CALUMET GP, LLC

Health Booklet

Plus Plan

Revised 10-01-2011

BENEFITS ADMINISTERED BY

A UnitedHealthcare Company

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CALUMET GP, LLC

GROUP HEALTH BENEFIT PLAN

SUMMARY PLAN DESCRIPTION

INTRODUCTION

Effective: 01-01-2011

The purpose of this document is to provide You and Your covered Dependents, if any, with summary information on benefits available under this Plan as well as information on a Covered Person's rights and obligations under the CALUMET GP, LLC Health Benefit Plan (the "Plan"). As a valued Employee of CALUMET GP, LLC, we are pleased to sponsor this Plan to provide benefits that can help meet Your health care needs.

CALUMET GP, LLC is named the Plan Administrator for this Plan. The Plan Administrator has retained the services of independent Third Party Administrators to process claims and handle other duties for this self-funded Plan. The Third Party Administrators for this Plan are UMR, Inc. (hereinafter "UMR") for medical claims, and Prescription Solutions for pharmacy claims. The Third Party Administrators do not assume liability for benefits payable under this Plan, as they are solely claims paying agents for the Plan Administrator.

The employer assumes the sole responsibility for funding the Plan benefits out of general assets; however, Employees help cover some of the costs of Covered Benefits through contributions, Deductibles, Co-pays and Plan Participation amounts as described in the Schedule of Benefits. All claim payments and reimbursements are paid out of the general assets of the employer and there is no separate fund that is used to pay promised benefits. The Plan is intended to comply with and be governed by the Employee Retirement Income Security Act of 1974 (ERISA) and its amendments.

The Plan Administrator believes this Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that this Plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example the elimination of lifetime limits on benefits.

Questions regarding which protection apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administrator at:

CALUMET GP, LLC
2780 WATERFRONT PARKWAY EAST DR
STE 200
INDIANAPOLIS IN 46214
317-328-5660.

You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Some of the terms used in this document begin with a capital letter, even though the term normally would not be capitalized. These terms have special meaning under the Plan and most will be listed in the Glossary of Terms. Other capitalized terms are defined within the provision the term is used. When reading this Summary Plan Description (SPD), please refer to the Glossary of Terms. Becoming familiar with the terms defined in the Glossary will help to better understand the provisions of this group health Plan.

The requirements for being covered under this Plan, the provisions concerning termination of coverage, a description of the Plan benefits (including limitations and exclusions), cost sharing, the procedures to be followed in submitting claims for benefits and remedies available for appeal of claims denied are outlined in the following pages of this document. Please read this document carefully and contact Your Human Resources or Personnel office if You have questions.

Individuals covered under this Plan will be receiving an identification card that should be presented to the provider whenever services are received. On the back of this card are phone numbers to call in case of questions or problems.

This document summarizes the benefits and limitations of the Plan and is known as a Summary Plan Description. It is being furnished to You in accordance with ERISA.

This document becomes effective on May 1, 2007.

PLAN INFORMATION

Effective: 01-01-2009

Plan Name	CALUMET GP, LLC Group Benefit Plan
Name And Address Of Employer	CALUMET GP, LLC 2780 WATERFRONT PARKWAY EAST DR STE 200 INDIANAPOLIS IN 46214
Name, Address And Phone Number Of Plan Administrator	CALUMET GP, LLC 2780 WATERFRONT PARKWAY EAST DR STE 200 INDIANAPOLIS IN 46214 317-328-5660
Named Fiduciary	CALUMET GP, LLC
Employer Identification Number Assigned By The IRS	36-4579817
Plan Number Assigned By The Plan	501
Type Of Benefit Plan Provided	Self-Funded Health & Welfare Plan providing Group Health Benefits
Type Of Administration	The administration of the Plan is under the supervision of the Plan Administrator. The Plan is not financed by an insurance company and benefits are not guaranteed by a contract of insurance; however, a reinsurance company may reimburse the employer for certain expenses. UMR provides administrative services such as claim payments for medical and pharmacy claims.
Name, Title, And Address Of The Principal Place Of Business Of Each Trustee Of The Plan (If The Plan Has A Trust)	CALUMET GP, LLC VOLUNTARY EMPLOYEE BENEFICIARY ASSOCIATION 2780 WATERFRONT PARKWAY EAST DR STE 200 INDIANAPOLIS IN 46214
Name And Address Of Agent For Service Of Legal Process	CALUMET GP, LLC 2780 WATERFRONT PARKWAY EAST DR STE 200 INDIANAPOLIS IN 46214 Services of legal process may also be made upon the Plan Administrator or plan trustee.
Funding Of The Plan	Employer and Employee Contributions Benefits are provided by a benefit plan maintained on a self-insured basis by Your employer.

Effective: 01-01-2011

Collective Bargaining Provisions	The Plan is maintained pursuant to one or more collective bargaining agreements. A copy of the agreements may be obtained upon written request to the Plan Administrator, and such agreements are available for examination.
Benefit Plan Year	Benefits begin on January 1 and end on the following December 31. For new Employees and Dependents, a Benefit Plan Year begins on the individual's Effective Date and runs through December 31 of the same Benefit Plan Year.
ERISA Plan Year	January 1 through December 31
ERISA and Other Federal Compliance	It is intended that this Plan meet all applicable requirements of ERISA and other federal regulations. In the event ERISA or other federal regulations impose any requirement that is inconsistent with this Plan, the provisions of ERISA and the federal regulations shall be deemed controlling, and any inconsistent part of this Plan shall be deemed superseded to the extent of the inconsistency.
Discretionary Authority	The Plan Administrator shall perform its duties as the Plan Administrator and in its sole discretion, shall determine appropriate courses of action in light of the reason and purpose for which this Plan is established and maintained. In particular, the Plan Administrator shall have full and sole discretionary authority to interpret all plan documents including this SPD, and make all interpretive and factual determinations as to whether any individual is entitled to receive any benefit under the terms of this Plan. Any construction of the terms of any plan document and any determination of fact adopted by the Plan Administrator shall be final and legally binding on all parties, except that the Plan Administrator has delegated certain responsibilities to the Third Party Administrators for this Plan. Any interpretation, determination or other action of the Plan Administrator or the Third Party Administrators shall be subject to review only if a court of proper jurisdiction determines its action is arbitrary or capricious or otherwise a clear abuse of discretion. Any review of a final decision or action of the Plan Administrator or the Third Party Administrators shall be based only on such evidence presented to or considered by the Plan Administrator or the Third Party Administrators at the time it made the decision that is the subject of review. Accepting any benefits or making any claim for benefits under this Plan constitutes agreement with and consent to any decisions that the Plan Administrator or the Third Party Administrators make, in its sole discretion, and further, means that the Covered Person consents to the limited standard and scope of review afforded under law.

SCHEDULE OF BENEFITS

Benefit Plan(s) P01, P02

Effective: 01-01-2011

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

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

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

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

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Individual Annual Maximum ***Note: The Plan Guarantees A Minimum Of $750,000 Of This Maximum Will Be For Essential Benefits*** ***Note: Medical And Pharmacy Expenses Are Subject To The Same Annual Maximum***	$2,000,000	
Annual Deductible Per Calendar Year • Per Person • Per Family	 $300 $600	 $300 $600
Plan Participation Rate, Unless Otherwise Stated Below: • Paid By Plan After Satisfaction Of Deductible	 80%	 60%
Annual Out-Of-Pocket Maximum: • Per Person • Per Family	 $1,500 $3,000	 $3,000 $6,000
Ambulance Transportation: • Paid By Plan After In-Network Deductible And Out-Of Pocket	80%	80%
Chiropractic Services: **Manipulations:** • Maximum Visits Per Calendar Year • Paid By Plan After Deductible	 10 Visits 80%	 60%
Durable Medical Equipment: • Paid By Plan After Deductible	 80%	 60%
Emergency Care: **Convenience Care Clinics (Including Express Care Clinics):** • Office Visit Co-pay Per Visit • Paid By Plan After Deductible	 $20 100% (Deductible Waived)	 Not Applicable 60%

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Emergency Room / Emergency Physician Charges • Paid By Plan After In-Network Deductible And Out-Of Pocket	80%	80%
Urgent Care: • Office Visit Co-pay Per Visit • Paid By Plan After Deductible • Charges Other Than Office Visit Paid By Plan After Deductible	 $40 100% (Deductible Waived) 80%	 Not Applicable 60% 60%
Extended Care Facility Benefits Such As Skilled Nursing, Convalescent Or Subacute Facility: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 90 Days 80%	 60%
Home Health Care Benefits: • Paid By Plan After Deductible ***Note: A Home Health Care Visit Will Be Considered A Periodic Visit By Either A Nurse Or Therapist, As The Case May Be, Or Up To Four (4) Hours Of Home Health Care Services.***	80%	60%
Hospice Care Benefits: • Paid By Plan After Deductible	80%	60%
Hospital Services: **Inpatient Services / Inpatient Physician Charges Room And Board Subject To The Payment Of Semi-private Room Rate Or Negotiated Room Rate:** • Paid By Plan After Deductible **Outpatient Services / Outpatient Physician Charges:** • Paid By Plan After Deductible **Outpatient Lab And X-ray Charges:** • Paid By Plan After Deductible **Outpatient Surgery / Surgeon Charges:** • Paid By Plan After Deductible ***Note: Covered Services Provided By A Radiologist, Anesthesiologist, Pathologist, Or Emergency Room Physician Will Be Payable At The PPO Level Of Benefits When Rendered In A PPO Hospital.***	 80% 80% 80% 80%	 60% 60% 60% 60%
Mental Health, Substance Abuse And Chemical Dependency Benefits: **Inpatient And Residential Hospitalization:** • Paid By Plan After Deductible **Outpatient Or Partial Treatment:** • Paid By Plan After Deductible	 80% 80%	 60% 60%

SUMMARY OF BENEFITS	IN-NETWORK	OUT-OF-NETWORK
Office Visit: • Co-pay Per Visit • Paid By Plan After Deductible	 $20 100% (Deductible Waived)	 Not Applicable 60%
Orthotic Appliances: • Maximum Benefit Per Calendar Year • Paid By Plan After Deductible	 $25,000 80%	 60%
Physician Office Visit: **Office Visit:** • Co-pay Per Visit • Paid By Plan After Deductible **Specialist Visit:** • Co-pay Per Visit • Paid By Plan After Deductible	 $20 100% (Deductible Waived) $40 100% (Deductible Waived)	 Not Applicable 60% Not Applicable 60%
Physician Office Services: • Paid By Plan After Deductible	 80%	 60%
Preventive / Routine Care Benefits. See Glossary Of Terms For Definition. Benefits Include: • Immunizations (Including Flumist Vaccine) • Routine Physical Exams • Routine Diagnostic Tests, Lab And X-rays (Such As Routine Mammograms, GYN Exams, Pap Test, And Prostate Exams/Tests) • Routine Colonoscopy • Routine Hearing Exam • Tobacco Addiction • Paid By Plan	 100% (Deductible Waived)	 No Benefit
Private Duty Nursing: • Maximum Days Per Calendar Year • Paid By Plan After Deductible	 60 Days 80%	 60%
Temporomandibular Joint Disorder Benefits: • Paid By Plan After Deductible	 80%	 60%
Therapy Services: • Paid By Plan After Deductible	 80%	 60%
Wigs, Toupees Or Hairpieces Related To Cancer Treatment For Alopecia Areata: • Maximum Benefit Per Lifetime • Paid By Plan After Deductible	 $500 80%	 60%
All Other Covered Expenses: • Paid by Plan After Deductible	 80%	 60%

REASONABLE ACCESS

Treatment rendered while traveling or living (for the purposes other than seeking medical care) “Out-of-Area” will be covered at In-Network rates. “Out-of-Area” is defined as 20 miles or more from the nearest In-network Provider.

TRANSPLANT SCHEDULE OF BENEFITS Benefit Plan(s) B01, B02, P01, P02 Effective: 01-01-2011		
Transplant Services: Designated Transplant Facility **Transplant Services:** • Paid By Plan **Travel And Housing:** • Maximum Benefit Per Transplant • Paid By Plan Travel And Housing At Designated Transplant Facility For Up To One Year From Date Of Transplant.	 100% $10,000 100%	
Transplant Services: Non-Designated Transplant Facility	**In-Network (Tier One)**	**Out-of-Network (Tier Two)**
Transplant Services: • Paid By Plan After Deductible	50%	50%

PRESCRIPTION SCHEDULE OF BENEFITS PRESCRIPTION SOLUTIONS Benefit Plan(s) B01, B02 Effective: 01-01-2011	
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 30-Day Supply: 10% 40% with a minimum of $50
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 3-Month Supply (At Least 84 Days): 10% 40% with a minimum of $150
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 90-Day Supply: 10% 40% with a minimum of $100
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 30-Day Supply: 10% 40% with a minimum of $50
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Will Require Payment For The Prescription Upfront. The Covered Person May Then Submit A Claim Reimbursement Form With A Receipt To Prescription Solutions For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.

PRESCRIPTION SCHEDULE OF BENEFITS PRESCRIPTION SOLUTIONS Benefit Plan(s) P01, P02 Effective: 01-01-2011	
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 30-Day Supply: 10% 20% with a minimum of $25
By Participating Retail Pharmacy • Covered Person's Co-pay Amount Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 3-Month Supply (At Least 84 Days): 10% 20% with a minimum of $75
By Participating Mail Order Pharmacy • Covered Person's Co-pay Amount Per Prescription Product Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 90-Day Supply: 10% 20% with a minimum of $50
By Specialty Pharmacy Vendor • Covered Person's Co-pay Amount Generic Products (Tier 1) Preferred Brand Products (Tier 2)	For Up To A 30-Day Supply: 10% 20% with a minimum of $25
By Non-Participating Pharmacy	Use Of A Non-Participating Pharmacy, Will Require Payment For The Prescription Upfront. The Covered Person May Then Submit A Claim Reimbursement Form With A Receipt To Prescription Solutions For Reimbursement. Reimbursement For Covered Prescription Products Will Be Based On The Lowest Contracted Amount Of A Participating Pharmacy Minus Any Applicable Deductible And/Or Retail Co-pay Shown In This Schedule.

OUT-OF-POCKET EXPENSES AND MAXIMUMS

CO-PAYS

A Co-pay is the amount that the Covered Person must pay to the provider each time certain services are received. Co-pays do not apply toward satisfaction of Deductibles or out-of-pocket maximums. The Co-pay and out-of-pocket maximum is shown on the Schedule of Benefits.

DEDUCTIBLES

Deductible refers to an amount of money paid once a Plan Year by the Covered Person before any Covered Expenses are paid by this Plan. A Deductible applies to each Covered Person up to a family Deductible limit. When a new Plan Year begins, a new Deductible must be satisfied.

Deductible amounts are shown on the Schedule of Benefits. The applicable Deductible must be met before any benefits will be paid under this Plan, unless indicated otherwise.

Only Covered Expenses will count toward meeting the Deductible. Pharmacy expenses do not count toward meeting the Deductible of this Plan. The Deductible amounts that the Covered Person incurs for Covered Expenses will be used to satisfy the Deductible(s) shown on the Schedule of Benefits.

The Deductible amounts that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total individual and family Deductible.

If You have family coverage, any combination of covered family members can help meet the maximum family Deductible, up to each person's individual Deductible amount.

If two or more covered family members are injured in the same Accident, only one Deductible needs to be met for those Covered Expenses which are due to that Accident, and Incurred during that Calendar year.

PLAN PARTICIPATION

Plan Participation means that, after the Covered Person satisfies the Deductible, the Covered Person and the Plan each pay a percentage of the Covered Expenses, until the Covered Person's (or family's, if applicable) annual out-of-pocket maximum is reached. The Plan Participation rate is shown on the Schedule of Benefits. The Covered Person will be responsible for paying any remaining charges due to the provider after the Plan has paid its portion of the Covered Expense, subject to the Plan's maximum fee schedule, Negotiated Rate, or Usual and Customary amounts as applicable. Once the annual out-of-pocket maximum has been satisfied, the Plan will pay 100% of the Covered Expense for the remainder of the Plan Year.

Any payment for an expense that is not covered under this Plan will be the Covered Person's responsibility.

ANNUAL OUT-OF-POCKET MAXIMUMS

The annual out-of-pocket maximum is shown on the Schedule of Benefits. Amounts the Covered Person incurs for Covered Expenses, such as any Plan Participation expense, will be used to satisfy the Covered Person's (or family's, if applicable) annual out-of-pocket maximum(s). Pharmacy expenses the Covered Person incurs do not apply toward the out-of-pocket maximum of this Plan.

The following will not be used to meet the out-of-pocket maximums:

- Co-pays.
- Penalties, legal fees and interest charged by a provider.
- Expenses for excluded services.

- Any charges above the limits specified elsewhere in this document.
- Co-pays and Participation amounts for Prescription products.
- Individual and family Deductibles.
- Any amounts over the Usual and Customary amount, Negotiated Rate or established fee schedule that this Plan pays.

The eligible out-of-pocket expenses that the Covered Person incurs at all benefit levels (whether Incurred at an in-network or out-of-network provider) will be used to satisfy the total out-of-pocket maximum.

INDIVIDUAL ANNUAL MAXIMUM BENEFIT

All benefit options under the Plan are integrated and Essential and Non-Essential Health Benefits Incurred under one benefit option will be applied against all benefit options. Covered Persons will not receive a new Annual Maximum Benefit if they change benefit options midyear.

All Essential or Non-Essential Health Benefits will count toward the Covered Person's individual medical Annual Maximum Benefit that is shown on the Schedule of Benefits. Please note that $750,000 of the Annual Maximum is guaranteed for Essential Benefits.

The Schedule of Benefits contains separate Maximum Benefit limitations for specified conditions. All separate Maximum Benefits are part of, and not in addition to, the Annual Maximum Benefit.

For Covered Persons who were terminated from the Plan and are later reinstated after a lapse in coverage (for example, a Covered Person ends employment and later is re-hired and re-enrolls in this Plan), the Annual Maximum Benefit will not start over. The Annual Maximum Benefit will continue to accumulate from the level satisfied at the time of Covered Person's termination.

NO FORGIVENESS OF OUT-OF-POCKET EXPENSES

The Covered Person is required to pay the out-of-pocket expenses (including Deductibles, Co-pays or required Plan Participation) under the terms of this Plan. The requirement that You and Your Dependent(s) pay the applicable out-of-pocket expenses cannot be waived by a provider under any "fee forgiveness", "not out-of-pocket" or similar arrangement. If a provider waives the required out-of-pocket expenses, the Covered Person's claim may be denied and the Covered Person will be responsible for payment of the entire claim. The claim(s) may be reconsidered if the Covered Person provides satisfactory proof that he or she paid the out-of-pocket expenses under the terms of this Plan.

ELIGIBILITY AND ENROLLMENT

Effective 01-01-2011

ELIGIBILITY AND ENROLLMENT PROCEDURES

You are responsible for enrolling in the manner and form prescribed by Your employer. The Plan's eligibility and enrollment procedures include administrative safeguards and processes designed to ensure and verify that eligibility and enrollment determinations are made in accordance with the Plan. The Plan may request documentation from You or Your Dependents in order to make these determinations. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

ELIGIBILITY REQUIREMENTS

An **eligible Employee** is a person who is classified by the employer on both payroll and personnel records as an Employee who regularly works full time 36 or more hours per week, but for purposes of this Plan, it does not include the following classifications of workers except as determined by the employer in its sole discretion:

- Temporary or leased employees.
- An Independent Contractor who signs an agreement with the employer as an Independent Contractor or other Independent Contractors as defined in this document.
- A consultant who is paid on other than a regular wage or salary by the employer.
- A member of the employer's Board of Directors, an owner, partner, or officer, unless engaged in the conduct of the business on a full-time regular basis.

For purposes of this Plan, eligibility requirements are used only to determine a person's initial eligibility for coverage under this Plan. An Employee may retain eligibility for coverage under this Plan if the Employee is temporarily absent on an approved leave of absence, with the expectation of returning to work following the approved leave as determined by the employer's leave policy, provided that contributions continue to be paid on a timely basis. The employer's classification of an individual is conclusive and binding for purposes of determining eligibility under this Plan. No reclassification of a person's status, for any reason, by a third-party, whether by a court, governmental agency or otherwise, without regard to whether or not the employer agrees to such reclassification, shall change a person's eligibility for benefits.

Note: Eligible Employees and Dependents who decline to enroll in this Plan must state so in writing. In order to preserve potential Special Enrollment rights, eligible individuals declining coverage must state in writing that enrollment is declined due to coverage under another group health plan or health insurance policy. Proof of such plan or policy may be required upon application for Special Enrollment.

An **eligible Dependent** includes:

- Your legal spouse who is a husband or wife of the opposite sex in accordance with the federal Defense of Marriage Act provided he or she is not covered as an Employee under this Plan. An eligible Dependent does not include an individual from whom You have obtained a legal separation or divorce. Documentation on a Covered Person's marital status may be required by the Plan Administrator.

- A Dependent Child that resides in the United States until the Child reaches his or her 26th birthday. The term "**Child**" includes the following Dependents:

  - A natural biological Child;
  - A step Child;
  - A legally adopted Child or a Child legally Placed for Adoption as granted by action of a federal, state or local governmental agency responsible for adoption administration or a court of law if the Child has not attained age 26 as of the date of such placement;

- A Child under Your (or Your Spouse's) Legal Guardianship as ordered by a court;
- A Child who is considered an alternate recipient under a Qualified Medical Child Support Order;

- A Dependent does not include the following:

  - A Child who is under the age of 26, who is eligible for group health benefits under his or her employer or his or her spouse's employer;
  - A Dependent Child if the Child is covered as a Dependent of another Employee at this company.

Employees have the right to choose which eligible Dependents are covered under the Plan.

NON-DUPLICATION OF COVERAGE: Any person who is covered as an eligible Employee shall not also be considered an eligible Dependent under this Plan.

RIGHT TO CHECK A DEPENDENT'S ELIGIBILITY STATUS: The Plan reserves the right to check the eligibility status of a Dependent at any time throughout the year. You and Your Dependent have a notice obligation to notify the Plan should the Dependent's eligibility status change throughout the Plan year. Please notify Your Human Resources Department regarding status changes.

EXTENDED COVERAGE FOR DEPENDENT CHILDREN

A Dependent Child may be eligible for extended Dependent coverage under this Plan under the following circumstances:

- The Dependent Child was covered by this Plan on the day before the Child's 26th birthday; or
- The Dependent Child is a Dependent of an Employee newly eligible for the Plan; or
- The Dependent Child is eligible due to a Special Enrollment event or a Qualifying Status Change event, as outlined in the Section 125 Plan.

and the Dependent Child fits the following category:

- If You have a Dependent Child covered under this Plan who is under the age of 26 and Totally Disabled, either mentally or physically, that Child's health coverage may continue beyond the day the Child would cease to be a Dependent under the terms of this Plan. You must submit written proof that the Child is Totally Disabled within 30 calendar days after the day coverage for the Dependent would normally end. The Plan may, for two years, ask for additional proof at any time, after which the Plan can ask for proof not more than once a year. Coverage can continue subject to the following minimum requirements:

  - The Dependent must not be able to hold a self-sustaining job due to the disability; and
  - Proof must be submitted as required; and
  - The Employee must still be covered under this Plan.

  A Totally Disabled Dependent Child older than 26 who loses coverage under this Plan may not re-enroll in the Plan under any circumstances.

IMPORTANT: It is Your responsibility to notify the Plan Sponsor within 60 days if Your Dependent no longer meets the criteria listed in this section. If, at any time, the Dependent fails to meet the qualifications of Totally Disabled, the Plan has the right to be reimbursed from the Dependent or Employee for any medical claims paid by the Plan during the period that the Dependent did not qualify for extended coverage. Please refer to the COBRA Section in this document.

EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Your coverage will begin on the later of:

- If You apply within 30 days of hire, Your coverage will become effective the first day of the month coinciding with or following Your date of hire; or

- If You apply after 30 days of hire, You will be considered a Late Enrollee. Coverage for a Late Enrollee will become effective the first day of the month coinciding with or following the date You apply for coverage, or

- If You are eligible to enroll under the Special Enrollment Provision, Your coverage will become effective on the date set forth under the Special Enrollment Provision if application is made within 30 days of the event.

EFFECTIVE DATE OF COVERAGE FOR YOUR DEPENDENTS

Your Dependent's coverage will be effective on the later of:

- The date Your coverage with the Plan begins if You enroll the Dependent at that time; or

- The date You acquire Your Dependent if application is made within 30 days of acquiring the Dependent; or

- The first day of the month coinciding with or following the date an enrollment application is properly made if the Dependent is a Late Enrollee. The Dependent will be considered a Late Enrollee if You request coverage for Your Dependent more than 30 days of Your hire date, or more than 30 days following the date You acquire the Dependent; or

- If Your Dependent is eligible to enroll under the Special Enrollment Provision, the Dependent's coverage will become effective on the date set forth under the Special Enrollment Provision, if application is made within 30 days following the event; or

- The date specified in a Qualified Medical Child Support Order.

A contribution will be charged from the first day of coverage for the Dependent, if additional contribution is required. In no event will Your Dependent be covered prior to the day Your coverage begins.

ANNUAL OPEN ENROLLMENT PERIOD

During the annual open enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Also, eligible Employees and their Dependents who enroll in during the annual open enrollment period will be considered Late Enrollees. Covered Employees will be able to make a change in coverage for themselves and their eligible Dependents.

Coverage Waiting Periods and Pre-Existing Condition Limits are waived during the annual open enrollment period for covered Employees and covered Dependents changing from one Plan to another Plan or changing coverage levels within the Plan.

The annual open enrollment does not apply to Retirees or their Dependents.

Effective: 01-01-2011

If You and/or Your Dependent become covered under this Plan as a result of electing coverage during the annual open enrollment period, the following shall apply:

- The annual open enrollment period shall typically be in the month of November. The employer will give eligible Employees written notice prior to the start of an annual open enrollment period; and

- This Plan does not apply to charges for services performed or treatment received prior to the Effective Date of the Covered Person's coverage; and

- The Effective Date of coverage shall be January 1 following the annual open enrollment period.

DEPENDENT CHILD SPECIAL OPEN ENROLLMENT PERIOD

On the first day of the first plan year beginning on or after September 23, 2010, this Plan will provide a 30-day Dependent Child special open enrollment period for Dependent Children who have not yet reached the limiting age under this Plan. During this Dependent Child special open enrollment period, Employees who are adding a Dependent Child and who have a choice of coverage options will be allowed to change options.

Coverage begins on the first day of the Plan Year if the Employer receives the completed enrollment form and the applicable contribution within 31 days of the date the Dependent becomes eligible to enroll under this special open enrollment period.

During this special enrollment period, eligible Employees will be able to enroll themselves and their eligible Dependents for coverage under this Plan. Covered employees will also be able to make a change in coverage for themselves and their eligible Dependents.

SPECIAL ENROLLMENT PROVISION

Under the Health Insurance Portability and Accountability Act

Effective: 02-17-2009

This Plan gives eligible persons special enrollment rights under this Plan if there is a loss of other health coverage or a change in family status as explained below. The coverage choices that will be offered to You will be the same choices offered to other similarly situated Employees.

LOSS OF HEALTH COVERAGE

Current Employees and their Dependents have a special opportunity to enroll for coverage under this Plan if there is a loss of other health coverage. Loss of other health coverage triggers special enrollment rights only if other coverage was in effect at the time coverage was declined. The Plan will not recognize a special enrollment right due to a loss of coverage if other coverage was not in effect at the time enrollment was declined. An eligible person declined enrollment if he or she did not enroll in the Plan during the Plan's annual open enrollment period, a special enrollment period or upon COBRA being offered.

You and/or Your Dependents may enroll for health coverage under this Plan due to loss of health coverage if the following conditions are met:

- You and/or Your Dependents were covered under a group health plan or health insurance policy at the time coverage under this Plan is offered; and

- You and/or Your Dependent stated in writing that the reason for declining coverage was due to coverage under another group health plan or health insurance policy; and

- The coverage under the other group health plan or health insurance policy was:

  - COBRA continuation coverage and that coverage was exhausted; or
  - Terminated because the person was no longer eligible for coverage under the terms of that plan or policy; or
  - Terminated and no substitute coverage is offered; or
  - Exhausted due to an individual meeting or exceeding a lifetime limit on all benefits; or
  - No longer receiving any monetary contribution toward the premium from the employer.

You or Your Dependent must request and apply for coverage under this Plan no later than 30 calendar days after the date the other coverage ended, or in situations where a Covered Person meets or exceeds a lifetime limit on all benefits, no later than 30 calendar days after a claim is denied for that reason. The Plan will assume that the written explanation of benefits (EOB) form is received five calendar days after the Plan mails the EOB form.

- You and/or Your Dependents were covered under a Medicaid plan or state child health plan and Your or Your Dependents coverage was terminated due to loss of eligibility. You must request coverage under this Plan within 60 days after the date of termination of such coverage.

You or Your Dependents may not enroll for health coverage under this Plan due to loss of health coverage under the following conditions:

- Coverage was terminated due to failure to pay timely premiums or for cause such as making a fraudulent claim or an intentional misrepresentation of material fact, or

- You or Your Dependent voluntarily canceled the other coverage, unless the current or former employer no longer contributed any money toward the premium for that coverage.

CHANGE IN FAMILY STATUS

Current Employees and their Dependents, COBRA Qualified Beneficiaries and other eligible persons have a special opportunity to enroll for coverage under this Plan if there is a change in family status. Retired Employees who are Covered Persons have a special opportunity to enroll newly acquired Dependents for coverage under this Plan if there is a change in family status.

If a person becomes Your eligible Dependent through marriage, birth, adoption or Placement for Adoption, the Employee, spouse and newly acquired Dependent(s) who are not already enrolled, may enroll for health coverage under this Plan during a special enrollment period. You must request and apply for coverage within 30 calendar days of marriage, birth, adoption or Placement for Adoption.

NEWLY ELIGIBLE FOR PREMIUM ASSISTANCE UNDER MEDICAID OR CHILDREN'S HEALTH INSURANCE PROGRAM

Current Employees and their Dependents may be eligible for a Special Enrollment period if the Employee and/or Dependents are determined eligible, under a state's Medicaid plan or state child health plan, for premium assistance with respect to coverage under this Plan. The Employee must request coverage under this Plan within 60 days after the date the Employee and/or Dependent is determined to be eligible for such assistance.

EFFECTIVE DATE OF COVERAGE UNDER SPECIAL ENROLLMENT PROVISION

If an eligible person properly applies for coverage during this special enrollment period, the coverage will become effective:

- In the case of marriage, on the date of the marriage; or
- In the case of a Dependent's birth, on the date of such birth; or
- In the case of a Dependent's adoption, the date of such adoption or Placement for Adoption; or
- In the case of eligibility for premium assistance under a state's Medicaid plan or state child health plan, on the date the approved request for coverage is received; or
- In the case of loss of coverage, on the date following loss of coverage.

RELATION TO SECTION 125 CAFETERIA PLAN

This Plan may also allow additional changes to enrollment due to change in status events under the employer's Section 125 Cafeteria Plan. Refer to the employer's Section 125 Cafeteria Plan for more information.

TERMINATION

Effective: 01-01-2011

Please see the COBRA section of this SPD for questions regarding coverage continuation.

EMPLOYEE'S COVERAGE

Your coverage under this Plan will end on the earliest of:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution towards the cost of coverage when due; or
- The date this Plan is canceled; or
- The date coverage for Your benefit class is canceled; or
- The last day of the month in which You tell the Plan to cancel Your coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or
- The last day of the month in which You are no longer a member of a covered class, as determined by the employer except as follows:
  - If You are temporarily absent from work due to an approved leave of absence for medical or other reasons, Your coverage under this Plan will continue during that leave for up to six months, provided that the applicable Employee contribution is paid when due.
  - If You are temporarily absent from work due to active military duty, refer to USERRA under the USERRA section.
- The last day of the month in which Your employment ends; or
- The date You submit a false claim or are involved in any other form of fraudulent act related to this Plan.

YOUR DEPENDENT'S COVERAGE

Coverage for Your Dependent will end on the earliest of the following:

- The end of the period for which Your last contribution is made, if You fail to make any required contribution toward the cost of Your Dependent's coverage when due; or
- The last day of the month in which Your coverage ends; or
- The last day of the month in which Your Dependent is no longer Your legal spouse due to legal separation or divorce, as determined by the law of the state where the Employee resides; or
- The last day of the month in which Your Dependent Child attains the limiting age listed under the Eligibility section, unless the Child qualifies for Extended Dependent Coverage; or
- If Your Dependent Child qualifies for Extended Dependent Coverage as Totally Disabled, the last day of the month in which Your Dependent Child is no longer deemed Totally Disabled under the terms of the Plan; or
- The date Dependent coverage is no longer offered under this Plan; or

- The last day of the month in which You tell the Plan to cancel Your Dependent's coverage if You are voluntarily canceling it while remaining eligible because of change in status, special enrollment, or at annual open enrollment periods; or

- The last day of the month in which the Dependent becomes covered as an Employee under this Plan; or

- The date You or Your Dependent submits a false claim or are involved in any other form of fraudulent act related to this Plan.

RESCISSION OF COVERAGE

As permitted by the Patient Protection and Affordable Care Act, the Plan reserves the right to rescind coverage. A rescission of coverage is a retroactive cancellation or discontinuance of coverage due to fraud or intentional misrepresentation of material fact.

A cancellation/discontinuance of coverage is **not** a rescission if:

- it has only a prospective effect; or
- it is attributable to non-payment of premiums or contributions.

REINSTATEMENT OF COVERAGE

If Your coverage ends due to termination of employment, leave of absence or lay-off and You later return to active work within 6 months, You are eligible for coverage on the date of return to active work for this company. If You return to work after the 6 month period, You must meet all requirements of a new Employee. Refer to the information on Family and Medical Leave Act or Uniformed Services Employment and Reemployment Act for possible exceptions, or contact Your Human Resources or Personnel office.

PRE-EXISTING CONDITION PROVISION

Effective: 01-01-2011

Note: Pre-Existing Condition exclusions will not apply to any Covered Person under the age of 19.

(Applies to Late Enrollees Over Age 19)
A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the six consecutive month period ending on the Covered Person's Enrollment Date. Medical advice, diagnosis, care or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.

(Applies to New Employees and Dependents Over Age 19)
A Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the three consecutive month period ending on the Covered Person's Enrollment Date. Medical advice, diagnosis, care or treatment (including taking prescription drugs) is taken into account only if it is recommended or received from a licensed Physician.

This Plan has an exclusion for Pre-Existing Conditions. Benefits will not be paid for Covered Expenses for a Pre-Existing Condition until the earliest of the following:

- 6 consecutive months from the Covered Person's Enrollment Date, if You apply for coverage under Plan procedure; or **(Applies to New Employees Over Age 19)**
- 12 consecutive months from the Covered Person's Enrollment Date, if You apply for coverage under Plan procedure; or **(Applies to Dependents Over Age 19)**
- 18 consecutive months from the Covered Person's Enrollment Date, if the Covered Person is considered a Late Enrollee. **(Applies to Late Enrollees Over Age 19)**

Benefits will then be payable for Covered Expenses Incurred for a Pre-Existing Condition after such period of time, reduced by Creditable Coverage as described below.

EXCEPTIONS

The Pre-Existing Condition exclusion does not apply to:

- Any person who, on the Enrollment Date, had 6 consecutive months of Creditable Coverage. **(Applies to New Employees Over Age 19)**
- Any person who, on the Enrollment Date, had 12 consecutive months of Creditable Coverage. **(Applies to Dependents Over Age 19)**
- Any person who, on the Enrollment Date, had 18 consecutive months of Creditable Coverage. **(Applies to Late Enrollees Over Age 19)**
- Pregnancy, including complications.
- Genetic information, in the absence of a diagnosis of an Illness related to such information. For example, if You have a family history of diabetes but You Yourself have had no problem with diabetes, the Plan will not consider diabetes to be a Pre-Existing Condition just because You have a family history of this disease.
- Treatment recommendations made prior to the six consecutive month period before the Enrollment Date when the Covered Person did not act upon the recommendation.

- Any Employees or Dependents added as a result of an acquisition of an entire company or entire division moving into this Plan will be effective upon notification by the Employer to the Plan Administrator. The Pre-Existing Condition exclusion period under this Plan will apply. However, the Plan Administrator, in its discretion, may waive the Pre-Existing Condition exclusion period with respect to all similarly situated Employees who were covered under the other employer's group health plan at the time of such acquisition and/or honor any shorter Pre-Existing Condition exclusion period contained in such other employer's group health plan.

REDUCTION OF PRE-EXISTING CONDITION EXCLUSION TIME PERIOD (Creditable Coverage)

If on the Enrollment Date, a Covered Person has less than 6 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies. **(Applies to New Employees Over Age 19)**

If on the Enrollment Date, a Covered Person has less than 12 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies. **(Applies to Dependents Over Age 19)**

If on the Enrollment Date, a Covered Person has less than 18 consecutive months of Creditable Coverage, the Plan will reduce the length of the Pre-Existing Condition exclusion period for each day of Creditable Coverage the Covered Person had in determining whether the Pre-Existing Condition exclusion applies. **(Applies to Late Enrollees Over Age 19)**

Creditable Coverage means that the Covered Person had coverage under a group health plan, health insurance policy, Medicare or any one of several other health plans as described in the Glossary of Terms section of this SPD, and coverage was not interrupted by a Significant Break in Coverage.

If a Covered Person has a Significant Break in Coverage, any days of Creditable Coverage that occur before the Significant Break in Coverage will not be counted by the Plan to reduce the Pre-Existing Condition exclusion time period. Waiting Periods will not count towards a Significant Break in Coverage.

CERTIFICATES OF CREDITABLE COVERAGE

New Employees and covered Dependents are encouraged to get a Certificate of Creditable Coverage from the person's prior employer or insurance company as soon as possible. If You or Your Dependents are having difficulty obtaining this, contact Your Human Resources or Personnel office for assistance.

In addition, Covered Persons will receive a Certificate of Creditable Coverage from this Plan when the person loses coverage under this Plan, when the person loses COBRA coverage, or upon a written request to this Plan.

Please submit written requests for a Certificate of Creditable Coverage from this Plan to:

UMR
ENROLLMENT SERVICES
PO BOX 8052
WAUSAU WI 54402-8052

Effective: 01-01-2009

THE RIGHT TO REQUEST A REVIEW OF A DETERMINATION OF PRE-EXISTING CONDITION EXCLUSION PERIOD

If You feel that a determination of the Pre-Existing Condition Exclusion (PCE) period is incorrect, You may submit a written request for review.

Send Your request to:

UMR
ENROLLMENT SERVICES
PO BOX 8052
WAUSAU WI 54402-8052

Your written request must be made within 60 days from the date of the notice. However, if Your request is based on additional evidence that shows that You or Your Dependent had more Creditable Coverage than recognized originally, You may take longer.

Your written request should state the reasons that You believe the original determination is incorrect and include any additional facts that support Your position. You should submit any additional evidence that shows that You or Your Dependent had more Creditable Coverage.

Your request will usually be decided within 60 days after it is submitted. If additional time is needed to complete the review, You will be notified. You will be notified in writing of the decision on Your request if You submit additional evidence to consider or if the original Determination of PCE period is modified. If You do not receive notice of a decision within 60 calendar days after You submit the request, this means that the original decision was upheld.

Similar to an initial determination, any new determination will set forth:

- The specific reason(s) for the decision; and
- The specific Plan provision(s) and other documents or information on which the decision is based.

COBRA CONTINUATION OF COVERAGE

Effective: 01-01-2009

Important. Read this entire provision to understand a Covered Person's COBRA rights and obligations.

The following is a summary of the federal continuation requirements under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This summary generally explains COBRA continuation coverage, when it may become available to You and Your covered Dependents, and what You and Your Dependents need to do to protect the right to receive it. This summary provides a general notice of a Covered Person's rights under COBRA, but is not intended to satisfy all of the requirements of federal law. Your employer or the COBRA Administrator will provide additional information to You or Your Dependents as required.

The COBRA Administrator for this Plan is: UMR

INTRODUCTION

Federal law gives certain persons, known as Qualified Beneficiaries, the right to continue their health care benefits beyond the date that they might otherwise terminate. The Qualified Beneficiary must pay the entire cost of the COBRA continuation coverage, plus an administrative fee. In general, a Qualified Beneficiary has the same rights and obligations under the Plan as an active participant.

A Qualified Beneficiary may elect to continue coverage under this Plan if such person's coverage would terminate because of a life event known as a Qualifying Event, outlined below. When a Qualifying Event causes (or will cause) a Loss of Coverage, then the Plan must offer COBRA continuation coverage. Loss of Coverage means more than losing coverage entirely. It means that a person ceases to be covered under the same terms and conditions that are in effect immediately before the Qualifying Event. In short, a Qualifying Event plus a Loss of Coverage allows a Qualified Beneficiary the right to elect coverage under COBRA.

Generally, You, Your covered spouse, and Dependent Children may be Qualified Beneficiaries and eligible to elect COBRA continuation coverage even if the person is already covered under another employer-sponsored group health plan or is enrolled in Medicare at the time of the COBRA election.

COBRA CONTINUATION COVERAGE FOR QUALIFIED BENEFICIARIES

The length of COBRA continuation coverage that is offered varies based on who the Qualified Beneficiary is and what **Qualifying Event** is experienced as outlined below.

An Employee will become a Qualified Beneficiary if coverage under the Plan is lost because either one of the following Qualifying Events happens:

Qualifying Event	**Length of Continuation**
• Your employment ends for any reason other than Your gross misconduct	up to 18 months
• Your hours of employment are reduced	up to 18 months

(There are two ways in which this 18-month period of COBRA continuation coverage can be extended. See the section below entitled "The Right to Extend Coverage" for more information.)

The spouse of an Employee will become a Qualified Beneficiary if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• Your spouse dies	up to 36 months
• Your spouse's hours of employment are reduced	up to 18 months
• Your spouse's employment ends for any reason other than his or her gross misconduct	up to 18 months
• Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both)	up to 36 months
• You become divorced or legally separated from Your spouse	up to 36 months

The Dependent Children of an Employee become Qualified Beneficiaries if coverage is lost under the Plan because any of the following Qualifying Events happen:

Qualifying Event	Length of Continuation
• The parent-Employee dies	up to 36 months
• The parent-Employee's employment ends for any reason other than his or her gross misconduct	up to 18 months
• The parent-Employee's hours of employment are reduced	up to 18 months
• The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both)	up to 36 months
• The parents become divorced or legally separated	up to 36 months
• The Child stops being eligible for coverage under the plan as a Dependent	up to 36 months

COBRA NOTICE PROCEDURES

NOTICE(S) A COVERED PERSON MUST PROVIDE UNDER THIS SUMMARY PLAN DESCRIPTION

To be eligible to receive COBRA continuation coverage, covered Employees and their Dependents have certain obligations with respect to certain Qualifying Events (including divorce or legal separation of the Employee and spouse or a Dependent Child's loss of eligibility for coverage as a Dependent) to provide written notices to the administrator. Follow the rules described in this procedure when providing notice to the administrators, either Your employer or the COBRA Administrator.

A Qualified Beneficiary's written notice must include all of the following information: (A form to notify the COBRA Administrator is available upon request.)

- The Qualified Beneficiary's name, their current address and complete phone number,
- The group number, name of the employer that the Employee was with,
- Description of the Qualifying Event (i.e., the life event experienced), and
- The date that the Qualifying Event occurred or will occur.

Effective: 01-01-2009

Send all notices or other information required to be provided by this Summary Plan Description in writing to:

UMR
COBRA ADMINISTRATION
PO BOX 8046
WAUSAU WI 54402-8046
Phone Number: (715) 841-2918 or (800) 826-9781 x2918

For purposes of the deadlines described in this Summary Plan Description, the notice must be postmarked by the deadline. In order to protect Your family's rights, the Plan Administrator should be informed of any changes in the addresses of family members. Keep a copy of any notices sent to the Plan Administrator or COBRA Administrator.

COBRA NOTICE REQUIREMENTS AND ELECTION PROCESS

EMPLOYER OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

Your employer will give notice to the COBRA Administrator when coverage terminates due to Qualifying Events that are the Employee's termination of employment or reduction in hours, death of the Employee, or the Employee becoming eligible for Medicare benefits due to age or disability (Part A, Part B, or both). Your employer will notify the COBRA Administrator within 30 calendar days when these events occur.

EMPLOYEE OBLIGATION TO PROVIDE NOTICE OF THE QUALIFYING EVENT

The Covered Person must give notice to the Plan Administrator in the case of other Qualifying Events that are divorce or legal separation of the Employee and a spouse, a Dependent Child ceasing to be eligible for coverage under the Plan, or a second Qualifying Event. The covered Employee or Qualified Beneficiary must provide written notice to the Plan Administrator in order to ensure rights to COBRA continuation coverage. The Covered Person must provide this notice within the 60-calendar day period that begins on the latest of:

- The date of the Qualifying Event; or
- The date on which there is a Loss of Coverage (or would lose coverage); or
- The date on which the Qualified Beneficiary is informed of this notice requirement by receiving this Summary Plan Description or the General COBRA Notice.

The Plan Administrator will notify the COBRA Administrator within 30 calendar days from the date that notice of the Qualifying Event has been provided.

The COBRA Administrator will, in turn, provide an election notice to each Qualified Beneficiary within 14 calendar days of receiving notice of a Qualifying Event from the employer, covered Employee or the Qualified Beneficiary.

MAKING AN ELECTION TO CONTINUE GROUP HEALTH COVERAGE

Each Qualified Beneficiary has the independent right to elect COBRA continuation coverage. A Qualified Beneficiary will receive a COBRA election form that must be completed to elect to continue group health coverage under this Plan. A Qualified Beneficiary may elect COBRA coverage at any time within the 60-day election period. The election period ends 60 calendar days after the later of:

- The date Your Plan coverage terminates due to a Qualifying Event; or
- The date the Plan Administrator provides the Qualified Beneficiary with an election notice.

A Qualified Beneficiary must notify the COBRA Administrator of their election in writing to continue group health coverage and must make the required payments when due in order to remain covered. If the Qualified Beneficiary does not choose COBRA continuation coverage within the 60-day election period, group health coverage will end on the day of the Qualifying Event.

Effective: 01-01-2011

PAYMENT OF CLAIMS

No claims will be paid under this Plan for services that the Qualified Beneficiary receives on or after the date You lose coverage due to a Qualifying Event. If, however, the Qualified Beneficiary decides to elect COBRA continuation coverage, group health coverage will be reinstated back to the date coverage was lost, provided that the Qualified Beneficiary properly elects COBRA on a timely basis and makes the required payment when due. Any claims that were denied during the initial COBRA election period will be reprocessed once the COBRA Administrator receives Your completed COBRA election form and required payment.

PAYMENT FOR CONTINUATION COVERAGE

Qualified Beneficiaries are required to pay the entire cost of continuation coverage, which includes both the employer and Employee contribution. This may also include a 2% additional fee to cover administrative expenses (or in the case of the 11-month extension due to disability, a 50% additional fee). Fees are subject to change at least once a year.

If Your employer offers annual open enrollment opportunities for active Employees, each Qualified Beneficiary will have the same options under COBRA (for example, the right to add or eliminate coverage for Dependents). The cost of continuation coverage will be adjusted accordingly.

The **initial payment** is due no later than 45 calendar days after the Qualified Beneficiary elects COBRA as evidenced by the postmark date on the envelope. This first payment must cover the cost of continuation coverage from the time coverage under the Plan would have otherwise terminated, up to the time the first payment is made. If the initial payment is not made within the 45-day period, then coverage will remain terminated without the possibility of reinstatement. There is no grace period for the initial payment.

