Existing Condition Limitation (unless this time period is reduced or eliminated by the application of Creditable Coverage).

PRIVACY OFFICERS UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996, AS AMENDED (HIPAA):

The following employees, or classes of employees, or other persons under control of the Plan Sponsor, shall be given access to the protected health information (PHI) to be disclosed:

- a. The following persons under control of the Plan Sponsor shall be given access to the PHI: Administrative Director, Associate Director, and Administrative Assistant of the Plan and Treasurers, Business Managers, and/or Human Resources Managers, and Benefit Representatives designated by Treasurers, Business Managers, and/or Human Resources Managers of the Participating Employers.
- b. The access to and use of PHI by the individuals described in subsection (i) above shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.

In the event any of the individuals described in subsection (i) above do not comply with the provisions of the Plan Document relating to use and disclosure of PHI, the Plan's Privacy Officer shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs.

PPO SCHEDULE OF COVERED EXPENSES AND PROVISIONS

I. Medical Deductibles, Out of Pocket Maximums and Cost Containment Penalties

Basic Plan		
<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
<p>Calendar Year Deductible (<i>Combined, for all medical and prescription drug expenses, unless specifically waived</i>)</p> <p>* Note: Any combination of family members' expenses may contribute toward the Employee + 1 or Family Deductible for that Calendar Year.</p>	<p>Employee Only = \$2,500 Employee + 1 = \$4,000* Family = \$5,500*</p>	<p>Individual = \$5,000 Employee + 1 = \$8,000 Family = \$10,500</p>
	<p>Note that In and Out of Network Deductibles are separately tracked. * Note: The entire Employee + 1 or family Deductible must be met before any benefits are payable under this Plan for any covered family member.</p>	
Deductible Carry-Over	N/A	
<p>Out-of-Pocket Maximum per Calendar Year (<i>AFTER Deductible</i>). After amount is reached, 100% level of benefits applies for that Calendar Year. <u>In-Network and Out-of-Network maximums are separately tracked.</u></p> <p>Note that amounts you pay under the Prescription Drug Card or Mail Order Drug Programs apply to the combined medical/prescription drug Out of Pocket Maximum. However, exceptions shown at right do not apply to and are not affected by this provision.</p>	N/A	<p>\$4,000 per Individual \$8,000 per Employee + 1 \$12,000 per Family</p>
	<p><u>Medical Expenses Not Included</u> under this provision are as follows:</p> <ul style="list-style-type: none"> • Calendar Year Deductible • Non-Compliance Penalty • Non-covered charges, charges in excess of any Plan maximum or limit, charges in excess of U&C charges for out of network providers. • Patient's portion of co-insurance for 1) jaw/joint treatment, 2) smoking/tobacco cessation, 3) treatment of a Pre-Existing Condition (applies to members and dependents over age 19) 	
Benefits subject to a \$200 "Non-Compliance Penalty" per occurrence (<i>after Deductible</i>) when pre-certification procedures are not followed in regard to Inpatient Hospital admissions	TO PRE-CERTIFY, CALL THE TOLL-FREE NUMBER ON YOUR ID CARD	
Annual Benefit Maximum	\$3,000,000	
Lifetime Maximum	Unlimited	
Claims Filing Limit	All charges, and corresponding requested documentation, must be submitted within 1 year of the date incurred.	
Coordination of Benefits	If it is determined that this Plan is the Secondary Payer, Benefits will be adjusted and reduced (standard). Benefits payable from both plans shall not exceed 100% of the eligible U&C charges.	

II. Prescription Drugs (utilizing Plan's contracted pharmacy vendor for retail/mail order drugs)

Basic Plan		
<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
Separate Retail Prescription Deductible per Calendar Year	Not Applicable	
Annual Out of Pocket Prescription Maximum	Not Applicable	
Prescription Drug Card Program up to 30-day supply through participating pharmacies. Note co-pays only apply after the Annual deductible has been met.	<ul style="list-style-type: none"> • \$10 co-pay per Generic prescription, • \$30 co-pay per Preferred Brand prescription, • \$50 co-pay per Non-Preferred Brand prescription 	
Mail Order Drug Benefit up to 90-day supply per prescription. Note co-pays only apply after the Annual deductible has been met.	<ul style="list-style-type: none"> • \$25 co-pay per Generic prescription, • \$75 co-pay per Preferred Brand prescription, • \$125 co-pay per Non-Preferred Brand prescription 	
Limitation on filling maintenance drugs at a retail pharmacy	Not Applicable	
Specialty Pharmacy up to 30 day supply	Provides injectable and other specialty medications to members with free delivery to patient's home or physician's office. Retail co-pay applies.	
Brand when generic is available	Patient must pay the cost difference between the brand and generic drug in addition to your co-pay or co-insurance	
Prior Authorizations	Patient may call the pharmacy benefit manager with questions regarding quantity limitations or prior authorizations	

III. Wellness Care

<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
<i>The Preventive Care Services benefit listed below, covers all services referenced within the Recommendations of the United States Preventive Service Task Force, Recommendations of the Advisory Committee On Immunization Practices (ACIP) That Have Been Adopted by the Director of the Centers for Disease Control and Prevention and appear on the immunization schedules of the Centers for Disease Control and Prevention, and the Comprehensive Guidelines Supported by the Health Resources and Services Administration (HRSA).</i>		
Preventive Care Services- (must be billed with a routine diagnosis) This plan includes coverage for physical exams, immunizations, tests, x-rays, pap smears and analysis, mammograms (age 40 and older, one per person per Calendar Year), PSA test, bone density tests (for women age 60 and older, every 5 Calendar Years) and sigmoidoscopies/colonoscopies (age 50 and older, every 5 Calendar Years, but not both). <u>(This benefit specifically does not cover heart scans, full body scans, Executive Physicals, CAT scans, MRI's, PET or other similar tests)</u>	100% <u>Deductible Waived</u>	50% After the Deductible
Routine Vision Exam (one exam paid every 24 months) Note routine vision exams from birth to age 5 are payable under the "Preventive Care Services" benefit above.	100% <u>Deductible Waived</u>	Paid same as In-Network
School Flu Shots and Health Screenings (provided at school site wellness events for covered employees and spouses)	100% <u>Deductible Waived</u>	100% <u>Deductible Waived.</u>

IV. Physician Services

Basic Plan		
<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
Primary Care Medically Necessary Physician Office Visit <i>(Exam charge only)</i>	100%	50%
Outpatient <i>(including office and independent laboratories)</i> Diagnostic Testing and Interpretation <i>(including X-rays and laboratory services, MRI, CAT and PET scan services, and other generally accepted diagnostic tests).</i>	100%	50%*
	Includes tests and interpretation when performed in the absence of symptoms, but due to documented family history of disease (with “family” meaning parents, grandparents and siblings) * However, note that tests performed at Lab Card draw sites are payable at 100%. Also, note that any provider may, at the request of the Participant, utilize the Lab Card program which provides services for interpretation of lab tests/x-rays that are payable at 100% by the Plan.	
Contraceptive Management <i>(for contraceptive devices that can only be obtained from a Physician and associated services).</i>	100%	50%
Physician Charges for Surgery and Anesthesia , regardless of where performed.	100%	50%
Second Surgical Opinion <i>(not required). Includes associated lab tests and x-rays.</i>	100%	50%
Nutritional Counseling <i>(up to 3 visits are covered when prescribed by your physician and a medical condition exists)</i>	100%	50%
Physical, Speech, Occupational, Biofeedback and Inversion Therapy <i>(maximum of 20 visits per Calendar Year per each therapy type, without medical certification as to the need for additional visits). Specific conditions apply.</i>	100%	50%
Other Therapy Services <i>(dialysis, radiation, chemotherapy and respiratory therapy)</i>	100%	50%
Chiropractic Services <i>(maximum of 24 visits per Participant per Calendar Year).</i>	100%	50%
Urgent Care Facility Services <i>(professional and facility services provided; this includes non-routine care by Student Health Facilities)</i>	100%	50%
Other Physician Services <i>(except as may be stated differently in the Plan Document)</i>	100%	50%

V. Facility Services

Basic Plan		
<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
Inpatient Hospital Services <ul style="list-style-type: none"> • Room and board not to exceed the semi-private room rate unless when required due to Medically Necessary isolation purposes, and • Necessary services and supplies including, but not limited to, intensive care unit and a cardiac care unit 	100%	50%
Hospital Emergency Room Care (professional and facility services provided) <i>Co-pay will be waived if admitted.</i>	\$150 co-pay, then paid at 100%	
Outpatient Facility Diagnostic Testing	100%	50%*
	* However, note that tests performed at Lab Card draw sites are payable at 100%. Also, note that any provider may, at the request of the Participant, utilize the Lab Card program which provides services for <u>interpretation</u> of lab tests/x-rays that are payable at 100% by the Plan with no Deductible.	
Other Outpatient Facility Services (including Birthing Centers)	100%	50%
Ambulatory Surgical Facility	100%	50%
Home Health Care when provided by a licensed home health care agency in accordance with a written treatment plan prepared by the patient's attending Physician.	100%	50%
Hospice Care (appropriate Inpatient and Outpatient services applicable when the patient is not expected to live more than six months)	100%	Paid at In-Network Level
Extended Care Facility (also known as Skilled Nursing Facility) – Includes: <ul style="list-style-type: none"> ▪ room, board and floor nursing care (up to the facility's semi-private room rate) ▪ physical, occupational or speech therapy ▪ drugs, biologicals, supplies, appliances and equipment for use in the facility ordinarily furnished by the facility for the care and treatment of in-patients 	100%	50%

VI. Mental Health Services

<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
Mental Health Services (Mental/Nervous, Alcohol and Drug Abuse)		
Inpatient (Pre-certification applies)	100%	50%
Outpatient (note that medication management office visits will also be paid under this benefit)	100%	50%

VII. Other Services

Basic Plan		
<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
Ambulance Service <i>by ground or air as Medically Necessary</i>	100%	Paid at In-Network Level
Durable Medical Equipment <i>(purchase or rental- up to purchase price – of Durable Medical Equipment)</i>	100%	50%
Hearing Aids for routine hearing loss <i>(devices only; subject to a maximum payment of \$500 for both ears within a 3 year replacement cycle; fittings are not covered).</i>	100%	50%
Smoking/Tobacco Cessation Treatment <i>limited to hypnosis and smoking/tobacco cessation sessions by qualified organizations. Nicotine patch costs will be covered for a maximum of six weeks per Calendar Year. Prescription drugs are also covered. Not covered treatment includes gum, books, tapes, videos and mail order programs. Maximum payment of \$300 per Participant per Lifetime.</i>	50% <u>Deductible Waived</u>	50% <u>Deductible Waived</u>
Prosthetics <i>(for purchase of internal or external prosthetic appliances used to aid in the function of or to replace a limb or organ if the appliance is the original appliance or a replacement is required by pathological change or normal growth).</i>	100%	50%
Orthotics <i>(custom made when Medically Necessary – does not include corrective shoes)</i>	100%	50%
Wigs after Chemo or Radiation therapy <i>(limited to a Calendar Year maximum payment of \$200)</i>	100%	50%
Well Newborn Care <i>(other than as covered under the Wellness Care benefit) includes but is not limited to Nursery Care Services and Circumcision.</i>	100%	50%
Blood and blood products <i>(if not donated or replaced), intravenous injections and solutions</i>	100%	50%
Organ Transplant Coverage <i>(covered transplants are listed in the Plan Document) Per Transplant Donor Coverage Maximum of \$5,000</i>	100%	50%
Infertility Treatment <i>(for any promotion of conception including in-vitro fertilization, artificial insemination, GIFT or ZIFT, and prescription drugs related to treatment of infertility).</i>	Not Covered	Not Covered
Jaw Joint Treatment. <i>Covered Services include one jaw joint appliance but will not include orthodontic related expenses even if Medically Necessary.</i>	100%	50%
Orthopedic Equipment and Appliances	100%	50%
Maternity Services <i>(covered same as any Illness and includes charges for prenatal, delivery and postpartum services)</i>	100%	50%

VII. Other Services

Basic Plan		
<u>BENEFITS and PROVISIONS</u>	IN NETWORK	OUT OF NETWORK
Dental Related Treatment <i>(includes services required in connection with an accidental non-biting or chewing Injury to sound natural teeth or jaw, and performed within 6 months of the accident)</i>	100%	50%
Voluntary Sterilization <i>(but not the reversal of such procedures)</i>	100%	50%
Cosmetic Surgery <i>limited to surgical charges for reconstructive surgery following mastectomy (as mandated by the Womens' Health and Cancer Rights Act) or to treat an accidental Injury or birth defect.</i>	100%	50%
Gastric Bypass surgery	Not Covered	
Pre-Existing Conditions <i>(if pre-existing conditions apply, covered expenses are limited to 50% of in-network charges up to a maximum payment of \$5,000 per condition during the first 12 months of coverage. Pre-Existing Conditions do not apply to members or dependents under age 19.</i>	50%	Not Applicable
Services provided by a non-patient selected Out of Network Physician while being treated in a Network Hospital	Not Applicable	Paid same as In-Network
Other Covered Services and Items	100% Unless included under a previous category	50% Unless included under a previous category

PRE-CERTIFICATION PROGRAM

Your Plan also includes a **Pre-Certification Program**. The toll-free number you must use for pre-certification is shown on your member ID card. **Failure to follow the guidelines listed below will subject your benefits to a Penalty for Non-Compliance as discussed in this section and referenced in the Schedule of Covered Expenses and Provisions.**

The following service requires pre-certification:

1. Inpatient Hospital admissions.

If your Physician recommends any service listed above, please follow these steps:

1. Notify your Physician that you participate in a Pre-Certification Program. Please note that this applies even if this Plan is the secondary payer under Coordination of Benefits.
2. You or your Physician must call the number shown on your member ID card 2 weeks before or, if less than 2 weeks, as soon as scheduled for an elective Hospital admission or any of the services listed above.
3. If you have an emergency admission, pre-certification is required within 48 hours or the next business day following admission.

The following information will be needed to pre-certify:

<u>Regarding Patient:</u>	<u>Regarding Employee:</u>
Name	Name
Address	Address
Telephone #	Telephone #
Date of Birth	Date of Birth
Relationship to Employee	Gender
Physician's Name	Social Security Number
Physician's Phone Number	Name of Employer
Hospital/Address	Name of Claims Processor: <i>Allied Benefit Systems, Inc.</i>

4. A nurse may call your Physician to review a proposed Inpatient admission or other listed service. If admission is necessary, an assigned length of stay will be determined. If additional days are later thought to be necessary, these additional days must also be pre-certified.
5. When you or your Physician call to pre-certify an Inpatient admission or other listed service, the call will be logged so that:

- a. The facility can verify that pre-certification has been done and can track expected length of stay.
- b. The Claims Processor can verify that the pre-certification requirements have been met when the claim is received for processing.

Note: Pre-Certification assists in determining medical necessity and the best place for treatment. This service, however, does not guarantee payment, which is subject to eligibility and coverage at the time services are rendered.

PENALTY FOR NON-COMPLIANCE:

The non-compliance penalty specified in the Schedule of Covered Expenses and Provisions will apply under one or more of the following circumstances: a) a pre-certification call is not made according to the instructions within this section; b) an Inpatient stay exceeds the amount of days pre-certified; or c) a patient is admitted as an Inpatient when treatment could have been performed on an Outpatient basis.

This penalty will be applied in addition to any applicable Deductible and will not be applied to any Out-of-Pocket Maximum as specified in the "Schedule of Covered Expenses and Provisions". The penalty will be applied to covered expenses that were incurred during the days that were not pre-certified.

PRESCRIPTION DRUG BENEFIT

Prescription drug benefits are provided through the pharmacy benefit plan manager listed in the Prescription Drug Benefit section of the Schedule of Covered Expenses and Provisions. Benefits will be paid as stated in the Schedule of Covered Expenses and Provisions for charges made by a participating pharmacy for treatment of You or Your eligible Dependents Illness or Injury. A covered charge is considered made on the date the prescription is dispensed by the pharmacist.

Covered Prescription Drugs: Except for excluded items, the Plan covers drugs that, by law, may be dispensed only by prescription, and that fall within one of the following categories:

1. Federal (United States) Legend Drugs (including oral and injectable contraceptives);
2. State restricted drugs; or
3. Compound drugs that contain at least one Prescription Legend Drug.

