SUMMARY PLAN DESCRIPTION

Wabash City Schools
Vision Only

For Your

EMPLOYEE BENEFIT PLAN

GENERAL INFORMATION

Covered Employee:

Each person employed by the Employer who in accordance with the terms and conditions of the Plan, has satisfied the requirements for coverage under the Plan until the coverage is terminated and who has been issued a Group Employee Benefit I.D. Card.

Name of Plan: Wabash City Schools Employee Benefit Plan (Plan)

Employer Identification No. (EIN) Assigned by IRS: 35-1102136

Group Number: 6926

Type of plan: Comprehensive Major Medical Benefits

Plan effective date: October 1, 2018

Plan Year: October 1, 2018 to September 30, 2019 and each successive twelve (12) month period

Source of funding: Employer/Employee contributions to Wabash City Schools Employee Benefit Plan

Plan Administrator & Named Fiduciary:

Wabash City Schools
PO Box 744
Wabash IN 46992

Third Party Administrator:

Automated Group Administration, Inc.
7605 Westfield Drive
Fort Wayne, IN 46825
Phone Number: (260) 489-6447

Name and Title of Person(s) Designated as Agent for Service of Legal Process and Address at which Process may be Served:

Service of legal process may be made on the Plan Administrator

Amy Sivley, Superintendent
Wabash City Schools
PO Box 744
Wabash IN 46992

Name, Address, Phone Number and Fax Number of COBRA Coordinator:

Matt Stone Phone Number: (260) 563-2151
Wabash City Schools
PO Box 744
Wabash IN 46992

DISCLOSURES

The Plan is a self funded employee welfare plan established by the Employer in accordance with the Employee Retirement Income Security Act of 1974, as amended from time to time, and other applicable law.

The Employer will establish, and may from time to time change, the contribution amounts required for coverage provided under the Plan for a Covered Person. The Employer will collect such contributions from the Covered Employees and combine such amounts with additional funding required by the Employer.

The Third Party Administrator (TPA) has contracted with the Employer to perform certain administrative functions on behalf of the Plan Administrator. Funding of the Plan is the sole responsibility of the Employer using Employee and Employer contributions. The TPA is not responsible for funding the payment of any claim for a Covered Person.

The Employer has purchased excess loss insurance which will provide reimbursement to the Plan for certain claims paid under the Plan. However the insurance company providing this insurance is not responsible for paying any benefit under the Plan to or on behalf of a Covered Person.

Questions regarding the terms and conditions of the Plan, including coverage or benefits, should be directed to the TPA. If the Covered Person has any questions about their rights under ERISA, the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, may be contacted. The telephone number may be listed in a local telephone directory. The address of the national office is:

Division of Technical Assistance and Inquires
Pension and Welfare Benefits Administration
U. S. Department of Labor
200 Constitution Avenue, N.W.
Washington, D. C. 20210

This Plan is a Non-Grandfathered Health Plan under the Patient Protection and Affordable Care Act.

SCHEDULE OF BENEFITS

Effective Date - October 1, 2025

WAITING PERIOD ..... Ends 12:01 a.m. the first day of the month following date of hire

FULL-TIME EMPLOYMENT ..... Minimum of 30 Hours per Week

A. Employee not covered by the Certified Employment Contract ..... Minimum of 30 Hours per Week

B. Employee covered by the Certified Employment Contract ..... Work specified by the contract to be eligible for the Employer-Sponsored Health Plan

C. Teaching Assistants, Para-Professionals ..... Minimum of 30 Hours per Week
- minimum hours waived during school holidays, school breaks and summer vacation

D. Retired Employee of the Employer in accordance with Indiana Code 5-10-8-2.6 and their spouse ..... No Minimum Hourly Requirement

BENEFITS

MAJOR MEDICAL EXPENSE BENEFITS ..... Not Included

THE MAJOR MEDICAL EXPENSE BENEFITS ARE NOT INCLUDED

VISION BENEFITS

- Vision Examination (One every 12 months)
  - Co-pay $25
  - Maximum Benefit $100
  - Subject to Calendar Year Deductible ..... No
  - Benefit Percentage 100%

- Glasses Lenses
  - Co-pay $0
  - Subject to Calendar Year Deductible ..... No
  - Benefit Percentage 100%
  - Maximum Benefit (Every 12 months)
    - Single (per lens) $50
    - Bifocal (per lens) $65
    - Trifocal (per lens) $75
- Frames
  - Co-pay $0
  - Subject to Calendar Year Deductible ..... No
  - Benefit Percentage 100%
  - Maximum Benefit (Every 24 months) $130

- Contact Lenses
  - Co-pay $0
  - Subject to Calendar Year Deductible ..... No
  - Maximum Benefit (Every 12 months) $130
  - Benefit Percentage 100%

COBRA PROCEDURES

A. Qualifying Event Involving Divorce or Loss of Dependent Status

1. Notification to Plan

Qualified beneficiaries who lose coverage (or will lose coverage) because of a divorce or legal separation or because a dependent no longer qualifies as a Dependent (defined in the Plan), must notify the Plan in writing, via either facsimile or U.S. Mail to indicate the qualified beneficiary's desire for COBRA coverage after the date of the divorce or loss of dependent status. Such notice must be sent to:

COBRA Coordinator indicated on the General Information page of the Plan

Notice may be made by the employee/former employee or a spouse or dependent of the former employee. Such notice may be given before the occurrence of the divorce or loss of dependent status, but must, in all cases, be given no later than sixty (60) days after the date of the divorce or the loss of dependent status. Oral notice or notice by e-mail is not sufficient under these Procedures.

2. Documents Required for Divorce/Separation

When divorce or legal separation is the qualifying event, the qualified beneficiary must provide the Plan with a copy of the Court Decree dissolving the marriage. If the divorce or legal separation has not yet been concluded, the qualified beneficiary must provide the Plan with any court documents that have been filed (such as Petition for Dissolution) and indicate the date that the divorce or legal separation is expected to be final.

B. Qualifying Event Involving Termination, Reduction in Hours, Death and Bankruptcy – Notification by Plan

Qualified beneficiaries who lose coverage because of a termination, reduction in hours, death or bankruptcy will receive a COBRA election form which permits the employee/former employee (and dependents) to elect coverage and indicates the premium for such coverage. The election form will be sent by U.S. Mail, postage pre-paid, to the last known address of the employee/former employee unless the Plan has been notified in writing to the contrary. The last known address shall be deemed to be the most recent address contained in the employee/former employee's personnel file. In the event the employee/former employee changes address, it is his or her responsibility to notify the Plan of any change in address and the Plan shall not be responsible for notices sent to the wrong address if the more recent address was not provided in the above manner. Notification to an employee/former employee who elected spousal coverage will be sent addressed to both individuals. Election forms sent to an employee/former employee that has one or more children/dependants covered shall be addressed to the employee (if the spouse was not covered) or to the employee and spouse (if spousal coverage was elected), and each shall be deemed to include notification to any dependent children, unless the Plan has actual knowledge of a different address for a dependent child before the date the election form is mailed and provided further that any such notification to the Plan was in writing sent via either U.S. Mail or facsimile.

C. Errant Notices

In the event an individual receives a COBRA election form before the date the Plan determines that the individual is not eligible to elect COBRA (either because of an error concerning the individual's eligibility or because the individual was fired for gross misconduct), the Plan will via U.S. Mail notify the individual that they are not eligible for COBRA coverage.

D. Early Termination of COBRA

In the event a qualified beneficiary's COBRA coverage terminates before the duration of COBRA coverage (either 18, 29, or 36 months after the qualifying event), the Plan will notify the qualified beneficiary of the early termination date and the reason for early termination of COBRA coverage.

E. Postmark Date

All notifications, payments and other correspondence from a qualified beneficiary (or a possible qualified beneficiary) shall be deemed to have been received on the date that the item is postmarked, if sent by U.S. Mail. In the event communication or correspondence is sent via facsimile, the communication or correspondence shall be deemed to have been received on the date it is transmitted. All correspondence must be sent to the COBRA Coordinator identified in paragraph A. above.

F. Eleventh Month Disability Extension

COBRA continuees who are determined by Social Security to be disabled within the first 60 days of COBRA continuation coverage (or earlier) may elect to extend the 18 month COBRA period by eleven (11) months. The eleven month extension will only be given if the Plan is notified in writing, via either U.S. Mail or facsimile, of the Social Security determination. This written notification must also contain a copy of the Social Security determination. Qualified beneficiaries are required to request the eleven month extension within 30 days of receiving the Social Security determination and, in any event, must be provided to the Plan before the end of the 18 month COBRA continuation period. Any qualified beneficiary not meeting each of these rules will not be entitled to elect the eleven month extension. Qualified beneficiaries who were originally determined to be disabled but had that determination reversed must notify the Plan within 30 days of notification of the reversal. In the event the qualified beneficiary does not notify the Plan of any such reversal, the qualified beneficiary shall be required to repay the Plan for any claims which were incurred after the date of reversal.

G. Multiple Qualifying Events

In the event a qualified beneficiary experiences a second qualifying event during the original 18 or 29 month period, who wishes to apply for an extension of the 18 or 29 months because of a second qualifying event, must notify the Plan via either U.S. Mail or facsimile, of the occurrence of the second qualifying event within 60 days after the event occurs. Any qualified beneficiary who fails to notify the Plan of the occurrence of the second qualifying event will not be entitled to extend coverage past the end of the 18 or 29 month period. COBRA coverage shall not extend beyond 36 months from the day of the original qualifying event, regardless of the occurrence of multiple qualifying events. Whether the subsequent qualifying event entitles a qualified beneficiary to extend coverage, under the applicable regulations, will be determined by the Plan.

H. Payment Requirements

COBRA payments must be paid monthly in the amount designated on the Election Form. The first COBRA payment is due within forty-five (45) days after the election form is executed. This payment covers the cost of the health care coverage provided from the date of the qualifying event (or loss of coverage, if later) through the date of the election. After the first payment, all subsequent COBRA payments are due on the first of each month for the applicable month. If a monthly premium is not paid by its due date, the qualified beneficiary may pay the premium within a thirty (30) day grace period beginning on the due date for the premium. When the premium is not paid prior to the end of the grace period, COBRA coverage will terminate at the end of the period for which the last premium was paid.

All payments of COBRA premiums should be made by check, money order or cashier's check. If payment is made by personal check, the qualified beneficiary shall be solely responsible for maintaining sufficient funds in his/her account so that the check will clear when presented. If a COBRA payment paid by personal check does not clear when first presented, the Plan shall make a second attempt to cash the check if the Plan has at least five (5) working days notice before the end of the thirty (30) day grace period. It is the obligation of the qualified beneficiary to confirm that his/her COBRA personal checks have cleared the bank. The Plan shall not be under any obligation to notify the qualified beneficiary if a check does not clear. Additionally, if the Plan is presented with a personal check that does not clear, the Plan shall have the option of requiring all subsequent COBRA payments to be made by guaranteed funds (i.e. money order or cashier's check).

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AMENDMENT NO. 1

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The second paragraph of the ***BENEFIT PERCENTAGE AND DEDUCTIBLE*** provision of the Major Medical Expense Benefits section (page 25 of the Plan Document and Summary Plan Description) is hereby deleted in its entirety and replaced as follows:

> The Deductible applies to the Covered Expenses incurred by a Covered Person in each Deductible Accumulation Period, but it applies only once for each Covered Person within the Deductible Accumulation Period regardless of the number of Illnesses or Injuries. However, the maximum amount of Covered Expenses used to satisfy Deductibles for all Covered Persons in a Family during a Deductible Accumulation Period will not exceed the Deductible Per Family shown on the Schedule of Benefits.

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 2

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The PRE-EXISTING CONDITIONS provision (pages 22 - 23 of the Plan Document and Summary Plan Description) is hereby deleted.

The effective date of this Amendment is October 1, 2018.

In all other respects the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)
Signature

COO
Title

AMENDMENT NO. 3

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The definition of DEPENDENT (page 12 of the Plan Document and Summary Plan Description) is hereby deleted in its entirety and replaced as follows:

Dependent means:

A. A Covered Employee's legal spouse who is a resident of the same country in which the Covered Employee resides. Such spouse must have met all requirements for a valid legal marriage; or

B. A Covered Employee's child who meets all of the following conditions:

1. Is a natural child or a legally adopted child, step-child, child placed under the legal guardianship of the Covered Employee or a child placed in the home of the Covered Employee by the relevant agency prior to the date the adoption of the child by the Covered Employee becomes final;

   A child shall be considered placed in the home of the Covered Employee on the date the Covered Employee assumes, and for the period the Covered Employee retains, a legal obligation for support of the child in anticipation of adoption by the Covered Employee;

2. Is less than twenty-six (26) years of age on the last day of the prior month;

   The age limitation above is also waived for any mentally retarded or physically handicapped child covered under the Plan on the attainment of the otherwise limiting age while the child continues to be incapable of self-sustaining employment and is chiefly dependent upon the Covered Employee for support and maintenance. Proof of such incapacity must be furnished by the Covered Employee to the Plan Administrator within thirty-one (31) days of such limiting age and as frequently thereafter as required by the Plan Administrator, but not more frequently than annually after the two (2) year period following the child's attainment of that limiting age.

Persons specifically excluded from the definition of a Dependent are:

A. A spouse legally separated or divorced from the Covered Employee;

B. A person while on active military duty;

C. A person covered under the Plan as a Dependent of another Covered Employee.

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 4

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The ***PLAN EXCLUSIONS AND LIMITATIONS*** (pages 29 - 32 of the Plan Document and Summary Plan Description) is hereby modified as follows:

Exclusion E. is deleted and replaced as follows:

Condition or charge incurred as the result of an injury which occurred while the Covered Person was under the influence of illegal drugs or when the Covered Person was operating a motor vehicle while under the influence of illegal drugs. A person will be considered under the influence of an illegal drug if use of the drug by the Covered Person is established by a laboratory test.

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 5

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The SPECIAL ENROLLMENT PERIOD provision (page 20 of the Plan Document and the Summary Plan Description) is deleted in its entirety and replaced as follows:

SPECIAL ENROLLMENT PERIOD

A Special Enrollment Period is a thirty (30) day period which begins on the following dates:

A. If the Employee declined coverage under the Plan for the Employee or a Dependent because of coverage required to be Creditable Prior Coverage under HIPAA, the date such coverage under the other plan terminated as a result of:

1. Loss of eligibility for coverage under the plan when COBRA continuation coverage is not elected; or

2. Expiration of COBRA continuation coverage.

A Special Enrollment Period also begins when the Employee or Dependent becomes responsible for paying the full premium after the premium was subsidized by an employer or other party. However a Special Enrollment Period does not begin when coverage terminated as a result of:

1. Non-payment of a required premium by or on behalf of a person.

2. Termination of COBRA coverage except at the end of the person's eligibility.

B. The date the Employee acquires a Dependent as the result of marriage, birth, adoption or placement of a child in the home of the Employee prior to adoption of the child by the Employee.

The thirty (30) day period is extended to sixty (60) days from the date the Employee or an Employee's dependent has lost eligibility under Medicaid or the Children's Health Insurance program (CHIP) or becomes eligible for a Medicaid or CHIP premium subsidy.

A Special Enrollment Period also begins on the date stipulated by a Qualified Medical Child Support Order (QMCSO) as defined under ERISA Section 609(a)(2) including a National Medical Support Notice (NMSN). A copy of the Plan Procedures for a QMCSO may be obtained from the Plan Administrator upon request or receipt of a Medical Support Order.

During the Special Enrollment Period, the Employee may Enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also Enroll any Dependent of the Employee under the Plan.

The effective date of this Amendment is October 1, 2018.