The due date for **subsequent payments** is typically the first day of the month for any particular period of coverage, however the Qualified Beneficiary will receive specific payment information including due dates, when the Qualified Beneficiary becomes eligible for and elects COBRA continuation coverage. Payments postmarked within a 30 day grace period following the due date are considered timely payments.

If, for whatever reason, any Qualified Beneficiary receives any benefits under the Plan during a month for which the payment was not made on time, then the Qualified Beneficiary will be required to reimburse the Plan for the benefits received.

If the COBRA Administrator receives a check that is missing information or has discrepancies regarding the information on the check (i.e., the numeric dollar amount does not match the written dollar amount), the COBRA Administrator will provide a notice to the Qualified Beneficiary and allow him/her 14 days to send in a corrected check. If a corrected check is not received within the 14-day timeframe, then the occurrence will be treated as non-payment and the Qualified Beneficiary(s) will be termed from the Plan in accordance with the plan language above.

Note: Payment will not be considered made if a check is returned for non-sufficient funds.

A QUALIFIED BENEFICIARY'S NOTICE OBLIGATIONS WHILE ON COBRA

Always keep the COBRA Administrator informed of the current addresses of all Covered Persons who are or who may become Qualified Beneficiaries. Failure to provide this information to the COBRA Administrator may cause You or Your Dependents to lose important rights under COBRA.

In addition, after any of the following events occur, written notice to the COBRA Administrator is required within 30 calendar days of:

- The date any Qualified Beneficiary marries. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date a Child is born to, adopted by, or Placed for Adoption by a Qualified Beneficiary. Refer to the Special Enrollment section of this SPD for additional information regarding special enrollment rights.

- The date of a final determination by the Social Security Administration that a disabled Qualified Beneficiary is no longer disabled.

- The date any Qualified Beneficiary becomes covered by another group health plan.

- Additionally, if the COBRA Administrator or the Plan Administrator requests additional information from the Qualified Beneficiary, the Qualified Beneficiary must provide the requested information within 30 calendar days.

LENGTH OF CONTINUATION COVERAGE

COBRA coverage is available up to the maximum periods described below, subject to all COBRA regulations and the conditions of this Summary Plan Description:

- For Employees and Dependents. 18 months from the Qualifying Event if due to the Employee's termination of employment or reduction of work hours. (If an active Employee enrolls in Medicare before his or her termination of employment or reduction in hours, then the covered spouse and Dependent Children would be entitled to COBRA continuation coverage for up to the greater of 18 months from the Employee's termination of employment or reduction in hours, or 36 months from the earlier Medicare Enrollment Date, whether or not Medicare enrollment is a Qualifying Event.)

- For Dependents only. 36 months from the Qualifying Event if coverage is lost due to one of the following events:

  - Employee's death.
  - Employee's divorce or legal separation.
  - Former Employee becomes enrolled in Medicare.
  - A Dependent Child no longer being a Dependent as defined in the Plan.

- For Retired Employees and Dependents of Retired Employees only. If bankruptcy of the employer is the Qualifying Event that causes Loss of Coverage, the Qualified Beneficiaries can continue COBRA continuation coverage for the following maximum period, subject to all COBRA regulations. The covered Retired Employee can continue COBRA coverage for the rest of his or her life. The covered spouse, surviving spouse or Dependent Child of the covered Retired Employee can continue coverage until the earlier of:

  - The date the Qualified Beneficiary dies; or
  - The date that is 36 months after the death of the covered Retired Employee.

THE RIGHT TO EXTEND THE LENGTH OF COBRA CONTINUATION COVERAGE

While on COBRA continuation coverage, certain Qualified Beneficiaries may have the right to extend continuation coverage provided that written notice to the COBRA Administrator is given as soon as possible but no later than the **required** timeframes stated below.

Social Security Disability Determination (For Employees and Dependents): A Qualified Beneficiary may be granted an 11-month extension to the initial 18-month COBRA continuation period, for a total maximum of 29 months of COBRA. In the event that the Social Security Administration determines the Qualified Beneficiary to be disabled some time before the 60th day of COBRA continuation coverage. This extension will not apply if the original COBRA continuation was for 36 months.

If the Qualified Beneficiary has non-disabled family members who are also Qualified Beneficiaries, those non-disabled family members are also entitled to the disability extension.

The Qualified Beneficiary must give the COBRA Administrator a copy of the Social Security Administration letter of disability determination within 60 days of the later of:

- The date of the SSA disability determination;
- The date the Qualifying Event occurs;
- The date the Qualified Beneficiary loses (or would lose) coverage due to the Qualifying Event or the date the Plan coverage was lost; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the disability by receiving this Summary Plan Description or the General COBRA Notice.

Note: Premiums may be higher after the initial 18-month period for persons exercising this disability extension provision available under COBRA.

If the Social Security Administration determines the Qualified Beneficiary is no longer disabled, the Qualified Beneficiary must notify the Plan of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Events: (Dependents Only) If Your family experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, the spouse and Dependent Children in Your family can receive up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second event is provided to the COBRA Administrator. This additional coverage may be available to the spouse or Dependent Children if the Employee or former Employee dies, becomes entitled to Medicare (part A, part B or both) or is divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent. These events will only lead to the extension when the event would have caused the spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

You or Your Dependents must provide the notice of a second Qualifying Event to the COBRA Administrator within a 60-day period that begins to run on the latest of:

- The date of the second Qualifying Event; or
- The date the Qualified Beneficiary loses (or would lose) coverage due to the second Qualifying Event; or
- The date on which the Qualified Beneficiary is informed of the requirement to notify the COBRA Administrator of the second Qualifying Event by receiving this Summary Plan Description or the General COBRA Notice.

EARLY TERMINATION OF COBRA CONTINUATION

COBRA continuation coverage may terminate before the end of the above maximum coverage periods for any of the following reasons:

- The employer ceases to maintain a group health plan for any Employees. (Note that if the employer terminates the group health plan that the Qualifying Beneficiary is under, but still maintains another group health plan for other similarly-situated Employees, the Qualifying Beneficiary will be offered COBRA continuation coverage under the remaining group health plan, although benefits and costs may not be the same).

- The required contribution for the Qualified Beneficiary's coverage is not paid on time.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes entitled to and enrolled with Medicare.

- After electing COBRA continuation coverage, the Qualified Beneficiary becomes covered under another group health plan that does not contain any exclusion or limitation with respect to any Pre-Existing Condition(s) for the beneficiary.

- The Qualified Beneficiary is found not to be disabled during the disability extension. The Plan will terminate the Qualified Beneficiary's COBRA continuation coverage one month after the Social Security Administration makes a determination that the Qualified Beneficiary is no longer disabled.

- Termination for cause, such as submitting fraudulent claims.

SPECIAL NOTICE (Read This If Thinking Of Declining COBRA Continuation Coverage)

Electing COBRA continuation coverage now may protect some of Your (or Your Dependent's) rights if You or Your Dependent need to obtain an **individual health insurance policy** soon. The Health Insurance Portability and Accountability Act (HIPAA) requires that all health insurance carriers who offer coverage in the individual market must accept any eligible individuals who apply for coverage without imposing Pre-Existing Condition exclusions, under certain conditions. Some of those conditions pertain to COBRA continuation coverage. To take advantage of this HIPAA right, COBRA continuation coverage under this Plan must be elected and maintained (by paying the cost of coverage) for the duration of the COBRA continuation period. In the event that an individual health insurance policy is needed, You or Your Dependent must apply for coverage with an individual insurance carrier after COBRA continuation coverage is exhausted and before a 63-day break in coverage.

If You or Your Dependent(s) will be obtaining **group health coverage** through a new employer, keep in mind that HIPAA requires employers to reduce Pre-Existing Condition exclusion periods if there is less than a 63-day break in health coverage (Creditable Coverage).

DEFINITIONS

Qualified Beneficiary means a person covered by this group health Plan immediately before the Qualifying Event who is the Employee, the spouse of a covered Employee or the Dependent Child of a covered Employee. This includes a Child who is born to or Placed for Adoption with a covered Employee during the Employee's COBRA coverage period if the Child is enrolled within the Plan's Special Enrollment Provision for newborns and adopted Children. This also includes a Child who was receiving benefits under this Plan pursuant to a Qualified Medical Child Support Order (QMCSO) immediately before the Qualifying Event.

Qualifying Event means Loss of Coverage due to one of the following:

- The death of the covered Employee.

- Voluntary or involuntary termination of the covered Employee's employment (other than for gross misconduct).

- A reduction in work hours of the covered Employee.

- Divorce or legal separation of the covered Employee from the Employee's spouse. (Also, if an Employee terminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation may be considered a Qualifying Event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the Plan or the COBRA Administrator in writing within 60 calendar days after the divorce or legal separation and can establish that the coverage was originally eliminated in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation).

- The covered former Employee becomes enrolled in Medicare.

- A Dependent Child no longer being a Dependent as defined by the Plan.

Loss of Coverage means any change in the terms or conditions of coverage in effect immediately before the Qualifying Event. Loss of Coverage includes change in coverage terms, change in plans, termination of coverage, partial Loss of Coverage, increase in Employee cost, as well as other changes that affect terms or conditions of coverage. Loss of Coverage does not always occur immediately after the Qualifying Event, but it must always occur within the applicable 18 or 36-month coverage period. A Loss of Coverage that is not caused by a Qualifying Event may not trigger COBRA.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

INTRODUCTION

Employers are required to offer COBRA-like health care continuation coverage to persons in the armed service if the absence for military duty would result in loss of coverage as a result of active duty. Employees on leave for military service must be treated like they are on leave of absence and are entitled to any other rights and benefits accorded to similarly situated Employees on leave of absence or furlough. If an employer has different types of benefits available depending on the type of leave of absence, the most favorable benefits must apply to Employees on military leave. Reinstatement following the military leave of absence cannot be subject to Pre-Existing Conditions and Waiting Periods.

COVERAGE

The maximum length of health care continuation coverage required under USERRA is the lesser of:

- 24 months beginning on the day that the Uniformed Service leave begins, or
- a period beginning on the day that the Service leave begins and ending on the day after the Employee fails to return to or reapply for employment within the time allowed by USERRA.

USERRA NOTICE AND ELECTION

An Employee or an appropriate officer of the uniformed service in which his or her service is to be performed must notify the employer that the Employee intends to leave the employment position to perform service in the uniformed services. An Employee should provide notice as far in advance as is reasonable under the circumstances. The Employee is excused from giving notice due to military necessity, or if it is otherwise impossible or unreasonable under all the circumstances.

Upon notice of intent to leave for uniformed services, Employees will be given the opportunity to elect USERRA continuation. Unlike COBRA, Dependents do not have an independent right to elect USERRA coverage. Election, payment and termination of the USERRA extension will be governed by the same requirements set forth under the COBRA Section, to the extent these COBRA requirements do not conflict with USERRA.

PAYMENT

If the military leave orders are for a period of 30 days or less, the Employee is not required to pay more than the amount he or she would have paid as an active Employee. If an Employee elects to continue health coverage pursuant to USERRA, such Employee and covered Dependents will be required to pay up to 102% of the full premium for the coverage elected.

EXTENDED COVERAGE RUNS CONCURRENT

Employees and their Dependents may be eligible for both COBRA and USERRA at the same time. Election of either the COBRA or USERRA extension by an Employee on leave for military service will be deemed an election under both laws, and the coverage offering the most benefit to the Employee will generally be extended. Coverage under both laws will run concurrently. Dependents who chose to independently elect extended coverage will only be deemed eligible for COBRA extension because they are not eligible for a separate, independent right of election under USERRA.

PROVIDER NETWORK

Effective: 01-01-2011

The word **"Network"** means that an outside organization has contracted with various providers to provide health care services to Covered Persons at a Negotiated Rate. Providers who participate in a Network have agreed to accept the negotiated fees as payment in full, including any portion of the fees that the Covered Person must pay due to the Deductible, Participation amounts or other out-of-pocket expenses. In all cases the network contract determines what the Plan will consider as a Covered Expense. A provider who does not participate in a Network may bill Covered Persons for additional fees over and above what the Plan pays.

Knowing which Network a provider belongs to will help a Covered Person to determine how much he or she will need to pay for certain services. To obtain the highest level of benefits under this Plan, Covered Persons need to see an In-Network provider, however this Plan does not limit a Covered Person's right to choose his or her own provider or medical care. If a medical expense is not a Covered Expense under this Plan, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service at his or her own personal expense.

To find out which Network a provider belongs to, please refer to the Provider Directory, or call the toll-free number that is listed on the back of the Plan's identification card. The participation status of providers may change from time to time.

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **In-Network** benefit levels that are listed on the Schedule of Benefits:

  58 - UnitedHealthcare Options PPO Network
  7M - Sagamore Health Network
  0C - PHCS HD Travel

- If a provider belongs to one of the following Networks, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits, but the providers have agreed to discount their fees. This means that the Covered Person may pay a little less for a particular claim.

  ZM - Multiplan Shared Savings
  0C - First Health

- For services received from any other provider, claims for Covered Expenses will normally be processed in accordance with the **Out-of-Network** benefit levels that are listed on the Schedule of Benefits. These providers charge their normal rates for services, so Covered Persons may need to pay more. The Covered Person is responsible for paying the balance of these claims after the Plan pays its portion, if any.

- **For Transplant Services at a Designated Transplant Facility, the Network is:**

  OptumHealth

Effective: 01-01-2010

Provider Directory Information

Each covered Employee, those on COBRA, and Children or guardians of Children who are considered alternate recipients under a Qualified Medical Child Support Order, will automatically be given or electronically made available, a separate document, at no cost, that lists the participating Network providers for this Plan. The Employee should share this document with other covered individuals in Your household. If a covered spouse or Dependent wants a separate provider list, they should make a written request to the Plan Administrator. The Plan Administrator may make a reasonable charge to cover the cost of furnishing complete copies to the spouse or other covered Dependents.

REASONABLE ACCESS

In addition to the above *reasonable access* provision on the schedule of benefits, the following exceptions will be payable at the preferred provider level of benefits even though eligible services and supplies are obtained from a non-preferred provider:

- Emergency treatment provided at a non-preferred facility.
- Non-preferred anesthesiologist if the operating surgeon is a preferred provider.
- Radiologist or pathologist services for interpretation of x-rays and laboratory tests provided by a non-preferred provider when the facility providing such services is a preferred provider.
- Emergency room physician services provided by a non-preferred provider when the facility providing such services is a preferred provider.
- Diagnostic laboratory and pathology tests performed by a non-preferred provider when referred by a preferred provider.
- While confined to a preferred provider hospital, a consultation from a non-preferred provider requested by the preferred provider physician.
- Eligible services and supplies which are not available through any preferred provider in the geographical area. It is the participant's responsibility to obtain documentation from the preferred provider organization and provide it to the Plan Claims Administrator.
- Eligible expenses incurred by a covered Dependent when residing outside the service area of the preferred provider organization for either of the following reasons:
  - The covered Dependent is attending college on a full-time basis; or
  - The Employee is legally required to furnish health care coverage on the Dependent under a court order or divorce decree. (Proof of such requirement must be furnished at time of enrollment application.)
- Carle Clinic in Urbana, Illinois will be treated as an in-network provider.

COVERED MEDICAL BENEFITS

Effective: 01-01-2010

This Plan provides coverage for the following Covered Benefits if services are authorized by a Physician and are necessary for the treatment of an Illness or Injury, subject to any limits, maximums, exclusions or other Plan provisions shown in this SPD. The Plan does not provide coverage for services if medical evidence shows that treatment is not expected to resolve, improve, or stabilize the Covered Person's condition, or that a plateau has been reached in terms of improvement from such services.

1. **Abortions:** If a Physician states in writing that:
   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy, or
   - Pregnancy due to rape or incest.

2. **Allergy Treatment** including: injections, testing and serum as shown in the Schedule of Benefits.

3. **Ambulance Transportation:** When Clinical Eligibility for Coverage is met, ground and air transportation to the nearest medically appropriate Hospital.

4. **Anesthetics and their Administration.**

5. **Aquatic Therapy.** (See Therapy Services below)

6. **Autism Services (PDD Pervasive Development Disorder):** Limited treatment, consisting of:

   - Therapy to develop interactive skills and skills necessary to perform the significant Activities of Daily Living (see Glossary of Terms). The therapy must be ordered by a licensed medical provider. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Plan Administrator and updated annually with a report on the patient's condition, progress and future treatment plans. The provider must submit an evaluation every six months including objective evidence of progression towards goals.

   - Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the Child.

   - Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or Legal Guardian of an autistic individual to teach the principles and practical applications of behavior modification.

7. **Blood Transfusions.**

8. **Cardiac Pulmonary Rehabilitation** when Clinical Eligibility for Coverage is met for Activities of Daily Living (See Glossary of Terms) as well as a result of an Illness or Injury.

9. **Cardiac Rehabilitation** programs are covered if referred by a Physician, for patients who have:

    - had a heart attack in the last 12 months; or
    - had coronary bypass surgery; or
    - a stable angina pectoris.

    Services covered include:

    - Phase I, while the Covered Person is an Inpatient.
    - Phase II, while the Covered Person is in a Physician supervised Outpatient monitored low-intensity exercise program. Services generally will be in a Hospital rehabilitation facility and include monitoring of the Covered Person's heart rate and rhythm, blood pressure and symptoms by a health professional. Phase II generally begins within 30 days after discharge from the Hospital.

10. **Chiropractic Treatment** by a Qualified chiropractor. Services for diagnosis by physical examination and plain film radiography, and when Clinical Eligibility for Coverage is met for treatments for musculoskeletal conditions. Refer to Maintenance Therapy under the General Exclusions section of this SPD.

11. **Circumcision** and related expenses when care and treatment meet the definition of the Clinical Eligibility for Coverage. Circumcision of newborn males is also covered as stated under nursery and newborn medical benefits.

12. **Cleft Palate and Cleft Lip:** Benefits will be provided for the treatment of cleft palate or cleft lip. Such coverage includes oral surgery and pre-graft palatal expander when the Clinical Eligibility for Coverage is met.

13. **Congenital Heart Disease:** If a Covered Person is being treated for congenital heart disease, and chooses to obtain the treatment at a United Resource Transplant Network (URN) facility, the Plan will provide the same housing and travel benefits that are outlined in the Transplant Benefits section and on the Transplant Schedule of Benefits.

14. **Cornea Transplants** are payable at the percentage listed under All Other Covered Expenses on the Schedule of Benefits.

15. **Dental Services** include:

    - The care and treatment of natural teeth and gums if an Injury is sustained in an Accident, excluding implants.
    - Inpatient or Outpatient Hospital charges including professional services for x-ray, lab, and anesthesia while in the Hospital if the Clinical Eligibility for Coverage is met.
    - Removal of all teeth at an Inpatient or Outpatient Hospital or dentist's office if removal of the teeth is part of standard medical treatment that is required before the Covered Person can undergo radiation therapy for a covered medical condition.

16. **Diabetes Treatment:** Charges Incurred for the treatment of diabetes and diabetic self-management education programs and nutritional counseling. This also includes use of equipment or supplies, unless covered through the Prescription Benefits section. Charges are paid the same as any other Illness.

17. **Dietician Services**, for known medical disorder when prescribed by a physician for preventing progression of a known medical disorder.

18. **Durable Medical Equipment** subject to all of the following:

    - The equipment must meet the definition of Durable Medical Equipment as defined in the Glossary of Terms. Examples include, but are not limited to crutches, wheelchairs, hospital-type beds and oxygen equipment.
    - The equipment must be prescribed by a Physician.
    - The equipment is subject to review under the Utilization Management Provision of this SPD, if applicable.
    - The equipment will be provided on a rental basis; however, such equipment may be purchased at the Plan's option. Any amount paid to rent the equipment will be applied towards the purchase price. In no case will the rental cost of Durable Medical Equipment exceed the purchase price of the item.
    - The Plan will pay benefits for only ONE of the following: a manual wheelchair, motorized wheelchair or motorized scooter, unless necessary due to growth of the person or changes to the person's medical condition require a different product, as determined by the Plan.
    - If the equipment is purchased, benefits may be payable for subsequent repairs excluding batteries or replacement only if required:
        - due to the growth or development of a Dependent Child;
        - when necessary because of a change in the Covered Person's physical condition; or
        - because of deterioration caused from normal wear and tear.

      The repair or replacement must also be recommended by the attending Physician. In all cases, repairs or replacement due to abuse or misuse, as determined by the Plan, are not covered and replacement is subject to prior approval by the Plan.
    - This Plan covers taxes, shipping and handling charges for Durable Medical Equipment.

19. **Emergency Room Hospital and Physician Services** including Emergency room services for stabilization or initiation of treatment of a medical Emergency condition provided on an Outpatient basis at a Hospital, as shown in the Schedule of Benefits.

20. **Extended Care Facility Services** for both mental and physical health diagnosis. Charges will be paid under the applicable diagnostic code: Services must be certified in advance. (Refer to the Utilization Management section of this SPD). The following benefits are covered:

    - Room and board.
    - Miscellaneous services, supplies and treatments provided by an Extended Care Facility, including Inpatient rehabilitation.

21. **Foot Care (Podiatry)** that is recommended by a Physician as a result of infection. The following charges for foot care will also be covered:

    - Treatment of any condition resulting from weak, strained, flat, unstable or unbalanced feet, when surgery is performed.
    - Treatment of corns, calluses and toenails, when at least part of the nail root is removed or when needed to treat a metabolic or peripheral vascular disease.
    - Treatment of bunions when an open cutting operation or arthroscopy is performed.
    - Covered charges do not include Palliative Foot Care.

22. **Genetic Counseling or Testing** based on Clinical Eligibility for Coverage (See Glossary of Terms of this SPD).

23. **Hearing Deficit Services** include exams, tests, services and supplies for other than Preventive Care, to diagnose and treat a medical condition.

24. **Home Health Care Services:** (Refer to Home Health Care section of this SPD). This does not include services of a person who lives in Your home, or who is a member of Your immediate family or Your spouse's immediate family, services that are considered custodial or services of a social worker.

25. **Hospice Care Services:** Treatment given at a Hospice Care Facility must be in place of a stay in a Hospital or Extended Care Facility, and can include:

    - **Assessment:** includes an assessment of the medical and social needs of the Terminally Ill person, and a description of the care to meet those needs.
    - **Inpatient Care:** in a facility when needed for pain control and other acute and chronic symptom management, psychological and dietary counseling, physical or occupational therapy and part-time Home Health Care services.
    - **Outpatient Care:** Provides or arranges for other services as related to the Terminal Illness which include: services of a Physician; physical or occupational therapy; nutrition counseling provided by or under the supervision of a registered dietitian.

    The Covered Person must be Terminally Ill with an anticipated life expectancy of about six months. Services, however, are not limited to a maximum of six months if continued Hospice Care is deemed appropriate by the Physician, up to the maximum hospice benefits available under the Plan.

    This does not include funeral arrangements, pastoral, financial or legal counseling, including estate planning and drafting of a will, respite care, homemaker or caretaker services not solely related to the care of the individual. This includes sitter and companion services for either the individual or other member of the family, transportation, house cleaning and house maintenance.

26. **Hospital Services (Includes Inpatient Services, Surgical Centers and Birthing Centers).** The following benefits are covered:

    - Semi-private room and board. For network charges, this rate is based on network repricing. For non-network charges, any charge over a semi-private room charge will be a Covered Expense only when Clinical Eligibility for Coverage is met.
    - Intensive care unit room and board.
    - Miscellaneous and Ancillary Services.
    - Blood, blood plasma and plasma expanders, when not available without charge.

27. **Hospital Services (Outpatient).**

28. **Laboratory or Pathology Tests and Interpretation Charges** for Covered Benefits.