Covered Pharmaceutical Products: The Plan also covers insulin, diabetic testing devices, test strips, syringes, and needles.

Drugs and Pharmaceuticals Not Covered:

The Plan does not pay for any of the following medications or pharmaceutical products listed:

1. Any covered drug in excess of the quantity specified by the Physician, or any refill dispensed after 1 year from the Physician's order
2. Any device or appliance (e.g. orthotics and other non-medical substances)
3. Diagnostic medications
4. Experimental drugs
5. Fertility Drugs
6. Fluoride Preparations
7. Gold Compounds – prepared with raw chemical ingredients, or legend drugs prepared in a non-FDA approved dosage form
8. Irrigation Solutions
9. Medications furnished on an in-patient basis covered under any other carrier providing group coverage for prescription legend drugs or insulin through Coordination of Benefits provision (e.g. major medical, home health care benefits, outpatient benefits)
10. Medical Supplies (e.g. Ostomy Supplies)
11. More than a 30-day supply of a covered Drug
12. More than a 90-day supply of a covered Maintenance Drug
13. Over-the Counter products
14. Pharmaceutical Products used for Cosmetic purposes
15. Prescription vitamins, except pre-natal
16. Serums, Toxoids, and Vaccines
17. Smoking Cessation Products (See Smoking Cessation benefit)
18. Therapeutic Devices or Appliances
19. Yohimebine

MAIL ORDER DRUG BENEFIT

This benefit offers a mail order service which delivers required prescription drugs directly to your home after a per prescription co-pay has been made (see Schedule of Covered Expenses and Provisions for co-pay amount). The mail order drug benefit permits up to a 91-day supply of medication and up to one year of refills upon authorization.

You should receive a packet providing complete details on how to use your mail order drug benefit. If you have any questions regarding this aspect of your coverage, please contact your Human Resources Department.

SPECIALTY DRUG PHARMACY BENEFIT

Certain specialty medications may be required to be purchased through your pharmacy vendor's or Allied's specialty pharmacy program. Typically, these medications are very costly, require special storage or handling, are for long term use, or require careful monitoring and management. You will be notified by the pharmacy at the time of purchase if a particular drug is in this specialty pharmacy program, or you may call the pharmacy vendor (see your member ID card) as soon as a drug has been prescribed to determine how it must be dispensed. The specialty pharmacy unit will coordinate fast shipment to the location a member chooses, such as your home or your Physician's office. Alternatively, if your pharmacy vendor indicates that they can not dispense the drug, please contact Allied's customer service team (see your member ID card) to determine how the specialty drug that has been prescribed must be dispensed. Please refer to previous pages for coverage provisions.

TRANSPLANTS

Preferred Transplant Network Facility:

A Preferred Transplant Network Facility is a facility contracted with the Plan's Preferred Transplant Network (PTN) to furnish particular services and supplies to You or Your Dependent in connection with one or more highly specialized medical procedures. The maximum charge made by the PTN for such services and supplies will be the amount agreed to between the Plan's PTN and the PTN facility.

Transplant Expenses

Once it has been determined that you or one of your Dependents may require an **organ** transplant, you or your Physician should follow the guidelines listed in the Pre-Certification Program to coordinate your transplant care. You must follow any pre-certification requirements. **Organ** means solid organ, stem cell, bone marrow, or tissue.

While all organ transplants (other than cornea or skin transplants) are covered only under this section, benefits may vary if a PTN facility or non-PTN facility is used. The PTN facility must be specifically approved and designated by the PTN to perform the procedure you require. A transplant will be covered as in-network only if performed in a facility that has been designated as a PTN facility for the type of transplant in question. Any treatment or service related to transplants that are provided by a facility that is not specified as a PTN facility, even if the facility is considered as a network facility for other types of services, will not be considered in-network. Additionally, if a PTN facility is utilized, you may be eligible for certain travel benefits related to the organ transplant.

Covered Transplant Expenses

Covered transplant expenses include the following (unless stipulated otherwise by a separate transplant agreement between the Plan, PTN, and PTN facility):

- Inpatient and Outpatient expenses directly related to a transplant.
- Charges made by a Physician or transplant team.
- Charges made by a Hospital, outpatient facility or Physician for the medical and surgical expenses of a live donor, but only to the extent not covered by another plan or program.
- Related supplies and services provided by the PTN facility during the transplant process. These services and supplies may include: physical therapy, speech therapy and occupational therapy; bio-medicals and immunosuppressants; and home health care expenses and home infusion services.

Covered transplant expenses are typically incurred during the four phases of transplant care described below. Expenses incurred for one transplant during these four phases of care will be considered one Transplant Occurrence.

A Transplant Occurrence is considered to begin at the point of evaluation for a transplant and end either: (1) 180 days from the date of the transplant; or (2) upon the date you are discharged from the Hospital or outpatient facility for the admission or visit(s) related to the transplant, whichever is later.

The four phases of one Transplant Occurrence and a summary of covered transplant expenses during each phase are:

1. Pre-transplant Evaluation/Screening: Includes all transplant-related professional and technical components required for assessment, evaluation and acceptance into a transplant facility's transplant program.
2. Pre-transplant/Candidacy Screening: Includes HLA typing/compatibility testing of prospective organ donors who are immediate family members.
3. Transplant Event: Includes Inpatient and Outpatient services for all covered transplant-related health services and supplies provided to you and a donor during the one or more surgical procedures or medical therapies for a transplant; prescription drugs provided during your Inpatient stay or Outpatient visit(s), including bio-medical and immunosuppressant drugs; physical, speech or occupational therapy provided during your Inpatient stay or Outpatient visit(s); cadaveric and live donor organ procurement.
4. Follow-up Care: Includes all covered transplant expenses; home health care services; home infusion services; and transplant-related outpatient services rendered within 180 days from the date of the transplant event.

For the purposes of this section, the following organ transplants will be considered one Transplant Occurrence:

- Heart transplant.
- Lung transplant.
- Heart/lung transplant.
- Simultaneous Pancreas Kidney (SPK) transplant.
- Pancreas transplant.
- Kidney transplant.
- Liver transplant.
- Intestine transplant.
- Bone marrow/stem cell transplant.
- Multiple organs replaced during one transplant surgery.
- Sequential transplants.
- Re-transplant of same organ type within 180 days of the first transplant.
- Any other single organ transplant, unless otherwise excluded under the Plan.

The following will be considered to be more than one Transplant Occurrence:

- Re-transplant after 180 days of the first transplant.

- Pancreas transplant following a kidney transplant.
- A transplant necessitated by an additional organ failure during the original transplant surgery/process.
- More than one transplant when not performed as part of a planned tandem or sequential transplant (e.g., a liver transplant with subsequent heart transplant).

Limitations

The transplant coverage does not include charges for:

- Outpatient drugs, including bio-medicals and immunosuppressants, not expressly related to an Outpatient Transplant Occurrence.
- Services and supplies furnished to a donor when recipient is not a Covered Person.
- Home infusion therapy after the Transplant Occurrence.
- Harvesting or storage of organs, without the expectation of immediate transplantation for an existing illness.
- Harvesting and/or storage of bone marrow, tissue or stem cells without the expectation of transplantation within 12 months for an existing illness.
- Cornea (corneal graft with amniotic membrane) or cartilage (autologous chondrocyte or autologous osteochondral mosaicplasty) transplants, unless otherwise authorized by the Plan.
- For donor services if you or your covered Dependent are a donor.

WHAT IS NOT COVERED

Although the Plan covers charges for most Illnesses and Injuries, it does not cover charges for or in connection with:

Cosmetic Surgery

The Plan does not pay for cosmetic surgery unless provided:

1. For reconstructive purposes following mastectomy,
2. In connection with an accidental Injury, or
3. To treat a birth defect.

Dental Services

The Plan does not pay for dental treatment unless provided in connection with accidental Injuries to sound natural teeth and begun within six months after the accident.

Eye Care

The Plan does not pay for eye care for visual training, surgical treatment of visual refractive problems (such as radial keratotomy), or prescription or fitting of eyeglasses or contact lenses (except for eye examination and the first set of lenses and frames following cataract surgery).

Foot Care

The Plan does not pay for routine foot care such as:

1. Treatment of corns, fallen arches, flat feet, chronic foot strain or other symptomatic complaints of the feet, or purchase of related items such as corrective shoes, wedges, splints or pads.
2. Treatment of calluses or cutting of toenails. However, treatment will be covered for ingrown toenails, and where Medically Necessary because of diabetes or other medical conditions.
3. Treatment of bunions, except by capsular or bone surgery.

Gastric By-Pass Surgery

Surgical treatment of morbid obesity is not a covered benefit.

Government Service and Illegal Acts

The Plan does not pay for treatment of a condition or Injury resulting from or caused or prolonged by:

1. Involvement in an illegal occupation.
2. War (whether declared or undeclared), civil war, invasion, hostilities, riot, or resistance to armed aggression.
3. Duty as a member of the armed forces of any country or state.
4. Public service, where the U.S. Government or any state or local government provides the treatment.
5. Services or supplies that are in violation of any law.
6. Performance or attempted performance of an assault or felony.
7. An altercation in which you were the aggressor.

Hearing Exams

The plan does not pay for hearing examinations or examinations for prescribing and fitting hearing aids except as stated (See “Schedule of Covered Expenses”).

Incidental and Personal Convenience Items

The Plan does not pay for incidental and personal convenience items such as:

1. Telephone, television, haircuts, and newspapers while you are a Hospital inpatient.
2. Completion of claim forms.
3. Missed appointments.
4. Travel mileage or lodging.

Infertility Treatment

The Plan will not pay for the diagnosis, treatment or medications prescribed for the treatment of Infertility.

Non-Medical and Experimental Procedures

The Plan does not pay for:

1. Physical examinations, tests and reports performed for non-medical reasons, such as those for insurance, school, camp, employment, sports, governmental or legal reasons, or travel.
2. Experimental or Investigational drugs or procedures, or care, service or treatment provided under a study, grant or research program, or for research purposes.

Pre-Existing Conditions for members and dependents age 19 and older

If you have a pre-existing condition when you enroll in the Plan, Plan payment of charges for treatment of that condition will be limited to 50% of In-Network charges, up to a maximum payment of \$5,000 during your first 12 consecutive months of Plan coverage. You will be responsible for paying the other 50% of these charges, as well as all charges over the Plan’s \$5,000 payment. Amounts you pay for treatment of a pre-existing condition will not count

toward your Out-of-Pocket Maximum. Any Deductible requirement will be applied prior to consideration of any payment at 50%.

A pre-existing condition is any Illness, Injury or related condition for which you received treatment during the three months immediately before you became covered by the Plan. For the purposes of this section, treatment includes advice, a physical examination, diagnosis, prescription for medication, or administration of medication.

Covered charges for an Illness or Injury you develop after your effective date of coverage will be paid as described in this Plan Document beginning on your effective date of coverage. After 12 consecutive months of Plan coverage, your pre-existing condition will be covered just like any other Illness or Injury covered by the Plan.

Some or all of the pre-existing condition waiting period may be waived:

1. If you provide satisfactory proof of acceptable creditable coverage (See Definitions— "Creditable Coverage.") that you had prior to your coverage under this Plan, and you have not experienced a break in coverage greater than 63 days.
2. If you were previously enrolled in your Spouse's health plan and you enrolled in this Plan within 31 days after your Spouse's coverage ended.
3. If you have been a regular Employee of a Participating Employer for a period of at least 12 consecutive months and then choose to enroll in this Plan during an Open Enrollment.
4. In the case of maternity claims.

Services or Supplies

The Plan does not pay for services and supplies:

1. That are self-administered;
2. That are provided by a member of your immediate family or by a person who normally lives with you;
3. That are provided in a medical department or clinic maintained by your Employer; or
4. For which you would not be required to pay if you didn't have Plan coverage.

Work-Related Injury/Illness

The Plan does not cover treatment of any Illness or Injury received or developed in the course of any work for wage or profit:

1. Unless and until the claim has been submitted to, and a final decision made by, the State Bureau of Workers' Compensation, and thereafter the Plan will cover such charges only to the extent they are not allowed by Workers' Compensation, and subject to all other Plan limitations and requirements.
2. If the Bureau of Workers' Compensation denies the claim because it was not submitted to the Bureau within applicable time limits.

3. By a self-employed Plan Participant who did not obtain Workers' Compensation coverage.

Other Exclusions

The Plan does not pay for the following, even if recommended or prescribed by a Doctor:

1. Acupuncture.
2. Aromatherapy.
3. Biofeedback, except as specified covered. (See "Schedule of Covered Expenses" — "Smoking/Tobacco Cessation").
4. Care, service, treatment, or items that:
 - a. Were provided before your effective date of Plan coverage or after your coverage ended;
 - b. Are not Medically Necessary as initially determined by the Claim Administrator and as may be confirmed through the appeals process;
 - c. Are routine services except as specified. (See— "Schedule of Covered Expenses");
 - d. Are provided by any Out-of-Network Provider, to the extent the charges are more than the Usual and Customary charges as determined by the Claim Administrator; or
5. Custodial care, maintenance therapy or supportive care, including services provided primarily for pain relief.
6. Developmental speech therapy.
7. Donation of human organ, tissue, or bone marrow to a recipient who is not a Plan Participant.
8. Educational services or classes.
9. Elective abortion, except for care in connection with a spontaneous abortion or complications resulting from an abortion.
10. Enrollment in a health, athletic, or similar club.
11. Homeopathic Treatment.
12. Hospitalization for change of environment.
13. Hypnotism- (See "Schedule of Covered Expenses"—"Smoking/Tobacco Cessation.").
14. Maintenance contracts for purchased durable medical equipment.
15. Marital counseling.
16. Massages or other personal services.
17. Medical evacuation to return home when traveling outside of the continental United States.
18. Nutritional supplements.
19. Organ donation. The Plan does not pay for donation of human organ, tissue, or bone marrow to a recipient who is not a Plan Participant.
20. Postmortem expenses.
21. Private duty professional services while confined as an inpatient.
22. Purchase or rental of:
 - a. Items of common or personal use such as thermometers, bandages, first aid ointments and supplies, non-allergy pillows and mattresses, air purifiers, air

- conditioners, water purifiers, exercise equipment, saunas, steam baths, swimming pools, and waterbeds.
- b. Motorized transportation equipment, chair lifts, escalators, or elevators, except for Medically Necessary equipment such as wheelchairs.
 - c. Spare or duplicate prosthetics, orthotics, appliances, or supplies.
23. Recreational, educational, self-help, or self-care training, except for Medically Necessary, Hospital-based, nutritional counseling related to the treatment of newly-diagnosed diabetes.
 24. Rest cures.
 25. Reversal of sterilization procedures.
 26. Seeing-eye dogs or other domestic animals providing therapy or assistance with daily living.
 27. Sex change procedures.
 28. Testing, treatment, or training related to learning disabilities.
 29. Treatment of non-morbid obesity or enrollment in a weight loss or similar program.
 30. Vitamins or minerals, unless administered by a Physician in an injectable form.

DEFINITIONS

Certain words and terms used herein shall be defined as follows:

AMBULATORY SURGICAL CENTER

Any private or public establishment with: a) an organized medical staff of Physicians; b) permanent facilities that are equipped and operated primarily for the purpose of performing Outpatient surgical procedures; c) continuous Physician services and registered professional nursing services whenever a patient is in the facility and which does not provide services or other accommodations for patients to stay overnight.

ASC REIMBURSEMENT FEE SCHEDULE

The ambulatory surgical center reimbursement rate set by Centers for Medicare and Medicaid Services (CMS).

CALENDAR YEAR

That period of time commencing at 12:01 a.m. on January 1st and ending at 12:01 a.m. on the next succeeding January 1st. Each succeeding like period will be considered a new Calendar Year.

CASE MANAGEMENT PROGRAM

A program of medical management typically utilized in situations involving extensive and on-going medical treatment, which provides a comprehensive and coordinated delivery of services under the oversight of a medically responsible individual or agency. Such programs may provide benefits not normally covered under Plan provisions in lieu of in-Hospital treatment.

