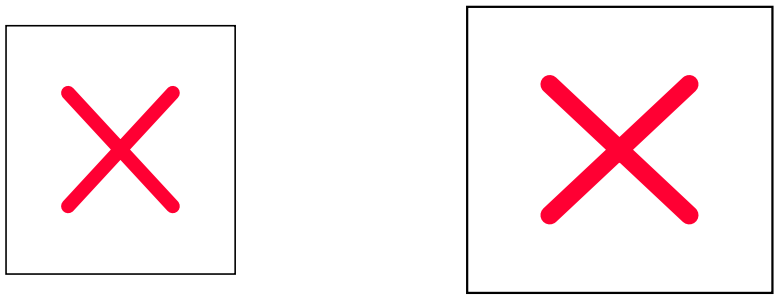

ELDORADO COMPUTING, INC.

and

ELDORADO CLAIMS SERVICES, INC.

EMPLOYEE BENEFIT PLAN

PLAN EFFECTIVE DATE

October 1, 1999

ADOPTION

Eldorado Computing, Inc. and Eldorado Claims Services, Inc. have caused this Employee Benefit Plan ("Plan") to take effect as of the 1st of October 1999, at Phoenix, Arizona. I have read the document herein, and certify the document reflects the terms and conditions of the Employee Welfare Benefit Plan as established by Eldorado Computing, Inc. and Eldorado Claims Services, Inc.

By: _____ Date: _____
Plan Administrator

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STATEMENT OF ERISA RIGHTS

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

1. Examine, without charge, at the Plan Administrator's office and at other locations (work sites, etc.) all Plan Documents, including insurance contracts, and collective bargaining agreements, a copy of the latest annual report (Form 5500 Series), and copies of all documents filed by the Plan with the U. S. Department of Labor.
2. Obtain copies of all Plan Documents governing the operation of the Plan, and other Plan information, upon written request to the Plan Administrator. The Plan Administrator may make reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
4. Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA Continuation Coverage rights.
5. Reduction or elimination of exclusionary periods of coverage for re-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided, free of charge, a certificate of creditable insurance coverage from your prior group or individual health insurance carrier when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18)) months if a Late Enrollee) after your enrollment date in your new plan.

In addition to creating rights for Plan participants, ERISA imposes obligations upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants and beneficiaries. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The court will decide who will pay the costs and legal fees. If you lose, the court may order you to pay these costs and fees: for example, if it finds your claim frivolous. If you are successful, the court may order the person you have sued to pay these costs and fees.

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

If your claim for benefits under the Plan is denied in whole or in part, you must receive written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or federal court.

Under ERISA, there are steps you can take to enforce your rights. For instance, if you request material from the Plan and do not receive such within thirty (30) days, you may file suit in a federal court. In such case, the court may require the Plan Administrator to provide the material and pay you up to $110 a day until you receive the material, unless the material was not provided for reasons beyond the control of the Plan Administrator.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about the rights under ERISA, you should contact the nearest office of the Pension and Welfare Benefits Administration, U. S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefits Administration, U. S. Department of Labor, 200 Constitution Avenue, N. W., Washington, D. C. 20210. The nearest Area Office to the Employer/Plan Sponsor is the Los Angeles Regional Office, 790 E. Colorado Boulevard, Suite 514, Pasadena, California, 91101, Phone 1.626.583.7876.

SUMMARY PLAN DESCRIPTION

Name of Plan:	Eldorado Computing, Inc. and Eldorado Claims Services, Inc. Employee Benefit Plan
Name and Address of Employer and Plan Sponsor:	Eldorado Computing, Inc./ Eldorado Claims Services, Inc. 5353 North 16th Street #410 Phoenix, Arizona 85016 601-604-3131
Employer ID Number:	86-0411502
Plan Number:	501
Type of Plan:	Employee Welfare Benefit Plan: Medical and Dental
Type of Administration:	Contract Administration
Plan Administrator and Named Fiduciary:	Eldorado Computing, Inc. / Eldorado Claims Services, Inc.
Agent for Service of Legal Process:	Eldorado Computing, Inc. / Eldorado Claims Services, Inc.
Eligibility Requirements:	Refer to ***Eligibility, Enrollment***, and ***Effective Date of Coverage.***
Termination of Coverage:	Refer to the ***Termination of Coverage*** and ***COBRA Continuation Coverage.***
Source of Plan Contributions:	The Employer evaluates the costs of the Plan and determines the amount to be contributed by the Employer and the amount to be contributed by the Employees for their coverage. The amount of such contributions will be determined by the Employer based on projected expenses.
Funding Method:	The Employer pays Plan benefits and administration expenses from general assets as needed. Contributions received from Covered Persons are partial reimbursement to the Plan for Plan expenses previously paid.
Procedures for Filing Claims	Refer to ***Claim Procedures and Payment of Benefits***.
Ending Date of Plan's Fiscal Year:	September 30th
Third Party Claims Processor:	Eldorado Claims Services, Inc. 5353 North 16th Street, P. O. Box 55237 Phoenix, Arizona 85016 1-602-604-3131 or 1-800-539-2695

PLAN HIGHLIGHTS

ELIGIBILITY AND EFFECTIVE DATE OF COVERAGE:

Active, regular Full-time Employees working a minimum of thirty (30) hours per workweek are eligible to enroll in the Plan. An eligible Employee's coverage will begin on the first day of the month coincident with or next following 90 days of continuous, Active employment with the Employer. Certain family members are eligible for Dependent coverage under the Plan; their coverage will begin at the same time as the Employee's coverage. Employees must apply for coverage within thirty-one (31) days from the date of their eligibility. Employees and Dependents who do not choose to be covered as soon as they are eligible may be subject to Late Enrollment and Pre-existing Conditions provisions, if they desire to obtain coverage at a later date. Refer to the sections entitled ***Eligibility, Enrollment,*** and ***Effective Date of Coverage.***

PRE-EXISTING CONDITIONS:

"Pre-existing Condition" means a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment, including the use of prescription drugs or medicines was recommended by or received from a licensed Physician or licensed health Practitioner within the one hundred eighty (180) day period ending on the Covered Person's Enrollment Date. Benefits will be provided for the Pre-existing Condition(s) after the earliest of the following:

1. Twelve***** (12) months continuous coverage under the Plan, if the Employee has no prior creditable coverage; or
2. Eighteen***** (18) months continuous coverage under the Plan, if the Employee was a Late Enrollee.

*** IMPORTANT:** This twelve (12) or eighteen (18) month period may be reduced for periods the Employee was covered under other Creditable Coverage.

Pre-existing Conditions provisions will not apply to a newly adopted child, a newborn child, or to Pregnancy. Refer to the sections entitled ***Eligibility, Enrollment,*** and ***Effective Date of Coverage.***

COST OF COVERAGE:

The Employer shares the cost of coverage with Employees and, where applicable, their Dependents. Employees are required to make a modest contribution in an amount determined by the Employer. The Employer may change the amount of the Employee contribution from time to time. The Employer will notify Employees of the contribution amount when coverage becomes effective, and will also notify the Employees of any subsequent changes in that amount. Individuals who continue their coverage pursuant to COBRA will be required to pay the entire cost of that coverage plus the legally permitted administration fee. Refer to the section entitled ***C OBRA Continuation Coverage.***

BENEFITS PROVIDED:

The Plan provides Medical and Dental benefits for Employees and their Dependent(s). The Plan offers Employees and their Dependent(s) an opportunity to choose between two separate benefit programs through the Preferred Provider Organization (PPO) or through the utilization of Non-preferred Providers. Refer to the section entitled ***Plan Options*** for a detailed explanation. The Plan will pay higher benefits for services rendered by a Preferred Provider. Refer to the section entitled ***Schedule of Benefits.***

DEDUCTIBLES:

The Plan has a Calendar Year Deductible the Covered Person must pay from his/her own pocket before Plan benefits apply. For certain services the Calendar Year Deductible is waived. Refer to the section entitled ***Schedule of Benefits*** for more information.

EXCLUSIONS:

There are categories of expenses that are not covered by the Plan. A general listing of services and items excluded from the Plan can be found in the sections entitled ***Medical Expense Benefit Exclusions*** and ***Plan Exclusions.***

COORDINATION OF BENEFITS:

This Plan is designed to help the Covered Person meet the cost of Illness or Injury. It is not intended to provide benefits greater than actual expenses. Therefore, the Plan will take into account and coordinate with the benefits of any Other Plan providing medical benefits so the combined benefits of the Plans do not exceed 100% of the Allowable Expenses incurred during the Claim Determination Period. However, benefits paid under This Plan will not exceed those that would be payable in the absence of any Other Plan.

PRE-AUTHORIZATION:

All Inpatient Hospital or Facility admissions and Outpatient surgeries must be certified in advance with the Health Care Management Organization. If the Hospitalization, Outpatient surgery, Confinement, or treatment is planned in advance, the call must be made seven (7) days prior to admission or surgery. If it is an Emergency admission or maternity admission, the call must be made within forty-eight (48) hours of admission, or on the next business day after admission. If Pre-authorization is not obtained, Covered Expenses may be subject to an additional Deductible per occurrence and/or a reduced Coinsurance benefit. To contact the Health Care Management Organization, refer to your Medical Identification Card for the toll free number. Refer to the section entitled ***Health Care Management*** for further details regarding Pre-authorization.

FILING CLAIMS:

Generally, to make a claim for a benefit, the Health Care Provider should mail its bill directly to the Third Party Claims Processor, Eldorado Claims Services, Inc. To obtain reimbursement for Covered Expenses that have already been paid, the Covered Person must submit an itemized bill and receipt for payment to the Claims Processor. To receive prescription drug benefits, the prescription must be submitted to a participating pharmacy, and the prescription drug card issued by the Plan must be presented to the pharmacist. Refer to the sections entitled ***Claim Procedures and Payment of Benefits*** and ***Prescription Drug Program***.

THIRD PARTY CLAIMS PROCESSOR
ELDORADO CLAIM SERVICES, INC.
5353 NORTH 16TH STREET, SUITE 410
PHOENIX, ARIZONA 85016
602-604-3131
800-539-2695
602-604-3103 FAX

CONTINUATION OF COVERAGE:

If coverage under the Plan ceases for certain reasons, coverage may be continued, at the Covered Person's expense, in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), as amended. Dependents covered by the Plan are also entitled to COBRA Continuation Coverage under certain circumstances. Refer to the section entitled ***COBRA Continuation Coverage.***

SUBROGATION/THIRD PARTY LIABILITY REIMBURSEMENT:

As a condition of receiving benefits under the Plan, the Covered Person agrees to the Plan's right to reimbursement of benefits paid on behalf of the Covered Person for expenses incurred due to the actions of a third party. Refer to the section entitled ***Subrogation/Third Party Liability.***