29. **Maternity Benefits** for Covered Persons include:

    - Prenatal and postnatal care.
    - Hospital or Birthing Center room and board.
    - Obstetrical fees for routine prenatal care.
    - Vaginal delivery or Cesarean section.
    - Diagnostic testing when Clinical Eligibility for Coverage is met.
    - Abdominal operation for intrauterine pregnancy or miscarriage.
    - Licensed Outpatient Birthing Centers.
    - Midwifes.

30. **Mental Health Treatment** (Refer to Mental Health section of this SPD).

31. **Nursery and Newborn Expenses Including Circumcision** are covered for the following Children of the covered Employee or covered spouse: natural (biological) Children and newborn Children who are adopted or Placed for Adoption at the time of birth.

32. **Occupational Therapy.** (See Therapy Services below)

33. **Oral Surgery** includes:

- Excision of partially or completely impacted teeth.
- Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth when such conditions require pathological examinations.
- Surgical procedures required to correct accidental injuries of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
- Reduction of fractures and dislocations of the jaw.
- External incision and drainage of cellulitus.
- Incision of accessory sinuses, salivary glands or ducts.
- Excision of exostosis of jaw and hard palate.

34. **Orthotic Appliances, Devices and Casts,** including the exam for required Prescription and fitting, when prescribed to aid in healing, provide support to an extremity, or limit motion to the musculoskeletal system after Injury. These devices can be used for acute Injury or to prevent Injury. Orthotic Appliances and Devices include custom molded shoe orthotics, supports, trusses, elastic compression stockings, and braces.

35. **Oxygen and Its Administration.**

36. **Pharmacological Medical Case Management** (Medication management and lab charges).

37. **Physical Therapy.** (See Therapy Services below)

38. **Physician Services** for Covered Benefits.

39. **Pre Admission Testing**, when related to planned surgery with admission to the hospital within 7 days of results.

40. **Prescription Medications** which are administered or dispensed as take home drugs as part of treatment while in the Hospital or at a medical facility and that require a Physician's Prescription.

    (Refer to the Prescription Benefits section of this SPD for coverage if there is a written Physician's Prescription and medication is obtained from a pharmacy).

41. **Private Duty Nursing Services** when Outpatient care is required 24 hours a day.

42. **Prosthetic Devices.** The initial purchase, fitting, repair and replacement of fitted prosthetic devices (artificial body parts, including limbs, eyes and larynx) which replace body parts.

43. **Radiation Therapy and Chemotherapy.**

44. **Radiology and Interpretation Charges.**

45. **Reconstructive Surgery** includes:

- Following a mastectomy (Women's Health and Cancer Rights Act)
  The Covered Person must be receiving benefits in connection with a mastectomy in order to receive benefits for reconstructive treatments. Covered Expenses are reconstructive treatments which include all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance; and prostheses and complications of mastectomies, including lymphedemas.

- Surgery to restore bodily function that has been impaired by a congenital Illness or anomaly, Accident, or from an infection or other disease of the involved part.

46. **Respiratory Therapy.** (See Therapy Services below)

47. **Second Surgical Opinion** must be given by a board-certified Specialist in the medical field relating to the surgical procedure being proposed. The Physician providing the second opinion must not be affiliated in any way with the Physician who rendered the first opinion.

48. **Speech Therapy.** (See Therapy Services below)

49. **Sterilizations (Voluntary).**

50. **Substance Abuse Services** (Refer to Substance Abuse section of this SPD).

51. **Surgery and Assistant Surgeon Services** if Clinical Eligibility for Coverage is met. For Multiple or Bilateral Procedures during the same operative session, it is customary for the health care provider to reduce their fees for any secondary procedures. In-network claims will be paid according to the network contract. For out-of-network claims, the industry guidelines are to allow the full Usual and Customary fee allowance for the primary procedure, and fifty percent (50%) of the Usual and Customary fee allowance for all secondary procedures. These allowable amounts are then processed according to Plan provisions. A global package includes the services that are a necessary part of the procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

52. **Temporomandibular Joint Disorder (TMJ) Services** includes:

    - Diagnostic services.
    - Non-surgical treatment (includes intraoral devices or any other non-surgical method to alter the occlusion and/or vertical dimension).

    This does not cover orthodontic services.

53. **Therapy Services:** Therapy must be ordered by a Physician and provided as part of the Covered Person's treatment plan. Services include:

    - **Occupational therapy** by a Qualified occupational therapist.
    - **Physical therapy** by a Qualified physical therapist.
    - **Respiratory therapy** by a Qualified respiratory therapist.
    - **Aquatic therapy** by a Qualified physical therapist.
    - **Speech therapy** by a Qualified speech therapist including therapy for stuttering due to a neurological disorder.

    The Plan allows coverage for occupational, physical, or speech therapy for Developmental Delays due to an Accident or Illness such as Bell's palsy, CVA (stroke), apraxia, cleft palate/lip, recurrent/chronic otitis media, vocal cord nodules, Down's syndrome and cerebral palsy.

54. **Tobacco Addiction:** Services, treatment or supplies related to addiction to or dependency on nicotine.

55. **Transplant Services** (Refer to Transplant section of this SPD).

56. **Urgent Care Facility** as shown in the Schedule of Benefits of this SPD.

57. **Wigs, Toupees, Hairpieces** for hair loss due to cancer treatment or alopecia related to a medical condition.

58. **X-ray Services** for Covered Benefits.

HOME HEALTH CARE BENEFITS

Effective: 01-01-2010

Home Health Care services are provided for patients who are unable to leave their home, as determined by the Utilization Review Organization. Covered Persons must be certified in advance before receiving services. Please refer to the Utilization Management section of this SPD for more details. Covered services can include:

- Home visits that are in lieu of visits to the provider's office, and that do not exceed the Usual and Customary charge to perform the same service in a provider's office.
- Intermittent nurse services. Benefits are paid for only one nurse at any one time, not to exceed four hours per 24-hour period.
- Nutrition counseling provided by or under the supervision of a registered dietitian.
- Physical, occupational, respiratory and speech therapy provided by or under the supervision of a licensed therapist.
- Medical supplies, drugs, or medication prescribed by a Physician, and laboratory services to the extent that the Plan would have covered them under this Plan if the Covered Person had been in a Hospital.

A Home Health Care Visit is defined as: A visit by a nurse providing intermittent nurse services. Each visit includes up to a four-hour consecutive visit in a 24-hour period if Clinical Eligibility for Coverage is met.

EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Homemaker or housekeeping services.
- Supportive environment materials such as handrails, ramps, air conditioners and telephones.
- Services performed by family members or volunteer workers.
- "Meals on Wheels" or similar food service.
- Separate charges for records, reports or transportation.
- Expenses for the normal necessities of living such as food, clothing and household supplies.
- Legal and financial counseling services, unless otherwise covered under this Plan.

TRANSPLANT BENEFITS (Dual Choice)

Effective: 01-01-2010

Refer to the Utilization Management section of this SPD for notification requirements

Designated Transplant Facility (URN) benefits effective 05-17-2007
Non-designated Transplant Facility benefits effective 05-01-2007

This coverage provides a choice for transplant care. Use of a Designated Transplant Facility provides incentives to You and Your covered Dependents. This coverage does not require that a Designated Transplant Facility be used in order to receive benefits, but it is preferred. Designated Transplant Facilities are facilities that must meet extensive criteria in the areas of patient outcomes to include patient and graft survival, patient satisfaction, Physician and program experience, program accreditations, and patient and caregiver education.

DEFINITIONS

The following terms are used for the purpose of the Transplant Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Approved Transplant Services means services and supplies for certified transplants when ordered by a Physician. Such services include, but are not limited to, Hospital charges, Physician's charges, organ and tissue procurement, tissue typing and Ancillary Services.

Designated Transplant Facility means a facility which has agreed to provide Approved Transplant Services to Covered Persons pursuant to an agreement with a transplant provider network or rental network with which the Plan has a contract.

Non-Designated Transplant Facility means a facility that does not have an agreement with the transplant provider network with whom the Plan has a contract. This may include facilities that are listed as participating providers.

Organ and Tissue Acquisition/Procurement means the harvesting, preparation, transportation and the storage of human organ and tissue which is transplanted to a Covered Person. This includes related medical expenses of a living donor.

Stem Cell Transplant includes autologous, allogeneic and syngeneic transplant of bone marrow, peripheral and cord blood stem cells.

BENEFITS

The Plan will pay for Covered Expenses Incurred by a Covered Person at a Designated or Non-designated Transplant Facility for an Illness or Injury, subject to any Deductibles, Plan Participation amounts, maximums or limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge or the Plan’s Negotiated Rate.

It will be the Covered Person's responsibility to obtain prior notification for all transplant related services. If prior notification is not obtained, benefits may not be payable for such services. Benefits may also be subject to reduced levels as outlined in individual Plan provisions. The approved transplant and medical criteria for such transplant must be considered medically appropriate for the medical condition for which the transplant is recommended. The medical condition must not be included on individual Plan exclusions.

COVERED EXPENSES

The Plan will pay for Approved Transplant Services at a Designated or Non-designated Transplant Facility for Organ and Tissue Acquisition/Procurement and transplantation, if a Covered Person is the recipient.

If a Covered Person requires a transplant, including bone marrow or stem cell transplant, the cost of Organ and Tissue Acquisition/Procurement from a living human or cadaver will be included as part of the Covered Person's Covered Expenses when the donor's own plan does not provide coverage for Organ and Tissue Acquisition/Procurement. This includes the cost of donor testing, blood typing and evaluation to determine if the donor is a suitable match.

The Plan will provide donor services at a non-designated facility for initial acquisition/procurement only, up to the maximum listed on the Schedule of Benefits, if any. Complications, side effects or injuries are not covered unless the donor is a Covered Person on the Plan.

Benefits are payable for the following transplants:

- Kidney.
- Kidney/Pancreas.
- Pancreas, which meets the criteria as determined by the Utilization Management.
- Liver.
- Heart.
- Heart/Lung.
- Lung.
- Bone Marrow or Stem Cell transplant (allogeneic and autologous) for certain conditions.
- Small Bowel.

SECOND OPINION

The Plan will notify the Covered Person if a second opinion is required at any time during the determination of benefits period. If a Covered Person is denied a transplant procedure by the Designated or Non-designated Transplant Facility, the Plan will allow them to go to a second Designated Transplant Facility for evaluation. If the second facility determines, for any reason, that the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third transplant facility accepts the Covered Person for the procedure.

ADDITIONAL PROVISION FOR DESIGNATED TRANSPLANT FACILITIES

TRAVEL EXPENSES

If a transplant is performed at a Designated Transplant Facility and the Covered Person lives more than 50 miles from the transplant facility, the Plan will pay for the following, up to the maximum listed on the Schedule of Benefits:

- Transportation to and from the Designated Transplant Facility for:
  - The Covered Person; and
    - One or two parents of the Covered Person (if the Covered Person is a Dependent Child, as defined in this Plan); or
    - An adult to accompany the Covered Person;
  - Living donor if the donor lives more than 50 miles from the transplant facility.

- Lodging at or near the Designated Transplant Facility for the living donor, Covered Person and/or adult(s) who accompanied the Covered Person while the Covered Person is receiving transplant-related services at such Designated Transplant Facility. Lodging for purposes of this Plan does not include private residences.

Benefits shall be payable for up to one year from the date of the transplant while the Covered Person is receiving services at the Designated Transplant Facility.

Lodging reimbursement that is greater than $50 per person per day, may be subject to IRS codes for taxable income.

TRANSPLANT EXCLUSIONS AT DESIGNATED AND NON-DESIGNATED TRANSPLANT FACILITIES

In addition to the items listed in the General Exclusions section of this SPD, benefits will NOT be provided for any of the following:

- Expenses if a Covered Person donates an organ and/or tissue and the recipient is not a Covered Person under this Plan.
- Expenses for Organ and Tissue Acquisition/Procurement and storage of cord blood, stem cells or bone marrow, unless the Covered Person has been diagnosed with a condition for which there would be Approved Transplant Services.
- Expenses for any post-transplant complications of the donor, if the donor is not a Covered Person under this Plan.
- Transplants considered Experimental, Investigational or unproven.
- Solid organ transplant in patients with carcinoma unless the carcinoma is in complete remission for five (5) years or considered cured. Exceptions, which will require additional review for Clinical Eligibility for Coverage, include: diagnoses of squamous cell and basal cell carcinoma of the skin and hepatocellular carcinoma.
- Solid organ transplantation, autologous transplant (bone marrow or peripheral stem cell) or allogeneic transplant (bone marrow or peripheral stem cell), for conditions that are not considered to meet Clinical Eligibility for Coverage and/or are not appropriate, as determined by the Plan.
- Expenses related to, or for, the purchase of any organ.

PRESCRIPTION BENEFITS

Effective: 01-01-2009

The Pharmacy Benefits Administrator for this Plan is: Prescription Solutions

Note: The Medicare Prescription Drug Improvement and Modernization Act of 2003 provides all Medicare eligible individuals the opportunity to obtain Prescription Drug coverage through Medicare. Medicare eligible individuals generally must pay an additional monthly premium for this coverage. Individuals may be able to postpone enrollment in the Medicare Prescription Drug coverage if their current drug coverage is at least as good as Medicare Prescription Drug coverage. If individuals decline Medicare Prescription Drug coverage and do not have coverage at least as good as Medicare Prescription Drug coverage, they may have to pay an additional monthly penalty if they change their mind and sign up later. Medicare eligible individuals should have received a Notice informing them whether their current Prescription Drug coverage provides benefits that are at least as good as benefits provided by the Medicare Prescription Drug coverage. For a copy of this notice, please contact the Plan Administrator.

DEFINITIONS

The following terms are used for the purpose of the Prescription Benefits section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Brand Product means a brand name or trademark name which is typically the originator of the product. A brand status is determined by First Data Bank or any other industry source. Brand status may change depending on the cost of the product as issued by the manufacturer.

Contracted Amount means the discounted amount negotiated by the Pharmacy Benefits Administrator with the Plan that is providing the Prescription benefit. This amount may include applicable sales tax and pharmacy dispensing fees associated with the dispensing of any Prescription.

Generic Product means a non-Brand Product, which is a pharmaceutical equivalent to a Brand Product, but is typically sold at a lower cost. The generic status is determined by First Data Bank or any other industry source. Generic status often changes depending on the cost of the product as issued by the manufacturer.

Medical Professional means any person licensed under the laws of any state to prescribe and administer Medicines and supplies.

Medicine or Medication means a substance or preparation that alleviates or treats a sickness, disease, or Injury and may be available by Prescription only or over-the-counter (OTC). Medicine includes only substances and preparations that qualify as a medical care under the Internal Revenue Code §213. In general, medical care means care for the diagnosis, cure, mitigation, treatment or prevention of disease or for the purpose of affecting any structure or function of the body.

Non-Participating Pharmacy means any retail or mail order pharmacy that is not contracted by the Pharmacy Benefits Administrator and is excluded from the network of pharmacies.

Non-Prescription Drugs means an over-the-counter (OTC) Medication or supply, normally purchased without a Prescription and which are prepackaged for use by the consumer and labeled in accordance with the requirements and statutes and regulations of any state and the federal government.

Participating Pharmacy means any retail or mail order pharmacy that is contracted by Pharmacy Benefits Administrator to be included in a network of pharmacies at a contracted amount.

Pharmacy and Therapeutics Committee is a committee comprised of independent Physicians and pharmacists, organized by the Pharmacy Benefits Administrator that meets on a quarterly basis to review Medications and supplies.

Pharmacy Benefits Administrator is an organization that manages payment for Prescriptions and services under the Plan.

Prescription means any order authorized by a Medical Professional for a Prescription or Non-Prescription Drug, that could be a Medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the Medical Professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the Medication or supply prescribed.

Prescription Drug means licensed Medicine that is regulated by legislation to require a Prescription before it can be obtained.

Prior Authorization means if a Medical Professional believes that the Covered Person needs a Prescription product that is on the Prior Authorization List, or is not covered for other reasons he or she may contact the Pharmacy Benefits Administrator to request the Plan's review of the situation. A Medical Professional will provide the Pharmacy Benefits Administrator required information on the Covered Person's medical condition so the Plan can properly evaluate the Covered Person's need for the requested products. Upon review by a licensed pharmacist, the Pharmacy Benefits Administrator may do one of the following:

- Approve the Medical Professional's request and authorize coverage of this Medication for a certain period of time at the appropriate Co-pay.
- Recommend an alternate Medication for consideration by the Medical Professional.
- Deny the request to cover the requested Medication.

If the Prescription Medication that the Covered Person needs requires Prior Authorization but the Covered Person cannot wait for the Prior Authorization review to take place, request a drug sample from the Medical Professional. If a sample is not available, the pharmacy may provide the Covered Person with a short-term supply (such as a 5-day supply) while the Prior Authorization review is taking place. The Covered Person will be responsible for the Co-pay at this time. This Co-pay will not be credited toward this Prescription if dispensed on a later date.

PROGRAM INFORMATION

Quantity Limits means limiting the dispensing quantities applied to Medications that are appropriate for acute use. Quantity Limits are designed to provide sufficient amounts for the treatment of one or more acute episodes. Quantity Limits are established based on FDA (Food and Drug Administration) guidelines, clinical recommendations published in peer review journals, as well as manufacturer packaging and labeling instructions. Some Quantity Limits are based on the number of units per dispensing while others are specified as a per month limit. The Pharmacy and Therapeutics Committee or the Pharmacy Benefits Administrator will review and modify this list periodically as new information becomes available.

Specialty Pharmacy Program except injectable contraceptives and injectable vitamins means a program that has been determined by the Pharmacy Benefits Administrator to require reimbursement only through the approved specialty pharmacy vendor(s) at the "specialty pharmacy program" level of benefits as indicated in the Prescription Benefits Summary for Medications determined to be part of the Specialty Pharmacy Program. The Pharmacy and Therapeutics Committee or Pharmacy Benefit Administrator will review and modify the list of products included in the Specialty Pharmacy Program periodically as new information becomes available.

Effective: 01-01-2011

Retail 90 Rx means a program that allows Covered Persons to fill a three-month supply (at least 84 days) of their Prescription drug at a retail pharmacy with a reduced ingredient cost. The number of days supplied to the Covered Person will be three times the days supplied for a traditional monthly Prescription. The pharmacy network for Retail 90 Rx is a limited network and is not the full pharmacy network Prescription Solutions currently administers. Prescription drug supplies for between 35 and 83 days are not available through this program. Covered Persons must either elect to receive the traditional one-month supply or a three-month supply under Retail 90 Rx.

COVERED EXPENSES

The Plan will pay for Covered Expenses (including dispensing fees) for Prescription products Incurred by a Covered Person, in accordance with the Prescription Schedule of Benefits and at the Contracted Amount minus the Co-pays.

Expenses will not be paid for Prescription products purchased before coverage with this Plan begins, or after coverage under this Plan or this provision terminates.

COVERED BENEFITS

The following are considered Covered Benefits:

- **Prescription products which are:**
  - Necessary for the care and treatment of an Illness or Injury and are prescribed by a duly licensed Medical Professional; and
  - Can be obtained only by Prescription and are dispensed in a container labeled "Rx only"; and
  - The following Non-Prescription products prescribed by a duly licensed Medical Professional:
    - Compounded Medications of which at least one ingredient is a Prescription drug;
    - Any other Medications which due to state law may only be dispensed when prescribed by a duly licensed Medical Professional; and
    - Non-Prescription, (or over-the-counter) products determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription; and
    - In an amount not to exceed the day's supply outlined in the Prescription Schedule of Benefits.
- **Injectable insulin and the following diabetic supplies** as prescribed by a duly licensed Medical Professional:
  - Lancets, alcohol swabs, reaction treating tablets, blood glucose monitors, urine test strips, blood test strips, insulin syringes and needles and anti-diabetic products.
- **Non-combination Prescription** requiring products containing folic acid or vitamins A, D, E or K.
- **Prescription prenatal vitamins.**
- **Prescription smoking deterrent products.**

- **Contraceptive products,** which are self administered and limited to oral tablets, patches, and self-insertable vaginal devices containing contraceptive hormones, regardless of the purpose.

- **Oral medications for cosmetic management of onychomycosis.**

- **Prescription Drugs lost as a direct result of a natural disaster.** Covered Persons will be given the opportunity to prove that Prescriptions otherwise considered Covered Benefits under this Plan were lost due to a natural disaster. Acceptable proof could include, but not necessarily be limited to, proof of other filed claims of loss (homeowner's, property, etc.).

- **Mail Order Prescriptions**

  The Plan will pay for Covered Expenses Incurred by a Covered Person for Prescription products dispensed through the Mail Order pharmacy identified by the Pharmacy Benefit Administrator. Prescription products may be ordered by mail with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Benefits Summary. By law, Prescription products cannot be mailed to a Covered Person outside the United States.

- **Specialty Pharmacy Program**

  The Plan will pay for Covered Expenses Incurred by a Covered Person through the Specialty Pharmacy Program vendor identified by the Pharmacy Benefit Administrator. Prescription products included in the Specialty Pharmacy Program shall be ordered from the specialty pharmacy vendor with a Co-pay from the Covered Person for each Prescription or refill. The Co-pay is shown on the Prescription Benefits Summary.

PRESCRIPTION PRODUCT EXCLUSIONS

In addition to the items listed in the General Exclusions section in this SPD, benefits will NOT be provided for any of the following:

- Charges which are in excess of the Contracted Amount.
- Therapeutic devices or appliances, including hypodermic needles, syringes (except as stated above), support garments and other non-medical substances, without regard to their intended use.
- Immunization agents, biological sera, blood or blood plasma.
- Products labeled: "Caution-limited by federal law to Investigational use", or Experimental drugs even though a charge is made to the Covered Person. Approved Prescription products which are prescribed for Experimental or Investigational purposes or in Experimental or Investigational dosages.
- Any charge for the administration of Prescription products.
- Any Medication, Prescription or Non-Prescription, which is taken or administered at the place where it is dispensed.
- Any Medication which is meant to be taken by or administered to the Covered Person, in whole or in part, while the Covered Person is treated at a Hospital, a Physician's office or Extended Care Facility (but is instead self-administered or administered elsewhere), unless expressly designated by the Pharmacy Benefits Administrator.
- Refilling a Prescription in excess of the number specified on the Prescription or any refill dispensed after one year from the order of the Medical Professional.
- Prescription products which are not dispensed by a licensed pharmacist or Medical Professional.
- Prescription products dispensed in a foreign country if the Covered Person traveled solely for the purpose of re-importing Prescription Drugs into the United States and/or used other means to ship or bring Prescription products from a foreign country into the United States.

- Prescriptions that are cosmetic in nature, unless the Prescription is necessary to ameliorate a deformity arising from, or directly related to a congenital abnormality, a personal Injury resulting from an Accident or trauma, or disfiguring disease.
- Prescription products which may be received without charge under local, state or federal programs, including worker's compensation.
- Replacement Prescription products resulting from loss, theft, or damage, except in the case of loss due directly to a natural disaster.
- Rogaine, or any other cosmetic hair growth Prescription products.
- Prescription products, if a prior authorization – was needed but not requested; and Prescription products, if prior authorization was requested but denied.
- Anabolic steroids.
- Prescription products available over-the-counter that do not require a Prescription order by federal or state law and any Medication that is equivalent to an over-the-counter Medication unless the product is a Non-Prescription (or over-the-counter) product determined by the Pharmacy and Therapeutics Committee to be appropriate for coverage when accompanied by a Prescription.
- Anorectics or any other products used for the purpose of weight control.
- Prescription topical acne products for a Covered Person who is over age 26.
- Approved Prescription products with no approved Food and Drug Administration (FDA) indications for the purpose for which prescribed.
- Prescription products used to enhance sexual function or satisfaction.
- Infertility products, unless used to sustain a Covered Person's pregnancy.
- Prescription products that are determined by the Pharmaceutical and Therapeutics Committee to be either marginally effective and/or are excessive in cost when compared to alternative Medication for the same condition.
- Growth hormone products, unless determined by the Plan to meet the definition of a Covered Benefit.
- All illegal Medications or supplies, even if prescribed by a duly licensed Medical Professional.
- Difference in cost between a Generic Product and a Brand Product, regardless of circumstances.