If, at any point in the progress of a given medical situation, after having considered Your opinions (and/or his legally responsible representatives), Your Physician and/or other medical authorities, the Plan Administrator determines that the benefits of this Plan may be best utilized through the implementation of a Case Management Program, the Plan reserves the right to require that further benefits be provided only under the administration of such a program.

CLAIMS PROCESSOR

The entity providing consulting services to the Plan in connection with the operation of the Plan and performing other functions, including processing of claims. The Claims Processor is Allied Benefit Systems, Inc., P. O. Box 909786-60690, Chicago, IL 60690.

CO-PAY

The amount that You must pay at the time services are rendered by a provider (co-pay amounts are Your responsibility.)

COSMETIC SURGERY/TREATMENT

Surgery or treatment that is intended to improve the appearance of a patient or to preserve or restore a pleasing appearance and does not meaningfully promote the proper function of the body or prevent or treat illness or disease (except when necessary to improve a deformity arising from, or directly related to, a congenital abnormality, a personal Injury resulting from an accident or trauma, or a disfiguring disease).

COVERED EXPENSES

These are expenses for certain Hospital and other medical services and supplies for the treatment of Injury or Illness. A detailed list of Covered Expenses is set forth in this booklet in the section entitled "Schedule of Covered Expenses and Provisions."

COVERED PERSON

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Employer employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse.

CREDITABLE COVERAGE

Coverage of an individual under a qualified medical plan, including but not limited to the following: group health plans, other health insurance coverage, Part A or Part B of Medicare, Medicaid, state health benefit risk pools, state children's health insurance program and public health plans of various sorts (including from other countries).

DEDUCTIBLE/CO-INSURANCE

The amount of eligible expense incurred in any Calendar Year, that You must pay before benefits are paid. Upon receipt of satisfactory proof You have incurred covered expenses as a result of an Injury or Illness, the Plan, after deducting the Deductible amount shown in the Schedule of Covered Expenses and Provisions from the covered expenses first incurred during that Calendar Year, will pay benefits at the appropriate Co-Insurance level as shown in the Schedule of Covered Expenses and Provisions.

DEPENDENTS

Spouse of the Employee who is a resident of the same country in which the Employee resides. Unless stated to the contrary in the Key Information section at the beginning of this document, this Plan complies with the federal Defense of Marriage Act, in which the word "marriage" means only a legal union between one man and one woman as husband and wife, and the word "spouse" refers only to a person of the opposite sex who is a husband or a wife. See Key Information section as to whether spouses of deceased retired Employees are eligible for coverage under this Plan and, if so, the circumstances under which coverage is provided.

Children from birth to their 26th birthday who live in the same country in which the Employee resides. The term "child" or "children" include children that are specified within the Key Information section at the beginning of this document.

A child who is physically or mentally incapable of self-support upon attaining age 26 may be continued under the health care benefits, while remaining incapacitated and unmarried, subject to the covered Employee's own coverage continuing in effect. To continue a child under this provision, the Plan must receive proof of incapacity within 31 days after coverage would otherwise terminate. Additional proof will be required from time to time.

DOMESTIC PARTNER

See the Key Information section at the beginning of this document.

ELECTIVE SURGICAL PROCEDURE

Any non-emergency surgical procedure which may be scheduled at a patient's convenience without jeopardizing the patient's life or causing serious impairment to the patient's bodily

functions and which is performed while the patient is confined in a Hospital as an Inpatient or in an Ambulatory Surgical Center.

EMERGENCY ROOM SERVICES

“Emergency Room Services” is defined as, with respect to a Medical Emergency, a medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate such Medical Emergency, and such further medical examination and treatment, to the extent they are within the capabilities of the staff and facilities available at the hospital, to Stabilize the patient.

EMPLOYEE

See the Key Information section at the beginning of this document.

EMPLOYER

See the Important Points section at the end of this document.

ENROLLMENT DATE

The first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period. The Enrollment Date is the point in time where the Look Back Period or Look Forward Period begins.

ESSENTIAL HEALTH BENEFITS

“Essential Health Benefits” include the following general categories and the items and services covered within the categories: Ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

EXTENDED CARE FACILITY

An institution (or a distinct part of an institution) which: (a) provides for Inpatients (1) 24-hour nursing care and related services for patients who require medical or nursing care, or (2) service for the rehabilitation of injured or sick persons; (b) has policies developed with the advice of (and subject to review by) professional personnel to cover nursing care and related services; (c) has a Physician, a registered professional nurse or a medical staff responsible for the execution of such policies; (d) requires that every patient be under the care of a Physician and makes a Physician available to furnish medical care in case of emergency; (e) maintains clinical records on all patients and has appropriate methods for dispensing drugs and biologicals; (f) has at least one registered professional nurse employed full time; (g) provides for periodic review by a group of Physicians to examine the need for admissions, adequacy of care, duration of stay and medical necessity of continuing confinement of patients; (h) is licensed pursuant to law, or is approved by appropriate authority as qualifying for licensing and is also approved by Medicare; (i) is not primarily a place for the aged, drug addicts, alcoholics, mentally retarded persons, or a place for rest, custodial or educational care or for the care of mental disorders.

FAMILY DEDUCTIBLE

If the amount of covered expenses incurred by family members and applied toward the Deductible totals the amount shown in the Schedule of Covered Expenses and Provisions, the Deductible amount shall be waived for all other members of that family unit for that Calendar Year.

GENDER NEUTRAL WORDING

A masculine pronoun in this document shall at all times be considered synonymous with a feminine pronoun unless the context indicates otherwise.

GENETIC INFORMATION

The term "genetic information" is defined as 1) an individual's own genetic tests, 2) the genetic tests of family members of such individual, and 3) the manifestation of a disease or disorder in family members of such individual. The term "genetic information" also encompasses family medical history. The term "genetic information" additionally extends to genetic information of any fetus carried by a pregnant woman. With respect to an individual or family member utilizing an assisted reproductive technology, genetic information includes the genetic information of any embryo legally held by the individual or family member. The term "genetic information" further extends to dependents and family members defined as first-degree, second-degree, third-degree, or fourth-degree relatives of the individual. The term additionally includes participation in clinical research involving genetic services.

HOME HEALTH CARE AGENCY

A public or private agency that is primarily engaged in providing skilled nursing and other therapeutic services and is either (1) licensed or certified as a home health agency by the governing jurisdiction; or (2) certified as a home health agency by Medicare.

HOSPICE

A facility established to furnish terminally ill patients a coordinated program of Inpatient and home care of a palliative and supportive nature. A hospice must be approved as meeting established standards, including any legal licensing requirements.

HOSPITAL

An institution which meets all of the following requirements; (a) maintains permanent and full-time facilities for bed care of resident patients; (b) has a doctor in regular attendance; (c) continuously provides 24 hour a day nursing services by Registered Nurses (R.N.); (d) is primarily engaged in providing diagnostic and therapeutic services and facilities for medical and surgical care of Injuries or Illnesses on a basis other than a rest home, nursing home, convalescent home, or a home for the aged; (e) maintains facilities on the premises for surgery; (f) is operating lawfully as a Hospital in the jurisdiction where it is located; and (g) is either accredited by the Joint Commission on the Accreditation of Healthcare Organizations or is Medicare approved.

In addition, the term "Hospital" shall mean, as defined by Medicare, a Psychiatric Hospital, which is qualified to participate in and is eligible to receive payments under and in accordance with the provisions of Medicare; or, which meets the following requirements; (a) is licensed by the jurisdiction in which it operates; and (b) is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.

HOSPITAL INTENSIVE CARE/CARDIAC CARE UNIT

Only a section, ward or wing within the Hospital which is distinguishable from other Hospital facilities because it (a) is operated solely for the purpose of providing room and board and professional care and treatment for critically ill patients, including constant observation and care by a Registered Nurse (R.N.) or other highly trained Hospital personnel, and (b) has special supplies and equipment necessary for such care and treatment, available on a standby basis for immediate use.

HOSPITAL SEMI-PRIVATE

The room and board charge is not to exceed the semi-private room rate. The difference between the semi-private room rate and the private room rate will be the patient's responsibility and will not apply to, or be affected by, any Out-of-Pocket Maximum provision. However, if 1) a private room is required due to Medical Necessity, or 2) the Hospital only has private rooms, the full private room charge will be considered.

ILLNESS

Only non-occupational sickness, disease, mental infirmity or pregnancy, all of which require treatment by a Physician.

INJURY

Only non-occupational bodily Injury which requires treatment by a Physician.

INPATIENT

You will be considered to be an "Inpatient" if You are treated at a Hospital and is confined for more than 18 consecutive hours. The term "Inpatient" shall also apply to those situations where "partial hospitalization" (defined as an on-going period of treatment involving full use of Hospital facilities excepting only room and board service) is recommended by Your Physician as an alternative to Hospital confinement.

LATE ENROLLMENT

An enrollment which takes place other than during the first period during which an individual was eligible for coverage, or other than during a period of Special Enrollment or Open Enrollment. This Plan does not have Late Enrollment.

LIFETIME

Shall mean, "while covered under the Plan". Under no circumstances will the word "Lifetime" mean "during Your lifetime".

LOOK BACK PERIOD

The period of time prior to the Enrollment Date that is used to determine if the individual has a Pre-Existing Condition (i.e., when the individual sought medical advice, diagnosis, or care, had treatment recommended or received treatment from a licensed or authorized person during this time). See the Key Information section at the beginning of this document for additional details and applicability.

LOOK FORWARD PERIOD

The period of time following the Enrollment Date, which is the time period during which the Plan will apply a Pre-Existing Conditions Limitation (unless this time period is reduced or eliminated by the application of Creditable Coverage). See the Key Information section at the beginning of this document for additional details and applicability.

MEDICAL EMERGENCY

A "Medical Emergency" is defined as a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in 1) a condition placing the health of the individual (or, with respect

to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; 2) serious impairment to bodily functions; or 3) serious dysfunction of any bodily organ or part.

MEDICALLY NECESSARY

Health care services, supplies or treatment which, in the judgment of the attending Physician, is appropriate and consistent with the diagnosis and which, in accordance with generally accepted medical standards, could not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered.

MEDICARE DRG OR APC REIMBURSEMENT RATE

The inpatient and outpatient reimbursement rates set by Centers for Medicare and Medicaid Services (CMS).

MENTAL/NERVOUS AND SUBSTANCE USE DISORDER SERVICES

Services for diagnoses that are listed in the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association that is current as of the date services are rendered.

NAMED FIDUCIARY

The person or entity who has the complete authority to control and manage the operation and administration of the Plan. The Named Fiduciary for the Plan is the Plan Sponsor. In exercising its fiduciary responsibilities, the Plan Sponsor shall have the discretionary authority to determine eligibility for benefits, review denied claims for benefits, interpret Plan provisions, construe disputed Plan terms and select managed care options. The Plan Sponsor shall be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously. Any other individual or entity exercising any discretionary authority with respect to the Plan shall also be deemed to have properly exercised such authority unless it has abused its discretion by acting arbitrarily and capriciously.

OPEN ENROLLMENT

Each year, a period of time may be designated as an "Open Enrollment" period. Except for Special Enrollment or Late Enrollment, if applicable, it is only during this period that an Employee or Dependent who did not enroll during their initial eligibility period may enroll in a Plan. Coverage will become effective on the date specified by your Employer. See the Key Information section at the beginning of this document for applicability, as well as your Employer for details.

OUT-OF-POCKET MAXIMUM

The "Out-of-Pocket Maximum" is the total amount of Co-Insurance for which You or Your covered family is responsible during the course of a Calendar Year. These amounts are shown in the "Schedule of Covered Expenses and Provisions".

OUTPATIENT

You shall be considered to be an "Outpatient" if he is treated at a Hospital and is confined less than 18 consecutive hours.

PHYSICIAN

A Physician who is duly qualified and licensed by the state in which he is resident to practice medicine, perform surgery and to prescribe drugs, or who is licensed to practice as a dentist, podiatrist, chiropractor, psychologist, social worker or practitioner of healing arts, and who is practicing within the scope of his license.

PLACEMENT FOR ADOPTION

The assumption and retention of a legal obligation for total or partial support in anticipation of adoption.

PLAN

The benefits and provisions for payment of same as described herein are the Employer Plan as described in the Important Points section at the end of this document. This is a Group Health Plan.

PLAN ADMINISTRATOR

The entity responsible for the day-to-day functions and overall management of the Plan. The Plan Administrator may employ persons or firms to process claims and perform other Plan connected services. The Plan Administrator is Butler Health Plan.

PLAN YEAR

The 12-month period defined in the Key Information section at the beginning of this document. Fiscal records are maintained for a Plan Year ending as of the date specified under the Key Information section.

PRE-EXISTING CONDITIONS LIMITATION

A limitation or exclusion of coverage due to a physical or mental condition that existed before the individual's Enrollment Date. To limit or exclude coverage for such a condition, the individual must have sought medical advice, diagnosis, care or treatment during the Look Back Period prior to Enrollment Date. Such limitations and exclusions of coverage are solely applicable with respect to Employees and Dependents 19 years of age and older. See the Key Information section at the beginning of this document for applicability.

QUALIFIED MEDICAL CHILD SUPPORT ORDER

A legal order requiring the coverage of specified child(ren) under an individual's medical plan benefits. If your employer determines that a separated or divorced spouse or any state child support or Medicaid agency has obtained a legal QMCSO, and your current plan offers dependent coverage, you will be required to provide coverage for any child(ren) named in the QMCSO. If you do not enroll the child(ren), your employer must enroll the child(ren) upon application from your separated/divorced spouse, the state child support agency or Medicaid agency and withhold from your pay your share of the cost of such coverage. You may not drop coverage for the child(ren) unless you submit written evidence to your employer that the child support order is no longer in effect. The plan may make benefit payments for the child(ren) covered by a QMCSO directly to the custodial parent or legal guardian of such child(ren). ERISA preemption of state laws does not apply to Qualified Medical Child Support Orders and provisions of state laws requiring medical child support. Group health plans may not deny enrollment of a child under the health coverage of the child's parent on the ground that the child is born out of wedlock, not claimed as a dependent on the parent's tax return, or not in residence with the parent or in the applicable service area. Additional information concerning "QMCSO" procedures are available from the Plan Administrator at no charge upon request.

REASONABLE/REASONABLENESS

“Reasonable” and/or “Reasonableness” shall mean in the Plan Administrator’s discretion, services or supplies, or charges for services or supplies, which are necessary for the care and treatment of Illness or Injury. Determination that charges or services/supplies are Reasonable will be made by the Plan Administrator, taking into consideration unusual circumstances or complications requiring additional time, skill and experience in connection with a particular service or supply; industry standards and practices as they relate to similar scenarios; and/or the cause of Injury or Illness necessitating the service(s) and/or charge(s).

This determination may consider, but not be limited to, the findings and assessments of the following entities: (a) national medical associations, societies, and organizations; and (b) The Food and Drug Administration. To be Reasonable, services, supplies and/or charges must be in compliance with the Plan Administrator’s policies and procedures relating to billing practices for unbundling or multiple procedures. The Plan Administrator retains discretionary authority to determine whether services, supplies and/or charges are Reasonable based upon information presented to the Plan Administrator.

The Plan reserves for itself and parties acting on its behalf the right to review charges processed and/or paid by the Plan, and to identify charges and/or services that are not Reasonable, and therefore not eligible for payment by the Plan.

RECONSTRUCTIVE BREAST SURGERY COVERAGE

Medical benefits under the Plan will be administered according to the terms of the Women’s Health and Cancer Rights Act of 1998. The Plan will provide to Covered Persons who are receiving Plan benefits in connection with such mastectomy coverage for: (1) all stages of reconstruction of the breast on which the mastectomy has been performed; (2) surgery and reconstruction of the other breast to produce symmetrical appearance; and (3) prostheses and physical complications of mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient. The coverage will be subject to the terms of the Plan established for other coverage under the Plan, including the annual deductible and coinsurance provisions.

RETIREE

See the Key Information section at the beginning of this document.

SECOND SURGICAL OPINION

Shall mean a written statement on the necessity for the performance of a covered surgical procedure. This Second Surgical Opinion must be given by a board-certified specialist who, by the nature of the Physician’s specialty, qualifies the Physician to consider the surgical procedure being proposed and who is otherwise not associated with the surgeon who initially recommended the surgery.