In all other respects the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)
Signature

COO
Title

AMENDMENT NO. 6

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

Exclusion L. in the Plan Exclusions and Limitations provision (pages 29-32 of the Plan Document and Summary Plan Description) is hereby deleted in its entirety and replaced as follows:

L. Charges incurred for psychiatric or psychoanalytic care or in connection with treatment of a functional, mental or nervous disorder, alcoholism, chemical dependency or drug abuse except to the extent indicated on the Schedule of Benefits.

The effective date of this Amendment is October 1, 2018.

In all other respects the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 7

THE WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

REINSTATEMENT OF COVERAGE

An Employee, whose coverage under the Plan was terminated as the result of leave of absence of employment, layoff or a reduction of hours, shall be eligible for reinstatement of coverage under the Plan subject to the following conditions:

1. The Employee is rehired or restored to Full-Time Employment within twenty-six (26) weeks after the date of their termination of coverage, in accordance with the Affordable Care Act Rehire Provision.

2. The Employee makes written request for coverage within thirty (30) days after the date of restoration to Full-Time Employment.

3. Dependent Coverage in effect on the termination date of the Employee's coverage, may be reinstated. However, any Dependent not covered on such termination date will not be included under the reinstated Dependent Coverage.

4. The effective date of the reinstated coverage will be 12:01 a.m. on the date of the Employee's restoration to Full-Time Employment. No benefits will be paid for charges incurred after the date of termination of coverage and before the effective date of the reinstated coverage.

5. Covered Expenses incurred prior to the termination of coverage which were applied toward the Deductible or any limit and any benefits which were accumulated toward a maximum, will be carried forward to the effective date of reinstated coverage.

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 8

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The CLAIM FILING AND APPEAL PROCEDURES ("PROCEDURES") provision (pages 34-37 of the Plan Document and Summary Plan Description) is hereby deleted and replaced as follows:

Claim Filing and Appeal Procedures

The following Procedures explain various rules and time limitations for filing a Claim for benefits under the Wabash City Schools Plan ("Plan") and additional rules and time limitations for filing an appeal of a Claim that is wholly or partially denied and/or for filing an external review. For purposes of interpreting these Procedures, the following terms have the following meanings as those terms appear herein:

A. Definitions

Adverse Benefit Determination means any Claim denial or partial denial.

Authorized Representative means an individual designated by the Claimant, in writing and communicated to the Plan Administrator, to exercise the Claimant's rights. An Authorized Representative cannot be any Employee of the Plan Administrator.

Claim means a request for a specific medical treatment or, for treatment which has already been rendered, a request for payment for medical services provided. For purposes of these Procedures, any interaction between a Claimant and a preferred or network provider shall not be treated as a Claim if the medical provider exercises no discretion. Similarly, any reply to a request for a pre-certification which does not deny coverage (or limit coverage) for medical services is not considered a "Claim". Additionally, a medical provider's refusal to render services without payment by the patient is not considered a Claim subject to these Procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered a Claim subject to these Procedures. Notwithstanding the foregoing, any action or inaction by a provider that is not treated as a Claim for these purposes will be treated as a Claim and be reviewed by the appropriate person or entity if a Claimant files a specific request with the Plan that any action or inaction by the provider be treated as a Claim under Plan.

Claimant means any individual filing a Claim under the Plan pursuant to these Procedures. The rights of a Claimant can be exercised by a Claimant's Authorized Representative.

Concurrent Care Claims means a Claim for specific ongoing medical treatment of an Illness or Injury. Except as otherwise specifically noted, all time limitations and other rules and restrictions for Concurrent Care Claims are identical to those for Pre-Service Claims, unless the Concurrent Care Claim qualifies as an Urgent Care Claim, in which case the Urgent Care Claim time limitations apply.

Electronic Notification means the transmission of Claim or medical information via email, fax or any other means other than the delivery of written information via first class mail. Any information transmitted pursuant to these Procedures via Electronic Notification must be resubmitted in writing, sent to the appropriate party via first class mail, within 72 hours of the Electronic Notification.

Final Adverse Benefit Determination means a Claim that is wholly or partially denied after an Internal Appeal.

IRO means an Internal Review Organization that has contracted with the Plan or the Plan's Third Party Administrator which an organization has received applicable accreditation.

Medical Judgment means Claims involving medical necessity, appropriateness of care, health care setting, level or care, effectiveness of a covered benefit and determination as to whether a treatment or procedure is Experimental.

Pre-Service Claims means a Claim for medical care that is required to obtain approval before obtaining care.

Post-Service Claims means a Claim for services already been rendered.

Rescission means any retroactive termination of coverage other than retroactive termination involving an act of fraud or intentional misrepresentation of a material fact.

Urgent Care Claims are those Claims where failing to make a determination (about eligibility, medical necessity, etc.) quickly could seriously jeopardize a Claimant's life, health or ability to gain maximum function, or could subject the Claimant to severe pain that could not be managed without the requested treatment. Notwithstanding the preceding sentence, any Claim designated by the treating Physician as an "Urgent Care Claim" will be treated as such for purposes of these Procedures.

B. Initial Claim Filing Requirements

How to file a Claim.

All Claims must be filed with the Third Party Administrator as designated on the insurance ID card.

Time Limits for Filing Initial Claims

All Claims must be filed with the Third Party Administrator within six (6) months after the expenses were incurred, unless the Claimant was legally incapacitated, in which case the Claim must be filed as soon as reasonably possible after such incapacitation ends.

Time Limits for Review of Initial Claims.

The Third Party Administrator shall review and process the following types of Claims within the following time limitations:

Urgent Care Claims – Initial determinations on Claims considered Urgent Care Claims shall be made as soon as possible but no later than 72 hours after it is received. Initial determinations on Concurrent Care Claims which qualify as Urgent Care Claims shall be made within 24 hours after the Claim is received.

Pre-Service Claims – Initial determinations shall be made within 15 days of the time the Claim is received. This time limitation may be extended by up to 15 days if the Third Party Administrator determines that additional time is necessary due to matters outside the control of the Third Party Administrator.

Post-Service Claims – Initial determinations shall be made within 30 days from the date the Claim is received. This time limitation may be extended by up to fifteen (15) days if the Third Party Administrator determines that additional time is necessary due to matters outside the control of the Third Party Administrator.

Incomplete Claims – For any Claim which does not provide information necessary for the Third Party Administrator to make the initial determination, the Claimant will be notified that additional information is needed within 24 hours for Urgent Care Claims, and within five (5) days for Pre-Service Claims. After receiving notification, the Claimant must provide the missing information within 48 hours for Urgent Health Care Claims and within 45 days for Pre-Service and Post-Service Claims. Failure to provide the missing information within the time deadlines specified shall result in the Claim being denied.

Response to Claim.

If a Claimant's Claim for benefits is wholly or partially denied, any notice of such adverse benefit determination under the Plan will:

1. State the specific reason(s) for the denial or partial denial;
2. Reference the specific plan provisions on which the determination was based;
3. Describe additional material or information necessary to complete the Claim and why such information is necessary;
4. Describe Plan procedures and time limits for appealing the determination (as set forth below) and the right to obtain information about those procedures and the right to sue in federal court;
5. Disclose any internal rule, guidelines, protocol or similar criteria relied on in making the Adverse Benefit Determination (or state that such information will be provided free of charge upon request); and
6. Upon request, provide all diagnostic or treatment codes given by a provider (and information involving interpretation of those codes) at no charge.

Notice of any adverse determination may be provided by the Plan via written or Electronic Notification, provided that an Electronic Notification will be sent via first class mail within seventy-two hours from the date it is originally received.

C. Internal Appeal Procedures

How to File an Appeal. In the event a Claimant's Claim is wholly or partially denied, the Claimant has the right to appeal to the Plan for review of the Claim. All appeals will be decided by the Plan Administrator. Appeals may be made via Electronic Notification by contacting the Third Party Administrator, but any appeal in Electronic form must be sent in writing within 72 hours via first class mail to the Third Party Administrator at the following address:

Automated Group Administration
7605 Westfield Drive
Fort Wayne, IN 46825
260-489-6447

Time Limitation for Filing Appeal. All Claims which are wholly or partially denied may be appealed pursuant to the Procedures set forth below. All appeals must be filed within 180 days of the date that the Claim was totally or partially denied. Failure to file an appeal of a Claim will result in the initial Claim decision becoming final and binding on all parties. Failure to file an appeal within the foregoing time limit will be deemed to void any right the Claimant may have to seek judicial review of the original Claim denial.

Appeal Review Time Limitations. The Plan Administrator shall review the initial determination and make a decision on any appeal of a Claim within the following deadlines:

Urgent Care Claims within 72 hours from the time the appeal was communicated.

Pre-Service Health Care Claims within 30 days from the date the Plan Administrator was notified of the appeal.

Post-Service Health Care Claims within 60 days from the date the Plan Administrator was notified of the appeal.

Your Rights During Appeal. Any Claimant making an appeal will have the opportunity to submit written comments, documents or other information in support of his appeal. Additionally, any Claimant filing an appeal will have all access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the Adverse Benefit Determination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination. After an appeal has been requested, coverage for any ongoing treatment or procedure shall remain covered by the Plan during the appeal process.

Any Claimant initiating an appeal shall, within ten (10) days after the appeal is initiated, be provided with all information considered by the Plan when the Adverse Benefit Determination was made and such Claimant shall be given the opportunity to review their Claim file and present evidence and/or testimony as part of the appeal process.

In the case of an appeal of a Claim denied or partially denied based on Medical Judgment, the Plan Administrator will consult with a health professional with the appropriate training and expertise. The health care professional who is consulted on appeal will not be the same individual who may have been consulted during the initial determination or subordinate of that individual. If the advice of a medical or vocation expert was obtained by the Plan in connection with the denial of your Claim, the names of each such expert shall be provided upon request. This administrative appeal process must be completed before any legal action regarding your Claim can be taken. Additionally, if any such judicial proceedings are undertaken, the evidence presented shall be strictly limited to the evidence presented to the Plan Administrator pursuant to this Claim Appeal Procedures.

Plan Administrator's Right to Construe and Interpret Plan. Making Claim determination or signing an appeal under these Procedures, the Plan document confers upon the Plan Administrator the discretion to construe and interpret the terms of the Plan and determine eligibility for benefits.

Time Limitation for Filing Claimant Action. Subject to other limitations contained in these Claim Filing and Appeal Procedures, in no event may any Claimant file a lawsuit seeking payment of wholly or partially denied Claims more than one year after the Claim is initially denied, or, if later, more than six months after the date the Appeal decision of the Plan Administrator is rendered. Any lawsuit seeking payment for wholly or partially denied Claims must be filed in state or federal court in the county (or federal district court) in which the Plan Administrator is located.

D. Request for External Review

Any Claimant receiving an Adverse Benefit Determination based on Medical Judgment or Rescission may request a review performed by an Internal Review Organization by filing a written request made by via Electronic Notification, which must be made within four (4) months after denial or partial denial of an appeal.

A Claimant may bypass the Plan's Internal Appeal process and proceed with an External Review if the Plan did not comply with the Internal Appeal Procedures unless such failure was (a) de minimus, (b) non-prejudicial to the Claimant, (c) attributed to good cause or matters beyond the Plan's control, or (d) was in the control of an ongoing, good-faith exchange of information between the Claimant and the Plan or not reflective on a pattern or practice of violations by the Plan.

A Claimant's request for diagnostic or treatment codes shall not be considered a request for Internal Appeal or External Review.

Standard External Review Procedures:

Preliminary Review: Within five business days of receiving the request for external review, the Plan shall complete a preliminary review of the request to determine whether:

The Claimant is or was covered under the Plan at the time the health care item or service was requested, or in the case of a retrospective review, was covered in the Plan at the time the health care item or service was provided;
The adverse benefit determination or final adverse benefit determination does not relate to the Claimant's failure to meet the Plan's eligibility requirements;
The Claimant has exhausted the Plan's internal appeal process, unless the Claimant is not required to do so as set forth above; and
The Claimant has provided all the information and forms required to process an external review.

Within one business day of completing the preliminary review, the Plan shall issue a written notice to the Claimant. If the request is complete but not eligible for external review, the notice shall include the reasons it is not eligible and contact information for the DOL's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, the notice shall describe the information or materials needed to complete the request and the Plan must allow the Claimant to perfect the request within the four-month filing period, or 48 hours after the receipt of the notice, whichever is later.

Communications with IRO:

The IRO will timely notify the Claimant in writing of the request's eligibility and acceptance for external review. The notice will include a statement that the Claimant may submit, within 10 business days, additional information in writing that that IRO must consider.
The IRO must maintain records of all claims, and notices associated with the External Review process for six years. It must make the records available for examination for the Claimant, Plan, or state or federal oversight agency upon request, unless the disclosure would violate state or federal privacy laws.

Expedited External Review Procedures

Request for Expedited External Review: A group health plan shall allow a Claimant to make a request for an expedited external review after receiving and adverse benefit determination if:

The time frame for a standard review would seriously jeopardize the health or life of the Claimant and the Claimant has filed a request for an expedited internal appeal; or
The final adverse determination involves an admission, availability of care, continued stay or health care item or service for which the Claimant has received emergency services but has not been discharged from a facility.

Preliminary Review: The Plan shall determine whether the request meets the standards for an external review immediately upon receiving the request for expedited external review. It must also immediately send a notice to the Claimant of its determination regarding eligibility for review.

Referral to Independent Review Organization (IRO): If the Plan determines that the request is eligible for external review, it will assign an IRO in accordance with the standard external review requirements. The Plan must provide all necessary documents and information related to the Claim to the assigned IRO electronically or by telephone or fax or any other available expeditious method. The assigned IRO shall consider any information that is available and appropriate under the procedures for standard review. The assigned IRO must review the *Claim de novo* and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

Notice of Final External Review Decision: The Plan shall require the IRO to notify the Claimant of the final external review decision as expeditiously the Claimant medical condition or circumstances require, but no more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the IRO shall provide written confirmation of the decision to the Claimant and the Plan within 48 hours of providing the initial notice.
To the extent External Review is utilized. The decision by the IRO shall be final and binding on all parties, subject to a Claimant's or the Plan Administrator's right to judicial review.

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 9

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The COVERED EXPENSES provision (pages 26-29 of the Plan Document and the Summary Plan Description) is expanded by adding the following:

W. Preventive Benefits are covered as shown on the Schedule of Benefits.

X. Coverage for Clinical Trials shall be limited to the minimum coverage required under the Patient and Protection Affordable Care Act of 2010 and the regulations and interpretations there under. All expenses directly or indirectly related to a Clinical Trial (including but not limited to drugs, hospitalization, testing, travel, etc.) shall be subject to any limitation or exclusion for Clinical trials. Notwithstanding the foregoing, this Plan will only cover the "routine expenses" of the Clinical Trial but shall not cover:

The cost of the investigational item, device or service.
The cost of items and services provided solely to satisfy data collection and analysis needs and that are not used in direct clinical management.
The cost for a service that is clearly inconsistent with widely accepted and established standards of care for a particular diagnosis.

The PLAN DEFINITIONS provision (pages 8-18 of the Plan Document and the Summary Plan Description) is expanded to include:

Clinical Trial

A phase I, phase II, phase III or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

a federally funded or approved trial;

a clinical trial conducted under an FDA investigational new drug application; or

a drug trial that is exempt from the requirement of an FDA investigational new drug application.

Preventive Services

Shall include services with a routine/preventive diagnosis and also includes:

1. Evidence-based items or services with an A or B rating recommended by the United States Preventive Services Task Force.

2. Immunizations for routine use in children, adolescents, or adults recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention;

3. Evidence-Informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA) for infants, children and adolescents; or;

4. Other evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by HRSA for women.

The effective date of this Amendment is October 1, 2018.