The Covered Person still has a right to purchase that product, even if the requested Medication or supply is not covered, however the entire cost of the product will be the Covered Person's responsibility.

Review of Medications and Supplies by the Pharmacy and Therapeutics Committee

The Pharmacy and Therapeutics Committee may, in its professional judgment modify Medications and supplies on the Preferred Products List as follows:

- Categorize certain Non-Prescription Products (over-the-counter products) as a Covered Expense.
- Place Medications into and remove Medications from the Specialty Pharmacy Program.

Actions by the Pharmacy and Therapeutics Committee take place quarterly, as medical technology evolves, as indications, or FDA (Food and Drug Administration) guidelines change.

The Pharmacy Benefits Administrator will inform Covered Persons of the actions taken by the Pharmacy and Therapeutics Committee as appropriate, including when benefits under this Plan are affected.

Coordination of Benefits

This Plan does not coordinate Prescription Benefits.

Appeal Procedures

Refer to the Claims and Appeal section of this SPD for additional details.

FOR MORE INFORMATION ON PRESCRIPTION BENEFITS

For more information about these Prescription benefits, please call the Pharmacy Benefits Administrator at 877-559-2955, or visit the website at www. UMR.com.

VISION CARE BENEFITS

The Plan will pay for Covered Expenses for vision care Incurred by a Covered Person, subject to any required Deductible, Co-pay if applicable, Participation amount, maximums and limits shown on the Schedule of Benefits. Benefits are based on the Usual and Customary charge, maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

- Protective lenses following cataract or aphakia surgery.

EXCLUSIONS

Benefits will NOT be provided for any of the following:

- Eye exam.
- Refraction.
- Lenses.
  - Single.
  - Bifocal.
  - Trifocal.
- Frames.
- Contacts.
- Safety lenses and frames.
- Eye surgeries used to improve/correct eyesight for refractive disorders including lasik surgery, radial keratotomy, refractive keratoplasty or similar surgery.
- Sunglasses or subnormal vision aids.
- The fitting and/or dispensing of non-prescription glasses or vision devices whether or not prescribed by a Physician or optometrist.
- Vision therapy services or supplies.
- Orthoptics (eye exercise) services or supplies.
- Correction of visual acuity or refractive errors.
- Aniseikonia.

MENTAL HEALTH BENEFITS

Effective: 01-01-2011

The Plan will pay the following Covered Expenses for services authorized by a Physician and deemed to meet the Clinical Eligibility for Coverage for the treatment of a Mental Health Disorder, subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits of this SPD. Benefits are based on the Usual and Customary amount, maximum fee schedule or the Negotiated Rate.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of Mental Health Disorders. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates as a residential treatment facility providing treatment of Mental Health Disorders. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person must have the ability to accept treatment.

- The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

- The Covered Person's Mental Health Disorder must be treatable in an Inpatient facility.

- The Covered Person's Mental Health Disorder must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's Mental Health Disorder must meet diagnostic criteria established and commonly recognized by the medical community in that region.

- The attending Physician must be a psychiatrist. If the admitting Physician is not a psychiatrist, a psychiatrist must be attending to the Covered Person within 24 hours of admittance. Such psychiatrist must be United States board eligible or board certified. If outside of the United States, Inpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. The program is designed to treat patients with serious mental or nervous disorders and offers major diagnostic, psychosocial and prevocational modalities. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following:

  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A state licensed or certified Social Worker practicing within the scope of his or her license or certification.
  - Licensed Professional Counselor.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located. The attending Physician must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of Mental Health Disorders.

ADDITIONAL PROVISIONS AND BENEFITS

- A medication evaluation by a psychiatrist may be required before a Physician can prescribe medication for psychiatric conditions. Periodic evaluations may be requested by the Plan.

- Any diagnosis change after a payment denial will not be considered for benefits unless the Plan is provided with all pertinent records along with the request for change that justifies the revised diagnosis. Such records must include the history and initial assessment and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis, or, if in a foreign country, must meet diagnostic criteria established and commonly recognized by the medical community in that region.

MENTAL HEALTH EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

- Treatment or care that is not considered to meet the Clinical Eligibility for Coverage or appropriate, as determined by the Plan.

- Inpatient charges for the period of time when full, active treatment meeting the Clinical Eligibility for Coverage for the Covered Person's condition is not being provided.

- Bereavement counseling, unless specifically listed as a Covered Benefit elsewhere in this SPD.

- Services provided for conflict between the Covered Person and society which is solely related to criminal activity.

- Conditions listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories:

  - Organic psychotic disorders; or
  - Personality disorders; or
  - Sexual/gender identity disorders; or
  - Behavior and impulse control disorders; or
  - "V" codes (including marriage counseling).

- Services for biofeedback.

SUBSTANCE ABUSE AND CHEMICAL DEPENDENCY BENEFITS

Effective: 01-01-2011

The Plan will pay the following Covered Expenses for a Covered Person subject to any Deductibles, Co-pays if applicable, Participation amounts, maximum or limits shown on the Schedule of Benefits. Benefits are based on the maximum fee schedule, Usual and Customary amount or the Negotiated Rate as applicable.

COVERED BENEFITS

Inpatient Services are payable subject to all of the following:

- The Hospital or facility must be accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or other recognized accrediting body or licensed by the state as an acute care psychiatric, chemical dependency or dual diagnosis facility for the treatment of substance abuse and chemical dependency. If outside of the United States, the Hospital or facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- This Plan also covers services provided at a residential treatment facility that is licensed by the state in which it operates as a residential treatment facility providing treatment of substance abuse and chemical dependency disorders. This does not include services provided at a group home. If outside of the United States, the residential treatment facility must be licensed or approved by the foreign government or an accreditation or licensing body working in that foreign country.

- The Covered Person must have the ability to accept treatment.

- The Covered Person must be ill to such an extent that they are rendered dysfunctional and require the intensity of an Inpatient setting for treatment. Without such Inpatient treatment, the Covered Person's condition would deteriorate.

- The Covered Person's condition must be treatable in an Inpatient facility.

- The Covered Person's condition must meet diagnostic criteria as described in the most recent edition of the American Psychiatric Association Diagnostic and Statistical Manual (DSM). If outside of the United States, the Covered Person's condition must meet diagnostic criteria established and commonly recognized by the psychiatric community in that region.

Day Treatment (Partial Hospitalization) means a day treatment program that offers intensive, multidisciplinary services not otherwise offered in an Outpatient setting. The treatment program is generally a minimum of 20 hours of scheduled programming extended over a minimum of five days per week. Such programs must be a less restrictive alternative to Inpatient treatment.

Outpatient Services are payable subject to all of the following:

- Must be in person at a therapeutic medical facility; and

- Include measurable goals and continued progress toward functional behavior and termination of treatment. Continued coverage may be denied when positive response to treatment is not evident; and

- Must be provided by one of the following:

  - A United States board eligible or board certified psychiatrist licensed in the state where the treatment is provided.
  - If outside of the United States, Outpatient Services must be provided by an individual who has received a diploma from a medical school recognized by the government agency in the country where the medical school is located, or a therapist with a Ph.D., or master's degree that denotes a specialty in psychiatry. The attending Physician, psychiatrist, or a counselor must meet the requirements, if any, set out by the foreign government or regionally recognized licensing body for treatment of substance abuse and chemical dependency disorders.
  - A therapist with a Ph.D. or master's degree that denotes a specialty in psychiatry (Psy.D.).
  - A state licensed psychologist.
  - A certified addiction counselor.
  - A state licensed or certified social worker practicing within the scope of his or her license or certification.

ADDITIONAL PROVISIONS AND BENEFITS

- Any claim re-submitted on the basis of a change in diagnosis after a benefit denial will not be considered for benefits unless the Plan is provided with all records along with the request for change. Such records must include: the history, initial assessment and all counseling or therapy notes, and must reflect the criteria listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) for the new diagnosis.

- Services, treatment or supplies related to addiction to or dependency on nicotine.

SUBSTANCE ABUSE EXCLUSIONS

In addition to the items listed in the General Exclusions section, benefits will NOT be provided for any of the following:

The Plan will not pay for:

- Treatment or care considered inappropriate or substandard as determined by the Plan.

- Inpatient charges for the period of time when full, active treatment meeting the Clinical Eligibility for Coverage for the Covered Person's condition is not being provided.

UTILIZATION MANAGEMENT
And Other Medical Management Services

Effective: 01-01-2009

Utilization Management is the process of evaluating whether services, supplies or treatment meet Clinical Eligibility for Coverage and are appropriate to help ensure cost-effective care. Utilization Management can eliminate unnecessary services, shorten Hospital stays, improve the quality of care, and reduce costs to the Covered Person and the Plan. The Utilization Management procedures include certain Notification requirements.

The benefit amounts payable under the Schedule of Benefits of this SPD may be affected if the requirements described for Utilization Management are not satisfied. Covered Persons should call the phone number on the back of the Plan identification card to request Notification at least two weeks prior to a scheduled procedure in order to allow for fact gathering and independent medical review, if necessary.

Special Notes: The Covered Person will not be penalized for failure to obtain Notification if a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would jeopardize the life or long-term health of the individual. However, Covered Persons who received care on this basis must contact the Utilization Review Organization (see below) as soon as possible within 24 hours of the first business day after receiving care or Hospital admittance. The Utilization Review Organization will then review services provided within 48 hours of being contacted.

This Plan complies with the Newborns and Mothers Health Protection Act. The Notification requirement is not required for Hospital or Birthing Center stays of 48 hours or less following a normal vaginal delivery or 96 hours or less following a Cesarean section. Notification may be required for stays beyond 48 hours following a vaginal delivery or 96 hours following a Cesarean section.

UTILIZATION REVIEW ORGANIZATION

The Utilization Review Organization is: **UMR CARE MANAGEMENT**

DEFINITIONS

The following terms are used for the purpose of the Utilization Management section of this SPD. Refer to the Glossary of Terms section of this SPD for additional definitions.

Notified or Notification means a determination by the Utilization Review Organization on behalf of the Plan, with respect to whether a service, treatment, supply or facility is the most appropriate and cost-effective treatment for the care and treatment of an Illness or Injury and meets Clinical Eligibility for Coverage.

Utilization Management means an assessment of the facility in which the treatment is being provided. It also includes a formal assessment of the effectiveness and appropriateness of health care services and treatment plans. Such assessment can be conducted on a prospective basis (prior to treatment), concurrent basis (during treatment), or retrospective basis (following treatment).

Effective: 01-01-2011

SERVICES REQUIRING NOTIFICATION

Call the Utilization Review Organization **before** receiving services for the following:

- Inpatient stay in a Hospital or Extended Care Facility.
- Organ and tissue transplants.
- Home Health Care.
- Durable Medical Equipment over $1500 or any Durable Medical Equipment rentals over $500/month.
- Prosthetics over $1,000.
- All Inpatient stays and Day Treatment (Partial Hospitalization) for Mental Health Disorders, substance abuse and chemical dependency and residential treatment facility.
- Inpatient stay in a Hospital or Birthing Center that is longer than 48 hours following a normal vaginal delivery or 96 hours following a Cesarean section.

Note that if a Covered Person receives Notification for one facility, but then the person is transferred to another facility, Notification is also needed before going to the new facility, except in the case of an Emergency (see Special Notes above).

The phone number to call for Notification is listed on the back of the Plan identification card.

Even though a Covered Person provides Notification to the Utilization Review Organization, that does not guarantee that this Plan will pay for the medical care. The Covered Person still needs to be eligible for coverage on the date services are provided. Coverage is also subject to all of the provisions described in this SPD.

Medical Director Oversight. A UMR Care Management medical director oversees the concurrent review process. Should a case have unique circumstances that raise questions for the Utilization Management specialist handling the case, the medical director will review the case to determine medical appropriateness using evidence-based clinical criteria.

Case Management Referrals. During the Notification review process, cases are analyzed for a number of criteria used to trigger case to case management for review. These triggers include ICD-9 diagnosis codes, CPT codes, length-of-stay criteria and claims dollar thresholds, as well as specific criteria requested by the Plan Administrator. Information is easily passed from Utilization Management to case management through our fully-integrated care management software system.

All Notification requests are used to identify the member's needs. Our goal is to intervene in the process as early as possible to determine the resources necessary to deliver clinical care in the most appropriate care setting.

Retrospective Review. Retrospective review is conducted by Plan Administrator request as long as the request is received within 30 days of the original determination. Retrospective reviews are performed according to our standard Notification policies and procedures.

Other Medical Management Services

Maternity Management provides prenatal education and high-risk pregnancy identification to help mothers carry their babies to term. This program increases the number of healthy, full term deliveries and decreases the cost of a long term hospital stay for both the mother and/or baby. Program members are contacted via telephone at least once each trimester and once postpartum. A comprehensive assessment to determine the member's risk level and educational need is done at that time. To increase participation, the program uses incentives to participate. The standard incentive is a gift card. Covered Persons who enroll via the web receive a special edition pregnancy information guide. UMR's pre-pregnancy coaching program helps women learn about risks and take action to prevent serious and costly medical complications before they become pregnant. Women with pre-existing health conditions, such as diabetes and high blood pressure, not only face risks to their babies, but also to themselves while they're pregnant. Members self-enroll in the pre-pregnancy coaching program by calling our toll-free number. They are then contacted by a nurse case manager who has extensive clinical background in obstetrics/gynecology. The nurse completes a pre-pregnancy assessment to determine risk level, if any, and provides them with education and materials based on their needs. The nurse also helps members understand their Plan's benefit information.

Case Management Services are designed to identify catastrophic and complex Illnesses, transplants and trauma cases. UMR Care Management's case management specialists identify, coordinate and negotiate rates for out-of-network services (where appropriate and allowed under the Plan) and help manage related costs by finding alternatives to costly Inpatient stays. Opportunities are identified from the Notification review process, national criteria and system flags based on ICD-9 diagnosis, CPT procedure code and potential high dollar claim criteria. UMR Care Management works directly with the patient, family members, treating Physician and facility to mobilize appropriate resources for the Covered Person's care. Our philosophy is that quality care from the beginning of the serious Illness helps avoid major complications in the future. The Covered Person can request that the Plan provide services and the Plan may also contact the Covered Person if the Plan believes case management services may be beneficial.

NurseLine service is a 24/7 health information line that assists Covered Persons with medical-related questions and concerns. NurseLine gives Covered Persons access to highly trained registered nurses so they can receive guidance and support when making decisions about their health and/or the health of their Dependents.

COORDINATION OF BENEFITS

Effective: 01-01-2011

Coordination of Benefits (COB) applies whenever a Covered Person has health coverage under more than one Plan, as defined below. The purpose of coordinating benefits is to help Covered Persons pay for Covered Expenses, but not to result in total benefits that are greater than the Covered Expenses Incurred.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount which will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays or Participation amounts, if any, will be applied before benefits are paid on the balance.

The Plan will coordinate benefits with the following types of medical or dental plans:

- Group health plans, whether insured or self-insured.
- Hospital indemnity benefits in excess of $200 per day.
- Specified disease policies.
- Foreign health care coverage.
- Medical care components of group long-term care contracts such as skilled nursing care.
- Medical benefits under group or individual automobile policies. See order of benefit determination rules and General Exclusions: No-Fault State for details (below).
- Medical benefits under homeowner's insurance policies.
- Medicare or other governmental benefits, as permitted by law. This does not include Medicaid.

Each contract for coverage is considered a separate plan. If a plan has two parts and COB rules apply to only one of the two parts, each of the parts is treated as a separate plan.

ORDER OF BENEFIT DETERMINATION RULES

The first of the following rules that apply to a Covered Person's situation is the rule to use:

- The plan that has no coordination of benefits provision is considered primary.

- When medical payments are available under motor vehicle insurance (including No-Fault policies), this Plan shall always be considered secondary regardless of the individual's election under PIP (Personal Injury Protection) coverage with the auto carrier. See General Exclusions – No-Fault State in this SPD for more details.

- The plan that covers the person as an Employee, member or subscriber (that is, other than as a Dependent) is considered primary. This Plan will deem any Employee plan beneficiary to be eligible for primary benefits from their employer's benefit plan. Employee plan beneficiaries do not include COBRA Qualified Beneficiaries or Retirees.

- The plan that covers a person as a Dependent (or beneficiary under ERISA) is secondary, unless both plans agree that COBRA or state continuation coverage should always pay secondary when the person who elected COBRA is covered by another plan as a Dependent. In that case the plan that covers a person as a Dependent is primary (see continuation coverage below). (Also see the section on Medicare, below, for exceptions).

- When an individual is covered under a spouse's Plan and also under his or her parent's plan, the Primary Plan is the plan of the individual's spouse. The plan of the individual's parent(s) is the Secondary Plan.

- If one or more plans cover the same person as a Dependent Child:

  - The Primary Plan is the plan of the parent whose birthday is earlier in the year if:

    - The parents are married; or
    - The parents are not separated (whether or not they have been married); or
    - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage; or
    - If both parents have the same birthday, the plan that covered either of the parents longer is primary.

  - If the specific terms of a court decree state that one of the parents is responsible for the Child's health care expenses or health care coverage and the plan of that parent has actual knowledge of those terms, that plan is primary.

  - If the parents are not married and reside separately, or are divorced or legally separated, the order of benefits is:

    - The plan of the custodial parent;
    - The plan of the spouse of the custodial parent;
    - The plan of the non-custodial parent; and then
    - The plan of the spouse of the non-custodial parent.

- Active or Inactive Employee: If an individual is covered under one plan as an active employee (or Dependent of an active employee), and is also covered under another plan as a retired or laid off employee (or Dependent of a retired or laid off employee), the plan that covers the person as an active employee (or Dependent of an active employee) will be primary.

- Continuation coverage under COBRA or state law: If a person has elected continuation of coverage under COBRA or state law and also has coverage under another plan, the continuation coverage is secondary. This is true even if the person is enrolled in another plan as a Dependent. If the two plans do not agree on the order of benefits, this rule is ignored. (See exception in the Medicare section.)

- Longer or Shorter Length of Coverage: The plan that covered the person as an employee, member, subscriber or retiree longer is primary.

- If an active Employee is on leave due to active duty in the military in excess of 30 days, the plan that covers the person as an active Employee, member or subscriber is considered primary.

- If the above rules do not determine the Primary Plan, the Covered Expenses can be shared equally between the plans. This Plan will not pay more than it would have paid, had it been primary.

MEDICARE

If You or Your covered spouse or Dependent is also receiving benefits under Medicare, including Medicare Prescription drug coverage, federal law may require this Plan to be primary over Medicare. When this Plan is not primary, the Plan will coordinate benefits with Medicare.

The order of benefit determination rules determine which plan will pay first (Primary Plan). The Primary Plan pays without regard to the possibility that another Plan may cover some expenses. A Secondary Plan pays for Covered Expenses after the Primary Plan has processed the claim. The balance remaining after the Primary Plan's payment, not to exceed the Covered Person's responsibility, is the amount which will be used in determining the benefits payable under the Secondary Plan. The Deductible, Co-pays or Participation amounts, if any, will be applied before benefits are paid on the balance.

When this Plan is not Primary and a Covered Person is receiving Part A Medicare but has chosen not to elect Part B, this Plan will reduce its payments on Part B services as though Part B Medicare was actually in effect.

ORDER OF BENEFIT DETERMINATION RULES FOR MEDICARE

This Plan complies with the Medicare Secondary Payer regulations. Examples of these regulations are as follows:

- This Plan generally has primary responsibility to pay claims before Medicare under the following circumstances:
  - You continue to be actively employed by the employer and You or Your covered spouse becomes eligible for and enrolls in Medicare because of age or disability.
  - You continue to be actively employed by the employer, Your covered spouse becomes eligible for and enrolls in Medicare, and is also covered under a retiree plan through Your spouse's former employer. In this case, this Plan will be primary for You and Your covered spouse, Medicare pays second, and the retiree plan would pay last.
  - For a Covered Person with End-Stage Renal Disease (ESRD), this Plan usually has primary responsibility for the claims of a Covered Person for 30 months from the date of Medicare eligibility based on ESRD. The 30-month period can also include COBRA continuation coverage or another source of coverage. At the end of the 30 months, Medicare becomes the primary payer.
- Medicare generally pays first (has primary responsibility) under the following circumstances:
  - You are no longer actively employed by an employer; and
  - You or Your spouse has Medicare coverage due to Your age, plus You also have COBRA continuation coverage through the Plan; or
  - You or a covered family member has Medicare coverage based on a disability, plus You also have COBRA continuation coverage through the Plan. Medicare normally pays first, however an exception is that COBRA may pay first for Covered Persons with End-Stage Renal Disease until the end of the 30-month period; or
  - You or Your covered spouse have coverage under a retiree plan plus Medicare coverage; or
  - Upon completion of 30 months of Medicare eligibility for an individual with ESRD, Medicare becomes the primary payer. (Note that if a person with ESRD was eligible for Medicare based on age or other disability ***before*** being diagnosed with ESRD and Medicare was previously paying primary, then the person can continue to receive Medicare benefits on a primary basis).
- Medicare is the secondary payer when no-fault insurance, worker's compensation, or liability insurance is available as primary payer.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Plan may obtain the information it needs from or provide such information to other organizations or persons for the purpose of applying those rules and determining benefits payable under this Plan and other plans covering the person claiming benefits. The Plan need not tell, or obtain the consent of, any person to do this. Each person claiming benefits under this Plan must provide the Plan any information it needs to apply those rules and determine benefits payable.

REIMBURSEMENT TO THIRD PARTY ORGANIZATION

A payment made under another plan may include an amount which should have been paid under this Plan. If it does, the Plan may pay that amount to the organization which made that payment. That amount will then be treated as though it were a benefit paid under this Plan. The Plan will not have to pay that amount again.

RIGHT OF RECOVERY

If the amount of the payments made by the Plan is more than it should have paid under this COB provision, the Plan may recover the excess from one or more of the persons it paid or for whom the Plan has paid; or any other person or organization that may be responsible for the benefits or services provided for the Covered Person.

RIGHT OF SUBROGATION, THIRD PARTY LIABILITY AND ASSIGNMENT OF RIGHTS

You, the Covered Person, are being provided benefits pursuant to the Plan implemented by Your employer. This Plan is designed to cover You and Your Dependent(s) with health benefits. This Plan is not intended to serve as a supplement to, or replacement for, any benefits You may recover from any Other Party with respect to any charges Incurred with respect to an Accident, Illness, Injury or other medical condition caused by an act or omission of said Other Party.

For purposes of this section, **Other Party** is defined to include, but is not limited to, the following:

- The party or parties that caused the Accident, Illness, Injury or other medical condition;
- The insurer or other indemnifier of the party or parties who caused the Accident, Illness, Injury or other medical condition;
- The Covered Person's own insurer including, but not limited to, uninsured motorist, underinsured motorist, medical payment or no-fault insurers;
- A worker's compensation or school insurer;
- Any other person, entity, policy or plan that is liable or legally responsible to make payments in relation to the Accident, Illness, Injury or other medical condition.

This section is applicable when a Covered Person and/or his or her Dependent(s) have Incurred charges for an Accident, Illness, Injury or other medical condition for an act or omission of any Other Party which gives the Covered Person and/or his or her Dependent(s) the legal right to seek restitution from such Other Party. In such cases, no benefits shall be due and all claims submitted thereon shall be denied under this Plan unless You, the Covered Person, agree to the following:

- That the Covered Person, or their legal representative, shall notify the Plan of any claim or potential claim the Covered Person and/or their Dependent(s) have against any Other Party within 30 days of the act which gives rise to such claim. That, if requested, the Covered Person or his or her Dependent(s) or legal representative shall supply the Plan with any information that is reasonably necessary to protect the Plan's subrogation interests.