SIGNIFICANT BREAK IN COVERAGE

A break in coverage of 63 days or more. Waiting periods do not count towards a Significant Break in Coverage. If an individual seeks coverage in the individual market, the Waiting Period shall begin on the date the individual submits a substantially completed application for coverage and ends on either the date coverage begins, or the date on which the application is denied by the issuer, or the date on which the offer of coverage lapses. Also, the days between the date an individual lost group health plan coverage and the first day of the second COBRA election period (under the Trade Act of 2002) are not taken into account in determining the length of a Significant Break in Coverage.

SPECIAL ENROLLMENT

An enrollment which takes place during the 30-day period following the date of the event which triggers the Special Enrollment period. See “Eligibility” section for details.

STABILIZE

“Stabilize” means, with respect to a Medical Emergency, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility.

SWITCH ENROLLMENT

Each year, a period of time may be designated as a “Switch Enrollment” period. Except for Special Enrollment, it is only during this period that an Employee who is currently covered under one Plan may switch to another. Coverage will become effective on the date specified by your Employer. Switch Enrollment is only allowed during Open Enrollment.

USUAL AND CUSTOMARY

“Usual and Customary” (U&C) shall mean Covered Expenses which are identified by the Plan Administrator, taking into consideration the charge(s) which the provider most frequently bills the majority of patients for the service or supply, the cost to the provider for providing the service or supply, the prevailing range of charges billed in the same “area” by providers of similar training and experience for the service or supply, and/or the Medicare reimbursement rates. The term(s) “same geographic locale” and/or “area” shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of providers, persons or organizations rendering such treatment, service, or supply for which a specific charge is made. To be Usual and Customary, the charge must be in compliance with the Plan Administrator’s policies and procedures relating to billing practices for unbundling or multiple procedures.

The term “Usual” refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term “Customary” refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term “Usual and Customary” does not necessarily mean the actual charge made nor the specific service or supply furnished to You by a provider of services or supplies. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator’s discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, average wholesale price (AWP) for prescriptions and/or manufacturer’s retail pricing (MRP) for supplies and devices.

WAITING PERIOD

The period of time before an individual is eligible to be covered under the terms of a group health plan. Any period before a Late Enrollment, Open Enrollment or Special Enrollment is not a Waiting Period. A Waiting Period does not count for Creditable Coverage or for a Significant Break in Coverage.

You and/or Your

A covered Employee or a covered Dependent. No person is eligible for health care benefits both as an Employee and as a Dependent under this Plan. When the Employer employs both husband and wife, any Dependent children may become covered hereunder only as Dependents of one spouse

ELIGIBILITY

WHO IS ELIGIBLE

See the Key Information section at the beginning of this document.

NON-DISCRIMINATION

In regard to the offering of coverage, the Plan will not discriminate against any individual on the basis of health status, medical condition (physical or mental), claims experience, receipt of health care, medical history, genetic information, evidence of insurability or disability. No otherwise eligible individual will be refused the opportunity to enroll in the Plan due to participation in any particular activity, regardless of its hazardous nature. The Plan will not discriminate against similarly situated individuals in regard to eligibility or benefits (however, this does not limit the Plan's ability to treat participants classifiable through non-health related criteria as different groups in different ways.) The Plan will not knowingly discriminate against any individual on the basis of health factors. However, the Plan may impose coverage limits or exclusions on all similarly situated individuals which may have an effect on only some individuals.

STANDARD EMPLOYEE COVERAGE

For date of eligibility, please see the Key Information section at the beginning of this document. The Plan will not exclude absences from work due to health related reasons from credit towards the waiting period, if applicable, as referenced in the Key Information section.

STANDARD DEPENDENT COVERAGE

Each Dependent of the eligible Employee becomes eligible for Dependent coverage under the Plan on the later of the following:

1. The date the Employee is eligible; or
2. The date the individual becomes a Dependent of the Employee if on that date the Employee is covered.

STANDARD INDIVIDUAL EFFECTIVE DATE

All persons become covered, as they become eligible subject to the following:

1. All Employees, who are eligible Employees, shall be covered on the day they become eligible.
2. Dependents shall be covered simultaneously with Employees covering them as Dependents.
3. Coverage for a spouse will begin from the date of marriage. Coverage for a newborn birth child will begin from the date of birth. Coverage for a child placed under legal guardianship, an adopted child or a child placed for adoption with the Employee will begin from the date of Placement for Adoption. Coverage for a stepchild or foster child will begin from the date the child meets the definition of "Dependent." With respect to a spouse, the spouse must be formally enrolled and appropriate coverage arranged within 30 days from date of marriage. With respect to a newborn birth child, the child must be formally enrolled and appropriate coverage arranged within 60 days from birth. With respect to a child placed under legal guardianship, an adopted child or child placed for adoption, the child must be formally enrolled and appropriate coverage arranged within 60 days from the date of Placement For Adoption. With respect to a stepchild or a foster child, the child must be formally enrolled and appropriate coverage arranged within 30 days from the date that the child meets the definition of "Dependent."

OPEN ENROLLMENT

See the Key Information section at the beginning of this document for applicability.

SPECIAL ENROLLMENT

The Plan permits a Special Enrollment period for an Employee (or a Dependent), who is eligible for coverage, but not enrolled, to enroll if the Employee (or Dependent) had other coverage and loses it, or if a person becomes a Dependent of the Employee through marriage, birth, adoption or Placement for Adoption. A person who enrolls during a Special Enrollment period is not treated as a late enrollee.

An individual may be eligible for Special Enrollment if the Employee, at the time coverage is declined, provides a statement, in writing, indicating the reason for declining coverage. To be eligible for Special Enrollment, the Employee must have declined coverage due to coverage under another plan. However, Special Enrollment will be available to Employees that decline coverage without having coverage under another plan and subsequently enroll in other coverage and loses that coverage. The Employee must have had an opportunity for Late Enrollment, Open Enrollment or Special Enrollment under this Plan but again chose not to enroll. Special Enrollment is also available to an Employee or Dependent who becomes eligible for a premium assistance subsidy under Medicaid or a state Children's Health Insurance (CHIP) program with respect to this Plan.

If the Employee declined coverage because the other coverage was COBRA coverage, then the COBRA coverage must be exhausted before Special Enrollment will be available. If the other coverage is not COBRA coverage, then to be eligible for Special Enrollment, the other coverage must be lost due to a loss of eligibility, or employer contributions must have ended. Loss of eligibility includes a loss of coverage due to:

- divorce;
- legal separation;
- death;
- termination of employment, or reduction in hours of employment;
- relocating outside of an HMO's service area (only if there is no access to other coverage through the HMO);
- a plan no longer offering benefits to a class of similarly situated individuals even if the plan continues to provide coverage to other individuals.
- The Employee or Dependent is covered under a Medicaid plan or under a state CHIP program, and coverage of the employee or dependent under such a plan/program is terminated as a result of loss of eligibility for such coverage.

An Employee who is already enrolled in a benefit option may enroll in another benefit option under the Plan if their Dependent has a Special Enrollment right because the Dependent lost other health coverage.

Under Special Enrollment, the Employee must request enrollment, in writing within 30 days after the exhaustion of COBRA, or termination of the other coverage (other than Medicaid or Children's Health Insurance, see below), or the date of the marriage, birth, adoption or placement for adoption. If eligible, enrollment in the Plan, in cases of marriage, birth or adoption/Placement for Adoption, will be effective as of the date of the event; otherwise, coverage will be available no later than the first day of the first month beginning after the completed request for enrollment is received.

Under Special Enrollment, the Employee must request enrollment, in writing within 60 days after the termination of Medicaid or Children's Health Insurance (CHIP) coverage, or when eligible for a premium assistance subsidy under Medicaid or a state CHIP program. If eligible,

enrollment in the Plan will be effective no later than the first day of the first month beginning after the completed request for enrollment is received.

TERMINATION OF COVERAGE

See the Key Information section at the beginning of this document for details.

PERSONNEL POLICIES

Except as stated below, or as required under the Family and Medical Leave Act or the Uniformed Services Employment and Reemployment Rights Act, the Employer's current personnel policies regarding waiting periods, continuation of coverage or reinstatement of coverage shall apply during the following situations: Employer certified disability, leave of absence, layoff, reinstatement, hire or rehire.

PRE-EXISTING CONDITIONS LIMITATION

Unless the Plan does not contain a Pre-Existing Condition Limitation as stated in the Key Information section at the beginning of this document, Pre-Existing Conditions are not covered under the Plan for Employees and Dependents age 19 and over. A Pre-Existing Condition is defined as a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the Look Back Period ending on the Enrollment Date. See the Key Information section for additional details and applicability with respect to the Look Back Period.

The Pre-Existing Conditions Limitation will not apply to any charges incurred after the Look Forward Period following Your Enrollment Date. See the Key Information section for additional details and applicability with respect to the Look Forward Period.

The Plan will reduce the Pre-Existing Conditions Limitation by any periods of Creditable Coverage. The Plan will determine within a reasonable period of time the length of the Pre-Existing Conditions Limitation based on a review of certificates of Creditable Coverage, or such other indications of Creditable Coverage as may apply.

The Plan will give credit to reduce the length of the Pre-Existing Conditions Limitation if You have prior Creditable Coverage under a qualified plan. A qualified plan includes, but is not limited to, group health plans, health insurance coverage, Part A or Part B of Medicare, Medicaid, state health benefit risk pools, the state children's health insurance program and public health plans of various sorts (including from other countries). Certain plans are excepted plans including, but not limited to, limited scope dental and vision plans, disability plans and fixed dollar indemnity insurance which pays a fixed dollar amount per day regardless of amount of expenses incurred.

You will only be given credit for prior coverage if You do not experience a Significant Break in Coverage. A Significant Break in Coverage is defined as 63 or more consecutive days during which You do not have any Creditable Coverage. Neither a Waiting Period nor an HMO affiliation period will be taken into consideration in determining a Significant Break in Coverage.

The Plan will not impose any Pre-Existing Conditions Limitation relating to pregnancy and conditions based solely on genetic information.

The Plan will not impose a Pre-Existing Conditions Limitation without notifying You in writing of the existence and terms of the limitation, any Waiting Period, and Your rights to demonstrate Creditable Coverage. You have the right to request a certification of Creditable Coverage from any previous plan or insurer. If necessary and requested, this Plan will assist in obtaining the certificate. If a certificate cannot be obtained, other means of demonstrating Creditable Coverage may also be considered.

If the Employee or any Dependent loses coverage under this Plan, a certificate of Creditable Coverage will be automatically provided. You may designate another individual or entity to receive the certificate on your behalf, if desired. Within 24 months after coverage ceases, the Plan will issue, upon request, a certificate of Creditable Coverage regardless of whether one has been previously provided.

NETWORK BENEFITS

Your Plan contains enhanced benefits through network providers. The name of the organization associated with these network providers is indicated on the front of your ID card, along with instructions regarding where to file medical claims. Benefits are generally paid at a higher level when using network Hospitals and network Physicians than when using non-network providers. Please refer to the appropriate Plan Schedule of Covered Expenses for benefits payable according to type of provider used. For on-line inquiry to locate a network provider near you, or to verify that a provider is in the PPO network, visit the website listed on your ID card. For direct assistance in locating network providers, call the "Provider Referral Number" listed on your ID card. Note: A printed listing of network providers will be furnished automatically upon request, without charge, as a separate document by the Plan Administrator.

You have a free choice of any provider for medical care. At any time, the Covered Person may choose any qualified provider with the understanding that different benefits may apply according to the provisions of the Plan.

PROCEDURES FOR FILING CLAIMS

Remember to Pre-Certify by calling the toll-free number shown on your ID card if required by your Plan.

KEY POINTS TO REMEMBER

The claims filing address you must use for filing all medical claims is shown on your ID card.

1. Each bill should be itemized as to services, show payment status, and include the name of the patient, the Employee's social security number or unique identification number ("UID"), and the name and/or group number of the Employer.
2. It is your responsibility to see that all bills are submitted as indicated above. Proper payment cannot be made without the proper bills.
3. All charges, and corresponding requested documentation, must be submitted within the time frame specified in the Schedule of Covered Expenses and Provisions. Failure to do so will result in the denial of the charges.
4. From time to time, additional information may be requested to process your claim. Any additional information, i.e. other insurance payments or information, completed claim forms or subrogation forms, accident details, police reports, etc. must be submitted by you or your provider(s) when requested within the time frame specified in the Schedule of Covered Expenses and Provisions. Your failure to do so will result in the denial of the claim.
5. Only clean claims will be adjudicated by the Plan. A clean claim is one that is complete and accurate, does not require further information for processing from the provider, patient, or any other person or entity, and leaves no issues regarding the Plan's responsibility for payment.

FILING A HOSPITAL CLAIM

When You are admitted as an Inpatient or is treated as an Outpatient, secure an itemized Hospital bill, including an admitting diagnosis. Check Your bill for any possible errors and then submit the charges as indicated above.

Always retain a copy of the hospital bill for your records.

MISCELLANEOUS CLAIMS FILING CONSIDERATIONS

It is necessary to keep separate records of your expenses with respect to each of your Dependents and yourself. The following items are important and should be carefully kept to be submitted with your claim:

1. All Physician's bills should show the following:
 - a. Name of patient and adequate membership information
 - b. Dates and charges for services, and payment status of each
 - c. Types of service rendered and procedure codes
 - d. Diagnosis information
2. Prescription drug expenses should show the following:
 - a. Name of patient and adequate membership information
 - b. Prescription number and name of drug
 - c. Cost of the drug and date of purchase. Cash register receipts and canceled checks cannot be accepted for payment
 - d. Generic Drugs should be indicated on the drug bill

3. Bills for all other covered medical charges, such as for ambulance service, durable medical equipment, etc. should show the following:
 - a. Name of patient and adequate membership information
 - b. Date of service
 - c. Charge and description of each service/item
 - d. Diagnosis information

Always retain a copy of the bill for your records.

If You Find Billing Errors

If you find a billing error that results in an overpayment and have it corrected, we will share the difference between the original charge and the correct amount with you. The Plan will pay you 50% of the difference up to a maximum payment of \$1,000. Here's how the program works:

Each time you receive care, service, or treatment (other than prescription drugs) be sure to get an itemized bill. Check this bill carefully to be sure that you actually received all the care or items you are being charged for. If you find a mistake in the amount billed or if you did not actually receive all of the care or items listed, take your bill to the Hospital, your Doctor, or the store where you bought the covered items, and ask for a corrected bill. Send a copy of the original bill and the corrected bill to the Claim Administrator. After verifying that you qualify, the Claim Administrator will send you a check for 50% of the difference between the erroneous and correct amounts, up to a maximum of \$1,000.

THIS PLAN AND MEDICARE

1. Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.
2. When an Employee becomes entitled to Medicare coverage and is still actively at work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. When a Dependent becomes entitled to Medicare coverage and the Employee is still actively at work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
4. If the Employee is still actively at work, and the Employee and/or Dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
5. If the Employee and/or Dependent elect to discontinue health coverage and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

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

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Office of Butler Health Plan. The Plan has retained the services of an independent Claims Processor experienced in claims processing. Fiscal records are maintained for a Plan Year ending as of the date specified under the Important Points section at the end of this document.

The Plan is a legal entity. Legal notices may be filed with, and legal process served upon, the Plan Administrator at the address specified in the Important Points section at the end of this document.

APPEALING A CLAIM

CLAIMS PROCEDURES

An explanation of benefits or other written or electronic notification will be provided by the Plan Administrator showing the calculation of the total amount payable for the claim, charges not payable, and the reason. If the claim is denied or reduced in whole or in part, it is considered an "Adverse Benefit Determination." An Adverse Benefit Determination also includes a rescission of coverage, whether or not the rescission has an adverse effect on any particular benefit at the time of the rescission. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. An Adverse Benefit Determination is subject to the provisions detailed below.