In all other respects the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)
Signature

COO
Title

AMENDMENT NO. 10

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

Item H. of the** PLAN EXCLUSIONS AND LIMITATIONS **provision (Pages 29 – 32 of the Plan Document and Summary Plan Description) is hereby deleted in its entirety and replaced as follows:

H. Condition or charge resulting from or incurred in the course of employment (whether such employment is with the Employer, another employer, or self-employment) when the Covered Person is covered or is required by law to be covered by workers compensation insurance.

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 11

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The ***LATE ENROLLMENT*** provision (page 20 of the Plan Document and Summary Plan Description) is hereby deleted in its entirety and replaced as follows:

A Late Entrant may only Enroll during the one (1) month period (August 1 – August 31) beginning two (2) months prior to the beginning of a Plan Year for coverage to be effective at the beginning of the Plan Year. The following items must be provided for the Late Entrant during the one (1) month enrollment period:

1. Enrollment Form

2. Medical Questionnaire

3. Other information requested by the Plan Administrator

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 12

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The ***DEPENDENT ELIGIBILITY*** provision (pages 19 – 20 of the Plan Document and Summary Plan Description) is hereby deleted in its entirety and replaced as follows:

DEPENDENT ELIGIBILITY

A Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for Dependent Coverage, subject to all limitations and requirements of the Plan, and in accordance with the following:

A. Newborn children of a Covered Employee will be covered from the moment of birth for Illness or Injury, including the necessary care or treatment of medically diagnosed Congenital Birth Defects, birth abnormalities or prematurity, provided the child is Enrolled as a Dependent of the Covered Employee within thirty (30) days of the child's date of birth. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.

B. A spouse will be considered a Dependent from the date of marriage.

C. If a child is acquired, other than at the time of birth, due to a court order or marriage, the child will be considered a Dependent from the date of such court order or marriage.

However, a Dependent who was eligible to enroll for coverage under the policy replaced by the Plan, but on the day preceding the Plan Effective Date was no longer eligible to enroll, will not become eligible to Enroll under the Plan as of the Plan Effective Date. Such Dependent can Enroll after the Plan Effective Date when eligible as a Late Entrant or during a Special Enrollment Period.

A working spouse is not eligible to enroll for coverage under the Plan, or continue under the Plan, if:

The spouse is eligible for medical expenses insurance under a plan sponsored by the spouse's employer (whether the spouse is currently covered or previously declined coverage under that plan).

The effective date of this Amendment is October 1, 2018.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 13

THE WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The PLAN EXCLUSION AND LIMITATIONS (page 29-32 of the Plan Document and the Summary Plan Description):

W. Charge for Physician's fee for any treatment which is not rendered by or in the physical presence of a Physician

is deleted in its entirety and replaced with:

W. Charge for Physician's fees for any treatment which is not rendered by or in the physical presence of a physician or not provided via an interactive audio and video telecommunications system that allows for real-time communication between the Physician and the Member. Charge for Telehealth originating site facility fees (location of the member at the time of service).

The effective date of this Amendment is May 12, 2023.

In all other aspects the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 14

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

The definition of Emergency Care (page 13 of the Plan Document and the Summary Plan Description) is deleted in its entirety and replaced with:

Emergency Care means a medical condition manifesting itself by **acute symptoms of sufficient severity** (including severe pain) such that a **prudent layperson** with an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

1. **Serious jeopardy** to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child);
2. **Serious impairment** to bodily functions; or
3. **Serious dysfunction** of any bodily organ or part.

It does not include care provided in an Emergency Room for the convenience of the Covered Person or a provider of health care services.

The effective date of this Amendment is June 1, 2025.

In all other aspects the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

AMENDMENT NO. 15

The WABASH CITY SCHOOLS EMPLOYEE BENEFIT PLAN (Plan) is hereby amended as follows:

1. The ***EMPLOYEE EFFECTIVE DATE*** section (pages 20 - 21 of the Plan Document and Summary Plan Description) is deleted in its entirety and replaced as follows:

   EMPLOYEE EFFECTIVE DATE

   Coverage under the Plan for an Employee will become effective on the date determined in accordance with the following:

   A. If the Employee is not required to make a contribution for his coverage, coverage will automatically become effective on the date of his eligibility.

   B. If the Employee is required to make a contribution for his coverage and the Employee has Enrolled within thirty (30) calendar days after the date of his eligibility, coverage will become effective on the date of his eligibility.

   C. If the Employee has Enrolled during a Special Enrollment Period, coverage will become effective on the first day of the Special Enrollment Period.

   An Employee, who does not Enroll within thirty (30) days after the date of his eligibility, will be eligible to Enroll later only if the Employee qualifies for a Special Enrollment Period.

   An Employee's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

2. The ***DEPENDENTS EFFECTIVE DATE*** section (page 21 of the Plan Document and Summary Plan Description) is deleted in its entirety and replaced as follows:

   DEPENDENTS EFFECTIVE DATE

   Coverage under the Plan will become effective with respect to a Dependent of an Employee on the date determined in accordance with the following:

   A. If the Covered Employee is not required to make a contribution for coverage of the Dependent, the coverage will automatically become effective on the date of eligibility of the Dependent.

   B. If the Covered Employee is required to make a contribution for coverage of the Dependent and the Covered Employee has Enrolled the Dependent within thirty (30) calendar days after the date of eligibility of the Dependent, coverage for the Dependent will become effective on the date of eligibility of the Dependent.

   C. If the Covered Employee has Enrolled the Dependent during a Special Enrollment Period, coverage will become effective on the first day of the Special Enrollment Period. However coverage for a Newborn or an adopted child will become effective as of the date of birth or placement for adoption provided the child is Enrolled within thirty (30) days after first becoming eligible.

   A Covered Employee, who does not Enroll a Dependent within thirty (30) days after the date of eligibility of the Dependent, will be eligible to Enroll the Dependent later only if the Dependent qualifies for a Special Enrollment Period.

   A Dependent's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

   If Dependent Coverage is effective retroactively, all terms, conditions and limitations of the Plan are applicable and must be complied with at the time a charge is incurred.

The effective date of this Amendment is October 1, 2025.

In all other respects, the terms and conditions of the Plan remain unchanged.

Wabash City Schools
Plan Administrator

Matt Stone (Nov 14, 2025 11:59:42 EST)

Signature

COO

Title

TABLE OF CONTENTS

ADDITIONAL BENEFITS

INTRODUCTION

The Employer hereby establishes the benefits, rights and privileges which shall pertain to Covered Persons, as herein defined, and for whom benefits are provided through a fund established by the Employer and hereinafter referred to as the "Plan".

PURPOSE

The purpose of the Plan Document is to set forth the provisions of the Plan which relate to the payment of certain health or disability benefits.

NAMED FIDUCIARY

The Employer shall be the Named Fiduciary, unless otherwise indicated on the GENERAL INFORMATION page, within the meaning of Section 405(a) of ERISA.

PLAN ADMINISTRATOR

The Employer shall be the Plan Administrator until the Employer has designated another party in writing as the Plan Administrator. The Employer shall also serve as the Plan Administrator for the period following the resignation of a Plan Administrator until a successor Plan Administrator has been appointed in writing.

The Plan Administrator has the following duties and responsibilities:

1. Maintain and retain Plan documents and records;
2. Interpret and administer the Plan in accordance with its terms and conditions;
3. Ratify or establish procedures relevant to the Plan;
4. Contract with third party vendors to provide services deemed appropriate under the Plan;
5. Answer questions and decide disputes relative to person's rights under the Plan;
6. Appoint or remove a Third Party Administrator;
7. Exercise general administrative authority over the Third Party Administrator;
8. Amend or terminate the Plan; and
9. Perform all necessary or required reporting.

The Plan Administrator may exercise discretion in the interpretation of the terms and conditions of the Plan. Such interpretation, to the extent it is not in contradiction to the written terms and conditions of the Plan Document, shall be binding upon the Employer, a Covered Person and a Third Party Administrator.

CONTRIBUTIONS TO THE PLAN

Contributions to the Plan are to be made on the following basis:

1. The Plan Administrator shall from time to time evaluate the costs of the Plan and determine the amount to be contributed by the Employer and the amount to be contributed (if any) by each Covered Employee.

2. Notwithstanding any other provision of the Plan, the Employer's obligation to pay claims otherwise allowable under the terms of the Plan shall be limited to its obligation to make contributions to the Plan as set forth in the preceding paragraph. Payment of said claims in accordance with these procedures shall discharge completely the Employer's obligation with respect to such payments.

3. On and after the effective date of termination of the Plan, the obligation of the Employer to make additional contributions to the Plan shall be limited to the amount required to assure payment of benefits under the Plan for expenses incurred prior to such date of termination.

AMENDMENT AND TERM/NATION OF THE PLAN

This Plan may be amended at any time by written resolution of the Plan Administrator's Board of Directors. Said resolution and amendment shall state the effective date of the amendment and shall be communicated to all persons participating in this Plan as soon as possible after the amendment is adopted. Any amendment that reduces benefits under the Plan shall not be effective until first communicated to such persons.

If the Plan is amended or terminated, no Employee or their Dependent or beneficiary shall be entitled to receive any other benefit described in the Plan and shall not be entitled to receive any different type of coverage or replacement coverage. Upon termination of the Plan, in the event that the assets of the Plan are insufficient to fund claims incurred, the Plan Administrator shall have the sole and absolute discretion to make any pro rata or other adjustment of benefits, if necessary, so long as said adjustment is made in a non-discriminatory manner.

CONTINUATION COVERAGE RIGHTS UNDER COBRA

(Applicable only while the Employer is subject to COBRA)

Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage is available to a Covered Employee who would otherwise lose coverage under the Plan. It can also become available to Covered Dependents under the Plan when they would otherwise lose their coverage under the Plan. An interested person can review the COBRA Procedures for additional information.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "Qualifying Event". Specific Qualifying Events are listed below. After a Qualifying Event, COBRA continuation coverage will be offered to each person who is a "Qualified Beneficiary". Each Covered Person could become a Qualified Beneficiary if coverage under the Plan is lost because of the Qualifying Event. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage - there is no Employer subsidy.

A Covered Employee will become a Qualified Beneficiary if coverage under the Plan ends as a result of either of the following Qualifying Events:

- Hours of employment are reduced, or
- Employment ends for any reason other than gross misconduct by the Covered Employee.

A covered spouse will become a Qualified Beneficiary if coverage under the Plan ends as a result of any of the following Qualifying Events:

- The Covered Employee dies;
  The Covered Employee's hours of employment are reduced;
- Employment of the Covered Employee ends for any reason other than gross misconduct by the Covered Employee;

- The Covered Employee is entitled to Medicare benefits (under Part A, Part B, or both); or
- The Covered Employee is divorced or legally separated from their spouse.

A covered child will become a Qualified Beneficiary if coverage under the Plan ends as a result of any of the following Qualifying Events:

- The Covered Employee dies;
- The Covered Employee's hours of employment are reduced;
- Employment of the Covered Employee ends for any reason other than gross misconduct by the Covered Employee;
- The Covered Employee is entitled to Medicare benefits (Part A, Part B, or both);
- The Covered Employee is divorced or legally separated from their spouse; or
- The covered child is no longer eligible for coverage under the Plan as a Dependent.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a Qualifying Event. If a proceeding in bankruptcy is filed, and that bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee will become a Qualified Beneficiary with respect to the bankruptcy. Covered Dependents will also become Qualified Beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

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

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the COBRA Coordinator has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, death of the Covered Employee, commencement of a proceeding in bankruptcy with respect to the Employer, or the Covered Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the Employer will notify the Plan Administrator of the Qualifying Event.

The Covered Employee Must Give Notice of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Covered Employee or a dependent child losing coverage under the Plan as a Covered Dependent), the COBRA Coordinator must be notified within 60 days (review the COBRA Procedures in your SPD for specific rules) after the Qualifying Event occurs. You must provide this notice to:

COBRA Coordinator indicated on the General Information page of the Plan

How is COBRA Coverage Provided?

After the COBRA Coordinator receives notice that a Qualifying Event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. A Covered Employee may elect COBRA continuation coverage on behalf of their spouse, and either the Covered Employee or their spouse may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Covered Employee, the Covered Employee becoming entitled to Medicare benefits (under Part A, Part B, or both), the divorce or legal separation of the Covered Employee, or a dependent child's losing coverage as a Covered Dependent, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Covered Employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18 month period of COBRA continuation coverage can be extended:

Disability extension of 18 month period of continuation coverage

If a Covered Person is determined by the Social Security Administration to be disabled and the COBRA Coordinator is notified in a timely fashion, each Covered Person may be entitled to receive (while the disability continues) up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18 month period of continuation coverage. An interested person can review the COBRA Procedures for additional rules.

Second qualifying event extension of 18 month period of continuation coverage

If a Covered Person experiences another Qualifying Event while receiving 18 months of COBRA continuation coverage, each Covered Dependent (but not the Covered Employee) can get up to 18 months additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to each Covered Dependent receiving continuation coverage if the Covered Employee or former employee dies, becomes entitled to Medicare benefits (under Part A, Part B, or both), or gets divorced or legally separated, or available to a Covered Dependent if the Covered Dependent stops being eligible under the Plan as a Dependent. The extension is available only if the event would have caused the Dependent to lose coverage under the Plan had the first Qualifying Event not occurred.

Questions

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

Keep Your Plan Informed of Address Changes

In order to protect rights under the Plan, the Covered Employee should keep the COBRA Coordinator informed of any change in the mailing address for the Covered Employee or a Covered Dependent. The Covered Employee should also keep a copy of any notices sent to the COBRA Coordinator.

COBRA Coordinator

The COBRA Coordinator is indicated on the General Information page of the Plan.

PLAN DEFINITIONS

Certain words and phrases are listed below with the definition or explanation of the manner in which the term is used in the Plan Document. Any term not listed shall be understood by its normal meaning within the context in which it is used.

Masculine pronouns used in the Plan Document shall include both the masculine and feminine gender unless the context indicates otherwise.

Words used in the Plan Document in the singular or plural shall also be construed as though they were in the plural or singular, as the case may be, in all cases where they would so apply.

Ambulatory Surgical Center means specialized institution or facility, either free standing or as part of a Hospital which:

A. Is established equipped and operated in accordance with applicable laws of the jurisdiction in which it is located primarily for the purpose of performing surgical procedures;

B. Is operated under the supervision of a Physician who devotes full-time to such supervision and permits a surgical procedure to be performed only by a Physician who at the time of the surgical procedure is privileged to perform such procedure in at least one Hospital in the area;

C. It requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the surgical procedure;

D. It provides the full-time services of one or more graduate nurses for patient care in operating rooms and post anesthesia recovery rooms. Also there shall be one registered nurse for each post anesthesia recovery room;

E. It maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require Hospital confinement after the surgical procedures; and

F. It maintains medical records for each patient; such records shall contain a diagnosis, medical history, operative report and post operative report.

An office maintained by a Physician for the practice of medicine or dentistry, or for the purpose of performing terminations of Pregnancy, shall not be considered to be an Ambulatory Surgical Center.

Amendment means a formal document that changes the provisions of the Plan Document.

Benefit Percentage means that portion of Covered Expenses in excess of the Deductible to be paid by the Plan in accordance with the coverage provisions as stated in the Plan. It *is* the basis used to determine any out-of-pocket expenses in excess of the Deductible which are to be paid by the Employee.