- If such act also results in payments being made under the Plan, that neither the Covered Person nor their Dependent(s) do anything that would prejudice the Plan's rights to recover payments.

- That, if requested, the Covered Person shall enter into a written agreement which shall expressly assign any payments made to them or their Dependent by any Other Party to the Plan, and which shall require them to direct their attorney (and other representatives) in writing to retain separately from any judgment, settlement or otherwise that the attorney or representative receive on the Covered Person's behalf an amount of money sufficient to reimburse the Plan as required by such agreement and to pay such money to the Plan. In the event the Covered Person does not sign or refuses to sign such an agreement, the Plan has no obligation to make any payment for any treatment required as a result of the act or omission of any Other Party. The form of the agreement issued by the Plan for this purpose is expressly incorporated in this Plan and will be provided to the Covered Person at anytime upon request.

- That the Plan is subrogated to all rights they may have, and acknowledge that the Plan will have a first priority lien and right of recovery, on any sum of money received from any Other Party, whether the recovery is by settlement, judgment, mediation, arbitration, or other means.

- That the Plan has a right to recover, either through subrogation, reimbursement or other appropriate equitable relief, the following:

  - Any payments, from the first dollar, that the Covered Person or any other person or organization on behalf of the Covered Person is entitled to receive as a result of the Accident, Illness, Injury or other medical condition, to the full extent of benefits paid or provided by the Plan; and
  - Any overpayments made directly to providers on behalf of the Covered Person for the Accident, Illness, Injury or other medical condition.

- That the Plan's right of recovery shall be in first priority, to the full extent of any and all benefits paid under the Plan, and will not be reduced due to the Covered Person's own negligence or due to the Covered Person not being made whole.

- That the Covered Person shall be solely responsible for all expenses of recovery from any Other Party, including but not limited to all attorney's fees and costs, which amounts will not reduce the amount of reimbursement payable to the Plan under the operation of any common fund doctrines.

- That the Plan will not pay any fees or costs associated with any claim or lawsuit without the Plan's express written consent in advance.

- That the Covered Person or their legal representative or guardian, shall be considered a constructive trustee with respect to any money received from any Other Party in consideration of an Accident, Illness, Injury or other medical condition for which they have received benefits, and that any such funds will be held separate by said trustee until the Plan's lien is addressed.

- The Plan's rights to recovery apply to the Covered Person, to the spouse and Dependent(s) of a Covered Person, COBRA beneficiaries, and any other person who may recover on behalf of a participant, including the Covered Person's estate.

- That the Plan reserves the right to independently pursue and recover paid benefits.

If the Plan has already made payments or provided benefits to You for charges Incurred as a result of an Accident, Illness, Injury or other medical condition for which any Other Party may be liable and You fail to comply with the requirements set forth above, the Plan may reduce future benefits otherwise payable under the Plan for *any* Illness, Injury or medical condition by the amounts recovered by You or Your Dependent(s) from the Other Party.

GENERAL EXCLUSIONS

Effective: 01-01-2010

Exclusions, including complications from excluded items are not considered Covered Benefits under this Plan and will not be considered for payment as determined by the Plan.

The Plan does not pay for Expenses Incurred for the following, unless otherwise stated below. The Plan does not apply exclusions based upon the source of the Injury or Illness to treatment listed in the Covered Medical Benefits section when the Plan has information that the Illness or Injury is due to a medical condition (including both physical and mental health conditions) or domestic violence.

1. **Abortions:** Unless a Physician states in writing that:
   - The mother's life would be in danger if the fetus were to be carried to term, or
   - Abortion is medically indicated due to complications with the pregnancy, or
   - Pregnancy due to rape or incest.

2. **Acts of War:** Injury or Illness caused or contributed to by international armed conflict, hostile acts of foreign enemies, invasion, or war or acts of war, whether declared or undeclared.

3. **Acupuncture Treatment,** except when it is performed by a Physician as a form of anesthesia for a covered surgical procedure.

4. **Alternative/Complimentary Treatment** includes: Treatment, services or supplies for holistic or homeopathic medicine, hypnosis, or other alternate treatment that is not accepted medical practice as determined by the Plan.

5. **Appointments Missed:** An appointment the Covered Person did not attend.

6. **Aquatic Therapy** unless provided by a Qualified physical therapist.

7. **Assistance With Activities of Daily Living.**

8. **Assistant Surgeon Services,** unless determined to meet the Clinical Eligibility for Coverage by the Plan.

9. **Augmentation Communication Devices** and related instruction or therapy.

10. **Before Enrollment and After Termination:** Services, supplies or treatment rendered before coverage begins under this Plan, or after coverage ends, are not covered.

11. **Bereavement Counseling.**

12. **Biofeedback Services**.

13. **Blood:** Blood donor expenses.

14. **Blood Pressure Cuffs / Monitors.**

15. **Breast Reductions.**

16. **Cardiac Rehabilitation** beyond Phase II including self-regulated physical activity that the Covered Person performs to maintain health that is not considered to be a treatment program.

17. **Chelation Therapy**, except in the treatment of conditions considered to meet the Clinical Eligibility for Coverage, medically appropriate and not Experimental or Investigational for the medical condition for which the treatment is recognized.

18. **Claims** received later than 12 months from the date of service.

19. **Contraceptive Products** (including injectables) unless covered elsewhere in this document.

20. **Cosmetic Treatment**, **Cosmetic Surgery,** or any portion thereof, unless the procedure is otherwise listed as a Covered Benefit.

21. **Cost** of materials used in any occupational therapy.

22. **Counseling Services** in connection with financial, marriage, family, child, career, social adjustment, and pastoral counseling.

23. **Court-Ordered:** Any treatment or therapy which is court-ordered, ordered as a condition of parole, probation, or custody or visitation evaluation, unless such treatment or therapy is normally covered by this Plan. This Plan does not cover the cost of classes ordered after a driving while intoxicated conviction or other classes ordered by the court.

24. **Criminal Activity:** Expenses resulting from or occurring during the commission of a felonious act, serious illegal act, participating in a riot or public disturbance, or aggravated assault by the Covered Person, or while the Covered Person is engaged in an illegal occupation. For purposed of the exclusion, the terms “felonious act” or “serious illegal act” shall mean any act or series of acts that, if prosecuted as a criminal offense, a sentence to a term of imprisonment in excess of one year could be imposed. It is not necessary that criminal charges be filed, or, if filed, that a conviction result, or that a sentence of imprisonment for a term in excess of one year be imposed for this exclusion to apply. Proof beyond a reasonable doubt is not required. This exclusion does not apply if the Injury or Illness resulted from an act of domestic violence or a medical (including both physical and mental health) condition.

25. **Custodial Care** as defined in the Glossary of Terms of this SPD.

26. **Dental Services:**

    - The care and treatment of teeth, gums or alveolar process or for dentures, appliances or supplies used in such care or treatment, or drugs prescribed in connection with dental care. This exclusion does not apply to Hospital charges including professional charges for x-ray, lab and anesthesia, or for charges for treatment of injuries to natural teeth, including replacement of such teeth with dentures, or for setting of a jaw which was fractured or dislocated in an Accident.
    - Injuries or damage to teeth, natural or otherwise, as a result of or caused by the chewing of food or similar substances.
    - Dental implants including preparation for implants.

27. **Duplicate Services and Charges or Inappropriate Billing** including the preparation of medical reports and itemized bills.

28. **Education:** Charges for education, special education, job training, music therapy and recreational therapy, whether or not given in a facility providing medical or psychiatric care.

29. **Environmental Devices:** Environmental items such as but not limited to, air conditioners, air purifiers, humidifiers, dehumidifiers, furnace filters, heaters, vaporizers, or vacuum devices.

30. **Examinations:** Examinations for employment, insurance, licensing or litigation purposes.

31. **Excess Charges:** Charges or the portion thereof which are in excess of the Usual and Customary charge, the Negotiated Rate or fee schedule.

32. **Experimental or Investigational:** Services, supplies, medicines, treatment, facilities or equipment which the Plan determines are Experimental or Investigational.

33. **Extended Care:** Any Extended Care Facility Services which exceed the appropriate level of skill required for treatment as determined by the Plan.

34. **Family Planning:** Consultation for family planning.

35. **Fitness Programs:** General fitness programs, exercise programs, exercise equipment and health club memberships, or other utilization of services, supplies, equipment or facilities in connection with weight control or body building.

36. **Foot Care (Podiatry):** Routine foot care.

37. **Hazardous Hobby:** Care and treatment of an Injury of Illness that results from engaging in a hazardous hobby or activity, except if the Injuries resulted from a medical condition, including a mental/nervous disorder. A hobby or activity is hazardous if it is an unusual activity that is characterized by a constant or increased threat of danger or risk of bodily harm. Examples of hazardous hobbies or activities include but are not limited to participation in: Any kind of organized vehicular motorized speed or endurance contest in the air, on land or water; skydiving; X-games or similar extreme-type competitive events, such as snowboarding, skateboarding, street luge, etc.; mountain climbing, where ropes or guides are customarily used; professional sporting events; hang gliding; unteathered rock climbing; bungee jumping; stunt driving; water or snow ski-jumping, aerobatics contests or demonstrations, and; experimental or ultra light aircraft flying.

38. **Hearing Deficit Services:**

    - Purchase or fitting of hearing aids.
    - Implantable hearing devices.

39. **Home Births** and associated costs.

40. **Home Modifications:** Modifications to Your home or property such as but not limited to, escalator(s), elevators, saunas, steambaths, pools, hot tubs, whirlpools, or tanning equipment, wheelchair lifts, stair lifts or ramps.

41. **Infant Formula** administered through a tube as the sole source of nutrition for the Covered Person.

42. **Infertility Services:**

    - Charges for diagnostic services. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.
    - Fertility tests.
    - Tests and exams done to prepare for induced conception.
    - Surgical reversal of a sterilized state which was a result of a previous surgery.
    - Sperm enhancement procedures.
    - Direct attempts to cause pregnancy by any means including, but not limited to hormone therapy or drugs.
    - Artificial insemination, In vitro fertilization, Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT).
    - Embryo transfer.
    - Freezing or storage of embryo, eggs, or semen.
    - Drugs.

43. **Lamaze Classes** or other Child birth classes.

44. **Learning Disability:** Special education, remedial reading, school system testing and other rehabilitation treatment for a Learning Disability. If another medical condition is identified through the course of diagnostic testing, any coverage of that condition will be subject to Plan provisions.

45. **Liposuction** regardless of purpose.

46. **Maintenance Therapy:** Such services are excluded if, based on medical evidence, treatment or continued treatment could not be expected to resolve or improve the condition, or that clinical evidence indicates that a plateau has been reached in terms of improvement from such services.

47. **Mammoplasty or Breast Augmentation** unless covered elsewhere in this document.

48. **Massage Therapy**.

49. **Military:** A Military related Illness or Injury to a Covered Person on active military duty.

50. **Nocturnal Enuresis Alarm** (Bed wetting).

51. **Non-Custom-Molded Shoe Inserts**.

52. **Non-Professional Care:** Medical or surgical care that is not performed according to generally accepted professional standards.

53. **Not Determined to Meet the Clinical Eligibility For Coverage:** Services, supplies, treatment, facilities or equipment which the Plan determines do not meet the guidelines for Clinical Eligibility for Coverage.

54. **Nursery and Newborn Expenses** for grandchildren of a covered Employee or spouse.

55. **Nutrition Counseling** unless covered elsewhere in this SPD.

56. **Nutritional Supplements:** All enteral feedings, supplemental feedings, over-the-counter electrolyte supplements and related supplies including feeding tubes, pumps, bags and products.

57. **Orthognathic, Prognathic and Maxillofacial Surgery.**

58. **Over-the-Counter Medication, Products, Supplies or Devices** unless covered elsewhere in this SPD.

59. **Panniculectomy/Abdominoplasty** unless determined by the Plan to meet Clinical Eligibility for Coverage.

60. **Personal Comfort:** Services or supplies for personal comfort or convenience, such as but not limited to private room, television, telephone and guest trays.

61. **Reconstructive Surgery** performed only to achieve a normal or nearly normal appearance, or any portion thereof, as determined by the Plan, unless covered elsewhere in this SPD.

62. **Recreation or diversional therapy.**

63. **Return to Work/School:** Telephone or Internet consultations or completion of claim forms or forms necessary for the return to work or school.

64. **Reversal of Sterilization:** Procedures or treatments to reverse prior voluntary sterilization.

65. **Room and Board Fees** when surgery is performed other than at a Hospital or Surgical Center.

66. **Self-Administered Services** or procedures that can be done by the Covered Person without the presence of medical supervision.

67. **Self-Inflicted** unless due to a medical condition (physical or mental) or domestic violence.

68. **Services at no Charge or Cost:** Services which the Covered Person would not be obligated to pay in the absence of this Plan or which are available to the Covered Person at no cost, or which the Plan has no legal obligation to pay, except for care provided in a facility of the uniformed services as per Title 32 of the National Defense code, or as required by law.

69. **Services** that should legally be provided by a school.

70. **Services Provided by a Close Relative.** See Glossary of Terms of this SPD for definition of Close Relative.

71. **Sex Therapy** for dysfunction or inadequacy**.**

72. **Sexual Function:** Diagnostic Services, non-surgical and surgical procedures and Prescription drugs (unless covered under the Prescription Benefits Section in this SPD) in connection with treatment for male or female impotence.

73. **Sex Transformation:** Treatment, drugs, medicines, services and supplies for, or leading to, sex transformation surgery.

74. **Surrogate Motherhood or Gestational Carrier Services** including any services or supplies provided in connection with a surrogate pregnancy and maternity charges Incurred by a Covered Person acting as a surrogate mother.

75. **Telemedicine, Telephone or Internet Consultations.**

76. **Third Party Liabilities:** Any Covered Expenses to the extent of any amount received from others for the bodily injuries or losses which necessitate such benefits. "Amounts received from others" specifically include, without limitation, liability insurance, worker's compensation, uninsured motorists, underinsured motorists, "no-fault" and automobile medical payments, and homeowner's insurance.

77. **Transportation:** Transportation services which are solely for the convenience of the Covered Person, the Covered Person's Close Relative, or the Covered Person's Physician.

78. **Travel:** Travel costs, whether or not recommended or prescribed by a Physician, unless authorized in advance by the Plan.

79. **Vision Care** unless covered elsewhere in this SPD. (Refer to the Vision Care Benefits section of this SPD).

80. **Vitamins, Minerals and Supplements,** even if prescribed by a Physician, except for Vitamin B-12 injections and IV iron therapy that are prescribed by a Physician and meet Clinical Eligibility for Coverage.

81. **Vocational Services:** Vocational and educational services rendered primarily for training or education purposes. This Plan also excludes work hardening, work conditioning and industrial rehabilitation services rendered for Injury prevention education or return-to-work programs.

82. **Weekend Admissions** to Hospital confinement (admission taking place after 3:00 p.m. on Friday or before noon on Sunday) are not eligible for reimbursement under the Plan, unless the admission is deemed an Emergency.

83. **Weight Control:** Treatment, services or surgery for weight control**,** whether or not prescribed by a Physician or associated with an Illness.

84. **Wigs, Toupees, Hairpieces, Hair Implants or Transplants or Hair Weaving,** or any similar item for replacement of hair regardless of the cause of hair loss unless covered elsewhere in this SPD.

85. **Worker's Compensation:** An Illness or Injury arising out of or in the course of any employment for wage or profit, including self-employment, for which the Covered Person was or could have been entitled to benefits under any Worker's Compensation, U.S. Longshoremen and Harbor Worker's or other occupational disease legislation, policy or contract, whether or not such policy or contract is actually in force.

The Plan does not limit a Covered Person's right to choose his or her own medical care. If a medical expense is not a Covered Benefit, or is subject to a limitation or exclusion, a Covered Person still has the right and privilege to receive such medical service or supply at the Covered Person's own personal expense.

CLAIMS AND APPEAL PROCEDURES

Effective: 01-01-2011

REASONABLE AND CONSISTENT CLAIMS PROCEDURES

The Plan's claims procedures include administrative safeguards and processes that are designed to ensure and verify that benefit claims determinations are made in accordance with the Plan documents. The Plan provisions will be applied consistently with respect to similarly situated individuals. UMR will normally send payment for Covered Expenses directly to the Covered Person's provider.

TYPE OF CLAIMS AND DEFINITIONS

- **Pre-Service Claim needing notification as required by the Plan and stated in this SPD.** This is a claim for a benefit where the Covered Person is required to get approval from the Plan ***before*** obtaining the medical care such as in the case of notification of health care items or service that the Plan requires. If a Covered Person or provider calls the Plan just to find out if a claim will be covered, that is not a Pre-Service Claim, unless the Plan and this SPD specifically require the person to call for notification. Giving notification does not guarantee that the Plan will ultimately pay the claim.

  Note that this Plan does not require notification for urgent or Emergency care claims, however Covered Persons may be required to notify the Plan following stabilization. Please refer to the Utilization Management section of this SPD for more details. A condition is considered to be an urgent or Emergency care situation when a sudden and serious condition such that a Prudent Layperson could expect the patient's life would be jeopardized, the patient would suffer severe pain, or serious impairment of his or her bodily functions would result unless immediate medical care is rendered. Examples of an urgent or Emergency care situation may include, but are not limited to: chest pain; hemorrhaging; syncope; fever equal to or greater than 103° F; presence of a foreign body in the throat, eye, or internal cavity; or a severe allergic reaction.

- **Post-Service Claim** means a claim that involves payment for the cost of health care that has already been provided.

- **Concurrent Care Claim** means that an ongoing course of treatment to be provided over a period of time or for a specified number of treatments has been approved by the Plan.

AUTHORIZED REPRESENTATIVE

Authorized Representative means a person (or provider) who can contact the Plan on the Covered Person's behalf to help with claims, appeals or other benefit issues. Minor Dependents must have the signature of a parent or Legal Guardian in order to appoint a third party as an Authorized Representative.

If a Covered Person chooses to use an Authorized Representative, the Covered Person must submit a written letter to the Plan stating the following: The name of the Authorized Representative, the date and duration of the appointment and any other pertinent information. In addition, the Covered Person must agree to grant their Authorized Representative access to their Protected Health Information. This letter must be signed by the Covered Person to be considered official.

Effective: 01-01-2011

PROCEDURES FOR SUBMITTING CLAIMS

Most providers will coordinate payment directly with the Plan on the Covered Person's behalf. If the provider will not coordinate payment directly with the Plan, then the Covered Person will need to send the claim to the Plan within the timelines discussed below. The address for submitting medical claims is on the back of the group health identification card.

For Prescription benefits, a claim is considered filed when a Covered Person has submitted the claim for benefits under the Pharmacy benefit terms outlined in this SPD. The address for submitting Prescription claims is on the back of the Pharmacy drug benefit identification card. If the Pharmacy refuses to fill the Covered Person's Prescription at the Pharmacy counter, the Covered Person should contact the number on the back of the Pharmacy drug benefit identification card for further instructions on how to proceed.

Covered Persons who receive services in a country other than the United States are responsible for ensuring the Provider is paid. If the Provider will not coordinate payment directly with the Plan, the Covered Person will need to pay the claim up front and then submit the claim to the Plan for reimbursement. The Plan will reimburse Covered Persons for any covered amount in U.S. currency. The reimbursed amount will be based on the U.S. equivalency rate that is in effect on the date the Covered Person paid the claim, or on the date of service if paid date is not known.

PROOF OF LOSS

Covered Persons are responsible for ensuring that complete claims are submitted to the Third Party Administrator as soon as possible after services are received, but no later than 12 months from the date of service. Covered Persons can request a Prescription claim form by writing Prescription Solutions at PO Box 8082, Wausau WI 54402-8082 or by calling the number on the back of the Prescription drug card. A complete claim means that the Plan has all information that is necessary to process the claim. Claims received after the proof of loss period will not be allowed.

INCORRECTLY FILED CLAIMS (Applies to Pre-Service Claims only)

If a Covered Person or Authorized Representative does not properly follow the Plan's procedures for requesting notification, the Plan will notify the person to explain proper procedures within five calendar days following receipt of a Pre-Service claim request. The notice will usually be oral, unless written notice is requested by the Covered Person or Authorized Representative.

HOW HEALTH BENEFITS ARE CALCULATED

When UMR receives a claim for services that have been provided to a Covered Person, it will determine if the service is a Covered Benefit under this group health Plan. If it is not a Covered Benefit, the claim will be denied and the Covered Person will be responsible for paying the provider for these costs. If it is a Covered Benefit, UMR will establish the allowable payment amount for that service, in accordance with the provisions of this SPD.

Claims for Covered Benefits are paid according to an established fee schedule, a Negotiated Rate for certain services, or as a percentage of the Usual and Customary fees.

Fee Schedule: Generally, providers are paid the lesser of the billed amount or the maximum fee schedule for the particular covered service, minus any Deductible, Plan Participation rate, Co-pay or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Covered Expenses.

Negotiated Rate: On occasion, UMR will negotiate a payment rate with a provider for a particular covered service such as transplant services, Durable Medical Equipment, Extended Care Facility treatment or other services. The Negotiated Rate is what the Plan will pay to the provider, minus any Co-pay, Deductible, Plan Participation rate or penalties that the Covered Person is responsible for paying. Where a network contract is in place, the network contract determines the Plan's Negotiated Rate.

Usual and Customary (U&C) is the amount that is usually charged by health care providers in the same geographical area for the same services, treatment or materials. An industry fee file is used to determine U&C fee allowances. The U&C level is at the 85th percentile. The U&C guidelines do not apply to In-network claims, which are governed by the network contract. A global package includes the services that are a necessary part of a procedure. For individual services that are part of a global package, it is customary for the individual services not to be billed separately. A separate charge will not be allowed under the Plan.

NOTIFICATION OF BENEFIT DETERMINATION

If a claim is submitted by a Covered Person or a provider on behalf of a Covered Person and the Plan does not completely cover the charges, the Covered Person will receive an Explanation of Benefits (EOB) form that will explain how much the Plan paid toward the claim, and how much of the claim is the Covered Person's responsibility due to cost-sharing obligations, non-Covered Benefits, penalties or other Plan provisions. Please check the information on each EOB form to make sure the services charged were actually received from the provider and that the information appears correct. For any questions or concerns about the EOB form, please feel free to call the Plan at the number listed on the EOB or on the back of the group health identification card. The provider will receive a similar form on each claim that is submitted.

Note: For Prescription benefits, Covered Persons will receive an EOB when a Covered Person files a claim directly with Prescription Solutions. Benefits received or denied at the point of sale in the Pharmacy are not considered claims. See Procedures For Submitting Claims for more information.

TIMELINES FOR INITIAL BENEFIT DETERMINATION

UMR will process claims within the following timelines, although the Covered Person may voluntarily extend these timelines:

- Pre-Service Claim: A decision will be made within 15 calendar days following receipt of a claim request, but the Plan can have an extra 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is given to the Covered Person within the original 15-day period.
- Post-Service Claims: Claims will be processed within 30 calendar days, but the Plan can have an additional 15-day extension, when necessary for reasons beyond the control of the Plan, if written notice is provided to the Covered Person within the original 30-day period.
- Concurrent Care Claims: If the Plan is reducing or terminating benefits before the end of the previously approved course of treatment, the Plan will notify the Covered Person prior to the coverage for the treatment ending or being reduced.
- Emergency and/or Urgent Care Claim: The Plan will notify a Covered Person or provider of a benefit determination (whether adverse or not) with respect to a claim involving Emergency or Urgent Care as soon as possible, taking into account the medical necessity, but not later than 24 hours after the receipt of the claim by the Plan.

A claim is considered to be filed when the claim for benefits has been submitted to UMR for formal consideration under the terms of this Plan.