PREFERRED PROVIDER OR NON-PREFERRED PROVIDER

PLAN OPTIONS:

This Plan offers Employees and their Dependents an opportunity to choose between two separate benefit programs through the Preferred Provider Organization or Non-Preferred Provider Organization (all other providers). A brief description is as follows:

PPO-PREFERRED PROVIDERS:

A Preferred Provider is a Physician, Hospital, or ancillary service that has an agreement in effect with the Preferred Provider Organization (PPO) to accept a reduced rate, known as the Negotiated Rate, for services rendered to the Covered Person. The Preferred Provider cannot bill the Covered Person for any amount in excess of the Negotiated Rate. Because the Covered Person and Plan save money when services or supplies are obtained from providers participating in the Preferred Provider Organization, benefits are usually greater than those available when using the services of a Non-Preferred Provider. To participate in the benefits for services under the PPO benefit schedule, the Covered Person must use a preferred Hospital, Preferred Provider Physician, preferred specialist, and other preferred ancillary services. A complete listing of Preferred Providers can be obtained at no cost from the Employer.

NON-PPO/NON-PREFERRED PROVIDERS:

A Non-Preferred Provider does not have an agreement in effect with the Preferred Provider Organization, and is free to charge patients at any rate. This Plan will allow only the Customary and Reasonable Charge as a Covered Expense; the Plan will pay its benefit percentage of the Customary and Reasonable Charge for the Non-Preferred Provider services. The Covered Person is responsible for the remaining percentage of the Customary and Reasonable Charge, plus the balance of the fees assessed by the provider. This results in greater expense to the Covered Person.

REFERRALS:

Referrals to a Non-Preferred Provider are covered as Non-Preferred Provider services, supplies, and treatments. It is the responsibility of the Covered Person to ensure services to be rendered are performed by PPO Physicians, Practitioners, and Facilities in order to receive the higher level of benefits.

If the Health Care Management Organization recommends that Medically Necessary services or supplies be obtained from a provider out-of-area, Covered Expenses will be paid at the PPO benefit level. If the Covered Person travels out-of-area for the purpose of obtaining medical services and supplies, without the recommendation of the Health Care Management Organization, Covered Expenses will be paid at the Non-PPO benefit level.

EXCEPTIONS:

The following listing of Covered Expenses represents services, supplies or treatments rendered by a Non-Preferred Provider which will be payable at the Preferred Provider level of benefits:

1. Such expenses are made by pathologists, radiologists, or anesthesiologists in connection with a covered Inpatient Preferred Hospital or Facility Confinement or a covered Outpatient procedure performed in a Preferred Hospital or Facility, and the attending Physician and/or operating surgeon is a Preferred Provider.
2. Such expenses are for Emergency treatment rendered at a Non-Preferred Facility. If the Covered Person is admitted to the facility after such Emergency treatment, Covered Expenses will be payable at the Preferred Provider benefit level.
3. Such expenses are for care, treatment, services, or supplies that are not rendered by any Preferred Provider.
4. Such expenses are for special consultations from a Non-Preferred provider, when requested by the attending Physician who is a Preferred Provider.
5. Diagnostic laboratory and pathology tests referred to a Non-Preferred Provider by a Preferred Provider.
6. Such expenses are for Emergency treatment incurred while traveling outside of the Preferred Provider area (50 miles or more from the nearest Preferred Provider), provided the Covered Person has not traveled outside the Preferred Provider area for the sole purpose of obtaining medical services.

7. Such expenses are incurred by a Covered Person or a Covered Dependent residing outside the service area (50 miles or more from the nearest Preferred Provider) of the Preferred Provider Organization, such as a Full-time Student away at school, or an Alternate Recipient.

SCHEDULE OF BENEFITS

The following ***Schedule of Benefits*** is designed as a quick reference. For complete provisions of the Plan's benefits, refer to the following sections: ***Health Care Management, Medical Expense Benefit, Medical Expense Benefit Exclusions*** and ***Plan Exclusions.*** Limitations are combined maximums for services and supplies rendered by Preferred and Non-Preferred Providers.

MEDICAL MAXIMUM BENEFITS:

Maximum Benefit per Covered Person while covered by this Plan for:

Medical Expenses	$ 2,000,000
Chemical Dependency and Substance Abuse	$ 25,000
Temporomandibular Joint Syndrome	$ 750

Maximum Benefit per Occurrence for Transplant Benefits:

Aggregate Maximum for Travel and Accommodations	$ 10,000

Maximum Benefit per Covered Person per Calendar Year for:

Mental and Nervous Disorders	
Inpatient Services	10 days per Calendar Year
Outpatient Services	20 visits per Calendar Year
Chemical Dependency Inpatient &/or Outpatient Hospital Combined	$ 10,000
Inpatient Services	$ 10,000
Chemical Dependency Outpatient Services*	$ 2,000
* (Included in the Inpatient and/or Outpatient limit of $10,000)	
Extended Care/Skilled Nursing Facility	90 days per Calendar Year
Wellness Benefits	$ 300
Chiropractic/Spinal Manipulation	26 visits per Calendar Year

Calendar Year Deductible:	**PPO Provider**	**Non-PPO Provider**
Individual Deductible	$ 200	$ 500
Family Deductible	$ 600	$ 1,500

Out-of-Pocket Expense Limit Per Calendar Year: (includes Deductible)	**PPO Provider**	**Non-PPO Provider**
PPO/Individual	$ 1,200	$ 2,500
PPO/Family	$ 2,400	$ 5,000