Birth Center means a facility which:

A. Is mainly a place for the delivery of a child or children at the end of a normal pregnancy; and

B. Meets one or both of the following two tests:

1. Is licensed as a birth center under the laws of the state where it is located; and

2. Meets all of the following requirements:

a. Is operated in accordance with the laws of the state where it is located;

b. Is equipped to perform all of the needed routine diagnostic and laboratory tests;

c. Has trained staff and equipment which is able to properly treat potential emergencies of the mother and child;

d. Is operated under the full-time supervision of a physician or a registered nurse (R.N.);

e. Has at all times a written agreement with at least one hospital in the area for immediate acceptance of a complication;

f. Maintains all medical records for each patient; and

g. Is expected to discharge or transfer each patient within twenty-four (24) hours after the delivery.

Calendar Month means a period of time commencing on the first day of a month and ending on the last day of the same month.

Calendar Year means a period of time commencing on January 1 and ending on December 31 of the same given year.

Close Relative means the spouse, parent, brother, sister, child, or spouse's parent of the Covered Person.

COBRA means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time.

College, see definition of University.

Complications of Pregnancy means:

A. Conditions, requiring Hospital confinement (when Pregnancy is not terminated), whose diagnoses are distinct from Pregnancy but are adversely affected by Pregnancy, including but not limited to gestational diabetes, acute nephritis, nephrosis, cardiac decompensation, missed abortion, hyperemesis gravidarum, pre-eclampsia and similar medical and surgical conditions of comparable severity, BUT SHALL NOT INCLUDE false labor, occasional spotting, Physician prescribed rest during the period of Pregnancy, morning sickness and similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct Complication of Pregnancy.

B. Non-elective cesarean section, termination of ectopic Pregnancy, and spontaneous termination of Pregnancy, occurring during a period of gestation in which a viable birth is not possible.

Congenital Birth Defect means a medical condition that existed at birth and is diagnosed within the first five (5) years of life.

Convalescent Nursing Facility means an institution, or distinct part thereof, operated pursuant to law which meets all of the following conditions:

A. It is licensed to provide, and is engaged in providing, on an Inpatient basis, for persons convalescing from Illness or Injury, professional nursing services rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a Physician or Registered Nurse and physical restoration services to assist patients to reach a degree of body functioning to permit self-care in essential daily living activities;

B. Its services are provided for compensation from its patients and under the full-time supervision of a Physician or Registered Nurse;

C. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse;

D. It maintains a complete medical record on each patient;

E. It has an effective utilization review plan;

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

G. It is approved as a provider of services under Medicare.

This term shall also apply to an institution which otherwise meets the required conditions, referring to itself as a Skilled Nursing Facility, Extended Care Facility, Convalescent Nursing Home, or any such other similar nomenclature .

Convalescent Period means a period of time commencing with the date of confinement by a Covered Person in a Convalescent Nursing Facility. Such confinement must meet all of the following conditions

A. Such confinement must commence within fourteen (14) days of the Covered Person's discharge from a Hospital;

B. Said Hospital confinement must have been for a period of not less than three (3) consecutive days;

C. It provides 24-hour per day nursing services by licensed nurses, under the direction of a full-time Registered Nurse; and

D. Both the Hospital and convalescent confinements must have been for the care and treatment of the same Illness or Injury.

A Convalescent Period will terminate when the Covered Person has been free of confinement in any and all institutions providing Hospital or nursing care for a period of ninety (90) consecutive days. A new Convalescent Period shall not commence until a previous Convalescent Period has been terminated.

The attending Physician must supply medical records for the Covered Person and certify that the proper treatment of the Illness or Injury would require continued confinement as an Inpatient in a Hospital in the absence of the services and supplies provided in a Convalescent Nursing Facility.

Co-pay means a specified dollar amount which must be paid by the Covered Person each time a specified treatment, service or supply is provided before the Covered Expense in excess of such amount can be considered for payment under the Plan at the Benefit Percentage.

Cosmetic Procedure means a medical or surgical procedure performed for the purpose of changing or altering the appearance of the body for any reason whether Medically Necessary or not.

Covered Dependent means a Dependent of a Covered Employee meeting the requirements for coverage as specified in the Plan Document while such Dependent remains properly enrolled for coverage in accordance with the provisions of the Plan Document.

Covered Employee means an Employee of the Employer meeting the requirements for coverage as specified in the Plan Document while such Employee remains properly enrolled for coverage in accordance with the provisions of the Plan Document.

No person serving as a director of the Employer may be a Covered Person except if the person is otherwise eligible for coverage under the Plan as an Employee of the Employer.

Covered Expense means the portion of a charge, incurred by a Covered Person for a health or medical treatment, service or supply, which is payable, subject to the Deductible and Benefit Percentage, as a benefit in accordance with the terms and conditions of the Plan.

Covered Person means a Covered Employee or a Covered Dependent.

Creditable Prior Coverage means coverage under a prior plan which will be recognized under the Plan to reduce the period during which coverage for Pre-Existing Conditions is excluded or reduced.

Custodial Care means care rendered to maintain the current condition of the Covered Person whether or not Totally Disabled, when improvement in their current condition is not anticipated. Such care may be designed to assist in the activities of daily living or personal care such as bathing, dressing, feeding, preparation of special diets, assistance in walking or in getting in and out of bed, and supervision over medication which can normally be self-administered.

Deductible means a specified dollar amount of Covered Expenses not payable under the Plan which must be incurred in each Deductible Accumulation Period before Covered Expenses in excess of such amount can be considered for payment at the Benefit Percentage.

Deductible Accumulation Period means the period of time during which Covered Expenses equal to the Deductible must be incurred before Covered Expenses incurred by the Covered Person during the period in excess of the Deductible can be considered for payment at the Benefit Percentage.

Dependent means:

A. A Covered Employee's legal spouse who is a resident of the same country in which the Covered Employee resides. Such spouse must have met all requirements for a valid legal marriage; or

B. A Covered Employee's child who meets all of the following conditions:

1. Is a resident of the same country in which the Covered Employee resides;

2. Is unmarried;

3. Is a natural child, legally adopted child, step-child in the custody of the Covered Employee, child placed under the legal guardianship of the Covered Employee or a child placed in the home of the Covered Employee by the relevant agency prior to the date the adoption of the child by the Covered Employee becomes final;

   A child shall be considered placed in the home of the Covered Employee on the date the Covered Employee assumes, and for the period the Covered Employee retains, a legal obligation for support of the child in anticipation of adoption by the Covered Employee;

4. Is less than nineteen (19) years of age. This requirement is waived while the child is less than twenty- five (25) years of age and is enrolled as a Full-Time Student in a high school, College or University located in the United States.

   The age limitation above is also waived for any mentally retarded or physically handicapped child covered under the Plan on the attainment of the otherwise limiting age while the child continues to be incapable of self-sustaining employment and is chiefly dependent upon the Covered Employee for support and maintenance. Proof of such incapacity must be furnished by the Covered Employee to the Plan Administrator within thirty-one (31) days of such limiting age and as frequently thereafter as required by the Plan Administrator, but not more frequently than annually after the two (2) year period following the child's attainment of that limiting age.

Persons specifically excluded from the definition of a Dependent are:

A. A spouse legally separated or divorced from the Covered Employee;

B. A person while on active military duty;

C. A person eligible for coverage under the Plan as a Covered Employee; however, a Covered Employee's spouse who meets all of the conditions of the definition, except that the spouse is eligible for coverage under the Plan as a Covered Employee, may be considered a Dependent of the Covered Person; or

D. A person covered under the Plan as an Employee or a Dependent of another Covered Employee.

Dependent Coverage means eligibility under the terms of the Plan for benefits payable as a consequence of Covered Expenses incurred by a Covered Dependent resulting from an Illness or Injury.

Durable Medical Equipment means equipment which is:

A. Able to withstand repeated use;
B. Primarily and customarily used to serve a medical purpose; and

C. Not generally useful to a person in the absence of an Illness or Injury.

Emergency Care means medical care for an Illness or Injury which is:

A. Life threatening; or

B. Expected to significantly worsen without immediate medical or surgical treatment.

It does not include care provided in an Emergency Room for the convenience of the Covered Person or a provider of health care services.

Emergency Room means a distinct area of a Hospital supervised by a Physician where 24-hour Emergency Care is available to Outpatients. It does not include an Urgent Care Facility.

Employee means a person retained for Full-Time Employment by the Employer.

Employer means the legal entity named the Employer in the Plan Document.

Enrolled means the Employee has requested coverage for a person by completing the enrollment form, provided any other required information including evidence of insurability, the TPA has received the required information and if required, the person has been approved for coverage by the TPA.

ERISA refers to the Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental Procedures or Experimental Treatments means any treatment, procedure, facility, equipment, drug, service, or supply which:

A. Is not accepted as standard medical treatment for the condition being treated; or

B. Requires but had not received federal or other governmental agency approval at the time of service.

The final determination will be made by a medical policy committee of the Employer consistent with the opinion of at least two independent Physicians. Each Physician will be Board Certified in the specialty for the condition being considered and will not be involved in providing (or associated with the Physician who will provide) the proposed medical treatment plan.

Family means a Covered Employee and his Covered Dependents.

Full-Time Employment (Full-Time Employee) means a basis of work whereby an Employee is employed for a Wage or Salary by the Employer for at least the minimum number of hours as shown on the Schedule of Benefits. Such work may occur either at the usual place of business of the Employer or at a location to which the business of the Employer requires the employee to travel, and for which he receives a Wage or Salary from the Employer. Unless indicated otherwise on the Schedule of Benefits, seasonal employment does not constitute Full-Time Employment, regardless of the number of hours worked.

The first day of Full-Time Employment is the first full day of employment for at least the proportionate number of hours for Full-Time Employment shown on the Schedule of Benefits.

Full-Time Student means a person who is enrolled in and regularly attending a high school, College or University for the minimum number of credit hours required by that University or College in order to maintain full-time student status.

HIPAA means the Health Insurance Portability and Accountability Act of 1996, as amended from time to time.

Home Health Care Agency means a public or private agency or organization that specializes in providing medical care and treatment in the home. Such a provider must meet all ofthe following conditions:

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

B. It has policies established by a professional group associated with the agency or organization; this professional group must include at least one Physician and at least one Registered Nurse to govern the services provided, and it must provide for full-time supervision of such services by a Physician or Registered Nurse;

C. It maintains a complete medical record on each person served; and

D. It has a full-time administrator.

Home Health Care Plan means a program established in writing by the Covered Person's attending Physician and approved by the Plan Administrator for the continued care and treatment of the Covered Person. The attending Physician must certify that the proper treatment of the Illness or Injury would require confinement as a resident Inpatient in a Hospital in the absence of the services and supplies provided by the Home Health Care Agency.

Hospice means a health care program approved by the Plan Administrator providing a coordinated set of services rendered at home, in Outpatient settings or in institutional settings for a Covered Person suffering from a condition having a terminal prognosis. A Hospice must have an interdisciplinary group of personnel which includes at least one Physician and one Registered Nurse, and it must maintain central clinical records on all patients. A Hospice must meet the standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospice Benefit Period means a specified amount of time during which the Covered Person undergoes treatment under a Hospice. Such time period begins on the date the attending Physician of a Covered Person certifies a diagnosis of terminal Illness or Injury, and the Covered Person is approved for a Hospice program by the Plan Administrator. The period shall end the earliest of six (6) months from such date or at the death of the Covered Person. Subject to the consent of the Plan Administrator, the period may be extended if the attending Physician certifies that the Covered Person is still terminally ill.

Hospital means an institution which meets all of the following conditions:

A. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis at the patient's expense;

B. It is established, licensed, and operated as a hospital in accordance with the laws of the jurisdiction in which it is located;

C. It maintains on its premises all the facilities necessary to provide for the diagnosis and the medical and major surgical treatment of an Illness or an Injury;

D. Such treatment is provided for compensation by or under the supervision of Physicians, with continuous twenty-four (24) hour nursing services by Registered Nurses;

E. It maintains a complete medical record on each person served;

F. It is accredited as a hospital by the Joint Commission on the Accreditation of Hospitals (JCAH);

G. It is approved as a provider of services under Medicare; and

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

Hospital Miscellaneous Expenses means the actual charges made by a Hospital on its own behalf for services and supplies rendered to the Covered Person which are Medically Necessary for the treatment of such Covered Person. Hospital Miscellaneous Expenses do not include charges for Room and Board or for professional services (including intensive nursing care by whatever name called), regardless of whether the services are rendered under the direction of the Hospital or otherwise.

Illness means a bodily disorder, disease, physical sickness, mental infirmity, or nervous disorder of a Covered Person. A recurrent Illness will be considered one Illness. Concurrent Illnesses will be considered one Illness unless the concurrent Illnesses are totally unrelated. All such disorders existing simultaneously which are due to the same or related causes shall be considered one Illness. However, if a Covered Person resumes the normal activities of a person of like age and sex for a continuous period of twelve {12} months, an expense incurred after such twelve (12) months will be considered to have resulted from a separate Illness.

Incurred Expense means the charge for a medical treatment, service or supply rendered to a Covered Person. Such charge shall be considered to have been incurred on the date the treatment or service was provided or the supply purchased.

Injury means a bodily condition which results directly from an accident and independently of all other causes.

Inpatient means the classification of a Covered Person while such Covered Person remains admitted to a Hospital as a registered bed patient for medical care, and charges are made for Room and Board as a result of such treatment.

Intensive Care Unit means a section, ward, or wing within a Hospital which is separated from other facilities and:

A. Is operated exclusively for the purpose of providing professional medical treatment for critically ill patients;

B. Has special supplies and equipment necessary for such medical treatment available on a standby basis for immediate use; and

C. Provides constant observation and treatment by Registered Nurses or other highly trained Hospital personnel.

Late Entrant means either an Employee or a Dependent of Covered Employee who submits a request for coverage under the Plan more than thirty (30) days after the date of their eligibility.

Licensed Practical Nurse means an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.

Massage and Manipulation Treatment means treatment for the detection or correction of structural imbalance, distortion or subluxation in human body, by manual or mechanical means, for the purpose of removing nerve interference or the effects thereof.

Medically Necessary describes health care treatments, services or supplies which are appropriate and consistent with the diagnosis and treatment of a medical condition and which. in accordance with generally accepted medical standards, could not have been omitted or performed by a less expensive procedure or in a less expensive setting or substituted by a less expensive service or supply without adversely affecting the patient's condition or the quality of medical care rendered.

Medicare means the Part A and Part B plans described in Title XVIII of the United States Social Security Act, as amended from time to time.

Morbid Obesity means a Covered Person has:

1. A weight of at least two (2) times their ideal weight for frame, age, height and gender as specified in the 1983 Metropolitan Life Insurance tables; or

2. A body mass index of at least thirty-five (35) kilograms per meter squared with comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea or diabetes; or

3. A body mass index of at least forty (40) kilograms per meter squared without comorbidity.

The body mass index equals weight in kilograms divided by height in meters squared.

Newborn refers to an infant child from the date of birth until the initial Hospital discharge or until the child is fourteen (14) days old, whichever occurs first.

OBRA 93 means the Omnibus Budget Reconciliation Act of 1993, as amended from time to time.

Occupational Therapy as distinct from Physical Therapy, is training to restore or develop work related skills.

Orthotic Appliance means an external device designed specifically for the Covered Person and intended to correct a defect in form or function of the human body.

Outpatient means the classification of a Covered Person while such Covered Person is receiving medical care, treatment, services or supplies at home, in an Emergency Room, Urgent Care Facility, Ambulatory Surgical Center, Physician's office, Outpatient Psychiatric Facility, Outpatient Alcoholism Treatment Facility or a Hospital if not admitted as an Inpatient.