Effective: 01-01-2010

CIRCUMSTANCES CAUSING LOSS OR DENIAL OF PLAN BENEFITS

Claims can be denied for any of the following reasons:

- Termination of Your employment.
- Covered Person is no longer eligible for coverage under the health Plan.
- Charges Incurred prior to the Covered Person's Effective Date or following termination of coverage.
- Covered Person reached the Maximum Benefit under this Plan.
- Amendment of group health Plan.
- Termination of the group health Plan.
- Employee, Dependent or provider did not respond to a request for additional information needed to process the claim or appeal.
- Application of Coordination of Benefits.
- Enforcement of subrogation.
- Services are not a Covered Benefit under this Plan.
- Services do not meet the Clinical Eligibility for Coverage.
- Failure to comply with notification requirements before receiving services.
- Misuse of the Plan identification card or other fraud.
- Failure to pay premiums if required.
- Employee or Dependent is responsible for charges due to Deductible, Plan Participation obligations or penalties.
- Application of the Usual and Customary fee limits, fee schedule or Negotiated Rates.
- Incomplete or inaccurate claim submission.
- Application of utilization review.
- Experimental or Investigational procedure.
- Other reasons as stated elsewhere in this SPD.

ADVERSE BENEFIT DETERMINATION (DENIED CLAIMS)

Adverse Benefit Determination means a denial, reduction or termination of a benefit, or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in a plan.

If a claim is being denied in whole or in part, the Covered Person will receive an initial claim denial notice within the timelines described above. A claim denial notice, usually referred to as an Explanation of Benefits (EOB) form will:

- Explain the specific reasons for the denial.
- Provide a specific reference to pertinent Plan provisions on which the denial was based.
- Provide a description of any material or information that is necessary for the Covered Person to perfect the claim, along with an explanation of why such material or information is necessary, if applicable.
- Provide appropriate information as to the steps the Covered Person can take to submit the claim for appeal (review).
- If an internal rule or guideline was relied upon, or if the denial was based on not meeting Clinical Eligibility for Coverage or Experimental treatment, the Plan will notify the Covered Person of that fact. The Covered Person has the right to request a copy of the rule/guideline or clinical criteria that was relied upon, and such information will be provided free of charge.

Effective: 01-01-2011

APPEALS PROCEDURE FOR ADVERSE BENEFIT DETERMINATIONS

If a Covered Person disagrees with the denial of a claim or a rescission of coverage determination, the Covered Person or his/her Personal Representative can request that the Plan review its initial determination by submitting a written request to the Plan as described below. An appeal filed by a provider on the Covered Person's behalf is not considered an appeal under the Plan unless the provider is a Personal Representative.

First Level of Appeal: This is a **mandatory** appeal level. The Covered Person must exhaust the following internal procedures before any outside action is taken.

- Covered Persons must file the appeal within 180 days of the date they received the Explanation of Benefits (EOB) form from the Plan showing that the claim was denied. The Plan will assume that Covered Persons received the written EOB form five days after the Plan mailed the EOB form.
- Covered Persons or their Authorized Representative will be allowed reasonable access to review or copy pertinent documents, at no charge.
- Covered Persons may submit written comments, documents, records and other information relating to the claim to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.
- The review will take into account all comments, documents, records and other information submitted that relates to the claim. This would include comments, documents, records and other information that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision and are not under the supervision of the person who originally denied the claim.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, Covered Persons will receive written notification letting them know if the claim is being approved or denied. The notification will provide Covered Persons with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Second Level of Appeal: This is a **voluntary** appeal level. The Covered Person is not required to follow this internal procedure before taking outside legal action.

- Covered Persons who are not satisfied with the decision following the first appeal, have the right to appeal the denial a second time.
- Covered Persons or their Authorized Representative must submit a written request for a second review within 60 calendar days following the date they received the Plan's decision regarding the first appeal. The Plan will assume that Covered Persons received the determination letter regarding the first appeal five days following the date the Plan sends the determination letter.
- Covered Persons may submit written comments, documents, records and other pertinent information to explain why they believe the denial should be overturned. This information should be submitted at the same time the written request for a second review is submitted.
- Covered Persons have the right to submit evidence that their claim is due to the existence of a physical or mental medical condition or domestic violence, under applicable federal nondiscrimination rules.

- The second review will take into account all comments, documents, records and other information submitted that relates to the claim that either were not submitted previously or were not considered in the initial benefit decision. The review will be conducted by individuals who were not involved in the original denial decision or the first appeal, and are not under the supervision of those individuals.
- If the benefit denial was based in whole or in part on a medical judgment, the Plan will consult with a health care professional with training and experience in the relevant medical field. This health care professional may not have been involved in the original denial decision or first appeal, nor be supervised by the health care professional who was involved. If the Plan has obtained medical or vocational experts in connection with the claim, they will be identified upon the Covered Person's request, regardless of whether the Plan relies on their advice in making any benefit determinations.
- After the claim has been reviewed, the Covered Person will receive written notification letting them know if the claim is being approved or denied. The notification will provide the Covered Person with the information outlined under the Adverse Benefit Determination section above. It will also notify them of their right to file suit under ERISA after they have completed all mandatory appeal levels described in this SPD.

Regarding the above voluntary appeal level, the Plan agrees that any statutory limitations that are applicable to pursuing the claim in court will be put on hold during the period of this voluntary appeal process. The voluntary appeal process is available only after the Covered Person has followed the mandatory appeal level as required above. This Plan also agrees that it will not charge the Covered Person a fee for going through the voluntary appeal process, and it will not assert a failure to exhaust administrative remedies if a Covered Person elects to pursue a claim in court before following this voluntary appeal process. A Covered Person's decision about whether to submit a benefit dispute through this voluntary appeal level will have no affect on their rights to any other benefits under the Plan. For any questions regarding the voluntary level of appeal including applicable rules, a Covered Person's right to representation (Authorized Representative) or other details, please contact the Plan. Refer to the ERISA Statement of Rights section of this SPD for details on a Covered Person's additional rights to challenge the benefit decision under section 502(a) of ERISA.

Appeals should be sent within the prescribed time period as stated above to:

Send first level Medical appeals to:
UMR
CLAIMS APPEAL UNIT
PO BOX 8086
WAUSAU WI 54402-8086

Send second level Medical appeals to:
CALUMET GP, LLC
2780 WATERFRONT PARKWAY EAST DR
STE 200
INDIANAPOLIS IN 46214

Send Pharmacy appeals to:
PRESCRIPTION SOLUTIONS
PO BOX 8082
WAUSAU WI 54402-8082

Effective: 01-01-2011

TIME PERIODS FOR MAKING DECISION ON APPEALS

After reviewing a claim that has been appealed, the Plan will notify the Covered Person of its decision within the following timeframes, although Covered Persons may voluntarily extend these timelines. In addition, if any new or additional evidence is relied upon or generated during the determination of the appeal, the Plan will provide it to You free of charge and sufficiently in advance of the due date of the response to the adverse benefit determination.

The timelines below will only apply to the mandatory appeal level. The voluntary appeal level will not be subject to specific timelines.

- Pre-Service Claim: Within a reasonable period of time appropriate to the medical circumstances but no later than 30 calendar days after the Plan receives the request for review.
- Post-Service Claim: Within a reasonable period of time but no later than 60 calendar days after the Plan receives the request for review.
- Concurrent Care Claims: Before treatment ends or is reduced.

LEGAL ACTIONS FOLLOWING APPEALS

After completing all mandatory appeal levels through this Plan, Covered Persons have the right to further appeal Adverse Benefit Determinations by bringing a civil action under the Employee Retirement Income Security Act (ERISA). Please refer to the ERISA Statement of Rights section of this SPD for more details. No such action may be filed against the Plan after three years from the date the Plan gives the Covered Person a final determination on their appeal.

PHYSICAL EXAMINATION AND AUTOPSY

The Plan may require that a Covered Person have a physical examination, at the Plan's expense, as often as is necessary to settle a claim. In the case of death, the Plan may require an autopsy unless forbidden by law.

RIGHT TO REQUEST OVERPAYMENTS

The Plan reserves the right to recover any payments made by the Plan that were:

- Made in error; or
- Made after the date the person should have been terminated under this Plan; or
- Made to any Covered Person or any party on a Covered Person's behalf where the employer determines the payment to the Covered Person or any party is greater than the amount payable under this Plan.

The Plan has the right to recover against Covered Persons if the Plan has paid them or any other party on their behalf.

FRAUD

Effective: 01-01-2011

Fraud is a crime that can be prosecuted. Any Covered Person who willfully and knowingly engages in an activity intended to defraud the Plan is guilty of fraud. The Plan will utilize all means necessary to support fraud detection and investigation. It is a crime for a Covered Person to file a claim containing any false, incomplete or misleading information with intent to injure, defraud or deceive the Plan. In addition, it is a fraudulent act when a Covered Person willfully and knowingly fails to notify the Plan regarding an event that affects eligibility for a Covered Person. Notification requirements are outlined in this SPD and other Plan materials. Please read them carefully and refer to all Plan materials that you receive (i.e., COBRA notices). A few examples of events that require Plan notification would be divorce, Dependent aging out of the Plan, and enrollment in other group health coverage while on COBRA (please note that the examples listed are not all inclusive).

These actions will result in denial of the Covered Person's claim or termination from the Plan, and are subject to prosecution and punishment to the full extent under state and/or federal law.

Covered Persons must:

- File accurate claims. If someone else - such as Your spouse or another family member - files claims on the Covered Person's behalf, the Covered Person should review the form before signing it;
- Review the Explanation of Benefits (EOB) form. Make certain that benefits have been paid correctly based on your knowledge of the expenses Incurred and the services rendered;
- Never allow another person to seek medical treatment under your identity. If your Plan identification card is lost, report the loss to the Plan immediately; and
- Provide complete and accurate information on claim forms and any other forms. Answer all questions to the best of your knowledge.
- Notify the Plan when an event occurs that affects a Covered Person's eligibility.

To maintain the integrity of this Plan, Covered Persons are encouraged to notify the Plan whenever a provider:

- Bills for services or treatment that have never been received; or
- Asks a Covered Person to sign a blank claim form; or
- Asks a Covered Person to undergo tests that the Covered Person feels are not needed.

Covered Persons concerned about any of the charges that appear on a bill or EOB form, or who know of or suspect any illegal activity, should call the toll-free hotline 1-800-356-5803. All calls are strictly confidential.

OTHER FEDERAL PROVISIONS

Effective: 01-01-2009

FAMILY AND MEDICAL LEAVE ACT (FMLA)

If an Employee is on a family or medical leave of absence that meets the eligibility requirements under FMLA, Your employer will continue coverage under this Plan in accordance with state and federal FMLA regulations, provided that the following conditions are met:

- Contribution is paid; and
- The Employee has written approved leave from the employer.

Coverage will be continued for up to the greater of:

- The leave period required by the federal Family and Medical Leave Act of 1993 and any amendment; or
- The leave period required by applicable state law.

An Employee can choose not to retain group health coverage during an FMLA leave. When the Employee returns to work following the FMLA leave, the Employee's coverage will usually be restored to the level the Employee would have had if the FMLA leave had not been taken, and no new pre-existing requirements will be imposed. For more information, please contact Your Human Resources or Personnel office.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS PROVISION

A Dependent Child will become covered as of the date specified in a judgment, decree or order issued by a court of competent jurisdiction or through a state administrative process.

The order must clearly identify all of the following:

- The name and last known mailing address of the participant;
- The name and last known mailing address of each alternate recipient (or official state or political designee for the alternate recipient);
- A reasonable description of the type of coverage to be provided to the Child or the manner in which such coverage is to be determined; and
- The period to which the order applies.

Please contact the Plan Administrator to request a copy of the written procedures, at no charge, that the Plan uses when administering Qualified Medical Child Support Orders.

NEWBORNS AND MOTHERS HEALTH PROTECTION ACT

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for a Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a vaginal delivery, or less than 96 hours following a Cesarean section. However, federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the Plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Effective: 01-01-2010

This group health Plan also complies with the provisions of the:

- Mental Health Parity Act.
- Women's Health and Cancer Rights Act of 1998 regarding breast reconstruction following a mastectomy.
- Pediatric Vaccines regulation, whereby an employer will not reduce its coverage for pediatric vaccines below the coverage it provided as of May 1, 1993.
- Coverage of Dependent Children in cases of adoption or Placement for Adoption as required by ERISA.
- Health Insurance Portability provisions of the Health Insurance Portability and Accountability Act (HIPAA).
- Medicare Secondary Payer regulations, as amended.
- TRICARE Prohibition Against Incentives and Nondiscrimination Requirements amendments.
- The Genetic Information Non-discrimination Act (GINA).

HIPAA ADMINISTRATIVE SIMPLIFICATION
MEDICAL PRIVACY AND SECURITY PROVISION

This Plan has been modified as required under the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). These modifications have or will become effective as required by applicable provisions of the Privacy and Security Regulations.

First, under HIPAA Privacy Regulations, this Plan has been modified to allow the Disclosure of Protected Health Information (PHI), as defined under HIPAA, to the Plan Sponsor. The USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section of this document specifies the terms under which the Plan may share PHI with the Plan Sponsor and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms contained in the USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA section have been adopted and the Plan Sponsor agrees to abide by these terms.

The HIPAA Privacy Regulation provision of this Plan took effect April 14, 2003.

Second, under HIPAA Security Regulations, this Plan has been modified to require the Plan Sponsor to reasonably and appropriately safeguard Electronic Protected Health Information (Electronic PHI), as defined under HIPAA, created, received, maintained or transmitted to or by the Plan Sponsor on behalf of this Plan.

Modifications made for the HIPAA Security Regulations are effective as of April 21, 2005 and can be identified in this provision by reference to Security Regulations or Electronic PHI.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION UNDER HIPAA PRIVACY AND SECURITY REGULATIONS

This Plan will Use a Covered Person's Protected Health Information (PHI) to the extent of and in accordance with the Uses and Disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, this Plan will Use and Disclose a Covered Person's PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations. Additionally, this Plan will Use and Disclose a Covered Person's PHI as required by law and as permitted by authorization. This section establishes the terms under which the Plan may share a Covered Person's PHI with the Plan Sponsor, and limits the Uses and Disclosures that the Plan Sponsor may make of a Covered Person's PHI.

This Plan shall Disclose a Covered Person's PHI to the Plan Sponsor only to the extent necessary for the purposes of the administrative functions of Treatment, Payment for health care or Health Care Operations.

The Plan Sponsor shall Use and/or Disclose a Covered Person's PHI only to the extent necessary for the administrative functions of Treatment, Payment for health care or Health Care Operations which it performs on behalf of this Plan.

This Plan agrees that it will only Disclose a Covered Person's PHI to the Plan Sponsor upon receipt of a certification from the Plan Sponsor that the terms of this section have been adopted and that the Plan Sponsor agrees to abide by these terms.

The Plan Sponsor is subject to all of the following restrictions that apply to the Use and Disclosure of a Covered Person's PHI:

- The Plan Sponsor will only Use and Disclose a Covered Person's PHI (including Electronic PHI) for Plan Administrative Functions, as required by law or as permitted under the HIPAA regulations. This Plan's Notice of Privacy Practices also contains more information about permitted Uses and Disclosures of PHI under HIPAA;

- The Plan Sponsor will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the Plan;

- The Plan Sponsor will require each of its subcontractors or agents to whom the Plan Sponsor may provide a Covered Person's PHI to agree to the same restrictions and conditions imposed on the Plan Sponsor with regard to a Covered Person's PHI;

- The Plan Sponsor will ensure that each of its subcontractors or agents to whom the Plan Sponsor may provide Electronic PHI to agree to implement reasonable and appropriate security measures to protect Electronic PHI;

- The Plan Sponsor will not Use or Disclose PHI for employment-related actions and decisions or in connection with any other of the Plan Sponsor's benefits or Employee benefit plans;

- The Plan Sponsor will promptly report to this Plan any impermissible or improper Use or Disclosure of PHI not authorized by the Plan documents;

- The Plan Sponsor will report to the Plan any security incident with respect to Electronic PHI of which Plan Sponsor becomes aware;

- The Plan Sponsor will allow a Covered Person or this Plan to inspect and copy any PHI about the Covered Person contained in the Designated Record Set that is in the Plan Sponsor's custody or control. The HIPAA Privacy Regulations set forth the rules that the Covered Person and the Plan must follow and also sets forth exceptions;

- The Plan Sponsor will amend or correct, or make available to the Plan to amend or correct, any portion of the Covered Person's PHI contained in the Designated Record Set to the extent permitted or required under the HIPAA Privacy Regulations;

- The Plan Sponsor will keep a Disclosure log for certain types of Disclosures set forth in the HIPAA Regulations. Covered Persons have a right to see the Disclosure log. The Plan Sponsor does not have to maintain a log if Disclosures are for certain Plan-related purposes such as Payment of benefits or Health Care Operations;

- The Plan Sponsor will make its internal practices, books and records relating to the Use and Disclosure of a Covered Person's PHI available to this Plan and to the Department of Health and Human Services or its designee for the purpose of determining this Plan's compliance with HIPAA;

- The Plan Sponsor must, if feasible, return to this Plan or destroy all of a Covered Person's PHI that the Plan Sponsor received from or on behalf of this Plan when the Plan Sponsor no longer needs the Covered Person's PHI to administer this Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is not feasible, the Plan Sponsor agrees to restrict and limit further Uses and Disclosures to the purposes that make the return or destruction infeasible;

- The Plan Sponsor will provide that adequate separation exists between this Plan and the Plan Sponsor so that a Covered Person's PHI (including Electronic PHI) will be used only for the purpose of plan administration; and

- The Plan Sponsor will use reasonable efforts to request only the minimum necessary type and amount of a Covered Person's PHI to carry out functions for which the information is requested.

DEFINITIONS

Administrative Simplification is the section of the law that addresses electronic transactions, privacy and security. The goals are to:

- Improve efficiency and effectiveness of the health care system;
- Standardize electronic data interchange of certain administrative transactions;
- Safeguard security and privacy of Protected Health Information;
- Improve efficiency to compile/analyze data, audit, and detect fraud; and
- Improve the Medicare and Medicaid programs.

Business Associate (BA) in relationship to a Covered Entity (CE) means a BA is a person to whom the CE discloses Protected Health Information (PHI) so that a person can carry out, assist with the performance of, or perform on behalf of, a function or activity for the CE. This includes contractors or other persons who receive PHI from the CE (or from another business partner of the CE) for the purposes described in the previous sentence, including lawyers, auditors, consultants, Third Party Administrators, health care clearinghouses, data processing firms, billing firms and other Covered Entities. This excludes persons who are within the CE's workforce.

Covered Entity (CE) is one of the following: a health plan, a health care clearinghouse or a health care provider who transmits any health information in connection with a transaction covered by this law.

Designated Record Set means a set of records maintained by or for a Covered Entity that includes a Covered Persons' PHI. This includes medical records, billing records, enrollment, Payment, claims adjudication and case management record systems maintained by or for this Plan. This also includes records used to make decisions about Covered Persons. This record set must be maintained for a minimum of 6 years.

Disclose or Disclosure is the release or divulgence of information by an entity to persons or organizations outside that entity.

Electronic Protected Health Information (Electronic PHI) is Individually Identifiable Health Information that is transmitted by electronic media or maintained in electronic media. It is a subset of Protected Health Information.

Health Care Operations are general administrative and business functions necessary for the CE to remain a viable business. These activities include:

- Conducting quality assessment and improvement activities;
- Reviewing the competence or qualifications and accrediting/licensing of health care professional plans;
- Evaluating health care professional and health plan performance;
- Training future health care professionals;
- Insurance activities relating to the renewal of a contract for insurance;
- Conducting or arranging for medical review and auditing services;
- Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination;

- Contacting of health care providers and patients with information about Treatment alternatives and related functions that do not entail direct patient care; and
- Activities related to the creation, renewal or replacement of a contract for health insurance or health benefits, as well as ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss and excess of loss insurance).

Individually Identifiable Health Information is information that is a subset of health information, including demographic information collected from a Covered Person, and that:

- Is created by or received from a Covered Entity;
- Relates to the past, present or future physical or mental health or condition of a Covered Person, the provision of health care or the past, present or future Payment for the provision of health care; and
- Identifies the Covered Person or with respect to which there is reasonable basis to believe the information can be used to identify the Covered Person.

Payment means the activities of the health plan or a Business Associate, including the actual Payment under the policy or contract; and a health care provider or its Business Associate that obtains reimbursement for the provision of health care.

Plan Sponsor means Your employer.

Plan Administrative Functions means administrative functions of Payment or Health Care Operations performed by the Plan Sponsor on behalf of the Plan including quality assurance, claims processing, auditing and monitoring.

Privacy Official is the individual who provides oversight of compliance with all policies and procedures related to the protection of PHI and federal and state regulations related to a Covered Person's privacy.

Protected Health Information (PHI) is Individually Identifiable Health Information transmitted or maintained by a Covered Entity in written, electronic or oral form. PHI includes Electronic PHI.

Treatment is the provision of health care by, or the coordination of health care (including health care management of the individual through risk assessment, case management and disease management) among, health care providers; the referral of a patient from one provider to another; or the coordination of health care or other services among health care providers and third parties authorized by the health plan or the individual.

Use means, with respect to Individually Identifiable Health Information, the sharing, employment, application, utilization, examination or analysis of such information within an entity that maintains such information.

STATEMENT OF ERISA RIGHTS

Covered Persons under this group health Plan, are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Covered Persons shall be entitled to:

RECEIVE INFORMATION ABOUT PLAN AND BENEFITS

- Examine, without charge, at the Plan Administrator's office and at other specified locations (such as at work sites) all documents governing the Plan, including insurance contracts, collective bargaining agreements if applicable, 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 Security Administration. No charge will be made for examining the documents at the Plan Administrator's principal office.

- Obtain, upon written request to the Plan Administrator, copies of documents that govern the operation of the Plan, including insurance contracts and collective bargaining agreements if applicable, and copies of the latest annual report 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 (Form 5500 series). The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

CONTINUE GROUP HEALTH COVERAGE

Covered Persons have the right to continue health care coverage if there is a loss of coverage under the Plan as a result of a COBRA qualifying event. You or Your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

PRE-EXISTING CONDITIONS EXCLUSION PERIOD

There will be a reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under this group health Plan if a Covered Person has Creditable Coverage from another plan. Covered Persons with Creditable Coverage from another plan should be provided a Certificate of Creditable Coverage free of charge, from the prior group health plan or health insurance issuer when coverage under the plan is lost, upon entitlement to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if requested by the Covered Person before losing coverage, or if requested by the Covered Person up to 24 months after losing coverage. Without evidence of Creditable Coverage, Covered Persons may be subject to a Pre-Existing Condition exclusion for 12 months if application is made when first eligible, or 18 months for Late Enrollees, after a Covered Person's Enrollment Date in coverage.

PRUDENT ACTIONS BY PLAN FIDUCIARIES

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

NO DISCRIMINATION

No one may terminate Your employment or otherwise discriminate against You or Your covered Dependents in any way to prevent You or Your Dependents from obtaining a benefit or exercising rights provided to Covered Persons under ERISA.

ENFORCING COVERED PERSONS' RIGHTS

If a claim for a benefit is denied or ignored, in whole or in part, Covered Persons 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 an Employee can take to enforce the above rights. For instance, if a Covered Person requests a copy of the Plan documents or the latest annual report from the Plan and does not receive them within thirty (30) days, the Covered Person may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Covered Person up to $110 a day until the materials are received, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If a claim for benefits is denied or ignored, in whole or in part, the Covered Person may file suit in a state or federal court. In addition, if a Covered Person disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical Child support order, the Covered Person may file suit in federal court. If it should happen that the Plan fiduciaries misuse the Plan's money or if a Covered Person is discriminated against for asserting his or her rights, the Covered Person may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Covered Person is successful, the court may order the person sued to pay these costs and fees. If the Covered Person loses, the court may order the Covered Person to pay these costs and fees (for example, if it finds the claim to be frivolous).