Additional Deductibles/Coinsurance Penalty:

Inpatient Admission **NOT** Pre-Authorized	$ 300
*Inpatient admissions include Hospitals, Rehabilitation Centers, Treatment Centers, and Extended Care or Skilled Nursing Facilities.	
Outpatient Surgery **NOT** Pre-Authorized	$ 300
Failure to utilize Approved/Designated Transplant Facility	20% reduction in Coinsurance

The Plan pays the percentage listed on the following pages for Covered Expenses incurred by a Covered Person during a Calendar Year after the Individual or Family Deductible has been satisfied and until the Individual or Family Out-of-Pocket Expense Limit has been reached. Thereafter, the Plan pays 100% of incurred Covered Expenses for the remainder of the Calendar Year, or until the Maximum Benefit has been reached. Refer to the section entitled ***Medical Expense Benefit, Out-of-Pocket Expense Limit*** for a listing of charges not applicable to the 100% Coinsurance.

BENEFIT DESCRIPTION	PPO PROVIDER	NON-PPO PROVIDER
INPATIENT HOSPITAL	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission.**		
OUTPATIENT HOSPITAL/SURGERY: Hospital or Ambulatory Surgical Centers	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Outpatient surgical services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved surgical procedure.**		
AMBULANCE	90% Subject to Deductible	50% Subject to Deductible
EMERGENCY ROOM SERVICES: Facility and Physician charges	90% after $50 Co-payment* Deductible Waived	50% Subject to Deductible
***The Co-payment is waived if Covered Person is admitted to the Hospital; coverage reverts to Hospital Inpatient as noted above.**		
URGENT CARE	100% after $25 Co-payment, Deductible Waived	50% Subject to Deductible
PRE-ADMISSION TESTING	90% Deductible Waived	50% Subject to Deductible
SECOND SURGICAL OPINION	100% after $10 Co-payment, Deductible Waived	50% Subject to Deductible
PHYSICIANS' SERVICES: Office visits, In-office surgical procedures, specialist consultation, in-office x-ray and lab, allergy testing	100% after $10 Co-payment, Deductible Waived	50% Subject to Deductible
PHYSICIAN SERVICES: Inpatient or Outpatient surgery, Inpatient Hospital visits	90% Deductible Waived	50% Subject to Deductible
WELLNESS CARE:	100% to Maximum Benefit of $300, Deductible Waived*	Denied
***Maximum Benefit of $300 per Covered Person per Calendar Year.**		
MAMMOGRAMS	100% Deductible Waived	50% Subject to Deductible
OUTPATIENT DIAGNOSTIC X-RAYS	90% Deductible Waived	50% Subject to Deductible
OUTPATIENT LABORATORY	90% Deductible Waived	50% Subject to Deductible
DURABLE MEDICAL EQUIPMENT	90% Subject to Deductible	50% Subject to Deductible
EXTENDED CARE/SKILLED NURSING FACILITY	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission. Maximum Benefit of 90 days per Calendar Year.**		
HOME HEALTH CARE	90% Subject to Deductible	50% Subject to Deductible
HOSPICE CARE	90% Subject to Deductible	50% Subject to Deductible
***Maximum Benefit per family unit for family bereavement counseling is $300.**		
PODIATRY SERVICES	90% Subject to Deductible	50% Subject to Deductible
MENTAL AND NERVOUS DISORDERS Inpatient Services	90% Subject to Deductible*	50% Subject to Deductible*

BENEFIT DESCRIPTION	PPO PROVIDER	NON-PPO PROVIDER
***Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission Inpatient services subject to maximum 10 days per calendar year.**		
Outpatient Services	90% Subject to Deductible*	50% Subject to Deductible*
***Outpatient services subject to Maximum Benefit of 20 visits per Calendar Year.**		
CHEMICAL DEPENDENCY		
Inpatient Services	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission Lifetime Maximum Benefit of $25,000 and $10,000 per Calendar Year per Covered Person for Inpatient and/or Outpatient services combined.**		
Outpatient Services	90% Subject to Deductible*	50% Subject to Deductible*
***Maximum Benefit of $2,000 per Calendar Year per Covered Person for Outpatient services (included in the Inpatient and/or Outpatient limit of $10,000 combined).**		
REHABILITATIVE SERVICES: Speech Therapy, Physical Therapy, Occupational Therapy	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required for Inpatient services. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission**		
THERAPEUTIC SERVICES: Radiology, Dialysis, Chemotherapy	90% Subject to Deductible*	50% Subject to Deductible*
***Pre-authorization is required. Benefits for Inpatient services not Pre-authorized will be subject to a separate and additional $300 Deductible per unapproved admission**		
CHIROPRACTIC CARE/SPINAL MANIPULATION	100% after $10 Co-payment, Deductible Waived*	50% Subject to Deductible*
*** Maximum Benefit of 26 visits per Calendar Year.**		
TEMPOROMANDIBULAR JOINT SYNDROME	90% Subject to Deductible*	50% Subject to Deductible*
***Maximum Lifetime Benefit of $750.**		
ALL OTHER COVERED EXPENSES	90% Subject to Deductible	50% Subject to Deductible

PRESCRIPTION DRUG PROGRAM

		Participating Pharmacy
Prescription Drug Card		
	Generic	$ 7 Co-payment / 30-Day Supply
	Name Brand	$ 14 Co-payment / 30-Day Supply
Mail Order Program		
	Generic	$14 Co-payment / 100-day supply.
	Brand Name	$28 Co-payment / 100-day supply.