Outpatient Alcoholism Treatment Facility means an institution which:

A. Provides a program for the diagnosis, evaluation, and effective treatment of alcoholism;

B. Provides detoxification services needed with such treatment program;

C. Provides infirmary-level medical services or arranges with a Hospital in the area for any other medical services that may be required;

D. Is at all times supervised by a staff of Physicians;

E. Provides at all times skilled nursing care by Licensed Practical Nurses or Registered Nurses who are directed by a full-time Registered Nurse;

F. Prepares and maintains a written plan of treatment for each patient based on medical, psychological and social needs;

G. Maintains a complete medical record on each person served; and

H. Meets all required licensing standards.

Outpatient Psychiatric Facility means an administratively distinct governmental, public, private or independent unit or part of such unit that provides Outpatient mental health services and which provides for a psychiatrist who has regularly scheduled hours in the facility, and who assumes the overall responsibility for coordinating the care of all patients.

Physical Therapy as distinct from Occupational Therapy, is training required to restore independence in performing activities of daily living such as dressing oneself, eating, writing or walking.

Physician means a practitioner who is:

A. A legally qualified physician or surgeon; or is a professional person deemed by state law to be the same as a legally qualified physician;

B. Acting within the lawful scope of his license to treat an Illness or Injury;

C. Not the Covered Person receiving the treatment from himself; and

D. Not a Close Relative of the Covered Person receiving treatment.

Plan means the terms and conditions of the health care benefit plan described in the Plan Document.

Plan Year means, for the first year, the period commencing on the Plan Effective Date and ending on the last day of the month preceding the date twelve months subsequent to the Plan Effective Date. Each subsequent Plan Year is the twelve month period commencing at the end of the previous Plan Year.

Pre-Existing Condition means an Illness or Injury of a Covered Person for which the Covered Person has been under the care of a Physician or has received (or has been recommended to receive) medical care, advice, consultation or services or has taken medication within the six (6) month period immediately preceding the earlier of the following dates:

A. Date of the first day of the Waiting Period for the Covered Person when the Covered Person was Enrolled within thirty (30) days after the end of the Waiting Period; or

B. The Covered Person's effective date of coverage under the Plan.

However the following conditions will not be considered Pre-Existing Conditions:

A. Conditions of a Newborn when coverage under the Plan is effective within thirty (30) days after birth;

B. Conditions of an adopted child when coverage under the Plan is effective within thirty (30) days after adoption or placement with the Covered Employee for adoption; and

C. Pregnancy.

Preferred Providers Organization (PPO) means Hospitals, Physicians and other providers of medical care, treatment, services and supplies if identified as such on the Schedule of Benefits.

Pregnancy means that physical state which is expected to result in childbirth.

Psychiatric Care or Psychoanalytic Care means diagnostic measures or treatment for a mental illness or disorder, a nervous disorder, alcoholism, or drug abuse.

Psychologist means an individual holding the degree of Ph.D. in the science of the mind and behavior and who is acting within the scope of his license to treat an Illness or Injury.

Reasonable and Customary refers to that portion of a charge, as determined by the Plan Administrator, made by a Physician or other provider of services, supplies, medications, or equipment which does not exceed the lesser of:

A. The general level of charges made by other providers rendering or furnishing such care, treatment or supplies within the same geographic area; or

B. The level of negotiated charges acceptable to the Preferred Provider Organization (PPO) as full payment in the geographical area covered by the Preferred Providers.

Registered Nurse means an individual who has received specialized nursing training, is authorized to use the designation of "R.N.." and who is duly licensed by the state or regulatory agency responsible for such licensing in the state in which the individual performs such nursing services.

Room and Board refers to the expenses incurred by an Inpatient which are made by a Hospital as a condition of occupancy. Such charges include normal nursing services provided to Inpatients not in an Intensive Care Unit but does not include the professional services of Physicians.

Routine Nursery Care means medical treatment, services or supplies rendered to a Newborn solely for the purposes of health maintenance and not for the treatment of an Illness or Injury, but shall not include circumcision.

Routine Well-Baby Care means medical treatment, services or supplies rendered to a child, other than a Newborn, solely for the purpose of health maintenance and not for the treatment of an Illness or Injury.

Semi-Private refers to a class of accommodations in a Hospital in which two patients' beds are available per room.

Special Enrollment Period means a thirty (30) day period during which a person, who declined coverage under the Plan when eligible, becomes eligible again to Enroll for coverage under the Plan.

TEFRA refers to the Tax Equity and Fiscal Responsibility Act of 1982, as amended from time to time.

Third Party Administrator (TPA) means an organization contracted by the Plan Administrator to perform certain administrative functions on behalf of the Plan Administrator with respect to the benefits provided under the Plan. Such functions may include the issuance of benefit summaries, basic record keeping and reporting, and the processing of claims.

Total Disability (Totally Disabled) means the Covered Person, as a direct result of an Illness or Injury, is unable to:

A. In the case of an Employee, perform the material and substantial duties of any occupation for which the Employee is or may become qualified by education, training or experience; and

B. In the case of a Dependent, perform the normal substantial activities of a person of like age and sex in good health.

In all cases, a person will be considered Totally Disabled during the period the Covered Person is determined to be disabled under Medicare or other government sponsored benefit program.

University or College means an institution offering at least a two-year educational program, located in the United States and listed in the current, generally recognized publication of accredited institutions of higher education.

Urgent Care Facility means a free-standing facility, by whatever actual name it may be called, which is engaged primarily in providing **minor** emergency and episodic medical care to a Covered Person. A Physician, a Registered Nurse, and a Registered X-ray Technician must be in attendance at all times that the clinic is open. It does not include an Emergency Room.

Wage or Salary means compensation from which federal withholding is applicable.

ELIGIBILITY, EFFECTIVE DATE AND TERMINATION

Coverage provided under the Plan for Employees and their Dependents shall be in accordance with their Eligibility, Effective Date, and Termination provisions of the Plan, including any Coverage Classification described on the Schedule of Benefits.

If health care benefits differ by Coverage Classifications shown on the Schedule of Benefits, any change in the coverage available to the Covered Person occasioned by a change in the Covered Employee's classification shall become effective automatically on the effective date of such change.

EMPLOYEE ELIGIBILITY

An Employee eligible for coverage under the Plan shall include only employees who meet all of the following conditions:

A. Has been employed by the Employer on a Full-Time Employment basis during the Waiting Period shown on the Schedule of Benefits; and

B. Is within a Coverage Classification.

However, an Employee who was eligible to enroll for coverage under the policy replaced by the Plan, but on the day preceding the Plan Effective Date was no longer eligible to enroll, will not become eligible to Enroll under the Plan as of the Plan Effective Date. Such Employee can Enroll after the Plan Effective Date when eligible as a Late Entrant or during a Special Enrollment Period.

An Employee eligible for Dependent Coverage is an Employee who has a dependent who satisfies the definition of a Dependent. Each Employee will become eligible for Dependent Coverage on the latest of the following:

A. The date the Employee is provided coverage under the Plan as a Covered Employee;

B. The date the Employee first acquires a Dependent; or

C. The date the Employee first comes within a Coverage Classification eligible for Dependent Coverage as shown on the Schedule of Benefits.

If both the Employee and the spouse of the Employee are employed by the Employer, and both are eligible for Dependent Coverage, either (but not both) may elect Dependent Coverage for the same eligible Dependent.

DEPENDENT ELIGIBILITY

A Dependent shall be considered eligible for coverage on the date the Employee becomes eligible for Dependent Coverage, subject to all limitations and requirements of the Plan, and in accordance with the following:

A. Newborn children of a Covered Employee will be covered from the moment of birth for Illness or Injury, including the necessary care or treatment of medically diagnosed Congenital Birth Defects, birth abnormalities or prematurity, provided the child is Enrolled as a Dependent of the Covered Employee within thirty (30) days of the child's date of birth. This provision shall not apply nor in any way affect the normal maternity provisions applicable to the mother.

B. A spouse will be considered a Dependent from the date of marriage.

C. If a child is acquired, other than at the time of birth, due to a court order or marriage, the child will be considered a Dependent from the date of such court order or marriage.

However, a Dependent who was eligible to enroll for coverage under the policy replaced by the Plan, but on the day preceding the Plan Effective Date was no longer eligible to enroll, will not become eligible to Enroll under the Plan as of the Plan Effective Date. Such Dependent can Enroll after the Plan Effective Date when eligible as a Late Entrant or during a Special Enrollment Period.

SPECIAL ENROLLMENT PERIOD

A Special Enrollment Period is a thirty (30) day period which begins on the following dates:

A. If the Employee declined coverage under the Plan for the Employee or a Dependent because of coverage required to be Creditable Prior Coverage under HIPAA, the date such coverage under the other plan terminated as a result of:

1. Loss of eligibility for coverage under the plan when COBRA continuation coverage is not elected; or

2. Expiration of COBRA continuation coverage.

A Special Enrollment Period also begins when the Employee or Dependent becomes responsible for paying the full premium after the premium was subsidized by an employer or other party. However a Special Enrollment Period does not begin when coverage terminated as a result of:

1. Non-payment of a required premium by or on behalf of a person.

2. Termination of COBRA coverage except at the end of the person's eligibility.

B. The date the Employee acquires a Dependent as the result of marriage, birth, adoption or placement of a child in the home of the Employee prior to adoption of the child by the Employee.

During the Special Enrollment Period, the Employee may Enroll himself for coverage under the Plan. Subject to coverage of the Employee under the Plan, the Covered Employee may also Enroll any Dependent of the Employee under the Plan.

LATE ENROLLMENT

A Late Entrant may only Enroll during the one (1) month period beginning three (3) months prior to the beginning of a Plan Year for coverage to be effective at the beginning of the Plan Year. The following items must be provided for the Late Entrant during the one (1) month enrollment period:

1. Enrollment Form

2. Medical Questionnaire

3. Other information requested by the Plan Administrator

EMPLOYEE EFFECTIVE DA TE

Coverage under the Plan for an Employee will become effective on the date determined in accordance with the following:

A. If the Employee is not required to make a contribution for his coverage, coverage will automatically become effective on the date of his eligibility.

B. If the Employee is required to make a contribution for his coverage and the Employee has Enrolled within fifteen (15) calendar days after the date of his eligibility, coverage will become effective on the date of his eligibility.

C. If the Employee is required to make a contribution for coverage and the Employee has Enrolled more than fifteen (15) calendar days but within thirty (30) calendar days after the date the Employee first became eligible, coverage will become effective as of the date the written application was received by the TPA.

D. If the Employee has Enrolled during a Special Enrollment Period, coverage will become effective as of the date the written application was received by the TPA.

E. If the Employee is a Late Entrant, coverage will become effective at the beginning of the first Plan Year following enrollment provided the Employee was Enrolled at least two (2) months prior to the beginning of the Plan Year.

An Employee's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

DEPENDENTS EFFECTIVE DA TE

Coverage under the Plan will become effective with respect to a Dependent of an Employee on the date determined in accordance with the following:

A. If the Covered Employee is not required to make a contribution for coverage of the Dependent, the coverage will automatically become effective on the date of eligibility of the Dependent.

B. If the Covered Employee is required to make a contribution for coverage of the Dependent and the Covered Employee has Enrolled the Dependent within fifteen (15) calendar days after the date of eligibility of the Dependent, coverage for the Dependent will become effective on the date of eligibility of the Dependent.

C. If the Covered Employee is required to make a contribution for coverage of the Dependent and the Covered Employee has Enrolled the Dependent more than fifteen (15) calendar days but within thirty (30) calendar days after the date of eligibility of the Dependent, coverage for the Dependent will become effective as of the date the written application was received by the TPA. However coverage for a Newborn or an adopted child will become effective on the date of birth or placement for adoption provided the child is Enrolled within thirty (30) days after first becoming eligible.

D. If the Covered Employee has Enrolled the Dependent during a Special Enrollment Period, coverage will become effective as of the date the application for the Dependent was received by the TPA. However coverage for a Newborn or an adopted child will become effective as of the date of birth or placement for adoption provided the child is Enrolled within thirty (30) days after first becoming eligible.

E. If the Dependent is a Late Entrant, coverage will become effective at the beginning of the first Plan Year following enrollment provided the Dependent was Enrolled at least two (2) months prior to the beginning of the Plan Year.

A Dependent's coverage under the Plan will commence at 12:01 a.m. Standard Time on the date such coverage is to be effective.

If Dependent Coverage is effective retroactively, all terms, conditions and limitations of the Plan are applicable and must be complied with at the time a charge is incurred.

EMPLOYEE TERMINATION

Employee coverage will automatically terminate immediately upon the earliest of the following dates:

A. Last day of the month, during which the Employee ceases to be a Full-Time Employee. However, Employee coverage will not automatically terminate as the result of the Employee not being a Full-Time Employee.

1. During a leave of absence requested by the Employee and approved by the Employer when taken pursuant to the terms and conditions of the Family and Medical Leave Act of 1993. Any extension pursuant to this paragraph one (1) shall run concurrent with any extended coverage taken pursuant to paragraphs two (2) or three (3) below;

2. During the period not to exceed three (3) months from the last day of Full-Time Employment, while the Employer continues the Wage or Salary of the Employee; or

3. During the period not to exceed one (1) month from the last day of Full-Time Employment, when the Employer does not continue the Wage or Salary of the Employee.

B. Date the Employee ceases to be in a Coverage Classification eligible for coverage;

C. Date the Employee fails to make any required contribution for coverage;

D. Date the Plan is terminated; or with respect to any particular benefit, the date of termination of such benefit; or

E. Date the Employee dies.

DEPENDENT TERM/NATION

Dependent Coverage of an Employee will automatically terminate immediately upon the earliest of the following dates:

A. Date the Dependent ceases to be an eligible Dependent as defined in the Plan;

B. Date coverage for the Employee under the Plan is terminated;

C. Date the Employee ceases to. be in a Coverage Classification eligible for Dependent Coverage;

D. Date the Employee fails to make a required contribution for Dependent Coverage;

E. Date the Plan is terminated; or with respect to any particular benefit, the date of termination of such benefit; or

F. Date the Employee dies.

CERTIFICATES OF COVERAGE

Upon termination of coverage under the Plan for a Covered Person, a certificate of coverage will be automatically issued in accordance with the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Additionally, a certificate of coverage will be provided on written request provided the request is made within two years after coverage terminated.

PRE-EXISTING CONDITIONS

Claims resulting from Pre-Existing Conditions are excluded from coverage under the Plan during the twelve (12) month exclusion period beginning with the Covered Person's effective date of coverage under the Plan. The twelve (12) month exclusion period is increased to eighteen (18) months if the Covered Person was not Enrolled within thirty (30) days after the end of the Waiting Period or during a Special Enrollment Period. The twelve (12) or eighteen (18) month exclusion period will be reduced by the duration of:

A. The Waiting Period for the Covered Person under the Plan except when Enrolled during a Special Enrollment Period or as a Late Entrant; and

B. Any Creditable Prior Coverage documented by the Covered Person with a certificate provided by a prior plan.

Creditable Prior Coverage is continuous coverage for the Covered Person which was in effect on the Covered Person's effective date of coverage under the Plan or terminated no more than sixty-three (63) days prior to coverage under the Plan. Coverage under the following types of plans will be recognized:

A. Individual or group health plans excluding limited scope or single disease plans;

B. Medicare or Medicaid;

C. Federal employee plans including plans for the uniformed services;

D. Federal plans for Indian or tribal organizations;

E. State sponsored plans including high risk pools; and

F. Any other plan required by HIPAA.

The Waiting Period under the Plan will not be considered in determining if a period of more than sixty-three (63) days exists between termination of coverage under a prior plan and coverage under the Plan. Days in a waiting period are not Creditable Prior Coverage under a plan nor are such days taken into account when determining the maximum sixty-three (63) days between coverage. Dates of Creditable Prior Coverage common to more than one prior plan will be included only for one of the prior plans.