The Plan Administrator will notify the claimant of an Adverse Benefit Determination within 30 days after receipt of the claim. However, in certain cases an extension of up to 15 days may be utilized if the Plan Administrator determines that the extension is necessary due to matters beyond the control of the Plan and the claimant is notified 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 Administrator expects to render a decision. If such an extension is necessary due to a failure of 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 given at least 45 days within which to provide the specified information. A notice of Adverse Benefit Determination will include the following:

- Sufficient information to identify the claim involved, including the date(s) of service, health care provider, and claim amount.
- The specific reason or reasons for the Adverse Benefit Determination, as well as the Plan's standard that was used in denying the claim, if applicable, and including identifying denial codes and providing their meaning.
- Reference to specific Plan provisions on which the Adverse Benefit Determination is based.
- 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.
- A description of the Plan's first level appeal procedures and the time limits applicable to such procedures, including information on how to initiate an appeal, the contact information for the Employee Benefits Security Administration (1-866-444-EBSA (3272)) to assist individuals with the first, second and third (external) level claim and appeal processes, and a statement of claimant's right to bring a civil action under Section 502(a) of ERISA following a determination of the third level (external) appeal.

- 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 will be set forth in the notice of Adverse Benefit Determination; or the notice will contain a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the notice of Adverse Benefit Determination, or the notice will contain a statement that such explanation will be provided free of charge upon request.

FIRST LEVEL APPEALS PROCEDURE

If you receive an Adverse Benefit Determination, you or your authorized representative may appeal the determination by filing a written application with the Plan Administrator, through Allied Benefit Systems, Inc., the Claims Processor, or the Pharmacy Benefit Administrator, whichever is applicable. Be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. In appealing an Adverse Benefit Determination, the Plan Administrator will provide you or your authorized representative:

- The opportunity to submit written comments, documents, records, and other information relating to the claim for benefits.
- Upon request and free of charge, reasonable access to, and copies of, all documents, records, the claim file, and other information relevant to the claim.
- A full and fair review that takes into account all comments, documents, records, and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. You must also be provided, free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan Administrator, as well as any new or additional rationale relied upon by the Plan Administrator in reaching its determination on appeal, that differs from that which the Plan Administrator relied on in its Adverse Benefit Determination. Such evidence and/or rationale must be provided as soon as possible and sufficiently in advance of the date on which the Plan Administrator's determination is required to be provided to give you a reasonable opportunity to respond prior to that date.
- A full and fair review that does not afford deference to the initial benefit determination and is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual.
- In deciding an appeal of an 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, that 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 and that the health care professional consulted shall neither be an individual who was consulted in connection with the initial Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of any such individual.

- Upon request, the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's Adverse Benefit Determination, without regard to whether the advice was relied upon in making the benefit determination.

A first level appeal must be filed within 180 days after the Adverse Benefit Determination is received. An appeal will be considered filed on the date it is received. An appeal for claims filed beyond the timely filing date will not be considered. The Plan Administrator will notify you or your authorized representative of its determination within 60 days after receipt of an appeal. The Plan Administrator's determination:

- Will contain sufficient information to identify the claim involved, including the date(s) of service, health care provider, claim amount, denial codes and their meaning, as well as the Plan's standard used in denying the claim.
- Will be in writing, setting forth specific reasons for the decision and reference to the specific Plan provisions upon which the determination is based.
- Will contain a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.
- Will contain a description of the Plan's second and third level (external) review processes, including information on how to initiate a second and third level appeal, and the contact information for the Employee Benefits Security Administration to assist individuals with the second and third level review processes (1-866-444-EBSA (3272)), as well as a statement of your right to bring a civil action under Section 502(a) of ERISA following the determination of the external review.
- If an internal rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination, either the specific rule, guideline, protocol, or other similar criterion will be set forth in the determination; or the determination will contain a statement that such rule, guideline, protocol, or other similar criterion was relied upon in making the Adverse Benefit Determination and that a copy of the rule, guideline, protocol, or other similar criterion will be provided free of charge to the claimant upon request.
- If the Adverse Benefit Determination is based on a medical necessity or experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the claimant's medical circumstances, will be set forth in the determination or the determination will contain a statement that such explanation will be provided free of charge upon request.

If the Plan does not strictly adhere to all the requirements of the first level claims and appeals process with respect to a claim, you are deemed to have exhausted the first level claims and appeals process. Accordingly, upon such a failure, you may directly bypass the second level, and initiate a third level (external) review and pursue any available remedies under applicable law.

SECOND LEVEL APPEALS PROCEDURE

If you are not satisfied with the Plan Administrator's benefit determination on review of your appeal, write to the appropriate administrator (Claims Processor or Pharmacy Benefit Manager) asking to have the Plan Sponsor review your claim. Again, be sure to say why you think the payment decision is not correct—in other words, why you think your claim should be paid. You must send this request to the appropriate administrator (Claims Processor or Pharmacy Benefit Manager) within 180 calendar days after you receive your Explanation of Benefits Form, or within 30 days after you receive the benefit determination on review of your appeal from the Plan Administrator, whichever is later.

In connection with your appeal, you have the right to:

1. Submit written comments, documents, records and other information relating to the claim for benefits; and
2. Review and obtain without charge copies of documents, records and other information relevant to the claim being appealed.

The Claims Processor or Pharmacy Benefit Manager, as applicable, will send the request to the Plan Administrator, and the Plan Sponsor will then make a full and fair review of the claim, taking into account everything you have submitted. The Plan Administrator may require the Participant to submit additional information to make the review.

In making a decision, the Plan Sponsor will:

1. Not give deference to the initial claim determination.
2. Not allow the same person who made the initial decision (or any subordinate of that person) to decide the appeal.
3. Consult with a health care professional on any appeal that involves the exercise of medical judgment. The health care professional will have training or experience in a field of medicine appropriate to the questions raised on appeal. The professional will not be the same person consulted in connection with the original denial or any subordinate of that person. The Plan Administrator will identify the professionals consulted upon written request.

The Plan Sponsor will make a final decision in writing. That decision will be given within 30 days after the date the Claim Administrator receives the request for review.

Your appeal will be determined on its own merits at each stage of review, and the decision on your appeal will not be considered as setting any precedent or creating any future liability with respect to You or Your eligible Dependents. If for any reason the Plan Sponsor fails to act within these time frames, the appeal will be deemed to be denied.

THIRD LEVEL (EXTERNAL) APPEALS PROCEDURE

If your second level appeal is denied, in whole or in part, such denial is called a Final Internal Adverse Benefit Determination. You or your authorized representative may file a third level (external) appeal of the Final Internal Adverse Benefit Determination by filing a written application with the Plan Administrator, through Allied Benefit Systems, Inc., the Claims Processor. (However, you may not file a third level appeal of the Final Internal Adverse Benefit Determination to the extent that determination related to a failure to meet the requirements for eligibility under the terms of the Plan.)

A third level appeal must be filed within 4 months after the Final Internal Adverse Benefit Determination is received. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday. The Plan Administrator reserves the right to charge a nominal filing fee, as allowed by applicable law.

Preliminary review. Within 5 business days following the date of receipt of the third level (external) review request, the Plan Administrator must complete a preliminary review of the request to determine whether:

- a. The claimant is or was covered under the Plan at the time the health care service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care service was provided;
- b. The Final Internal Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan;
- c. The claimant has exhausted the Plan's first level appeal process; and
- d. The claimant has provided all the information and forms required to process a third level review.

Within one business day after completion of the preliminary review, the Plan Administrator must issue a notification in writing to the claimant. If the request is complete but not eligible for a third level review, such notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA). If the request is not complete, such notification must describe the information or materials needed to make the request complete, and the Plan must allow a claimant to perfect the request for the third level review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization. The Plan Administrator must assign an independent review organization ("IRO") to conduct the third level (external) review. The assigned IRO will timely notify the claimant in writing of the acceptance for the third level review. This notice will include a statement that the claimant may submit in writing to the IRO within 10 business days following the date of receipt of the notice additional information that the IRO must consider when conducting the third level review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.

Within 5 business days after the date of assignment of the IRO, the Plan Administrator must provide to the assigned IRO the documents and any information considered in making the Final Internal Adverse Benefit Determination. If the Plan Administrator fails to timely provide the documents and information, the IRO may terminate the third level review and make a decision to reverse the Final Internal Adverse Benefit Determination. Within one business day after making the decision, the IRO must notify the claimant and the Plan Administrator.

Upon receipt of any information submitted by the claimant, the IRO must within one business day forward the information to the Plan Administrator. Upon receipt of any such information, the Plan Administrator may reconsider its Final Internal Adverse Benefit Determination that is the subject of the third level review. The third level review may be terminated as a result of the reconsideration only if the Plan Administrator decides, upon completion of its reconsideration, to reverse its Final Internal Adverse Benefit Determination and provide coverage or payment. Within one business day after making such a decision, the Plan Administrator must provide written notice of its decision to the claimant and the IRO. The IRO must terminate the third level review upon receipt of the notice from the Plan Administrator.

The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim without deference to the Plan and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO may also consider the following additional information:

- The claimant's medical records;
- The attending health care professional's recommendation;
- Reports from other health care professionals and other documents submitted by the Plan, claimant or claimant's treating provider;
- The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;
- Appropriate practice guidelines, including evidence-based standards and other guidelines developed by the Federal government, national or professional medical societies, boards and associations;
- Any applicable clinical review criteria developed and used by the Plan, unless such criteria are inconsistent with the terms of the Plan or applicable law; and
- The opinion of the IRO's clinical reviewer(s) to the extent the information or documents are available and the clinical reviewer(s) considers appropriate;

The IRO must provide written notice of its third level review decision within 45 days after it receives the request for the third level review. The notice must be provided to both the claimant and the Plan Administrator, and must include the following:

- A general description of the reason for the request for the review with enough information to identify the claim, and reason for the Final Internal Adverse Benefit Determination;
- The date the IRO received the assignment to conduct the third level review;
- The date of the IRO's decision;
- References to the evidence or documentation, including specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale and any evidence-based standards used;
- A statement that the determination is binding, except to the extent other legal remedies may be available under Federal or state law to the Plan or claimant;
- A statement that judicial review may be available to the claimant; and
- Current contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

The IRO must maintain records of all claims and notices associated with the third level review process for 6 years. An IRO must make such records available for examination by the claimant, Plan, or state or federal oversight agency upon request, except where such disclosure would violate state or federal privacy laws.

Reversal of the Plan's decision. Upon receipt of a notice of a final external review decision reversing the Final Internal Adverse Benefit Determination, the Plan must immediately pay the claim.

For questions about your appeal rights or for assistance, you can contact the Employee Benefits Security Administration at 1-866-444-EBSA (3272).

ASSIGNMENT OF BENEFITS

The Plan will use its best efforts to recognize assignments of benefits from providers of services but is not bound by such assignments. Notwithstanding the foregoing, the Plan will not recognize any assignment of Your right to bring a cause of action or otherwise initiate a legal proceeding arising from an adverse benefit determination. When payment is made directly to You (with or without an assignment), it is solely Your responsibility to reimburse the provider.

CLAIM AUDIT

Once a written claim for benefits is received, the Plan Administrator, at its discretion, may elect to have such claim reviewed or audited for accuracy, Reasonableness and/or the Usual and Customary nature of charges as part of the adjudication process. This process may include, but not be limited to, identifying charges for items/services that may not be covered or may not have been delivered, duplicate charges and charges beyond the Reasonable and/or Usual and Customary guidelines as determined by the Plan Administrator.

COMPLIANCE

The Plan shall comply with all federally mandated benefit laws and regulations pertaining to employee benefit plans. The intent of the Plan is to assure full compliance with all appropriate federal laws, rules and regulations and any act or omission through negligence or otherwise which results in any such violation, shall be construed as unintentional. The Claims Processor shall be fully discharged from liability under this Plan.

CONTACT INFORMATION FOR THE PLAN ADMINISTRATOR, NAMED FIDUCIARY, AND AGENT FOR SERVICE OF LEGAL PROCESS

Same as Employer.

CONTRIBUTIONS

The benefits provided under the terms of this Plan are purchased through Employer contributions. At the discretion of the Plan, Employees may be required to contribute on a payroll deduction basis.

ERISA AMENDMENTS

Any provision of this Plan that is in conflict with ERISA, which governs this Plan, shall be deemed amended to conform to the minimum requirements of the law.

FUNDING

This Plan is a Butler Health Plan sponsored self-funded reimbursement program for the benefits described in the Important Points section at the end of this document.

LIENS

To the full extent permitted by law, all rights and benefits accruing under this Plan shall be exempt from execution, attachment, garnishment, or other legal or equitable process, for the debts or liabilities of any Employee.

This Plan is not a substitute for and does not affect any requirement for coverage by Workers' Compensation Insurance.

NO WAIVER

A failure to enforce any provision of this Plan shall not affect any right thereafter to enforce any such provision, nor shall such failure affect any right to enforce any other provision of this Plan.

PLAN IS NOT A CONTRACT

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

PLAN AMENDMENT, MODIFICATION OR TERMINATION

Butler Health Plan reserves the right to amend, modify, revoke or terminate the Plan, in whole or in part, at any time and such amendment, modification, revocation or termination of the Plan shall be made by a written Plan endorsement signed by an authorized representative of the Plan. Any such changes to the Plan, which affect participants, will be communicated to such participants by the Plan Administrator. Upon termination of the Plan, the rights of participants to benefits are limited to claims incurred and due up to the date of termination.

PROHIBITION ON RESCISSION

The Plan cannot rescind coverage except in the case of fraud or an intentional misrepresentation of a material fact. A rescission is a cancellation or discontinuance of coverage that has retroactive effect, unless it is attributable to a failure to pay timely required premiums or contributions towards the cost of coverage. The Plan must provide 30 calendar days advance notice to an individual before coverage may be rescinded.

REIMBURSEMENT AND SUBROGATION PROVISIONS

PAYMENT CONDITION

The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an illness, injury, or disability is caused in whole or in part by, or results from the acts or omissions of, a Covered Person or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or grantor(s) of a third party (collectively "Coverage").

However, such payment of benefits by the Plan shall be made only if You first provide a reimbursement agreement in writing. Notwithstanding the foregoing, payment of any claim in the absence of a signed reimbursement agreement shall not invalidate the obligation of the Covered Person to otherwise reimburse the Plan.

You (including Your attorney, and/or legal guardian of a covered minor or incapacitated individual) agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits, You agree the Plan shall have an equitable lien on any funds received by You and/or his attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.

In the event that You settle, recover, or are reimbursed by any Coverage, You agree to reimburse the Plan for all benefits paid or that will be paid by the Plan on Your behalf. If You fail to reimburse the Plan out of any judgment or settlement received, You will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

If there is more than one party responsible for charges paid by the Plan, or who may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person is only one, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized, at the Plan's discretion.

If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the Illness, Injury or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection.

The Plan may, at its discretion, in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

If the Covered Person fails to file a claim or pursue damages against:

- a) the responsible party, its insurer, or any other source on behalf of that party;
- b) any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) any policy of insurance from any insurance company or guarantor of a third party;
- d) worker's compensation or other liability insurance company; or

- e) any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

the Covered Person authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person's and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

Right of Reimbursement

The Plan shall have the specific right of first recovery ("reimbursement"), and as such, shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.

No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.

This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable sickness, injury, disease or disability.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person(s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

WRONGFUL DEATH

In the event that the Covered Person dies as a result of his injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

OBLIGATIONS

It is Your obligation at all times, both prior to and after payment of medical benefits by the Plan:

- a) to cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
- b) to provide the Plan with pertinent information regarding the Illness, Injury, or disability, including accident reports, settlement information and any other requested additional information;
- c) to take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights, including providing to the Plan an executed reimbursement agreement;
- d) to do nothing to prejudice the Plan's rights of subrogation and reimbursement;
- e) to promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
- f) to not settle or release, without the prior consent of the Plan, any claim to the extent that You may have against any responsible party or Coverage.

If You and/or Your attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from You.

The Plan's rights to reimbursement and/or subrogation are in no way dependant upon Your cooperation or adherence to these terms.

OFFSET

Failure by You and/or Your attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits, and any funds, or payments due under this Plan on Your behalf may be withheld until You satisfy your obligation.

MINOR STATUS

In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his estate insofar as these subrogation and reimbursement provisions are concerned.

If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

SEVERABILITY

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purpose of determining the applicability of and implementing the terms of these benefits, the Plan Administrator may, without the consent of or notice to any person, release or obtain any information necessary to determine acceptability of any applicant for participation in the Plan.

In so acting, the Plan Administrator shall be free from any liability that may arise with regard to such action. Any person claiming benefits under this Plan shall furnish to the Plan Administrator such information as may be necessary to implement this provision.