DENTAL EXPENSE BENEFIT SCHEDULE:

The following are Covered Dental Services. Refer to the section entitled ***Dental Expense Benefit***, for details regarding the services covered, exclusions, limitations and other provisions of the Dental Benefit.

SERVICES

	PPO	Non-PPO
Class I – Basic Services*	100%	80%
***Subject to Maximum Annual Benefit per Covered Person; Deductible Waived**		
Class II – Restorative Services*	80%	60%
***Subject to Calendar Year Deductible and Maximum Annual Benefit per Covered Person**		
Class III – Major Services*	80%	60%
***Subject to Calendar Year Deductible and Maximum Annual Benefit per Covered Person**		
Class IV – Orthodontia*	50%	50%
***Subject to the separate and additional Orthodontia Deductible and Orthodontia Maximum Lifetime Benefit**		
Classes II, III and IV		
Calendar Year Deductible Per Covered Person (Maximum 3 per Family)	$ 50	$ 50
Classes I, II, and III		
Maximum Annual Benefit Per Covered Person	$ 1,000	$ 1,000
Class IV - Orthodontia		
Orthodontia Maximum Lifetime Benefit Per Covered Person	$ 2,000	$ 2,000
Covered Persons Limitation: Benefits payable for Dependent children under age nineteen (19) only.		

HEALTH CARE MANAGEMENT

Health Care Management is a means of monitoring services for Medical Necessity to help ensure cost-effective care. Health Care Management can eliminate unnecessary services, hospitalizations, and shorten Confinements, while improving quality of care and reducing costs to the covered Person and the Plan. **Pre-authorization of Medical Necessity by the Health Care Management Organization does NOT establish eligibility under the Plan nor guarantee benefits.** If you are unsure if a procedure, test, surgery or Inpatient admission requires Pre-authorization, contact the Health Care Management Organization. To contact the Health Care Management Organization, refer to the toll-free number on the Medical Identification Card.

PRE-AUTHORIZATION:

HOSPITAL:

All Inpatient Hospital or Facility admissions **MUST** be authorized **IN ADVANCE** (Pre-authorization) by the Health Care Management Organization, except for Emergencies. All Inpatient surgical procedures **MUST** be authorized **IN ADVANCE** by the Health Care Management Organization. In addition, admissions to Mental Health and Substance Abuse Centers, Inpatient Rehabilitation Centers, or Extended Care/Skilled Nursing Facilities must be Pre-authorized by the Health Care Management Organization, except for Emergencies. The Covered Person or their representative should call the Health Care Management Organization at least seven (7) days prior to admission. To contact the Health Care Management Organization, refer to the toll-free number on the Medical Identification Card.

After admission to the Hospital, the Health Care Management Organization will continue to evaluate the Covered Person's progress through Concurrent Review to monitor the length of Confinement. If the Health Care Management Organization disagrees with the length of Confinement recommended by the Physician, the Covered Person and the Physician will be advised. If the Health Care Management Organization determines that continued Confinement is no longer necessary, additional days will not be certified. **Coinsurance for additional days not Pre-authorized by the Health Care Management Organization will be denied.**

EMERGENCY ADMISSION/MATERNITY ADMISSION:

All Emergency Hospital or Facility admissions and Maternity admissions **MUST** be reported to the Health Care Management Organization within forty-eight (48) hours following admission, or on the next business day after admission. If the Covered Person is unable to contact the Health Care Management Organization due to the severity of the Illness or Injury, then the Covered Person's representative must, at the earliest time reasonably possible, contact the Health Care Management Organization. To contact the Health Care Management Organization, refer to the toll-free number on the Medical Identification Card.

As mandated by federal law, coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than forty-eight (48) hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to less than ninety-six (96) hours for both the mother (if a Covered Person) and the newborn child. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable). The Plan does not require authorization for a prescribed length of stay not in excess of forty-eight (48) hours, or ninety-six (96) hours, as applicable.

OUTPATIENT SURGERY:

All Outpatient surgical procedures must be Pre-authorized by the Health Care Management Organization. Procedures performed in the Physician's office do not require Pre-authorization, unless a Facility fee is involved. The Covered Person, or their representative, should call the Health Care Management Organization at least seven (7) days prior to surgery. If the Covered Person is unable to contact the Health Care Management Organization due to the severity of the Illness or Injury, then the Covered Person's representative must, at the earliest time reasonably possible, contact the Health Care Management Organization. To contact the Health Care Management Organization, refer to the toll-free number on the Medical Identification Card.

MATERNITY PROGRAM:

The Covered Person is required to call the Health Care Management Organization during the first trimester of Pregnancy. The Health Care Management Organization will gather information regarding the Covered Person's general health and medical history, and discuss the information with the attending Physician to determine the risk factor of the pregnancy.

PENALTY:

Benefits payable for charges arising out of a Hospital or Facility Admission, Inpatient Surgery or Outpatient surgical procedure will be subject to a separate and additional $300 Deductible per each admission or surgical procedure when Pre-authorization is not obtained. The Coinsurance will be reduced by 20% for failure to obtain Pre-authorization for Transplant services in a Designated / Approved Facility. *This additional Deductible and Coinsurance penalty is waived if the Covered Person is traveling outside the United States.* After the Covered Person has satisfied this "per occurrence" penalty deductible, the Calendar Year Deductible will apply, then the Plan's [reduced] Coinsurance will apply. Refer to the sections entitled ***Schedule of Benefits*** and ***Medical Expense Benefit*** for complete details.