This Pre-Existing Conditions provision does not apply to:

A. A condition of a Covered Person which was covered under the plan replaced by the Plan if the effective date of coverage for the Covered Person under the Plan is the Plan Effective Date; or

B. Charges incurred after the exclusion period indicated by this Pre-Existing Conditions provision.

SECOND SURGICAL OPINION

If a Physician recommends that a Covered Person have a surgical operation, the Covered Person may be required to obtain a second surgical opinion under the Hospital Admissions and Pregnancy Pre-Certification provision or may at his discretion seek a second surgical opinion from another Physician. The Physician rendering the second opinion must be qualified to render such a service, either through conference, specialist training, education or similar criteria and must not be affiliated in any way with the other Physician. The cost of the second surgical opinion will be paid as shown on the Schedule of Benefits.

WEEKEND HOSPITAL ADMISSIONS

Charges for Room and Board incurred in connection with a Hospital admittance of a Covered Person from 8:00 a.m. Friday to 12:00 p.m. Sunday are usually not Covered Expenses. They will be Covered Expenses only when the attending Physician states in writing that such admittance was an emergency Hospital admittance and was Medically Necessary.

PREGNANCY AND HOSPITAL ADMISSIONS PRE-CERTIFICATION

Pregnancy and Hospital Admissions Pre-Certification is a program designed to help insure that Covered Persons receive only Medically Necessary Care. Information concerning each Pregnancy and each emergency or non- emergency Hospital admission of a Covered Person must be provided to the Hospital Pre-Certification Organization shown on the Schedule of Benefits. However, pre-certification of the care as Medically Necessary does not guarantee benefits will be paid. Expenses associated with a pre-certified Hospital confinement will be considered under Major Medical Expense Benefits subject to other Plan conditions, exclusions and limitations.

The following procedures, to the extent deemed appropriate by the Hospital Pre-Certification Organization, will be used to avoid unnecessary Hospital admissions and to control expenses incurred by the Covered Person while an Inpatient.

A. Hospital Admission and Pregnancy Review. The Hospital Pre-Certification Organization must be notified, by or on behalf of the Covered Person within the following periods.

1. Pregnancy - within thirty (30) days following the diagnosis of a pregnancy and again within twenty-four (24) hours after delivery of a Newborn. If the mother is not a Covered Person but the Newborn is eligible to be covered, the Hospital Pre-Certification Organization must be notified within twenty-four (24) hours after delivery of the Newborn.

2. Emergency Hospitalization - within forty-eight (48) hours following the hospital admission.

3. Non-emergency Hospitalization - at least five (5) business days before the hospitalization.

The Hospital confinement shall be confirmed by the Hospital Pre-Certification Organization after the Physician treating the Covered Person has established to the satisfaction of the Hospital Pre-Certification Organization that such confinement is Medically Necessary.

B. Second Surgical Opinion. Prior to the performance of a non-emergency surgical procedure while the Covered Person is an Inpatient, a second surgical opinion may be required by the Hospital Pre-Certification Organization to verify such procedure is Medically Necessary. If the second surgical opinion does not confirm the medical necessity of the surgery, a third surgical opinion may be required by the Hospital Pre-Certification Organization.

If the second surgical opinion confirms the medical necessity of the surgery, or if such second surgical opinion does not confirm, but a third surgical opinion does, the expense of such surgery will be considered under the Major Medical Expense Benefits provision of the Plan, subject to all conditions, exclusions and limitations of the Plan.

The Physicians rendering the second and third surgical opinions must be approved by the Hospital Pre- Certification Organization as qualified to render such a service, either through conference, specialist training or education, or similar criteria, and must not be affiliated in any way with each other or the Physician who will perform the actual surgery.

If the surgery is Medically Necessary on an emergency basis, a second or third surgical opinion is not required. The cost of providing the second or third surgical opinions under this Hospital Admissions Pre- Certification provision shall be considered an expense of the Plan and not an expense payable in any part by the Covered Person.

C. During a hospitalization, the Hospital Pre-Certification Organization will contact the attending Physician and/or facility to help ensure that the Covered Person receives Medically Necessary care and treatment.

D. Hospital Discharge Planning. The Hospital Pre-Certification Organization shall consult with the Physician treating the Covered Person to coordinate the timely discharge of the Covered Person or movement to other facilities providing appropriate levels of care.

E. Large Case Management. The Hospital Pre-Certification Organization may refer a Covered Person, identified as having a major illness or injury, chronic disease, or other condition which can be expected to result in high costs, to Large Case Management (LCM). LCM works intensively with the Covered Person, their family members and Physicians, to coordinate quality health care.

The cost of providing the services of the Hospital Pre-Certification Organization and Large Case Management under this Hospital Admissions Pre-Certification provision shall be considered an expense of the Plan and not an expense payable in any part by the Covered Person.

Benefits for the Hospital confinement will be reduced as indicated on the Schedule of Benefits if the Hospital admission of the Covered Person is not reported to the Hospital Pre-Certification Organization in accordance with the written procedures and guidelines provided by the Plan Administrator to the Covered Employee. Benefits will also be reduced or denied as follows:

A. No benefits will be paid for treatments, services or supplies that cannot be confirmed as Medically Necessary;

B. No benefits will be paid for charges incurred while a Hospital Inpatient beyond the time established as Medically Necessary by the Hospital Pre- Certification Organization; and

C. No benefits will be paid when the Covered Person does not obtain a second or third opinion when asked to do so by the Hospital Pre-Certification Organization.

MAJOR MEDICAL EXPENSE BENEFITS

BENEFIT PERCENTAGE AND DEDUCTIBLE

Upon receipt of a properly filed claim, the Plan will pay to the Covered Employee (or the appropriate Qualified Beneficiary if applicable) Major Medical Expense Benefits at the Benefit Percentage, by category of Covered Expenses as shown on the Schedule of Benefits, for Covered Expenses incurred in each Deductible Accumulation Period, unless otherwise stated in the Plan, which are in excess of the Deductible per Covered Person. For each Covered Person, the benefits payable under the Plan, regardless of whether coverage under the Plan is continuous or not, will be subject to an applicable maximum shown on the Schedule of Benefits.

The Deductible applies to the Covered Expenses incurred by a Covered Person in each Deductible Accumulation Period, but it applies only once for each Covered Person within the Deductible Accumulation Period regardless of the number of Illnesses or Injuries. Covered Expenses incurred in the last three months of a Deductible Accumulation Period, or in the Deductible Accumulation Period if the Deductible Accumulation Period is less than three months, which are used to satisfy the Deductible will also be applied to the Deductible for the subsequent Deductible Accumulation Period. However, the maximum amount of Covered Expenses used to satisfy Deductibles for all Covered Persons in a Family during a Deductible Accumulation Period will not exceed the Deductible Per Family shown on the Schedule of Benefits.

PREFERRED PROVIDERS

Selected providers of medical treatments, services and supplies may be identified on the Schedule of Benefits as Preferred Providers. The Benefit Percentages and Deductibles shown on the Schedule of Benefits are applicable independently to Covered Expenses for treatments, services and supplies provided by Preferred Providers, if any, compared to Covered Expenses for treatments, services and supplies delivered by providers who are not Preferred Providers. However, any maximum is applicable to treatments, services or supplies delivered by all providers.

ALLOCATION AND APPORTIONMENT OF BENEFITS

The Plan Administrator reserves the right to allocate the Deductible to any Covered Expense and to apportion the benefits to the Covered Person and any assignees. Such allocation and apportionment by the Plan Administrator will be conclusive and will be binding upon the Covered Person and all assignees.

COVERED EXPENSES

Covered Expenses under this Major Medical Expense Benefits provision are charges for medical treatments, services and supplies to the extent they are:

A. Incurred by a Covered Person while coverage under the Plan is in effect with respect to the Covered Person;

B. Medically Necessary for the diagnosis or treatment of an Illness or Injury;

C. Administered or ordered by a Physician;

D. Not excluded or in excess of a limit indicated on the Schedule of Benefits or otherwise stipulated under the Plan; and

E. Not in excess of the Reasonable and Customary charge for the treatment, service or supply.

Covered Expenses are subject to any exclusion or limitation under the Plan. An expense will be considered under only one provision of the Plan.

The following Incurred Expenses will be considered Covered Expenses:

A. Charges made by a Hospital for:

1. Room and Board or confinement in an Intensive Care Unit; however, charges for Routine Nursery Care for a healthy Newborn Dependent child will not be covered except to the extent, if any, such is indicated on the Schedule of Benefits. Charges made by a Hospital having only private rooms will be considered a Covered Expense in an amount equal to the amount indicated by the Hospital as their most Common Semi-Private rate; or if such rates is not available, the Covered Expense is equal to 90% of the Hospital's lowest private room rate.

2. Necessary services and supplies other than Room and Board furnished by the Hospital, including Inpatient miscellaneous service and supplies, Outpatient Hospital treatments for chronic conditions and emergency room use, physical therapy treatments, hemodialysis, and X-ray and linear therapy; however, charges incurred for such miscellaneous services and supplies by a healthy Newborn Dependent child will not be covered except to the extent, if any, such is indicated on the Schedule of Benefits.

B. Charges made by a Convalescent Nursing Facility under a program of care approved by the Plan Administrator for the following services and supplies furnished by the Convalescent Nursing Facility during any one Convalescent Period. Only charges incurred in connection with convalescence from the Illness or Injury for which the Covered Person is confined will be eligible for benefits. These expenses include:

1. Room and board, including any charges made by the facility as a condition of occupancy, or on a regular daily or weekly basis such as general nursing services. If private room accommodations are used, the daily room and board charge allowed equal to the amount indicated by the Hospital as their most Common Semi-Private rate; or if such rates is not available, the Covered Expense is equal to 90% of the Hospital's lowest private room rate.
2. Medical services customarily provided by the Convalescent Nursing Facility, with the exception of private duty or special nursing services and Physician's fees;
3. Drugs, biologicals, solutions, dressings and casts, furnished for use during the Convalescent Period, but no other supplies.

C. Charges made under a Hospice program approved by the Plan Administrator for:

1. . Nursing care by a Registered Nurse, a Licensed Practical Nurse, a vocational nurse or a public health nurse who is under the direct supervision of a Registered Nurse;
2. Physical therapy and speech therapy when rendered by a licensed therapist;
3. Medical supplies, including drugs and biologicals and the use of medical appliances;
4. Physician's services;
5. Services, supplies, and treatments deemed Medically Necessary and ordered by a licensed Physician.

D. Charges for the services of a legally qualified Physician for medical care and/or surgical treatments including office and home visits, Hospital Inpatient care, Hospital Outpatient visits and exams, clinic care, and surgical opinion consultations. However, fees for Massage and Manipulation Treatments shall be limited as indicated on the Schedule of Benefits.

E. Fees of a Registered Nurse or Licensed Practical Nurse for private duty nursing.

F. Charges for treatment or services rendered by a licensed physical therapist in a home setting or at a facility or institution whose primary purpose is to provide medical care for an Illness or Injury.

G. Fees of a legally qualified Physician or qualified speech therapist for restorative or rehabilitative speech therapy for speech loss or impairment due to an Illness or Injury, other than a functional disorder, or due to surgery performed on account of an Illness or Injury. If the speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to the therapy .

H. Charges for professional ground ambulance service to the nearest Hospital where care or treatment can be provided. If the Hospital lacks resources to provide needed care or treatment, Covered Expenses will include charges for one subsequent professional ground service to the nearest Hospital where such resources are available . Except as indicated on the Schedule of Benefits charges for air ambulance services are not Covered Expenses.

I. Charges for drugs that can only be obtained by written prescription from a licensed Physician. When the prescription drug is available through a prescription drug purchasing program, the charge is a Covered Expense only when obtained through such program.

J. Charges for X-rays,microscopic tests, and laboratory tests.

K. Charges for chemotherapy or radiation therapy or treatment.

L. Charges for cosmetic and reconstructive surgery when such surgery resulted from:

1. An Injury;

2. A Congenital Birth Defect; or

3. Surgical removal of breast tissue as a result of Illness.

A Covered Person who is receiving benefits under the Plan as a result of a mastectomy and who elects breast reconstruction, charges for the following procedures will be considered Covered Expenses:

1. Reconstruction of the breast after mastectomy;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

3. Prostheses and treatment of physical complications at all stages of the mastectomy and reconstruction, including lymphedemas.

M. Charges for the processing and administration of blood or blood components, but not for the cost of the actual blood or blood components if replaced.

N. Charges for oxygen and other gases and their administration.

0. Charges for electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

P. Charges for the cost and administration of an anesthetic.

Q. Charges for dressings, sutures, casts, splints, trusses, crutches, braces, or other necessary medical supplies, with the exception of dental braces or corrective shoes.

R. Subject to the prior written approval by the Plan Administrator, charges for the rental of a wheelchair, hospital bed or other Durable Medical Equipment required for temporary therapeutic use or, at the option of the Plan Administrator, the purchase of such equipment.

S. Charges for an initial artificial limb, eye or larynx; or the initial Orthotic Appliance. The charge for the repair or replacement of an artificial limb will be considered a Covered Expense when:

(1) The expense for the repair or replacement of the artificial limb was incurred as a result of the maturation of a Covered Dependent child; or

(2) The expense for the repair or replacement of the artificial limb was incurred by a Covered Person at least five (5) years after the last Covered Expense under the Plan for the artificial limb.

T. Charges for voluntary sterilization.

U. Charges made by an Ambulatory Surgical Center or Minor Emergency Medical Clinic if treatment has been rendered.

V. Charges made by a Home Health Care Agency for care in accordance with a Home Health Care Plan approved by the Plan Administrator. Such expenses include:

1. Part-time or intermittent nursing care by a Registered Nurse or by a Licensed Practical Nurse, a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

2. Home health aides; and

3. Medical supplies, drugs, and medicines prescribed by a Physician, and laboratory services provided by or on behalf of a Hospital but only to the extent that they would have been covered under the Plan if the Covered Person had remained in the Hospital.

Specifically excluded from coverage under the Home Health Care Plan are the following:

1. Services and supplies not included in the Home Health Care Plan;

2. Services of a person who ordinarily resides in the home of the Covered Person, or is a Close Relative of the Covered Person;

3. Transportation services; and

4. Meals.

MATERNITY EXPENSE BENEFITS

If birth of a Newborn occurs while coverage of the mother is in effect, benefits for charges incurred by the Covered Employee, or their spouse while a Covered Person, as a result of the Pregnancy will be paid under Major Medical Expense Benefits the same as for an Illness.

No Maternity Expense Benefits or benefits for Complications of Pregnancy will be paid for a charge incurred by a Covered Person if:

1. The Covered Person is a child of the Covered Employee or a child of the Covered Employee's spouse; or

2. The charge was incurred prior to the Effective Date of her coverage; or

3. The charge was incurred after her coverage is terminated.

PLAN EXCLUSIONS AND LIMITATIONS

No benefit will be paid, except to the extent specifically indicated on the Schedule of Benefits, for the following charges, or for expenses or complications related, directly or indirectly, to the following charges or conditions:

A. Charge incurred prior to the Covered Person's effective date of coverage under the Plan, or after such coverage is terminated.

B. Charge not related to the treatment of an Illness or Injury.

C. Condition or charge incurred which resulted from war or any act of war, whether declared or undeclared, or caused during service in the armed forces of any country.

D. Condition or charge incurred which resulted from or occurred:

1. While the Covered Person is engaged in an illegal occupation;

2. While the Covered Person is committing or attempting to commit a felonious act or aggravated assault;

3. While the Covered Person is participating in a riot or civil insurrection; or

4. As the result of court ordered treatment regardless of whether or not the Covered Person is found guilty of any wrongdoing. This exclusion is applicable whether or not the Covered Person is charged or convicted of the activity or offense.