RIGHTS OF RECOVERY

Whenever payments have been made by the Plan which are in excess of the maximum amount allowed under the Plan or are otherwise not covered under any provision of the Plan, the Claims Processor or Plan Administrator shall have the right to recover such payments from among one or more of the following: any persons to, for or with respect to whom such payments were made; any providers of service; any insurance companies or any other organizations. Current benefit payments may be reduced to satisfy outstanding reimbursements.

SEVERABILITY

Should any provision of this Summary Plan Description be declared invalid or illegal for any reason, such invalidity or illegality shall not affect the remaining portions of the Summary Plan Description. Any remaining portions shall remain in full force and effect, as if this Summary Plan Description did not contain the invalid or illegal provision.

SUBMISSION OF CLAIM

All charges, and corresponding requested documentation, must be submitted by the date specified in the Schedule of Covered Expenses and Provisions. Failure to do so will result in the denial of the charges.

SUMMARY OF MATERIAL MODIFICATIONS

You shall be furnished summary descriptions of material modifications in the terms of this Plan and changes in the information required to be included in the Summary Plan Description pertaining to this Plan not later than 210 days after the end of the Plan Year in which the change is adopted. However, in the case of any modification or change that is a material reduction in covered services or benefits provided under the Plan, You will be furnished a summary of such modification or change not later than 60 days after the adoption of the modification or change, unless the Employer provides summaries of modifications or changes at regular intervals of not more than 90 days.

SUMMARY PLAN DESCRIPTION

The Plan will issue to each Employee under the Plan, a document that shall summarize the benefits to which the person is entitled, to whom the benefits are payable, and the provisions of the Plan principally affecting the Employee. This document is intended to satisfy the requirement for both a Summary Plan Description and Plan Description as specified under ERISA.

SYSTEM FOR PROCESSING CLAIMS

Claims will be processed on the following basis: 1) first, any non-covered services or services in excess of Plan provisions will be subtracted from billed charges; 2) then, Reasonable and/or Usual and Customary limitations will be applied (if applicable); 3) then, any reduction authorized by agreements with provider networks will be applied to charges from network providers; and 4) then, any Deductible/Co-Insurance or uncollected co-pays will be deducted from the remaining eligible amount prior to payment.

TYPE OF ADMINISTRATION

The Plan is self-administered by the Plan Administrator. The Plan Administrator has hired a Claims Processor to process claims and provide consulting services and ministerial functions.

COORDINATION OF BENEFITS (COB)

The Coordination of Benefits provision is intended to prevent payments of benefits that exceed expenses. It applies when any other plan or plans also cover the person covered by this Plan. When more than one coverage exists, one plan normally pays its benefits in full and the other plans pay a reduced benefit. This Plan will always pay either its benefits in full or a reduced amount which, when added to the benefits payable by the other plan or plans, will not exceed 100% of allowable expenses. Only the amount paid by the Plan will be charged against the Plan maximums. See Schedule of Covered Expenses and Provisions to determine the type of Coordination of Benefits this Plan provides.

To coordinate benefits, it is necessary to determine in what order the benefits of various Plans are payable. This is determined as follows:

1. If a plan does not have a provision for the coordination of benefits, its benefits are payable before this Plan.
2. If a plan covers a person other than as a Dependent, its benefits are payable before this Plan. This includes Medicare covering a person other than as a Dependent (e.g. a retired Employee) and any Medicare Supplement Plan. However, in all instances, federal regulations regarding Medicare as a secondary payer will apply.
3. If a plan covers an active Employee, its benefits are payable before this Plan. This order of determination does not supersede 2 (2) above.
4. If an individual is covered as a Dependent under 2 separate plans, the benefits are payable first under the Employee's plan having the earliest birthday in a Calendar Year. However, if the Dependent is a child whose parents are separated or divorced, the "birthday rule" does not apply. The following order to determination will apply:

If the parent with custody has not remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the parent without custody is secondary.

If the parent with custody has remarried:

- a) The plan of the parent with custody is primary.
- b) The plan of the stepparent with custody is secondary.
- c) The plan of the parent without custody is tertiary (third).

There may be a court decree that makes one parent financially responsible for the health care expenses incurred by the child. If a plan covers the child as a Dependent of that parent, its benefits are payable before those of a plan that covers the child as a Dependent of the parent without financial responsibility.

5. If a plan covers an individual who is also allowed to be covered by this Plan pursuant to COBRA continuation coverage, its benefits are payable before this Plan.
6. If items 1, 2, 3, 4 or 5 do not apply, the benefits of a plan that has covered the person for the longest period of time will be payable before those of the other plan.

Any other "plan" means and includes, but is not necessarily limited to the following: any policy, contract or other arrangement for group insurance benefits, including any Hospital or medical service organization plan or other service or prepayment plan arranged through any employer, union, trustee, Employee benefit association, government agency or professional association;

or any homeowner's policy or other policy providing liability coverage; or any coverage for students sponsored by or provided through a school or other educational institution; or any coverage provided by a licensed Health Maintenance Organization (HMO); or any benefits payable under Medicare (to the extent permitted by law); or any government program or any coverage provided by statute.

The term "plan" shall also mean any mandatory "no-fault" automobile insurance coverage providing benefits under a medical expense reimbursement provision for Hospital, medical, or other health care services and treatment because of accidental bodily Injuries arising out of a motor vehicle accident; and any other payment received under any automobile policy.

To administer this provision, the Plan has the right to:

1. Release or obtain data needed to determine the benefits payable under this provision
2. Recover any sum paid above the amount that is required by this provision and
3. Repay any party for a payment made by the party, when the Plan should have made the payment.

COMPLIANCE REGULATIONS

STATEMENT OF RIGHTS UNDER THE NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Under federal law, group health plans and health insurance issuers offering group health insurance coverage generally may not restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a delivery by cesarean section. However, the plan or issuer may pay for a shorter stay if the attending provider (e.g., your Physician, nurse midwife or physician assistant), after consultation with the mother, discharges the mother or newborn earlier.

Also, under federal law, plans and issuers may not set the level of benefits or out-of-pocket costs so that any later portion of the 48-hour (or 96 hour) stay is treated in a manner less favorable to the mother or newborn than any earlier portion of the stay.

In addition, a plan or issuer may not, under federal law, require that a Physician or other health care provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). However, to use certain providers or facilities, or to reduce your out-of-pocket costs, you may be required to obtain pre-certification. For information on pre-certification, contact your Plan Administrator.

SOURCE OF INJURY RESTRICTIONS

The Plan will not limit coverage for Injuries or Illnesses resulting from 1) domestic violence, or 2) self-inflicted injury or attempted suicide. Further, the Plan will not limit coverage for Injuries or Illnesses resulting from participation in any activity if such Illness or Injury is as a result of a physical or mental condition.

WELLNESS VS. RISK FACTORS

The Plan will not charge Covered Persons who have adverse health factors, or who participate in certain adverse lifestyle activities, more than those similarly situated Covered Persons who do not have such factors or participate in such activities.* Further, the Plan will not provide rewards to Covered Persons who participate in, or meet the requirements of, positive lifestyle activities in excess of what is offered to those similarly situated Covered Persons who do not participate in, or meet the requirements of, such activities.*

* Except as such differential treatment is allowed through the incorporation of wellness program(s) meeting federally approved guidelines.

FAMILY MEDICAL LEAVE ACT (FMLA)

The following applies to companies with 50 or more employees

If the Covered Person is entitled to, and elects to take, a family or medical leave solely under the terms of the Family and Medical Leave Act of 1993 (FMLA), the Covered Person and his covered Dependents shall continue to be covered under this Plan while the Covered Person is absent from work on an FMLA leave as if there were no interruption of active employment. Provided the applicable premium is paid, such coverage will continue until the earlier of the expiration of such leave or the date notice is given to the Employer that the Covered Person does not intend to return to work at the end of the FMLA leave.

You may choose not to retain health coverage during the FMLA leave. If he returns to active working status on or before the expiration of the leave, he is entitled to have coverage reinstated on the same basis as it would have been if the leave had not been taken. (Coverage will be reinstated without any additional qualification requirements imposed by this Plan. This Plan's provisions with respect to pre-existing conditions, Deductibles and percentage of payments will apply on the same basis as they did prior to the FMLA leave.)

Military Leaves

If you are absent from work due to military service, you may elect to continue coverage under the Plan (including coverage for enrolled Dependents) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with your Employer under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)). Your contributions for continued coverage will be the same as for a COBRA beneficiary, except that, if you are absent for 30 days or less, your contribution will be the same as for similarly situated active participants in the Plan.

Whether or not you continue coverage during military service, you may reinstate coverage under the Plan on your return to employment under USERRA. The reinstatement will be without any waiting period otherwise required under the Plan, except to the extent that you had not fully completed any required waiting period prior to the start of military service.

GENETIC INFORMATION

The Plan may not adjust premium or contribution amounts for those covered under the Plan on the basis of genetic information. The Plan may also not request, require or purchase genetic information for underwriting purposes (or in connection with any individual prior to such individual's enrollment under the Plan). The term "underwriting" covers rules relating to the determination of eligibility (including enrollment and continued eligibility) for Plan benefits or coverage, the computation of premium or contribution amounts, application of pre-existing condition exclusions and any activities relating to the creation, renewal, or replacement of the Plan.

This Plan is prohibited from requesting or requiring genetic testing on the part of an individual or his family members. Genetic tests include analysis of human DNA, RNA, chromosomes, proteins, or metabolites that detect genotypes, mutations, or chromosomal changes. The term "genetic test" does not mean an analysis of proteins or metabolites that does not detect genotypes, mutations, or chromosomal changes; or an analysis of proteins or metabolites that is directly related to a manifested disease, disorder, or pathological condition that could reasonably be detected by a health care professional with appropriate training and expertise in the field of medicine involved.

The Plan may obtain and use the results of a genetic test when making payment determinations (so long as only the minimum amount of information is utilized necessary for the determination).

A plan may request (but not require) that a participant undergo a genetic test if 1) the plan clearly indicates that compliance is voluntary, and that noncompliance will have no effect on enrollment status or premium/contribution amounts, 2) no genetic information collected is used for underwriting purposes, and 3) the plan notify the applicable federal government agency that the plan is conducting activities pursuant to this exception and includes a description of the activities.

NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA

INTRODUCTION

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator.

WHAT IS COBRA CONTINUATION COVERAGE?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both);
- or
- You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason other than his gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your employer, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the

retired employee will become a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

WHEN IS COBRA COVERAGE AVAILABLE?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer (if the Plan provides retiree coverage), or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE WRITTEN NOTICE OF SOME QUALIFYING EVENTS

For the other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator within 60 days after the qualifying event occurs. You must send this notice in writing to the Plan Administrator at the address indicated in the Important Points section at the end of this document. **IF YOU, YOUR SPOUSE OR YOUR DEPENDENT FAIL TO PROVIDE TIMELY WRITTEN NOTICE TO THE PLAN ADMINISTRATOR AFTER A DIVORCE, LEGAL SEPARATION OR LOSS OF DEPENDENT CHILD ELIGIBILITY, THE RIGHT TO ELECT TO PURCHASE COBRA CONTINUATION COVERAGE IS WAIVED.**

HOW IS COBRA COVERAGE PROVIDED?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your divorce or legal separation, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage lasts for up to a total of 36 months.

If the Plan has retiree coverage, and if the employer from whose employment the covered retiree retired files a Chapter 11 bankruptcy reorganization, and the covered retiree loses coverage within one year before or after the bankruptcy filing, a qualifying event has occurred. That is, COBRA coverage could continue until the death of the retiree, or until the death of a covered surviving spouse of a deceased retiree, or for 36 months from the retiree's death in the case of a spouse or dependent.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA 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). Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA

continuation coverage generally lasts for only up to a total of 18 months. There are 2 ways in which this 18-month period of COBRA continuation coverage can be extended.

DISABILITY EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If you or anyone in your family covered under the Plan is determined by the Social Security Administration to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. A copy of the determination of disability by the Social Security Administration must be sent to the Plan Administrator at the address indicated in the Important Points section at the end of this document within 60 days after the date the determination is issued and before the end of the 18-month maximum coverage period that applies to the qualifying event. Any individual who is either the employee, a qualified beneficiary with respect to the qualifying event, or any representative acting on behalf of the employee or qualified beneficiary, may send the written notice to the Plan Administrator. Such individual(s) must further notify the Plan Administrator in writing within 30 days after a determination has been made that the person is no longer disabled. The Plan may require the payment of an amount that is up to 150 percent of the applicable premium for the period of extended coverage as long as the disabled individual is included in the extended coverage period.

SECOND QUALIFYING EVENT EXTENSION OF 18-MONTH PERIOD OF CONTINUATION COVERAGE

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months from the date of the first qualifying event, if notice of the second qualifying event is properly sent in writing to the Plan Administrator at the address indicated in the Important Points section at the end of this document. This extension may be available to the spouse and any dependent children receiving continuation coverage if the employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated. This extension may also be available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is sent written notice of the second qualifying event within 60 days of the second qualifying event.

ELECTION OF COBRA CONTINUATION COVERAGE

There is no requirement to show evidence of good health in order to choose COBRA coverage. However, the COBRA participant will have to pay all of the cost to the Plan for COBRA coverage, and may be charged an additional 2% administrative fee. A 50% administrative fee may be charged if coverage is extended due to a disability and the disabled individual is in the extended coverage period.

Any individual eligible for COBRA coverage has 60 days from the later of the date of the COBRA notification letter or the date coverage is lost to elect such coverage. Also, an eligible individual electing COBRA coverage has 45 days from the date of election to pay the initial premium. THEREAFTER, PAYMENT IS DUE ON THE FIRST DAY OF EACH MONTH WITH A 30-DAY GRACE PERIOD.

If a qualifying event occurs, the Plan Administrator will notify those eligible individuals of the procedure for electing COBRA coverage and the cost of such coverage.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

IF THE EMPLOYEE, SPOUSE OR DEPENDENT FAILS TO EXERCISE THE ELECTION WITHIN THE 60-DAY PERIOD, THE RIGHT TO ELECT TO PURCHASE COBRA COVERAGE IS WAIVED. IF ANY PREMIUM PAYMENT IS NOT MADE WITHIN THE TIME FRAMES SPECIFIED ABOVE, COBRA COVERAGE WILL BE FORFEITED.

If coverage under the Plan is modified for active Employees, coverage shall also be modified in the same manner for COBRA coverage participants. COBRA continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

TERMINATION OF COBRA CONTINUATION COVERAGE

Certain events can cut short the 18, 29 or 36 month continuation periods. They are:

1. The Employer's termination of the Plan.
2. The COBRA participant first becomes, after the date of election, entitled to Medicare benefits.
3. The COBRA participant first becomes, after the date of election, covered under another group health plan (as an employee or otherwise) which does not contain any exclusion or limitation with respect to any pre-existing condition of such participant.
4. The COBRA participant fails to pay the premium in a timely manner.

In no event shall coverage extend beyond the applicable maximum period.

TRADE ACT OF 2002

The Trade Act of 2002 created a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the applicable tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Customer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-626-4282. Information about the Trade Act is also available at www.doleta.gov/tradeact.

IF YOU HAVE QUESTIONS

Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified under Plan Contact Information in the Important Points section at the end of this document. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)

KEEP YOUR PLAN INFORMED OF ADDRESS CHANGES

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

PLAN CONTACT INFORMATION

If there are any questions regarding COBRA Continuation Coverage under the Plan, please contact the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document.

ERISA RIGHTS SECTION

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

RECEIVE INFORMATION ABOUT YOUR PLAN AND BENEFITS

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 and available at the Public Disclosure Room of the Employee Benefits Services Administration (EBSA).

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

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 GROUP HEALTH PLAN COVERAGE

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. Your 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.

Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health Plan, if you have creditable coverage from another plan (irrespective of creditable coverage, exclusionary periods for preexisting conditions may only apply if you or your Dependents are age 19 or over). You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

ENFORCE YOUR RIGHTS

If your claim for a welfare benefit is denied or ignored, in whole or in part, or if your coverage was rescinded, you have a right to know why this was done, to obtain copies of documents relating to the decision, without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report 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, or if your coverage was rescinded, you may file suit in a state or Federal court, subject to the procedures discussed in the Section "APPEALING A CLAIM" under "GENERAL PROVISIONS." In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in 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 court 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.