PRE-AUTHORIZATION APPEAL PROCESS:

In the event authorization for Medical Necessity is denied by the Health Care Management Organization, the Covered Person may appeal the decision. The Covered Person may call the Health Care Management Organization for more information concerning the appeal process.

CASE MANAGEMENT/ALTERNATE TREATMENT:

In cases where the Covered Person's condition is expected to be, or is, of a serious nature, the Employer may arrange for review and/or case management services from a professional qualified to perform such services. The Employer will have the right to alter or waive the normal provisions of this Plan when it is reasonable to expect a cost-effective result without a sacrifice to the quality of care. The use of case management or alternate treatment is a voluntary program to the Covered Person; however, the Plan will generally provide a greater benefit to the Covered Person who chooses to participate in the program.

Benefits provided under this section are subject to all other Plan provisions. Alternative care will be determined on the merits of each individual case, and any care or treatment provided will not be considered as setting any precedent or creating any future liability with respect to that Covered Person or any other Covered Person.

ELIGIBILITY

This section identifies the Plan's requirements for a person to be eligible to enroll. Refer to the sections entitled ***Enrollment*** and ***Effective Date of Coverage*** for more information.

EMPLOYEE ELIGIBILITY:

All Active, Full-time Employees who are regularly scheduled to work at least thirty (30) hours per workweek will be eligible to enroll for coverage. Employee eligibility does not include temporary or seasonal Employees.

DEPENDENT(S) ELIGIBILITY:

The following describes Dependent eligibility requirements. At its discretion, the Employer may require proof of Dependent status.

1. The term "spouse" means the spouse of the Employee under a legally valid existing marriage, unless court ordered separation exists.
2. The term "child(ren)" means the Employee's natural child(ren), stepchild(ren), and legally adopted child(ren), and a child(ren) for whom the Employee or covered spouse has been appointed legal guardian, provided the child meets all of the following requirements:
   a. The child(ren) is less than nineteen (19) years of age; and
   b. The child(ren) lives with the Employee in a parent-child relationship (unless residing away from home while attending an institution of higher learning) ; and
   c. The child(ren) is unmarried; and
   d. The child(ren) is principally dependent upon the Employee for support and maintenance. The phrase "principally dependent upon" shall mean dependent upon the Employee for support and maintenance as defined by the Internal Revenue Code, and the Employee must declare the child(ren) as an income tax deduction.
3. An eligible child(ren) will also include any other child(ren) of an Employee or his/her spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) that has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child(ren) is not residing in the Employee's household. Such child(ren) will be referred to as an Alternate Recipient(s). An Alternate Recipient(s) is eligible for coverage regardless of whether or not the Employee elects coverage for himself/herself. An application for enrollment must be submitted to the Employer for coverage under this Plan. The Employer will establish written procedures for determining whether a Medical Child Support Order is a QMCSO, and for administering the provision of benefits under the Plan pursuant to a valid QMCSO. The Employer reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency that issued the order, up to and including the right to seek a hearing before the court or agency.
4. An adopted child(ren) who is less than 18 years of age at the time of adoption will be considered eligible from the moment the child(ren) is Placed for Adoption. "Placed for Adoption" means the date the Employee assumes legal obligation for the total or partial support of the child(ren) during the adoption process.
5. Upon written notice to the Employer, an unmarried child(ren) who has reached his/her nineteenth (19^{th}) birthday and is principally dependent upon the Employee for support and maintenance, may also be included herein as an eligible Dependent(s) until the child(ren)'s twenty-fifth (25^{th}) birthday, provided such child(ren)is unmarried, and is a full-time student in a secondary school, accredited college, university or institution of higher learning. A Full-time Student residing away from home while attending school, who meets the all of the other qualifications, is considered eligible for coverage. It is the Employee's responsibility to provide the Third Party Claims Processor with proof of Full-time Student Status for each semester. Such proof must be obtained from the school's registrar. The Employee must notify the Employer when the Dependent(s) is no longer a Full-time Student.
6. An unmarried child(ren), incapable of self-sustaining employment and dependent upon the Employee for support due to a mental and/or physical disability, and who was covered under the Plan prior to reaching the maximum age limit or other loss of Dependent's eligibility, will remain eligible for coverage under this Plan beyond the date coverage would otherwise be lost. Proof of incapacitation must be provided within thirty-one (31) days of the child(ren)'s loss of eligibility and thereafter as requested by the Employer or Claims Processor, but not more than once every two (2) years. Eligibility may not be continued beyond the earliest of the following:
   a. Cessation of the mental and/or physical disability; or
   b. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.

The Employer must be notified of any change in eligibility of Dependents, including marriage, divorce, the birth of a child(ren) who is to be covered, and adding or deleting any other Dependent(s). Except as provided by COBRA Continuation Coverage, the Employee must notify the Employer of any change in family status within thirty-one (31) days of such change in status. Forms are available from the Employer for reporting changes in Dependents' eligibility as required.

Every eligible Employee may enroll eligible Dependents. However, if both the husband and wife are Employees, they may choose to have one covered as the Employee, and the spouse covered as the Dependent of the Employee, or they may choose to have both covered as Employees. An eligible child(ren) may be enrolled as a Dependent(s) of one spouse, but not both. A Dependent child(ren) who also qualifies as an eligible Employee must be enrolled as an Employee.