E. Condition or charge incurred as the result of an Injury which occurred while the Covered Person was under the influence of illegal drugs or when the Covered Person was operating a motor vehicle while under the influence of alcohol or illegal drugs. A person will be considered under the influence of alcohol if the level of their blood alcohol at the time the Injury occurred exceeded the legal limit for operating a motor vehicle in the jurisdiction where the Injury occurred, regardless of whether the Covered Person was operating a motor vehicle at the time the Injury was sustained . A person will be considered under the influence of an illegal drug if use of the drug by the Covered Person is established by a laboratory test.

F. Condition or charge incurred which resulted from an intentionally self-inflicted Illness or Injury regardless of whether the Covered Person was sane or insane. The intent of the Covered Person will be judged by the normal actions of prudent persons not intending to harm themselves.

G. Charge incurred as the result of an Injury sustained while participating in a non-sanctioned speed or endurance contest; auto racing or stunt driving; aerobatics, trapeze or high-wire demonstration or contest; hang gliding; scuba diving except when the Covered Person is certified by a nationally recognized scuba training organization or under the instruction of one of their instructors; sky diving; or riding a three (3) wheel all terrain vehicle.

H. Condition or charge resulting from or incurred in the course of employment, whether such employment is with the Employer, another employer, or self employment regardless of whether or not the Covered Person is covered by workers compensation insurance.

I. Charge incurred while the Covered Person is not under the direct care of a Physician.

J. Charge incurred in connection with services and supplies which are not Medically Necessary for the treatment of an Illness or Injury, or are in excess of the Reasonable and Customary charge, or are not recommended and approved by a Physician.

K. Charge incurred as the result of, or a complication of, a non-covered condition, treatment, service, drug or supply .

L. Charge incurred for psychiatric or psychoanalytic care or in connection with the treatment of a functional, mental or nervous disorder, alcoholism, chemical dependency or drug abuse, as an Inpatient or Outpatient except as such care or treatment is provided by a Physician and to the extent indicated on the Schedule of Benefits.

M. Charge incurred for which the Covered Person is not, in the absence of the coverage under the Plan, legally obligated to pay, or for which a charge would not ordinarily be made in the absence of the coverage under the Plan.

N. Charge incurred for the treatment of Temporomandibular Joint Dysfunction Syndrome (TMJ).

O. Charge incurred for treatment on or to the teeth, the nerves or roots of the teeth, gingival tissue or alveolar processes; however, benefits will be payable for a charge incurred (1) for the removal of impacted third molars teeth (no allowance for other extractions) on an Outpatient basis, unless Hospital confinement is deemed to be Medically Necessary, and (2) for treatment required because of Injury to natural sound teeth. Such expense must be incurred within six (6) months of the date of the Injury and coverage must be in effect on the date of treatment. Item (2) of this exception shall not in any event be deemed to include a charge for treatment for the repair or replacement of a denture.

P. Service, supply, procedure or treatment not recognized by the appropriate medical association in the United States as generally accepted and Medically Necessary for the diagnosis and/or treatment of an Illness or Injury; or a charge for procedures, surgical or otherwise, which are specifically recognized by the appropriate medical association in the United States as having no medical value.

Q. Charge incurred for services or supplies which constitute personal comfort or beautification items, television or telephone use, or in connection with Custodial Care, rest cures, education or training, Occupational Therapy, or expenses actually incurred by other persons.

R. Charge incurred in connection with eye refractions, the purchase or fitting of eyeglasses, contact lenses, hearing aids, or such similar aid devices. This exclusion shall not apply to the initial purchase of eyeglasses or contact lenses following cataract surgery, nor does it apply to the initial purchase of a hearing aid if the loss of hearing is a result of a surgical procedure. However, such expense will be considered a Covered Expense only to the extent of the least expensive service, supply or procedure which will correct the condition.

S. Charge for a Cosmetic Procedure. This exclusion will not apply when the charge can otherwise be considered a Covered Expense.

T. Removed in its entirety.

U. Charge incurred for weight control, malabsorption syndrome, or as the result of Morbid Obesity, including surgery for construction, reconstruction, or repair of a gastric bypass as a result of such condition.

V. Charge incurred to the extent such charge is paid or reimbursable through a program sponsored by the United States Government; or the treatment, service, or supply is available to the Covered Person at no cost or reduced cost through a Hospital or other facility owned or operated by the United States Government or an Agency thereof .

W. Charge for Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician.

X. Charge for a service rendered by a Physician, nurse, or licensed therapist if such Physician, nurse, or licensed therapist is a Close Relative of the Covered Person, or resides in the same household as the Covered Person.

Y. Charge for Room and Board incurred in connection with a Hospital admittance from 8:00 a.m. Friday to 12:00 p.m. Sunday unless the attending Physician states in writing that such admittance was an emergency Hospital admittance and was Medically Necessary.

Z. Charge incurred outside the United States for medical treatment, services, drugs or supplies on a date in excess of thirty (30) days from the date the first charge was incurred in a foreign location. However, no benefits will be paid if the Covered Person traveled to a foreign location for the primary purpose of obtaining medical treatment, services, drugs or supplies.

AA. Charge related to or in connection with fertility studies, sterility studies, procedures to restore or enhance fertility or reverse sterilization, artificial insemination, or in-vitro fertilization.

BB. Charge incurred for routine medical examinations or routine health check-ups, nutritional supplements, vitamins, or immunizations not necessary for the treatment of an Illness or Injury.

CC. Charge for hospitalization when such confinement occurs primarily for physiotherapy, hydrotherapy, convalescent or rest care, or any routine physical examinations or tests not connected with an Illness or Injury.

DD. Charge for medical treatment, services, drugs or supplies for a tissue or organ transplant, or complications thereof, except as indicated under the Organ or Tissue Transplant Services Expense Benefit.

EE. Charge for Experimental Procedures or Experimental Treatments; or drugs, treatments or procedures disclosed to the Covered Person as part of a research study.

FF. Charge for Routine Nursery Care or Routine Well-Baby Care, including the usual, ordinary, and routine care of a Newborn except to the extent, if any, such is indicated on the Schedule of Benefits.

GG. Charge related to sex transformations or sexual dysfunctions or inadequacies.

HH. Charge for laser eye surgery, such as LASIK or radial keratotomy, to correct defective vision.

II. Charge related to an abortion except:

1. A spontaneous miscarriage;

2. An abortion when the life of the Covered Person is threatened by the pregnancy; or

3. An abortion when the pregnancy resulted from rape or incest.

Notwithstanding any provision of this Plan to the contrary, charges related to complications of an abortion, whether or not charges for the abortion are covered, will be *covered* subject to all other applicable exclusions and limitations.

JJ. Charge incurred as the result of a Pre-Existing Condition except to the extent provided by the Pre-Existing Conditions provision of the Plan.

Except for Weekly Income Benefits, to the extent other benefits are generally provided for a type of Injury, the other benefits (otherwise payable for charges incurred as a result of the Injury) will be paid if the injury resulted from an act of domestic violence or a medical condition (including both physical and mental health conditions).

COORDINATION OF BENEFITS.

This Coordination of Benefits provision applies when the *Covered* Person entitled to medical benefits for Covered Expenses under the Plan is also covered by another plan or plans of health care benefits. This provision applies whether or not a claim is filed under the other plan or plans. If required by the Plan Administrator, authorization shall be given to the Plan Administrator by the *Covered* Employee or other appropriate person to obtain information concerning benefits or services available from the other plan or plans, or to recover overpayments.

DEFINITIONS

A. "Plan" as used in this provision will be expanded to include the Plan and any other plan providing benefits or services for medical or dental treatment when such benefits or services are provided by:

1. Group insurance or any other arrangement of coverage for persons in a group whether on an insured, partially insured or uninsured basis;

2. Hospital or medical service organizations on a group basis, group practice and other group pre-payment plans;

3. Hospital or medical service organizations on an individual basis having a provision similar in effect to this provision;

4. Any coverage for students which is sponsored by, or provided through, a school or other educational institution;
5. Any coverage under a Governmental program, and any coverage required or provided by any statute;

6. Group automobile insurance;

7. Individual automobile insurance coverage on an automobile leased or owned by the Employer; or

8. Individual automobile insurance coverage based upon the principles of "No-Fault" coverage.

The term "Plan" in this provision will be construed separately herein with respect to each policy, contract, or other arrangement for benefits or services, and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the benefits or services of other plans into consideration in determining its benefits and that portion which does not.

B. "Claim Determination Period" means a Calendar Year or that portion of a Calendar Year during which the Covered Person for whom claim is made has been covered under the Plan.

COORDINATION PROCEDURES

Notwithstanding other provisions of the Plan, benefits that would otherwise be payable under the Plan will be reduced so that the sum of the benefits payable for Covered Expenses incurred during any Claim Determination Period under:

A. All plans required to pay before the Plan; and

B. The Plan will not exceed the Covered Expenses under the Plan.

PAYMENTS

Each plan will make its benefit payment according to where it falls in the following order.

A. A plan which contains no provision for coordination of benefits pays before all other plans.

B. A health care plan sponsored by, or provided through, a school or other educational institution pays before any other plans with a provision for coordination of benefits.

C. Except when prohibited by law, Medicare Benefits and benefits provided under a government program will be paid prior to benefits under the Plan.

D. A plan which provides coverage to the claimant by virtue of current employment pays before a plan which provides coverage to the claimant by virtue of past or inactive employment. Within each category of plans, the following rules apply:

1. The plan which covers the claimant as an employee (or named insured) pays before a plan which covers the claimant as a dependent.

2. The plan which covers the claimant, other than a child whose parents are separated or divorced, as a dependent of a person whose date of birth, excluding year of birth, occurs earlier in a Calendar Year will be paid prior to the benefits of a plan which covers such claimant as a dependent of another person with a birthday later in a Calendar Year. If the other plan does not contain a provision similar to this item 2. which results in the inability to determine priority of benefits, the provisions of this item 2. shall apply, and the rule set forth in this Coordination Procedures provision shall determine the order of benefits.

3. The following rules will apply when the claimant is a dependent child whose parents are separated or divorced:

   a. If the parent with legal custody of the child has not remarried, the benefits of the plan covering the child as a dependent of that parent will be determined prior to the benefits of the plan covering the child as a dependent of the parent who does not have custody.

   b. If the parent with legal custody of the child has remarried, the benefits of the plan covering the child as a dependent of the parent with custody will be determined prior to the benefits of a plan covering the child as a dependent of the step-parent. The benefits of the plan covering the child as a dependent of the stepparent will be determined prior to the benefits of a plan covering the child as a dependent of the parent without custody.

   c. Items 1. and 2. above will not apply when the financial responsibility for medical care expenses is established by a court decree. In such case, the benefits of the plan covering the child as a dependent of the parent with such responsibility will be determined prior to the benefits of any other plan.

4. To the extent the above rules do not establish the order of benefit determination, the benefits of the plan which has covered the claimant for the longer period of time immediately prior to the incurred date of the claim shall be determined first.

If the benefits under any other plan are payable before the benefits under this Plan and the charge for the service has been negotiated under the other plan by a Health Maintenance Organization (HMO), Preferred Provider Organization (PPO) or other entity, the Covered Expense under this Plan will not exceed the negotiated charge.

The Plan Administrator has the right:

A. To require that the claimant provide the Plan Administrator with information on such other plans so that this provision may be implemented; and

B. To pay the amount due under the Plan to another insurer or other organization if this is necessary, in the Plan Administrator's opinion, to satisfy the terms of this provision.

COORDINATION WITH MEDICARE

Except when prohibited by law, Medicare Benefits will be paid prior to benefits under the Plan. If any Covered Person eligible for Medicare fails to enroll or maintain Medicare coverage, benefits will be paid under the Plan as though the Covered Person had received Medicare Benefits.

CLAIM FILING AND APPEAL PROCEDURES ("PROCEDURES")

The following Procedures explain various rules and time limitations for filing a Claim for benefits under the Plan and additional rules and time limitations for filing an appeal of a Claim that is wholly or partially denied. For purposes of interpreting these Procedures, the following terms have the following meanings as those terms appear herein:

DEFINITIONS

Claim means a request for a specific medical treatment, for coverage of a treatment which has already been rendered, or a request for payment of benefits for medical services provided. For purposes of these Procedures, any interaction between a Claimant and a preferred or network provider shall not be treated as a Claim if the medical provider exercises no discretion on behalf of the Plan. Similarly, any reply to a request for a pre- certification which does not deny coverage (or limit coverage) for medical services is not considered a "Claim". Additionally, a medical provider's refusal to render services without payment by the Claimant is not considered a Claim subject to these Procedures. Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims subject to these Procedures. Notwithstanding the foregoing, any action or inaction by a provider that is not treated as a Claim for these purposes will be treated as a Claim and be reviewed by the appropriate person or entity if a Covered Person files a specific request with the Plan that any action or inaction by the provider be treated as a Claim under the Plan.

Claimant means any Covered Person filing a claim under the Plan pursuant to these Procedures.

Concurrent Care Claim means a Claim for specific ongoing medical treatment of an Illness or Injury. Except as otherwise specifically noted, all time limitations and other rules and restrictions for Concurrent Care Claims are identical to those for Pre-Service Claims, unless the Concurrent Care Claim qualifies as an Urgent Care Claim, in which case the Urgent Care Claim time limitations apply.

Electronic Notification means the transmission of Claim or medical information via the internet, telephone or fax. Any information transmitted pursuant to these Procedures via Electronic Notification, except bills submitted by a provider for payment of benefits, must be resubmitted in writing, sent to the appropriate party via first class mail, within seventy-two (72) hours of the Electronic Notification.

Pre-Service Claim means a Claim for medical care, when the Covered Person is required to obtain approval before obtaining the care.

Post-Service Claim means a Claim submitted after the services have been rendered.

Urgent Care Claim is a Claim where the Plan is required to make a determination (about eligibility, medical necessity, etc.) before care can be rendered and a delay could seriously jeopardize a Covered Person's life, health or ability to gain maximum function, or could subject the Covered Person to severe pain that could not be managed without the requested treatment. Notwithstanding the preceding sentence, any Claim designated by the treating Physician as an "Urgent Care Claim" will be treated as such for purposes of these Procedures.

INITIAL CLAIM FILING REQUIREMENTS

A. How to file a Claim.

All Claims must be filed with the Plan's Third-Party Administrator' identified in the General Information section of the Plan. Although it is preferred that a Claim be filed in writing, information may be transmitted via Electronic Notification provided that the same information is provided in writing within seventy-two (72) hours to the Third Party Administrator.

B. Time Limits for Filing Initial Claims

All Claims for payment of benefits must be filed with the Third-Party Administrator within six (6) months after the expenses were incurred. If the Claim involves hospital confinement, the Claim must be filed within six (6) months after termination of such confinement.

C. Time Limits for Review of Initial Claims

The Third-Party Administrator shall review and process the following types of Claims within the following time limitations:

Urgent Care Claims - Initial determinations on Claims considered Urgent Care Claims shall be made as soon as possible but no later than seventy-two (72) hours after it is received. Initial determinations on Concurrent Care Claims which qualify as Urgent Care Claims shall be made within twenty-four (24) hours after the Claim is received.

Pre-Service Claims - Initial determinations shall be made within fifteen (15) days after the time the Claim is received. This time limitation may be extended by up to fifteen (15) days if the Third-Party Administrator determines that additional time is necessary due to matters outside the control of the Third-Party Administrator.

Post-Service Claims - Initial determinations shall be made within thirty (30) days after the date the Claim is received. This time limitation may be extended by up to fifteen (15) days if the Third-Party Administrator determines that additional time is necessary due to matters outside the control of the Third-Party Administrator.