ASSISTANCE WITH YOUR QUESTIONS

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Services Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Services Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA.

STANDARDS FOR PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “PRIVACY STANDARDS”)

ISSUED PURSUANT TO

The Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”)

1. Disclosure of Summary Health Information to the Plan Sponsor

In accordance with the Privacy Standards, the Plan may disclose Summary Health Information to the Plan Sponsor if the Plan Sponsor requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under this Plan or (b) modifying, amending or terminating the Plan.

“Summary Health Information” may be individually identifiable health information and it summarizes the claims history, claims expenses or the type of claims experienced by individuals in the Plan, but it excludes all identifiers that must be removed for the information to be de-identified, except that it may contain geographic information to the extent that it is aggregated by five-digit zip code.

2. Disclosure of Protected Health Information (“PHI”) to the Plan Sponsor for Plan Administration Purposes

In order that the Plan Sponsor may receive and use PHI for Plan Administration purposes, the Plan Sponsor agrees to:

- a. Not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law (as defined in the Privacy Standards);
- b. Ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI;
- c. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor, except pursuant to an authorization which meets the requirements of the Privacy Standards;
- d. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which the Plan Sponsor becomes aware;
- e. Make available PHI in accordance with Section 164.524 of the Privacy Standards (45 CFR 164.524);
- f. Make available PHI for amendment and incorporate any amendments to PHI in accordance with Section 164.526 of the Privacy Standards (45 CFR 164.526);
- g. Make available the information required to provide an accounting of disclosures in accordance with Section 164.528 of the Privacy Standards (45 CFR 164.528);
- h. Make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with Part 164, Subpart E, of the Privacy Standards (45 CFR 164.500 *et seq*);

- i. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made, 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 PHI infeasible; and
- j. Ensure that adequate separation between the Plan and the Plan Sponsor, as required in Section 164.504(f)(2)(iii) of the Privacy Standards (45 CFR 164.504(f)(2)(iii)), is established as follows:
 - i. The access to and use of PHI by the individuals described in the Key Information section at the beginning of this document shall be restricted to the Plan Administration functions that the Plan Sponsor performs for the Plan.
 - ii. In the event any of the individuals described in the Key Information section do not comply with the provisions of the Plan Documents relating to use and disclosure of PHI, the Plan Administrator shall impose reasonable sanctions as necessary, in its discretion, to ensure that no further non-compliance occurs. Such sanctions shall be imposed progressively (for example, an oral warning, a written warning, time off without pay and termination), if appropriate, and shall be imposed so that they are commensurate with the severity of the violation.

“Plan Administration” functions are activities that would meet the definitions of treatment, payment and health care operations. “Plan Administration” functions include, but are not limited to quality assurance, claims processing, auditing, monitoring, management, stop loss underwriting, stop loss claims filing, eligibility information requests, medical necessity reviews, certain appeal determinations, utilization review, case management and disease management. It does not include any employment-related functions or functions in connection with any other benefit or benefit plans.

The Plan shall disclose PHI to the Plan Sponsor only upon receipt of a certification by the Plan Sponsor that (a) the Plan Documents have been amended to incorporate the above provisions and (b) the Plan Sponsor agrees to comply with such provisions.

3. Disclosure of Certain Enrollment Information to the Plan Sponsor

Pursuant to Section 164.504(f)(1)(iii) of the Privacy Standards (45 CFR 164.504(f)(1)(iii)), the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or health maintenance organization offered by the Plan to the Plan Sponsor.

4. Other Disclosures and Uses of PHI

With respect to all other uses and disclosures of PHI, the Plan shall comply with the Privacy Standards.

NOTICE OF PRIVACY PRACTICES

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

This Notice of Privacy Practices (“Notice”) describes how protected health information may be used or disclosed by this Plan to carry out treatment, payment, health care operations and for other purposes that are permitted or required by law. This Notice also sets out this Plan’s legal obligations concerning a Covered Person’s protected health information and describes a Covered Person’s rights to access and control that protected health information.

Protected health information (“PHI”) is individually identifiable health information, including demographic information, collected from a Covered Person or created or received by a health care provider, a health plan, an employer (when functioning on behalf of the group health plan), or a health care clearinghouse and that relates to: (1) a Covered Person’s past, present or future physical or mental health or condition; (2) the provision of health care to a Covered Person; or (3) the past, present or future payment for the provision of health care to a Covered Person.

This Notice has been drafted to be consistent with what is known as the “HIPAA Privacy Rule,” and any of the terms not defined in this Notice should have the same meaning as they have in the HIPAA Privacy Rule.

If you have any questions or want additional information about the Notice or the policies and procedures described in the Notice, please contact the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document:

THE PLAN’S RESPONSIBILITIES

The Plan is required by law to maintain the privacy of a Covered Person’s PHI. The Plan is obligated to provide you with a copy of this Notice of the Plan’s legal duties and of its privacy practices with respect to PHI, and the Plan must abide by the terms of this Notice. The Plan reserves the right to change the provisions of this Notice and make the new provisions effective for all PHI that is maintained. If the Plan makes a material change to this Notice, a revised Notice will be mailed to the address that the Plan has on record.

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations.

Genetic information shall be treated as health information pursuant to the Health Insurance Portability and Accountability Act. The use or disclosure by the Plan of protected health information that is genetic information about an individual for underwriting purposes under the Plan shall not be a permitted use or disclosure.

However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law;
- uses or disclosures that are required for compliance with the HIPAA Privacy Rule; and
- uses or disclosures made pursuant to an authorization.

This Notice does not apply to information that has been de-identified. De-identified information is health information that does not identify an individual and with respect to which there is no reasonable basis to believe that the information can be used to identify an individual. It is not individually identifiable health information.

PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

The following is a description of how the Plan is most likely to use and/or disclose a Covered Person's PHI.

TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

The Plan has the right to use and disclose a Covered Person's PHI for all activities that are included within the definitions of "treatment, payment and health care operations" as described in the HIPAA Privacy Rule.

TREATMENT

The Plan will use or disclose PHI so that a Covered Person may seek treatment. Treatment is the provision, coordination or management of health care and related services. It also includes, but is not limited to consultations and referrals between one or more of a Covered Person's providers. For example, the Plan may disclose to a treating specialist the name of a Covered Person's primary care physician so that the specialist may request medical records from that primary care physician.

PAYMENT

The Plan will use or disclose PHI to pay claims for services provided to a Covered Person and to obtain stop-loss reimbursements, if applicable, or to otherwise fulfill the Plan's responsibilities for coverage and providing benefits. For example, the Plan may disclose PHI when a provider requests information regarding a Covered Person's eligibility for coverage under this Plan, or the Plan may use PHI to determine if a treatment that was received was medically necessary.

HEALTH CARE OPERATIONS

The Plan will use or disclose PHI to support its business functions. These functions include, but are not limited to quality assessment and improvement, reviewing provider performance, licensing, stop-loss underwriting, business planning and business development. For example, the Plan may use or disclose PHI: (1) to provide a Covered Person with information about a disease management program; (2) to respond to a customer service inquiry from a Covered Person or (3) in connection with fraud and abuse detection and compliance programs.

BUSINESS ASSOCIATES

The Plan contracts with individuals and entities (Business Associates) to perform various functions on its behalf or to provide certain types of services. To perform these functions or to provide the services, the Plan's Business Associates will receive, create, maintain, use or disclose PHI, but only after the Plan requires the Business Associates to agree in writing to contract terms designed to appropriately safeguard PHI. For example, the Plan may disclose PHI to a Business Associate to administer claims or to provide service support, utilization management, subrogation or pharmacy benefit management. Examples of the Plan's Business Associates would be its third party administrator, broker, preferred provider organization and utilization review vendor.

OTHER COVERED ENTITIES

The Plan may use or disclose PHI to assist health care providers in connection with their treatment or payment activities or to assist other covered entities in connection with payment activities and certain health care operations. For example, the Plan may disclose PHI to a health care provider when needed by the provider to render treatment to a Covered Person, and the Plan may disclose PHI to another covered entity to conduct health care operations in the areas of fraud and abuse detection or compliance, quality assurance and improvement activities or accreditation, certification, licensing or credentialing. This also means that the Plan may disclose or share PHI with other insurance carriers in order to coordinate benefits, if a Covered Person has coverage through another carrier.

PLAN SPONSOR

The Plan may disclose PHI to the Plan Sponsor of the group health plan for purposes of plan administration or pursuant to an authorization request signed by the Covered Person. Also, the Plan may use or disclose “summary health information” to the Plan Sponsor for obtaining premium bids or modifying, amending or terminating the group health plan. Summary health information summarizes the claims history, claims expenses or types of claims experienced by individuals for whom a Plan Sponsor has provided health benefits under a group health plan and from which identifying information has been deleted in accordance with the HIPAA Privacy Rule.

POTENTIAL IMPACT OF STATE LAW

The HIPAA Privacy Regulations generally do not “preempt” (or take precedence over) state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Regulations, might impose a privacy standard under which the Plan will be required to operate. For example, where such laws have been enacted, the Plan will follow more stringent state privacy laws that relate to uses and disclosures of PHI concerning HIV or AIDS, mental health, substance abuse/chemical dependency, genetic testing, reproductive rights, etc.

OTHER POSSIBLE USES AND DISCLOSURES OF PHI

The following is a description of other possible ways in which the Plan may (and is permitted to) use and/or disclose PHI.

REQUIRED BY LAW

The Plan may use or disclose PHI to the extent that federal law requires the use or disclosure. When used in this Notice, “required by law” is defined as it is in the HIPAA Privacy Rule. For example, the Plan may disclose PHI when required by national security laws or public health disclosure laws.

PUBLIC HEALTH ACTIVITIES

The Plan may use or disclose PHI for public health activities that are permitted or required by law. For example, the Plan may use or disclose information for the purpose of preventing or controlling disease, injury, or disability, or it may disclose such information to a public health authority authorized to receive reports of child abuse or neglect. The Plan also may disclose PHI, if directed by a public health authority, to a foreign government agency that is collaborating with the public health authority.

HEALTH OVERSIGHT ACTIVITIES

The Plan may disclose PHI to a health oversight agency for activities authorized by law, such as: audits; investigations; inspections; licensure or disciplinary actions; or civil, administrative, or criminal proceedings or actions. Oversight agencies seeking this information include government agencies that oversee: (1) the health care system; (2) government benefit programs; (3) other government regulatory programs and (4) compliance with civil rights laws.

ABUSE OR NEGLECT

The Plan may disclose PHI to a government authority that is authorized by law to receive reports of abuse, neglect or domestic violence. Additionally, as required by law, the Plan may disclose to a governmental entity, authorized to receive such information, a Covered Person's PHI if there is reason to believe that the Covered Person has been a victim of abuse, neglect, or domestic violence.

LEGAL PROCEEDINGS

The Plan may disclose PHI: (1) in the course of any judicial or administrative proceeding; (2) in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized) and (3) in response to a subpoena, a discovery request, or other lawful process, once the Plan has met all administrative requirements of the HIPAA Privacy Rule. For example, the Plan may disclose PHI in response to a subpoena for such information, but only after first meeting certain conditions required by the HIPAA Privacy Rule.

LAW ENFORCEMENT

Under certain conditions, the Plan also may disclose PHI to law enforcement officials. For example, some of the reasons for such a disclosure may include, but not be limited to: (1) it is required by law or some other legal process; (2) it is necessary to locate or identify a suspect, fugitive, material witness, or missing person or (3) it is necessary to provide evidence of a crime.

CORONERS, MEDICAL EXAMINERS, FUNERAL DIRECTORS, AND ORGAN DONATION

The Plan may disclose PHI to a coroner or medical examiner for purposes of identifying a deceased person, determining a cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Plan also may disclose, as authorized by law, information to funeral directors so that they may carry out their duties. Further, the Plan may disclose PHI to organizations that handle organ, eye or tissue donation and transplantation.

RESEARCH

The Plan may disclose PHI to researchers when an institutional review board or privacy board has: (1) reviewed the research proposal and established protocols to ensure the privacy of the information and (2) approved the research.

TO PREVENT A SERIOUS THREAT TO HEALTH OR SAFETY

Consistent with applicable federal and state laws, the Plan may disclose PHI if there is reason to believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. The Plan also may disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

MILITARY ACTIVITY AND NATIONAL SECURITY, PROTECTIVE SERVICES

Under certain conditions, the Plan may disclose PHI if Covered Persons are, or were, Armed Forces personnel for activities deemed necessary by appropriate military command authorities. If Covered Persons are members of foreign military service, the Plan may disclose, in certain circumstances, PHI to the foreign military authority. The Plan also may disclose PHI to authorized federal officials for conducting national security and intelligence activities, and for the protection of the President, other authorized persons or heads of state.

INMATES

If a Covered Person is an inmate of a correctional institution, the Plan may disclose PHI to the correctional institution or to a law enforcement official for: (1) the institution to provide health care to the Covered Person; (2) the Covered Person's health and safety and the health and safety of others or (3) the safety and security of the correctional institution.

WORKERS' COMPENSATION

The Plan may disclose PHI to comply with workers' compensation laws and other similar programs that provide benefits for work-related injuries or illnesses.

OTHERS INVOLVED IN YOUR HEALTH CARE

Using its best judgment, the Plan may make PHI known to a family member, other relative, close personal friend or other personal representative that the Covered Person identifies. Such use will be based on how involved the person is in the Covered Person's care or in the payment that relates to that care. The Plan may release information to parents or guardians, if allowed by law.

The Plan also may disclose PHI to an entity assisting in a disaster relief effort so that a Covered Person's family can be notified about his condition, status, and location.

If a Covered Person is not present or able to agree to these disclosures of PHI, then, using its professional judgment, the Plan may determine whether the disclosure is in the Covered Person's best interest.

REQUIRED DISCLOSURES OF PHI

The following is a description of disclosures that the Plan is required by law to make.

DISCLOSURES TO THE SECRETARY OF THE U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

The Plan is required to disclose PHI to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining the Plan's compliance with the HIPAA Privacy Rule.

DISCLOSURES TO COVERED PERSONS

The Plan is required to disclose to a Covered Person most of the PHI in a "designated record set" when that Covered Person requests access to this information. Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. The Plan also is required to provide, upon the Covered Person's request, an accounting of most disclosures of his PHI that are for reasons other than treatment, payment and health care operations and are not disclosed through a signed authorization.

The Plan will disclose a Covered Person's PHI to an individual who has been designated by that Covered Person as his personal representative and who has qualified for such designation in accordance with relevant state law. However, before the Plan will disclose PHI to such a person, the Covered Person must submit a written notice of his designation, along with the documentation that supports his qualification (such as a power of attorney).

Even if the Covered Person designates a personal representative, the HIPAA Privacy Rule permits the Plan to elect not to treat that individual as the Covered Person's personal representative if a reasonable belief exists that: (1) the Covered Person has been, or may be, subjected to domestic violence, abuse or neglect by such person; (2) treating such person as his personal representative could endanger the Covered Person, or (3) the Plan determines, in the exercise of its professional judgment, that it is not in its best interest to treat that individual as the Covered Person's personal representative.

OTHER USES AND DISCLOSURES OF PHI

Other uses and disclosures of PHI that are not described previously will be made only with a Covered Person's written authorization. If the Covered Person provides the Plan with such an authorization, he/she may revoke the authorization in writing, and this revocation will be effective for future uses and disclosures of PHI. However, the revocation will not be effective for information that has already been used or disclosed, relying on the authorization.

A COVERED PERSON'S RIGHTS

The following is a description of a Covered Person's rights with respect to PHI:

RIGHT TO REQUEST A RESTRICTION

A Covered Person has the right to request a restriction on the PHI the Plan uses or discloses about him/her for treatment, payment or health care operations.

The Plan is not required to agree to any restriction that a Covered Person may request. If the Plan does agree to the restriction, it will comply with the restriction unless the information is needed to provide emergency treatment.

A Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. It is important that the Covered Person directs his request for restriction to this individual or office so that the Plan can begin to process your request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send the request when the Covered Person's call is received. In this request, it is important that the Covered Person states: (1) the information whose disclosure he/she wants to limit and (2) how he/she wants to limit the Plan's use and/or disclosure of the information.