INELIGIBLE DEPENDENT(S):

Unless otherwise provided in this Plan Document, the following are not considered eligible Dependents:

1. A foster child(ren);
2. A child(ren) who has been placed in the Covered Employee's home, unless such child has been Placed for Adoption as defined above in the section entitled ***Eligible Dependent(s), #4;***
3. A grandchild(ren); child(ren) of a Dependent son or daughter, unless the Employee or Employee's spouse has been appointed Legal Guardian for such child(ren);
4. A Dependent who is, or becomes, a full-time member of the armed forces of any country;
5. Any other person not defined above in the section entitled ***Eligible Dependent(s).***
6. A person who is eligible as an Employee under the plan, except a spouse.
7. The legally separated or divorced former spouse of the Employee

ENROLLMENT

APPLICATION FOR ENROLLMENT:

The following provisions apply to all enrollment provisions, i.e. regular Enrollment, Special Enrollment Period(s), Late Enrollment, and Open Enrollment. It is the intent of this Plan to allow only those Employees who enroll for coverage for themselves to be entitled to enroll their eligible Dependent(s), except as provided by law.

An Employee must complete and return a written application to the Employer for coverage hereunder for him/herself and his/her eligible Dependent(s): 1) on, before, or within thirty-one (31) days of satisfying eligibility requirements for coverage; and 2) on, before, or within thirty-one (31) days of marriage or the acquiring of, or birth of, a child(ren). ***Acceptance of enrollment does not waive the Pre-existing Conditions provision.*** Refer to the section entitled ***Medical Expense Benefit, Pre-existing Conditions*** for details.

The Employee will have the responsibility of timely forwarding to the Employer all applications for enrollment hereunder, and for making any required premium contribution, either through direct payment to the Employer or the Employer's designee, or through payroll deduction. Failure to complete the application for enrollment within thirty-one (31) days or make the required contribution, will result in the application of the Late Enrollment provision to the Employee and/or Dependents. An Alternate Recipient, as defined in the section entitled ***Eligibility, Dependent Eligibility,*** can be enrolled in the Plan at any time and will not be subject to the Late Enrollment provision.

If the Employee elects to terminate Employee coverage while remaining eligible for coverage, then chooses to re-enroll at a later date, the Employee will be subject to the ***Late Enrollment*** provision below. Termination of Employee coverage will terminate Dependent(s) coverage, except as provided by law.

If the Employee elects to terminate Dependent(s) coverage while the Dependent(s) remain eligible for coverage, then chooses to re-enroll the Dependent(s) at a later date, the Dependent(s) will be subject to the ***Late Enrollment*** provision below.

A Dependent child(ren) who ceases to qualify for Full-time Student Status and whose coverage terminates will be eligible to re-enroll for coverage under the Plan upon re-attainment of Full-time Student Status, provided application for enrollment is submitted to the Employer within thirty-one (31) days of the return to Full-time Student Status.

Every eligible Employee may enroll eligible Dependents. However, if both the husband and wife are Employees, they may choose to have one covered as the Employee, and the spouse covered as the Dependent of the Employee, or they may choose to have both covered as Employees. An eligible child(ren) may be enrolled as a Dependent(s) of one spouse, but not both. A Dependent child(ren) who also qualifies as an eligible Employee must be enrolled as an Employee.

WAIVER OF COVERAGE:

Employees who elect **NOT** to enroll themselves and/or their Dependent(s) must complete the **Waiver of Coverage** portion of the enrollment form. The Waiver of Coverage must be submitted to the Employer within thirty-one (31) days of meeting the Plan's eligibility requirements. **If the Waiver of Coverage is due to the existence of other group health coverage upon meeting the Plan's eligibility requirements, it is the Employee's responsibility to notify the Employer in writing of the existence of the other coverage, and this being the reason for waiving the coverage upon meeting the eligibility requirements.**

SPECIAL ENROLLMENT PERIOD: (OTHER COVERAGE)

Applications for Employee or Dependent(s) coverage not filed with the Employer within thirty-one (31) days of meeting the eligibility requirements of the Plan **because other coverage existed**, will be subject to the ***Special Enrollment Period (Other Coverage)*** provision. An Employee or Dependent may request a Special Enrollment Period if he/she is no longer eligible for the other coverage, and if **ALL** of the following provisions are met:

1. The Employee or Dependent was covered under another group or individual health plan at the time coverage was initially offered; **and**
2. The Employee stated in writing at the time initial enrollment was offered that other coverage was the reason for declining enrollment in the Plan (Waiver of Coverage); **and**
3. The Employee or Dependent lost the coverage as a result of a specific event*, such as the loss of eligibility for coverage, expiration of COBRA Continuation Coverage, termination of employment, or employer contributions towards such coverage were terminated; **and**
4. The Employee requests such a Special Enrollment Period, and effects the enrollment, within thirty-one (31) days of loss of the other coverage.

The Effective Dates of Coverage as a result of a Special Enrollment Period (Other Coverage) will be the first day of the first calendar month following the Employer's receipt of the completed enrollment form. **Acceptance of enrollment does not waive the Pre-existing Conditions provision.**

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

SPECIAL ENROLLMENT PERIOD: (DEPENDENT ACQUISITION)

This ***Special Enrollment Period (Dependent Acquisition)*** provision allows an eligible Employee to enroll Dependents (and, if not otherwise enrolled, the Employee) when he/she marries or has a new child(ren) as a result of marriage, birth, adoption, or Placement for Adoption. A spouse of an Employee can be enrolled separately at the time of marriage, or when a child(ren) is born, adopted, or Placed for Adoption. A spouse of an Employee can be enrolled together with the Employee when they marry, or when a child(ren) is born, adopted, or Placed for Adoption. A child(ren) who becomes a Dependent(s) of an Employee as a result of marriage, birth, adoption, or Placed for Adoption, may be enrolled when the child(ren) becomes an eligible Dependent(s).