Incomplete Claims - For any Claim which does not provide information necessary for the Third-Party Administrator to make the initial determination, the Claimant will be notified that additional information is needed within twenty-four (24) hours for Urgent Care Claims, arid within five (5) days for Pre-Service Claims. After receiving notification, the Claimant must provide the missing information within forty-eight (48) hours for Urgent Health Care Claims and within forty-five (45) days for Pre-Service and Post-Service Claims. Failure to provide the missing information within the required time deadlines shall result in the denial of the Claim.

D. Response to Claim

If a Covered Person's Claim for benefits is wholly or partially denied, any notice of such adverse benefit determination under the Plan will:

a. State the specific reason(s) for the denial or partial denial;

b. Reference the specific Plan provisions on which the determination was based;

c. Describe additional material or information necessary to complete the Claim and why such information is necessary;

d. Describe Plan procedures and time limits for appealing the determination (as set forth below} and the right to obtain information about those procedures and the right to sue in Federal Court; and

e. Disclose any internal rule, guidelines, protocol or similar criteria relied on in making the adverse determination (or state that such information will be provided free of 9harge upon request} .

Notice of any adverse determination may be provided by the Plan via written or Electronic Notification, provided that information included in an Electronic Notification will also be sent via first class mail within seventy-two (72) hours after the date of the Electronic Notification.

APPEAL PROCEDURES

A. How to File an Appeal

In the event a Claim is wholly or partially denied, the Claimant has the right to appeal to the Plan Administrator of the Plan for review of the Claim. All appeals will be decided by the Plan Administrator, identified in the General Information section of the Plan. Appeals may be made via Electronic Notification by contacting the Plan Administrator, but any appeal in Electronic form must be sent in writing within seventy-two (72) hours via first class mail to the Plan Administrator at the address identified in General Information section of the Plan.

B. Time Limitation for Filing Appeal

All Claims which are wholly or partially denied may be appealed pursuant to the Procedures set forth below. All appeals must be filed within six (6) months of the date that the .Claim was totally or partially denied. Failure to file an appeal of a Claim will result in the initial Claim decision becoming final and binding on all parties. Failure to file an appeal within the foregoing time limit will be deemed to void any right the Claimant may have to seek judicial review of the original Claim denial.

C. Appeal Review Time Limitations

The Plan Administrator shall review the initial determination and make a decision on any appeal of a Claim within the following deadlines:

Urgent Care Claims within seventy-two (72) hours from the time the appeal was communicated.

Pre-Service Health Care Claims within thirty (30) days from the date the Plan Administrator was notified of the appeal.

Post-Service Health Care Claims within sixty (60) days from the date the Plan Administrator was notified of the appeal.

D. Your Rights During Appeal

Any Covered Person making an appeal will have the opportunity to submit written comments, documents or other information in support of the appeal. Additionally, any Covered Person filing an appeal will have access to all relevant documents as defined by applicable U.S. Department of Labor regulations. The review of the adverse benefit determination will take into account all new information whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

In the case of an appeal of a Claim denied or partially denied based on medical judgment, the Plan Administrator will consult with a health professional with the appropriate training and expertise. The health care professional who is consulted on appeal will not be the same individual who may have been consulted during the initial determination or subordinate of that individual. If the advice of a medical or vocational expert was obtained by the Plan in connection with the denial of the Claim, the names of each such expert shall be provided upon request. This administrative appeal process must be completed before any legal action regarding the Claim can be taken. Additionally, if any such judicial proceedings are undertaken, the evidence presented shall be strictly limited to the evidence presented to the Plan Administrator pursuant to the Appeal Procedures.

EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA)

A. Statement of ERISA Rights

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

1. Examine, without charge, at the Employer's office and at other specified locations, such as work sites and union halls, all plan documents, including insurance contracts, collective bargaining agreements and copies of all documents filed by the Plan with the collective bargaining agreements and copies of all documents filed by the Plan with the U.S. Department of labor, such as detailed annual reports and plan descriptions.

2. Obtain copies of all Plan documents and other Plan information upon written request to the Employer. The Employer may make a reasonable charge for the copies.

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

4. In addition to creating rights for Covered Persons, ERISA imposes duties upon those who are responsible for the operation of the Plan. Those who operate the Plan, called "fiduciaries of the Plan", have a duty to do so prudently and in the interest of the Covered Persons. A Covered Person cannot be discriminated against in order to prevent such Covered Person from obtaining a welfare benefit or any other right imposed by ERISA. If a Covered Person is denied in whole or in part, the Covered Person has the right to have the Employer review and reconsider the claim. Under ERISA, a Covered Person must receive requested documents from the Employer within thirty (30) days after a written request for them, or the Covered Person may file suit in Federal Court. In such a case, the court may require the Employer to provide the materials and pay the Covered Person up to $ 1 10 a day until receiving the materials, unless the materials were delayed due to reasons beyond the control of the Employer. If a Covered Person's claim for benefits is denied in whole or in part, he or she may file suit in a State or Federal Court. If the Plan's fiduciaries misuse the Plan's money or if a Covered Person is discriminated against due to filing for a claim, such 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. Any questions about this statement or about a Covered Person's rights under EHISA should be addressed to the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The website is www.dol.gov/ebsa.

B. Plan Administrator 's Right to Construe and Interpret Plan

The Plan documents confer upon the Plan Administrator the authority and discretion to construe and interpret the terms of the Plan and determine eligibility for benefits.

C. Time Limitation for Filing Individual Action.

Subject to the other limitations contained in these Claim Filing and Appeal Procedures, in no event may any Covered Person file a lawsuit seeking payment of wholly or partially denied Claims more than one year after the Claim is initially denied, or, if later, more that six (6) months after the date the Appeal decision of the Plan Administrator is rendered.

GENERAL PROVISIONS

EXAMINATION

The Plan Administrator shall have the right and opportunity to have the Covered Person examined whose Illness or Injury is the basis of a claim hereunder when and so often as it may reasonably require during pendency of claim hereunder. The Plan Administrator shall also have the right and opportunity to have an autopsy performed in case of death where it is not forbidden by law.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Effective April 14, 2004)

The Plan will use 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, the Plan will use and disclose PHI for purposes related to health care Treatment, Payment for health care and Health Care Operations.

The Plan will not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual.

The Employer agrees to:

A. Not use or further disclose PHI other than as permitted or required by the Plan or as required by law;

B. Ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

C. Not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

D. Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by an individual;

E. Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided of which it becomes aware;

F. Make PHI available to an individual in accordance with HIPAA's access requirements;

G. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

H. Make available the information required to provide an accounting of disclosures;

I. Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the HHS Secretary for the purposes of determining the Plan's compliance with HIPAA; and

J. If feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosures to those purposes that make the return or destruction infeasible).

In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:

A. the benefits manager;

B. staff designated by the benefits manager;

C. the Privacy Official;

D. the human resources manager.

These employees may only have access to and use and disclose PHI for plan administration functions that the Employer performs for the Plan. If these employees do not comply with the provisions of the Plan document, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

Treatment means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating tc a patient; or the referral of a patient for health care from one health care provider to another.

Payment includes activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of Plan benefits or to provide reimbursement for the provision of health care that relates to an individual to whom health care is provided.

These activities include, but are not limited to, the following:

A. Determination of eligibility, coverage and cost sharing amounts (for example, cost of a benefit, plan maximums and copayments as determined for an individual's claim);

B. Coordination of benefits;

C. Adjudication of health benefit claims (including appeals and other payment disputes);

D. Subrogation of health benefit claims;

E. Establishing employee contributions and COBRA premiums;

F. Risk adjusting amounts due based on enrollee health status and demographic characteristics;

G. Billing, collection activities and related health care data processing;

H. Claims management and related health care data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;

I. Obtaining payment under a contract of reinsurance (including stop-loss and excess of loss insurance);

J. Medical necessity reviews or review of health care services for coverage under the plan, appropriateness of care or justification of charges;

K. Utilization review, including precertification, preauthorization, concurrent review and retrospective review;

L. Disclosing the following information to consumer reporting agencies related to the collection of premiums or reimbursement: name, address, date of birth, Social Security number, payment history, account number and name and address of the provider and/or health plan); and

M. Reimbursement to the Plan.

Health Care Operations

A. Quality assessment and improvement activities;

B. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions that do not include treatment;

C. Rating provider and plan performance, including accreditation, certification, licensing or credentialing activities;

D. Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);

E. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

F. Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including, but not limited to, formulary development and administration, development or improvement of payment methods or coverage policies;

G. Business management and general administrative activities of the Plan, including, but not limited to: (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, (b) customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, (c) resolution of internal grievances, and (d) the sale, transfer, merger or consolidation of all or part of the covered entity with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and

H. Creating de-identified health information or a limited data set.

PAYMENT OF CLAIMS

Plan benefits will be paid to the Employee or, unless the Employee requests otherwise in writing not later than the time of filing proofs of such loss, will be paid directly to the provider of Hospital, nursing or surgical services. However, if any such benefit remains unpaid at the death of the Employee or if the Employee is a minor or is, in the opinion of the Plan Administrator, legally incapable of giving a valid receipt and discharge for any payment, the Plan Administrator may, at its option, pay such benefits to any one or more of the following relatives of the Employee: wife, husband, mother, father, child or children, brother or brothers, sister or sisters. Any payment so made will constitute a complete discharge of the obligation to the extent of such payment, and the Plan Administrator will not be required to oversee the proper application of the money so paid.

FACILITY OF PAYMENT

Whenever payments which should have been made under the Plan in accordance with this provision have been made under any other plan or plans, the Plan Administrator will have the right, exercisable alone and at its discretion, to pay to any insurance company or other organization or person making such other payments any amounts it will determine in order to satisfy the intent of this provision. The amounts so paid will be deemed to be benefits paid under the Plan and to the extent of such payments, the Plan Administrator will be fully discharged from liability under the Plan.

The benefits that are payable in accordance with this prov1s1on will be charged against any applicable maximum payment or benefit of the Plan rather than the amount payable in the absence of this provision.

RIGHTS OF RECOVERY

Whenever payments have been made in excess of the amount due under the Plan, the Plan Administrator shall have the right, exercisable alone and in its sole discretion, to recover such excess payments.

RIGHTS OF SUBROGATION

When a Covered Person incurs expenses as the result of an Injury or Illness for which a third party may be liable, any benefits under the Plan for such expenses will be advanced subject to the terms and conditions of this provision.

The Covered Person will reimburse the Plan out of the Covered Person's recovery for all benefits paid by the Plan which were incurred as a result of the claim or cause of action against the third party. The Plan will be reimbursed in full prior to the Covered Person receiving any monies recovered from any party or their insurer as a result of judgment, settlement or otherwise. The duty and obligations to reimburse the Plan shall apply even if the Covered Person is not fully compensated (or "made-whole") for their injuries and damages. The Plan shall have a property right in the form of a constructive trust

and an equitable lien on the proceeds of any settlement or other recovery. The Covered Person and their legal representative (if applicable) shall hold the Plan's interest in trust and shall repay the Plan for benefits paid on their behalf out of the recovery from the third party or insurer. Furthermore the Covered Person shall include the Plan's name as a co- payee on any settlement check.

The Covered Person shall fully cooperate with the Plan in any case involving the alleged negligence of a third party. In such cases, the Covered Person is obligated to provide the Plan with whatever information, assistance and records the Plan may require to enforce its rights. In the event the Plan has reason to believe that the Plan may have a subrogation lien, the Plan may require the Covered Person to complete a subrogation questionnaire, sign an acknowledgement of the Plan's subrogation rights and an agreement to provide ongoing information before the Plan pays, or continues payment of benefits according to its terms and conditions. Upon receipt of the requested materials, the Plan will commence, or continue, payment of benefits, according to its terms and conditions provided that said payment of benefits in no way prejudices the Plan's rights. Payment of benefits before the signed forms are received does not modify or invalidate the Plan's subrogation rights.

The Plan may, but is not obligated to, take any legal action it sees fit against the third party or the Covered Person, to recover benefits the Plan has paid. The Plan's exercise of this right will not affect the Covered Person's right to pursue other forms of recovery unless the Covered Person or their legal representative consent otherwise.

In the event that the Plan Administrator determines that a subrogation recovery exists, the Plan Administrator retains the right to employ the services of an attorney to recover money due to the Plan. The Covered Person shall cooperate with the attorney who is pursuing the subrogation recovery. The compensation that the Plan's attorney receives will be paid directly from amounts recovered and is in addition to the amount recoverable by the Plan for benefit payments.

The Plan has no duty or obligation to pay a fee to the Covered Person' s attorney for the attorney's services in making any recovery on behalf of the Covered Person.

The Covered Person is obligated to inform their attorney of the subrogation lien and to accept no distributions from any settlement or judgment which will in any way result in the Plan receiving less than the full amount of its lien without the written approval of the Plan.

The Covered Person shall not release any third party or their insurer without prior written approval from the Plan, and will take no action which prejudices the Plan's subrogation right. If the Covered Person impairs the Plan's subrogation right, or refuses to reimburse the Plan from any settlement or judgment received, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any additional benefits for the Covered Person and to reduce future benefits payable under the Plan by the amount due to the Plan.

The Covered Person shall refrain from characterizing any settlement in any manner so as to avoid repayment of the Plan's lien or right to reimbursement. Notwithstanding the preceding sentence, all money recovered from the third party shall be subject to the foregoing lien, regardless of whether the proceeds are characterized as medical expenses, pain and suffering, lost wages or any other characterization.

The Plan pays secondary to any and all PIP, Med-Pay or No-Fault coverage. The Plan has no duty or obligation to pay any benefits until PIP, Med-Pay or No-Fault coverage is exhausted. In the event that the Plan pays benefits that should have been paid by PIP, Med-Pay or No-Fault coverage under this provision, then the Plan has a right of recovery from the PIP, Med-Pay or No-Fault carrier.

In the case of a Michigan Covered Person who is covered by Michigan No-Fault coverage the Plan will not pay claims until and unless all of the Michigan No-Fault coverage is exhausted first.

FREE CHOICE OF PHYSICIAN

The Covered Person shall have free choice of any legally qualified Physician or surgeon, and the Physician-patient relationship shall be maintained.

WORKMEN'S COMPENSATION NOT AFFECTED

The Plan is not in lieu of, and does not affect any requirement for coverage by workmen's compensation insurance.

CONFORMITY WITH LAW

If any provision of the Plan is contrary to any law to which it is subject, such provision is hereby amended to conform thereto.

STATEMENTS

In the absence of fraud, all statements made by a Covered Person will be deemed representations not warranties. No such representations will be used to void coverage or be used in defense to a claim hereunder unless a copy of the instrument containing such representation is or has been furnished to such Covered Person.

MISCELLANEOUS

Section titles are for convenience of reference only and are not to be considered in interpreting the Plan.

No failure to enforce any provision of the Plan shall affect the right thereafter to enforce such provision, nor shall such failure affect its right to enforce any other provision of the Plan.

FUTURE OF THE PLAN

The Plan Administrator, as listed in GENERAL INFORMATION, expects and intends to continue this Plan indefinitely. However, the Plan Administrator reserves the right to amend or terminate the Plan at any time and for any reason. In no event will you become entitled to any vested rights under this Plan.

If the Plan is amended or terminated, you and your dependents may not receive benefits as described in other sections of this booklet. You may be entitled to receive different benefits, or benefits under different conditions. However, it is possible that you will lose all benefit coverage.

PLAN DOCUMENTS

The Plan Document contains all the provisions of the Plan and govern its legal operations.

DISCLAIMER

Every effort has been made to have the Summary Plan Description as complete and accurate as possible. However, if language in the Summary Plan Description conflicts with the wording in the Plan Document, the language in the Plan Document shall control over the language in the Summary Plan Description.