RIGHT TO REQUEST CONFIDENTIAL COMMUNICATIONS

If a Covered Person believes that a disclosure of all or part of his PHI may endanger him/her, that Covered Person may request that the Plan communicates with him/her regarding PHI in an alternative manner or at an alternative location. For example, the Covered Person may ask that the Plan only contact the Covered Person at a work address or via the Covered Person's work e-mail.

The Covered Person may request a restriction by contacting the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. It is important that the request for confidential communications is addressed to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

The Plan will want to receive this information in writing and will instruct the Covered Person where to send a written request upon receiving a call. This written request should inform the Plan: (1) that he/she wants the Plan to communicate his PHI in an alternative manner or at an alternative location and (2) that the disclosure of all or part of this PHI in a manner inconsistent with these instructions would put the Covered Person in danger.

The Plan will accommodate a request for confidential communications that is reasonable and that states that the disclosure of all or part of a Covered Person's PHI could endanger that Covered Person. As permitted by the HIPAA Privacy Rule, "reasonableness" will (and is permitted to) include, when appropriate, making alternate arrangements regarding payment.

Accordingly, as a condition of granting a Covered Person's request, he/she will be required to provide the Plan information concerning how payment will be handled. For example, if the Covered Person submits a claim for payment, state or federal law (or the Plan's own contractual obligations) may require that the Plan disclose certain financial claim information to the Plan Participant under whose coverage a Covered Person may receive benefits (e.g., an Explanation of Benefits "EOB"). Unless the Covered Person has made other payment arrangements, the EOB (in which a Covered Person's PHI might be included) will be released to the Plan Participant.

Once the Plan receives all the information for such a request (along with the instructions for handling future communications), the request will be processed usually within 2 business days or as soon as reasonably possible.

Prior to receiving the information necessary for this request, or during the time it takes to process it, PHI may be disclosed (such as through an EOB). Therefore, it is extremely important that the Covered Person contact the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document as soon as the Covered Person determines the need to restrict disclosures of his PHI.

If the Covered Person terminates his request for confidential communications, the restriction will be removed for all of the Covered Person's PHI that the Plan holds, including PHI that was previously protected. Therefore, a Covered Person should not terminate a request for confidential communications if that person remains concerned that disclosure of PHI will endanger him/her.

RIGHT TO INSPECT AND COPY

A Covered Person has the right to inspect and copy PHI that is contained in a "designated record set." Generally, a designated record set contains medical and billing records, as well as other records that are used to make decisions about a Covered Person's health care benefits. However, the Covered Person may not inspect or copy psychotherapy notes or certain other information that may be contained in a designated record set.

To inspect and copy PHI that is contained in a designated record set, the Covered Person must submit a request by contacting the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. It is

important that the Covered Person contact this individual or office to request an inspection and copying so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay the processing of the request. If the Covered Person requests a copy of the information, the Plan may charge a fee for the costs of copying, mailing or other supplies associated with that request.

The Plan may deny a Covered Person's request to inspect and copy PHI in certain limited circumstances. If a Covered Person is denied access to information, he/she may request that the denial be reviewed. To request a review, the Covered Person must contact the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. A licensed health care professional chosen by the Plan will review the Covered Person's request and the denial. The person performing this review will not be the same one who denied the Covered Person's initial request. Under certain conditions, the Plan's denial will not be reviewable. If this event occurs, the Plan will inform the Covered Person through the denial that the decision is not reviewable.

RIGHT TO AMEND

If a Covered Person believes that his PHI is incorrect or incomplete, he/she may request that the Plan amend that information. The Covered Person may request that the Plan amend such information by contacting the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. Additionally, this request should include the reason the amendment is necessary. It is important that the Covered Person direct this request for amendment to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request.

In certain cases, the Plan may deny the Covered Person's request for an amendment. For example, the Plan may deny the request if the information the Covered Person wants to amend is not maintained by the Plan, but by another entity. If the Plan denies the request, the Covered Person has the right to file a statement of disagreement with the Plan. This statement of disagreement will be linked with the disputed information and all future disclosures of the disputed information will include this statement.

RIGHT OF AN ACCOUNTING

The Covered Person has a right to an accounting of certain disclosures of PHI that are for reasons other than treatment, payment or health care operations. No accounting of disclosures is required for disclosures made pursuant to a signed authorization by the Covered Person or his personal representative. The Covered Person should know that most disclosures of PHI will be for purposes of payment or health care operations, and, therefore, will not be subject to this right. There also are other exceptions to this right.

An accounting will include the date(s) of the disclosure, to whom the Plan made the disclosure, a brief description of the information disclosed and the purpose for the disclosure.

A Covered Person may request an accounting by submitting a request in writing to the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. It is important that the Covered Person direct the request for an accounting to this individual or office so that the Plan can begin to process the request. Requests sent to individuals or offices other than the one indicated might delay processing the request. A Covered Person's request may be for disclosures made up to 6 years before the date of the request, but not for disclosures made before April 14, 2004. The first list requested within a 12-month period will be free. For

additional lists, the Plan may charge for the costs of providing the list. The Plan will notify the Covered Person of the cost involved and he/she may choose to withdraw or modify the request before any costs are incurred.

Right to a Paper Copy of This Notice

The Covered Person has the right to a paper copy of this Notice, even if he/she has agreed to accept this Notice electronically.

COMPLAINTS

A Covered Person may complain to the Plan if he/she believes that the Plan has violated these privacy rights. The Covered Person may file a complaint with the Plan by contacting the person(s) or office identified under Plan Contact Information in the Important Points section at the end of this document. A copy of a complaint form is available from this contact office.

A Covered Person also may file a complaint with the Secretary of the U.S. Department of Health and Human Services. Complaints filed directly with the Secretary must: (1) be in writing; (2) contain the name of the entity against which the complaint is lodged; (3) describe the relevant problems and (4) be filed within 180 days of the time the Covered Person became or should have become aware of the problem.

The Plan will not penalize or in any other way retaliate against a Covered Person for filing a complaint with the Secretary or with the Plan.

STANDARDS FOR SECURITY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION (THE “SECURITY STANDARDS”)

1. DEFINITIONS

- a. The term “Electronic Protected Health Information” (“EPHI”) has the meaning set forth in Section 160.103 of the Security Standards (45 C.F.R. 160.103) and generally means individually identifiable health information that is transmitted or maintained in any electronic media.
- b. The term “Security Incidents” has the meaning set forth in Section 164.304 of the Security Standards (45 C.F.R. 164.304) and generally means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with systems operations in an information system.

2. PLAN SPONSOR OBLIGATIONS

Where EPHI will be created, received, maintained, or transmitted to or by the Plan Sponsor on behalf of the Plan, the Plan Sponsor shall reasonably safeguard the EPHI as follows:

- a. Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of EPHI that Plan Sponsor creates, receives, maintains, or transmits on behalf of the Plan;
- b. Plan Sponsor shall ensure that the adequate separation that is required by Section 164.504 (f) (2) (iii) of the Security Standards (45 C.F.R. 164.504 (f) (2) (iii)) is supported by reasonable and appropriate security measures;
- c. Plan Sponsor shall ensure that any agents, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect such EPHI; and
- d. Plan Sponsor shall report to the Plan any Security Incidents of which it becomes aware as described below:
 - i.) Plan Sponsor shall report to the Plan within a reasonable time after the Plan Sponsor becomes aware of any Security Incident that results in unauthorized access, use, disclosure, modification, or destruction of the Plan’s EPHI; and
 - ii.) Plan Sponsor shall report to the Plan any other Security Incident on an aggregate basis every quarter, or more frequently upon the Plan’s request.
- e. Plan Sponsor shall make its internal practices, books, and records relating to its compliance with the Security Standards to the Secretary of the U.S. Department of Health and Human Services (“HHS”), or any other officer or employee of HHS to whom the authority involved has been delegated, for purposes of determining compliance by the Plan with the Security Standards.

IMPORTANT POINTS

PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION:

Butler Health Plan
400 North Erie Boulevard
Suite B
Hamilton, Ohio 45011
Phone: (513) 896-2300

IDENTIFICATION NUMBER (EIN) AS ASSIGNED BY THE INTERNAL REVENUE SERVICE (IRS):

31-1151537

PLAN NAME:

Butler Health Plan Basic Plan Option

PLAN CONTACT INFORMATION:

Butler Health Plan
400 North Erie Boulevard
Suite B
Hamilton, Ohio 45011
Phone: (513) 896-2300

PLAN NUMBER:

501

EMPLOYER:

Any employer participating under the terms and provisions of the Butler Health Plan.

STOP LOSS COVERAGE:

The Plan has purchased specific and aggregate stop-loss reinsurance coverage.

GROUP NUMBER:

A08103

SPD EFFECTIVE DATE:

January 1, 2011

PLAN YEAR:

The financial records of the Plan are kept on a Plan Year basis. The Plan Year ends each December 31st.

TYPE OF PLAN:

Medical and Prescription Drugs

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR:

Allied Benefit Systems, Inc.
P. O. Box 909786-60690
Chicago, IL 60690
Phone: (312) 906-8080 or (800) 288-2078 (outside IL)

INDEX (BASIC)

A

ALLERGY OR B-12 INJECTIONS	10
AMBULANCE SERVICE	12
AMBULATORY SURGICAL FACILITY	11
ANNUAL BENEFIT MAXIMUM	8
APPEALING A CLAIM	44

B

BLOOD AND BLOOD PRODUCTS	13
--------------------------------	----

C

CALENDAR YEAR DEDUCTIBLE	8
CHIROPRACTIC SERVICES	11
CLAIMS FILING LIMIT.....	8
COMPLIANCE REGULATIONS.....	58
CONTRACEPTIVE MANAGEMENT.....	10
COORDINATION OF BENEFITS.....	8, 57
COSMETIC SURGERY	13, 21
CUSTODIAL CARE	24

D

DEFINITIONS.....	26
DENTAL RELATED TREATMENT	13
DENTAL TREATMENT	21
DEPENDENTS.....	27
DIAGNOSTIC TESTING AND INTERPRETATION .	10
DURABLE MEDICAL EQUIPMENT	12

E

ELIGIBILITY.....	36
ERISA RIGHTS SECTION	66
EXTENDED CARE FACILITY	12
EYE CARE	21

F

FACILITY SERVICES.....	11, 12
FAMILY MEDICAL LEAVE ACT (FMLA).....	59
FOOT CARE	21

G

GASTRIC BY-PASS SURGERY	21
GENERAL PROVISIONS	44
GENETIC INFORMATION	59
GOVERNMENT SERVICE AND ILLEGAL ACTS....	21
GROUP NUMBER.....	80

H

HEARING AIDS FOR ROUTINE HEARING LOSS..	12
HOME HEALTH CARE	11
HOSPICE CARE.....	12
HOSPITAL EMERGENCY ROOM CARE.....	11

I

IDENTIFICATION NUMBER (EIN)	80
IMPORTANT POINTS	80
INCIDENTAL AND PERSONAL CONVENIENCE ITEMS	22
INFERTILITY TREATMENT	13, 22
INPATIENT HOSPITAL SERVICES.....	11
INTRAVENOUS INJECTIONS AND SOLUTIONS..	13

J

JAW JOINT TREATMENT.....	13
--------------------------	----

K

KEY INFORMATION	4
ELIGIBILITY.....	4
ENROLLMENT.....	5
NETWORK CONTACT INFORMATION	4
PRE-EXISTING CONDITION LIMITATION(S)....	6
PRIVACY OFFICERS (HIPAA).....	7
TERMINATION OF COVERAGE.....	6
WORKING SPOUSE COVERAGE SURCHARGE .	5

L

LEARNING DISABILITIES	25
LIFETIME MAXIMUM	8

M

MASSAGE THERAPY.....	24
MATERNITY SERVICES	13
MENTAL HEALTH SERVICES.....	12
INPATIENT	12
OUTPATIENT	12
MILITARY LEAVES	59

N

NAME, ADDRESS AND TELEPHONE NUMBER OF THE CLAIMS PROCESSOR.....	80
NETWORK BENEFITS	40
NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT	58
NON-MEDICAL AND EXPERIMENTAL PROCEDURES.....	22
NOTICE OF CONTINUATION COVERAGE RIGHTS UNDER COBRA.....	61
NOTICE OF PRIVACY PRACTICES.....	70

O

OBESITY	21, 25
ORGAN TRANSPLANT COVERAGE	13
ORTHOPEDIC EQUIPMENT AND APPLIANCES..	13
ORTHOTICS.....	13
OTHER COVERED SERVICES AND ITEMS.....	13
OTHER EXCLUSIONS	23
OTHER OUTPATIENT FACILITY SERVICES.....	11
OTHER PHYSICIAN SERVICES	11
OTHER SERVICES	12
OTHER THERAPY SERVICES.....	11
OUT-OF-POCKET MAXIMUM.....	8
OUTPATIENT.....	10
OUTPATIENT FACILITY DIAGNOSTIC TESTING..	11

P

PERSONNEL POLICIES.....	38
PHYSICAL	
SCHOOL OR SPORT	22
PHYSICAL, SPEECH, OCCUPATIONAL, BIOFEEDBACK AND INVERSION THERAPY	11
PHYSICIAN CHARGES FOR SURGERY AND	

ANESTHESIA	10
PHYSICIAN SERVICES.....	10, 11
PLAN ADMINISTRATOR/ PLAN SPONSOR CONTACT INFORMATION.....	80
PLAN NAME.....	80
PLAN NUMBER	80
PLAN YEAR.....	80
PRE-CERTIFICATION PROGRAM	14
PENALTY FOR NON-COMPLIANCE.....	15
PRE-EXISTING CONDITION LIMITATION(S) 13, 22, 38	
PRE-EXISTING CONDITIONS FOR MEMBERS AND DEPENDENTS AGE 19 AND OLDER	22
PRESCRIPTION DRUG BENEFIT.....	16
COVERED PHARMACEUTICAL PRODUCTS	16
COVERED PRESCRIPTION DRUGS	16
DRUGS AND PHARMACEUTICALS NOT COVERED	16
MAIL ORDER DRUG BENEFIT.....	17
SPECIALTY DRUG PHARMACY BENEFIT	17
PRESCRIPTION DRUGS	9
PRESCRIPTION DRUGS AND PHARMACEUTICAL PRODUCTS	
DRUGS AND PHARMACEUTICALS NOT COVERED	16
PREVENTIVE CARE SERVICES.....	9
PRIMARY CARE MEDICALLY NECESSARY PHYSICIAN OFFICE VISIT	10
PRIVACY STANDARDS	68
PROCEDURES FOR FILING CLAIMS.....	41
PROSTHETIC APPLIANCES	24
PROSTHETICS	12

Q

R

RENTAL EQUIPMENT	24
ROUTINE VISION EXAM	9

S

SCHEDULE OF COVERED EXPENSES	8
SCHOOL FLU SHOTS AND HEALTH SCREENINGS	9
SECOND SURGICAL OPINION	10

SECURITY STANDARDS	79
SERVICES OR SUPPLIES	23
SERVICES PROVIDED BY A NON-PATIENT SELECTED OUT OF NETWORK PHYSICIAN WHILE BEING TREATED IN A NETWORK HOSPITAL	13
SMOKING/TOBACCO CESSATION TREATMENT	12
SOURCE OF INJURY RESTRICTIONS	58
SPD EFFECTIVE DATE	80
SPECIALIST MEDICALLY NECESSARY PHYSICIAN OFFICE VISIT	10
STOP LOSS COVERAGE	80

T

THIS PLAN AND MEDICARE	43
TRANSPLANTS	18
TYPE OF PLAN	80

U

URGENT CARE FACILITY SERVICES.....	11
------------------------------------	----

V

VISION	21
VOLUNTARY STERILIZATION	13

W

WEIGHT LOSS.....	25
WELL NEWBORN CARE	13
WELLNESS CARE.....	9
WELLNESS VS. RISK FACTORS	58
WHAT IS NOT COVERED.....	21
WHEELCHAIR	24
WIGS AFTER CHEMO OR RADIATION THERAPY	13
WORKERS' COMPENSATION.....	23
WORK-RELATED INJURY/ILLNESS.....	23

X-Z