ASSISTANCE WITH QUESTIONS

If there are any questions about this Plan, the Plan Administrator should be contacted. For any questions about this statement or about a Covered Person's rights under ERISA, or for assistance in obtaining documents from the Plan Administrator, Covered Persons should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in the telephone directory, or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. Covered Persons may also obtain certain publications about their rights and responsibilities under ERISA by calling the publication hotline of the Employee Benefits Security Administration.

PLAN AMENDMENT AND TERMINATION INFORMATION

The Plan Sponsor fully intends to maintain this Plan indefinitely; however, the employer reserves the right to terminate, suspend or amend this Plan at any time, in whole or in part (and with respect to any class of Employees, Retirees or Dependents), including making modifications to the benefits under this Plan. No person or entity has any authority to make any oral change or amendments to this Plan. The Plan Administrator will provide written notice to Covered Persons within 60 days following the adopted formal action that makes material changes to the Plan.

COVERED PERSON'S RIGHTS IF PLAN IS AMENDED OR TERMINATED

If this Plan is amended, a Covered Person's rights are limited to Plan benefits in force at the time expenses are Incurred, whether or not the Covered Person has received written notification from the Plan Administrator that the Plan has been amended.

If this Plan is terminated, the rights of a Covered Person are limited to Covered Expenses Incurred before the Covered Person receives notice of termination.

The Plan will assume that the Covered Person received the written amendment or termination letter from the Plan Administrator five days after the letter is mailed regarding the changes.

No person will become entitled to any vested rights under this Plan.

NO CONTRACT OF EMPLOYMENT

This Plan is not intended to be, and may not be construed as a contract of employment between any Covered Person and the employer.

GLOSSARY OF TERMS

Effective: 01-01-2011

Accident means an unexpected, unforeseen and unintended event that causes bodily harm or damage to the body.

Acupuncture means a technique used to deliver anesthesia or analgesia, or for treating condition of the body (when clinical efficacy has been established for treatment of such conditions) by passing long, thin needles through the skin.

Activities of Daily Living (ADL) means the following, with or without assistance: Bathing, dressing, toileting and associated personal hygiene; transferring (which is to move in and out of a bed, chair, wheelchair, tub or shower); mobility, eating (which is getting nourishment into the body by any means other than intravenous), and continence (which is voluntarily maintaining control of bowel and/or bladder function; in the event of incontinence, maintaining a reasonable level of personal hygiene).

Adverse Benefit Determination means a denial, reduction or termination of a benefit or a failure to provide or make payment, in whole or in part, for a benefit. It also includes any such denial, reduction, termination or failure to provide or make payment that is based on a determination that the Covered Person is no longer eligible to participate in the Plan.

Ambulance Transportation means professional ground or air Ambulance Transportation in an Emergency situation or when deemed to meet the Clinical Eligibility for Coverage, which is:

- To the closest facility most able to provide the specialized treatment required; and
- The most appropriate mode of transportation consistent with the well being of You or Your Dependent.

Ancillary Services means services rendered in connection with Inpatient or Outpatient care in a Hospital or in connection with a medical Emergency including the following: ambulance, anesthesiology, assistant surgeon, pathology and radiology. This term also includes services of the attending Physician or primary surgeon in the event of a medical Emergency.

Birthing Center means a legally operating institution or facility which is licensed and equipped to provide immediate prenatal care, delivery and postpartum care to the pregnant individual under the direction and supervision of one or more Physicians specializing in obstetrics or gynecology or a certified nurse midwife. It must provide for 24 hour nursing care provided by registered nurses or certified nurse midwives.

Certificate of Creditable Coverage means a certificate or other documentation that is provided to a person upon losing health care coverage. The certificate or other documentation specifies how much Creditable Coverage a person has and is used to reduce the length of a Pre-Existing Condition exclusion period under a Plan.

Child (Children) means any of the following individuals with respect to an Employee: a natural biological Child; a step Child; a legally adopted Child or a Child legally Placed for Adoption; a Child under the Employee or Spouse's Legal Guardianship; or a Child who is considered an alternate recipient under a Qualified Medical Child Support Order (even if the Child does not meet the definition of "Dependent").

Clinical Eligibility for Coverage – Refer to Covered Benefits below.

Close Relative means a member of the immediate family. Immediate family includes You, Your spouse, mother, father, grandmother, grandfather, step parents, step grandparents, siblings, step siblings, half siblings, Children, step Children and grandchildren.

Effective: 01-01-2009

COBRA means Title X of the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and applicable regulations. This law gives Covered Persons the right, under certain circumstances, to elect continuation coverage under the Plan when active coverage ends due to a Qualifying Event.

Co-pay is the amount a Covered Person must pay each time certain covered services are provided, as outlined on the Schedule of Benefits.

Cosmetic Treatment means medical or surgical procedures which are primarily used to improve, alter or enhance appearance, whether or not for psychological or emotional reasons.

Covered Benefit or **Clinical Eligibility for Coverage** means treatment, services, supplies, medicines or facilities necessary and appropriate for the diagnosis, care or treatment of an Illness or Injury and that meet Clinical Eligibility for Coverage as determined by the Plan. Covered Benefits do not include those listed under the Exclusions section but include services, supplies, medicines or facilities that are:

- Generally provided in accordance with accepted medical practice and professionally recognized standards; and
- Provided safely at the appropriate level of care or services; and
- Not provided solely for the convenience of the Covered Person, his or her family, or any provider; and
- Known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence, then by professional standards, and finally by expert opinions; and
- Cost-effective for the condition, compared to alternative interventions, including no intervention. Cost-effective does not necessarily mean the lowest price.

In determining Covered Benefits, consideration is given to the customary practice of providers in the community or field of specialty. However, the fact that a provider may prescribe, order, recommend or approve a service, supply, medicine or facility does not, of itself, make the service a Covered Benefit.

Covered Expenses means any expense, or portion thereof, which is Incurred as a result of receiving a Covered Benefit under this Plan.

Covered Person means an Employee or Dependent who are enrolled under this Plan.

Creditable Coverage means coverage an individual has under the following as defined by federal law and applicable regulations:

- A group health plan;
- Health insurance coverage (through a group or individual policy);
- Medicare;
- Medicaid;
- A medical care program of the Uniformed Services;
- A medical care program of the Indian Health Services or of a tribal organization;
- A State health benefits risk pool;
- A State Children's Health Insurance Program;
- A health plan offered under the Federal Employee Health Benefits Program;
- A public health plan, including any plan established or maintained by a State, the US government, a foreign country or any political subdivision of the same; or
- A health benefit plan under Section 5(e) of the Peace Corps Act.

Creditable Coverage shall not include coverages for liability, disability income, limited scope dental or vision benefits, specified disease, supplemental benefits and other excepted benefits as defined by federal law and applicable regulations. A period of Creditable Coverage shall not be counted, with respect to enrollment under a group health plan, if there is a 63-day lapse in coverage between the end of the prior coverage and the beginning of the person's enrollment under this Plan.

Custodial Care means nonmedical care given to a Covered Person to administer medication and to assist with personal hygiene or other Activities of Daily Living rather than providing therapeutic treatment and services. Custodial Care services can be safely and adequately provided by persons who do not have the technical skills of a covered healthcare provider. Custodial Care also includes care when active medical treatment cannot be reasonably expected to reduce the disability or condition.

Deductible is the amount of Covered Expenses which must be paid by the Covered Person or the covered family before benefits are payable. The Schedule of Benefits shows the amount of the applicable Deductible (if any) and the health care benefits to which it applies.

Dependent – see Eligibility and Enrollment section of this SPD.

Developmental Delays is characterized by severe and pervasive impairment in various areas of development such as social interaction skills, adaptive behavior and communication skills. Developmental Delays may not always have a history of birth trauma or other Illness that could be causing the impairment such as a hearing problem, mental Illness or other neurological symptoms or Illness.

Durable Medical Equipment means equipment which:

- Can withstand repeated use.
- Is primarily used to serve a medical purpose with respect to an Illness or Injury.
- Generally is not useful to a person in the absence of an Illness or Injury.
- Is appropriate for use in the Covered Person's home.

Effective Date means the first day of coverage under this Plan as defined in this SPD. The Covered Person's Effective Date may or may not be the same as their Enrollment Date, as Enrollment Date is defined in the Plan.

Emergency means a serious medical condition, with acute symptoms that require immediate care and treatment in order to avoid jeopardy to the life and health of the person.

Employee – see Eligibility and Enrollment section of this SPD.

Enrollment Date means:

- For anyone who applies for coverage when first eligible, the Enrollment Date is the date that coverage begins, or if there is a Waiting Period, the first day of the Waiting Period, whichever is earlier.
- For anyone who enrolls under the Special Enrollment Provision, the Enrollment Date is the first day of coverage.
- For Late Enrollees, the Enrollment Date is the first day of coverage.

ERISA means the Employee Retirement Income Security Act of 1974, as amended from time to time and the applicable regulations.

Essential Health Benefits means any medical expense that falls under the following categories, as defined under the Patient Protection and Affordable Care Act; 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, etc.).

Experimental, Investigational or Unproven means any drug, service, supply, care and/or treatment that, at the time provided or sought to be provided, is not recognized as conforming to accepted medical practice or to be a safe, effective standard of medical practice for a particular condition. This includes, but is not limited to:

- Items within the research, Investigational or Experimental stage of development or performed within or restricted to use in Phase I, II, or III clinical trials (unless identified as a covered service elsewhere);

- Items that do not have strong research-based evidence to permit conclusions and/or clearly define long-term effects and impact on health outcomes (have not yet shown to be consistently effective for the diagnosis or treatment of the specific condition for which it is sought). Strong research-based evidence of safety and efficacy is identified as peer-reviewed published data derived from multiple, large, human randomized controlled clinical trials OR at least one or more large controlled national multi-center population-based studies;

- Items based on anecdotal and Unproven evidence of safety and efficacy (literature consists only of case studies or uncontrolled trials), i.e., lacks scientific validity, but may be common practice within select practitioner groups even though safety and efficacy is not clearly established;

- Items which have been identified through research-based evidence to not be effective for a medical condition and/or to not have a beneficial effect on health outcomes.

Note: FDA and/or Medicare approval does not guarantee that a drug, supply, care and/or treatment is accepted medical practice, however, lack of such approval will be a consideration in determining whether a drug, service, supply, care and/or treatment is considered Experimental, Investigational or Unproven. In assessing cancer care claims, sources such as the National Comprehensive Cancer Network (NCCN) Compendium, Clinical Practice Guidelines in Oncology™ or National Cancer Institute (NCI) standard of care compendium guidelines, or similar material from other or successor organizations will be considered along with benefits provided under the Plan and any benefits required by law. Furthermore, off-label drug or device use (sought for outside FDA-approved indications) is subject to medical review for appropriateness based on prevailing peer-reviewed medical literature, published opinions and evaluations by national medical associations, consensus panels, technology evaluation bodies, and/or independent review organizations to evaluate the scientific quality of supporting evidence of safety and efficacy.

Extended Care Facility includes, but is not limited to a skilled nursing, rehabilitation, convalescent or subacute facility. It is an institution or a designated part of one that is operating pursuant to the law for such an institution and is under the full time supervision of a Physician or registered nurse. In addition, the Plan requires that the facility: Provide 24 hour-a-day service to include skilled nursing care and therapies deemed to meet the Clinical Eligibility for Coverage for the recovery of health or physical strength; is not a place primarily for Custodial Care; requires compensation from its patients; admits patients only upon Physician orders; has an agreement to have a Physician's services available when needed; maintains adequate medical records for all patients; has a written transfer agreement with at least one Hospital and is licensed by the state in which it operates and provides the services under which the licensure applies.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and the applicable regulations. This law gives special enrollment rights, prohibits discrimination, and protects privacy of protected health information among other things.

Home Health Care means a formal program of care and intermittent treatment that is: Performed in the home; and prescribed by a Physician; and intermittent care and treatment for the recovery of health or physical strength under an established plan of care; and prescribed in place of a Hospital or an Extended Care Facility or results in a shorter Hospital or Extended Care Facility stay; and organized, administered, and supervised by a Hospital or Qualified licensed providers under the medical direction of a Physician; and appropriate when it is not reasonable to expect the Covered Person to obtain medically indicated services or supplies outside the home.

For purposes of Home Health Care, Nurse Services means Intermittent home nursing care by professional registered nurses or by licensed practical nurses. Intermittent means occasional or segmented care, i.e., care that is not provided on a continuous, non-interrupted basis.

Hospice Care means a health care program providing a coordinated set of services rendered at home, in Outpatient settings, or in Inpatient settings for Covered Persons suffering from a condition that has a terminal prognosis. Non-curative supportive care is provided through an interdisciplinary group of personnel. A hospice must meet the standards of the National Hospice Organization and applicable state licensing.

Hospice Care Provider means an agency or organization that has Hospice Care available 24 hours a day, seven days a week; is certified by Medicare as a Hospice Care Agency, and, if required, is licensed as such by the jurisdiction in which it is located. The provider may offer skilled nursing services; medical social worker services; psychological and dietary counseling; services of a Physician, physical or occupational therapist; home health aide services; pharmacy services; and Durable Medical Equipment.

Hospital means:

- A facility that is licensed as an acute Hospital; and
- Provides diagnostic and therapeutic facilities for the surgical or medical diagnosis, treatment, and care of injured and sick persons as Inpatients at the patient's expense; and
- Has a staff of licensed Physicians available at all times; and
- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or is recognized by the American Hospital Association (AHA) and is Qualified to receive payments under the Medicare program; and
- Always provides 24 hour nursing services by registered graduate nurses; and
- Is not a place primarily for Custodial or Maintenance Care.

For purposes of this Plan, Hospital also includes Surgical Centers and Birthing Centers licensed by the state in which it operates. Hospital does not include services provided in facilities operating as residential treatment centers.

Illness means a bodily disorder, disease, physical or mental sickness, functional nervous disorder, pregnancy or complication of pregnancy. The term "Illness" when used in connection with a newborn Child includes, but is not limited to, congenital defects and birth abnormalities, including premature birth.

Incurred means the date the service or treatment is given, the supply is received or the facility is used, without regard to when the service, treatment, supply or facility is billed, charged or paid.

Independent Contractor means an entity or individual who performs services to or on behalf of the employer who is not an Employee or an officer of the employer and who retains control over how the work gets done. The employer who hires the Independent Contractor controls only the outcome of the work and not the performance of the hired service. Determination as to whether an individual or entity is an Independent Contractor shall be made consistent with Section § 530 of the Internal Revenue Code.

Effective: 01-01-2011

Infertility Treatment means services, tests, supplies, devices, or drugs which are intended to promote fertility, achieve a condition of pregnancy, or treat an Illness causing an infertility condition when such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility Treatment includes, but is not limited to fertility tests and drugs; tests and exams done to prepare for induced conception; surgical reversal of a sterilized state which was a result of a previous surgery; sperm enhancement procedures; direct attempts to cause pregnancy by any means including, but not limited to: hormone therapy or drugs; artificial insemination; In vitro fertilization; Gamete Intrafallopian Transfer (GIFT), or Zygote Intrafallopian Transfer (ZIFT); embryo transfer; and freezing or storage of embryo, eggs, or semen.

Injury means an act causing harm or damage to the body.

Inpatient means a registered bed patient using and being charged for room and board at the Hospital or in a Hospital for 24 hours or more. A person is not an Inpatient on any day on which he or she is on leave or otherwise gone from the Hospital, whether or not a room and board charge is made.

Late Enrollee means a person who enrolls under this Plan other than on:

- The earliest date on which coverage can become effective under the terms of this Plan; or
- A special Enrollment Date for the person as defined by HIPAA.

Learning Disability means a group of disorders that results in significant difficulties in one or more of seven areas including: basic reading skills, reading comprehension, oral expression, listening comprehension, written expression, mathematical calculation and mathematical reasoning. Specific learning disabilities are diagnosed when the individual's achievement on standardized tests in a given area is substantially below that expected for age, schooling and level of intelligence.

Legal Guardianship/Guardian means the individual is recognized by a court of law as having the duty of taking care of a person and managing the individual's property and rights.

Maximum Benefit means the maximum amount to be paid by the Plan on behalf of the Covered Person for Covered Expenses which are Incurred while the person is covered under the Plan.

Medicare means the program of medical care benefits provided under Title XVIII of the Social Security Act as amended.

Mental Health Disorder means disorders that are clinically significant psychological syndromes associated with distress, dysfunction or Illness. The syndrome must represent a dysfunctional response to a situation or event that exposes the Covered Person to an increased risk of pain, suffering, conflict, Illness or death.

Mentally Disabled means an individual who has been diagnosed to have a psychiatric or behavior disorder that severely limits the individual's ability to function without daily supervision or assistance.

Multiple Surgical Procedures means when more than one surgical procedure is performed during the same period of anesthesia.

Negotiated Rate means the amount that providers have contracted to accept a payment in full for Covered Expenses of the Plan.

Non-Essential Health Benefits means any medical benefit that is not an Essential Health Benefit. Please refer to the Essential Health Benefits definition.

Orthognathic Condition means a skeletal mismatch of the jaw (such as when one jaw is too large or too small, too far forward or too far back). An Orthognathic Condition may cause overbite, underbite, or open bite. Orthognathic surgery may be performed to correct skeletal mismatches of the jaw.

Orthotic Appliances means braces, splints, casts and other appliances used to support or restrain a weak or deformed part of the body and is designed for repeated use, intended to treat or stabilize a Covered Person's Illness or Injury or improve function; and generally is not useful to a person in the absence of an Illness or Injury.

Outpatient means medical care, treatment, services or supplies in a facility in which a patient is not registered as a bed patient and room and board charges are not Incurred.

Palliative Foot Care means the cutting or removal of corns or calluses; the trimming of nails; other hygeniec and preventative maintenance care or debridement, such as cleaning and soaking of the feet, and the use of skin creams to maintain the skin tone of both ambulatory and non-ambulatory Covered Persons; and any services performed in the absence of localized Illness, Injury, or symptoms involving the foot.

Participating Pharmacy means a licensed entity, acting within the scope of their license in the state in which they dispense, that has entered into a written agreement with Prescription Solutions and has agreed to provide services to covered individuals for the fees negotiated in the agreement.

Physician means any of the following licensed practitioners, acting within the scope of their license in the state in which they practice, who perform services payable under this Plan: a doctor of medicine (MD), doctor of dental medicine including oral surgeons (DMD), osteopathy (DO), podiatry (DPM), dentistry (DDS), chiropractic (DC), optometry (OPT), a physician's assistant (PA), a nurse practitioner (NP), a certified nurse midwife (CNM), or a certified registered nurse anesthetist (CRNA). The term Physician also may include, at the Plan Sponsor's discretion, other licensed practitioners who are regulated by a state or federal agency, who perform services payable under this Plan, and who are acting within the scope of their license, unless specifically excluded by this Plan.

Placed or Placement for Adoption means the assumption and retention of a legal obligation for total or partial support of a Child in anticipation of adoption of such Child. The Child's placement with the person terminates upon the termination of such legal obligation.

Plan means CALUMET GP, LLC Group Health Benefit Plan.

Plan Participation means that the Covered Person and the Plan each pay a percentage of the Covered Expenses as listed on the Schedule of Benefits, after the Covered Person pays the Deductible(s).

Plan Sponsor means an employer who sponsors a group health plan.

Pre-Existing Condition means an Illness or Injury for which medical advice, diagnosis, care or treatment was recommended or received within the timeframe specified in the Pre-Existing Condition Provision section of this document.

Prescription means any order authorized by a medical professional for a Prescription or Non-Prescription Drug, that could be a medication or supply for the person for whom prescribed. The Prescription must be compliant with applicable laws and regulations and identify the name of the medical professional and the name of the person for whom prescribed. It must also identify the name, strength, quantity and the directions for use of the medication or supply prescribed.

Preventive / Routine Care means a prescribed standard procedure that is ordered by a Physician to evaluate or assess the Covered Person's health and well being, screen for possible detection of unrevealed Illness or Injury, improve the Covered Person's health, or extend the Covered Person's life expectancy. Generally, a procedure is routine if there is no personal history of the Illness or Injury for which the Covered Person is being screened. Benefits included as Preventive/Routine Care are listed in the Schedule of Benefits and will be paid subject to any listed limits or maximums. Preventive/Routine Care does not include benefits specifically excluded by this Plan, or treatment after the diagnosis of an Illness or Injury.

Primary Care Physician means a family practitioner, general practitioner, non-specializing internist (i.e., those that work out of a family practice clinic), pediatrician or obstetrician/gynecologist. Generally, these Physicians provide a broad range of services. For instance, family practitioners treat a wide variety of conditions for all family members; general practitioners give routine medical care; internist treat routine and complex conditions in adults; and pediatricians treat Children.

Prudent Layperson means a person with average knowledge of health and medicine who is not formally educated or specialized in the field of medicine.

Qualified means licensed, registered or certified by the state in which the provider practices.

QMSCO means a Qualified Medical Child Support Order in accordance with applicable law.

Reconstructive Surgery means surgical procedures performed on abnormal structures of the body caused by congenital Illness or anomaly, Accident, or Illness. The fact that physical appearance may change or improve as a result of Reconstructive Surgery does not classify surgery as Cosmetic when a physical impairment exists and the surgery restores or improves function.

Retired Employee (Retiree) means a person who was employed full time by the employer who is no longer regularly at work and who is now retired under the employer's formal retirement program.

Significant Break in Coverage means a period of 63 consecutive days during which a person does not have any Creditable Coverage.

Specialist means a provider who treats specific medical conditions. For instance, a neurologist treats nervous disorders, a gastroenterologist treats digestive problems, and an oncologist treats cancer patients. Providers that are not considered a Specialist include, but are not limited to, family practitioners, non-specializing internists, pediatricians, or obstetricians/gynecologists.

Surgical Center means a licensed facility that is under the direction of an organized medical staff of Physicians; has facilities that are equipped and operated primarily for the purpose of performing surgical procedures; has continuous Physician services and registered professional nursing services available whenever a patient is in the facility; generally does not provide Inpatient services or other accommodations; and offers the following services whenever the patient is in the center:

- Provides drug services as needed for medical operations and procedures performed;
- Provides for the physical and emotional well being of the patients;
- Provides Emergency services;
- Has organized administration structure and maintains statistical and medical records.

Telemedicine means the practice of health care delivery, diagnosis, consultation, treatment, transfer of medical data and education using interactive audio, video, or data communications.

Temporomandibular Joint Disorder (TMJ) shall mean a disorder of the jaw joint(s) and/or associated parts resulting in pain or inability of the jaw to function properly.

Terminal Illness or Terminally Ill means a life expectancy of about six months.

Third Party Administrator (TPA) is a service provider hired by the Plan to process claims and perform other administrative services. The TPA does not assume liability for payment of benefits under this Plan.

Totally Disabled is determined by the Plan in its sole discretion and generally means:

- That an Employee is prevented from engaging in any job or occupation for wage or profit for which the Employee is Qualified by education, training or experience; or
- That a covered Dependent has been diagnosed with a physical, psychiatric, or developmental disorder, or some combination thereof, and as a result cannot engage in Activities of Daily Living that a person of like age and sex in good health can perform, preventing an individual from attaining self-sufficiency.
- Diagnosis of one or more of the following conditions is not considered proof of Total Disability. Conditions are listed in the most recent American Psychiatric Association Diagnostic and Statistical Manual (DSM) in the following categories:

    - Organic psychotic disorders, or
    - Personality disorders, or
    - Sexual/gender identity disorders, or
    - Behavior and impulse control disorders, or
    - "V" codes.

Usual and Customary means the amount the Plan determines to be the reasonable charge for comparable services, treatment, or materials in a Geographical Area. In determining whether charges are Usual and Customary, due consideration will be given to the nature and severity of the condition being treated and any medical complications or unusual or extenuating circumstances. **Geographical Area** means a zip code area, or a greater area if the Plan determines it is needed to find an appropriate cross section of accurate data.

You, Your means the Employee.