The Employee must request the Special Enrollment Period, and effect the enrollment, within thirty-one (31) days of the acquisition of the Dependent(s). The effective date of coverage as a result of a Special Enrollment Period (Dependent Acquisition) will be:

1. In the case of marriage, the first day of the first calendar month following the Employer's receipt of the completed enrollment form;
2. In the case of a Dependent's birth, the date of such birth;
3. In the case of adoption or Placed for Adoption, the date of such adoption or Placed for Adoption.

Acceptance of enrollment does not waive the Pre-existing Conditions provision. Refer to the section entitled ***Medical Expense Benefit, Pre-existing Conditions*** for details.

LATE ENROLLMENT:

Applications for Employee or Dependent(s) coverage not completed and returned to the Employer within thirty-one (31) days of meeting the eligibility requirements of the Plan, and not falling under the provisions stated above in the provisions entitled ***Special Enrollment (Other Coverage)*** or ***Special Enrollment (Dependent Acquisition)*** will be subject to the ***Late Enrollment*** provision.

Late Enrollment applicants will be eligible to enroll for coverage only during the Plan's annual Open Enrollment Period. The Open Enrollment Period is at the discretion of the Employer and will be announced. Coverage is effective the first day of the first month following an Open Enrollment Period, provided the Employee requests and effects the enrollment. ***Acceptance of enrollment does not waive the Pre-existing Conditions provision.*** Refer to the section entitled ***Medical Expense Benefit, Pre-existing Conditions*** for details. This Late Enrollment provision does not apply to an Alternate Recipient.

OPEN ENROLLMENT:

An Open Enrollment Period will be permitted once in each Calendar Year; this Open Enrollment Period is at the discretion of the Employer and will be announced. During this Open Enrollment Period, an eligible Employee and/or his/her eligible Dependent(s) who were previously eligible for coverage, but not previously covered by this Plan, may elect coverage under this Plan. This will be considered a Late Enrollment. ***Acceptance of enrollment does not waive the Pre-existing Conditions provision.***

In subsequent years, an Employee is not required to complete a new election form during the Open Enrollment Period, unless the Employee elects to change his/her benefit program (if available). Employees and enrolled Dependents electing to change Plan options (if available) will not be subject to any additional Pre-existing Conditions provisions. When an Employee elects to change benefit programs, all previously incurred Covered Expenses, Coinsurance, Deductibles, and Out-of-Pocket Expenses will be transferred to the new Plan benefit program and will apply to the Calendar Year Deductibles, Calendar Year Maximum Benefits, Calendar Year Out-of-Pocket Expense Limit, and Maximum Benefit.

The Effective Dates of Coverage as a result of an Open Enrollment will be the first day of the first calendar month following the Open Enrollment Period, provided the Employer receives the completed enrollment form. ***Acceptance of enrollment does not waive the Pre-existing Conditions provision.*** Refer to the section entitled ***Medical Expense Benefit, Pre-existing Conditions*** for details.

FAMILY STATUS CHANGE:

Once enrolled in the Plan, it is the Employee's responsibility to notify the Employer of any change in eligibility of a Dependent(s), including the birth or adoption of a child(ren) to be covered, loss of Full-time Student Status of a Dependent child(ren) and/or adding or deleting any other Dependent(s). Forms are available from the Employer for reporting changes in family status as required. Refer to the section entitled ***Medical Expense Benefit, Adoption Benefits*** for further information regarding timely notification to the Plan Administrator when adopting a child(ren)

If the Employee elects to terminate Dependent(s) coverage while the Dependent(s) remain eligible for coverage, then chooses to re-enroll the Dependent(s), the Employee may re-enroll the Dependent(s), subject to the Late Enrollment provisions.

A Dependent child(ren), who ceases to qualify for Full-time Student Status and whose coverage terminates, but who subsequently returns to Full-time Student Status, may reapply for coverage without the application of Special or Late Enrollment provisions, provided application for re-enrollment is submitted to the Employer on, before, or within thirty-one (31) days of the return to Full-time Student Status eligibility.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE:

An eligible Employee, as defined in the section entitled ***Eligibility***, is effective for coverage under the Plan from the first of the month coincident with or next following completion of ninety (90) days of continuous, Active employment with the Employer, provided the Employee makes timely application for coverage within thirty-one (31) days from the date of eligibility and makes any required contributions, either by direct payment to the Employer or Employer's designee or through payroll deduction. If the Employee does not timely enroll for coverage on, before, or within thirty-one (31) days of meeting the Plan's eligibility requirements, the Effective Date of Coverage will be delayed. Refer to the section entitled ***Enrollment***.

In the event a Part-time Employee changes status to Full-time (30 hours or more), coverage will be effective on the first day of the month following the date the Employee achieves Full-time status, provided the Employee worked in a Part-time capacity for the Employer for at least the period of time equal to the Plan's Waiting Period. If the Employee does not enroll for coverage on, before, or within thirty-one (31) days of meeting the Plan's eligibility requirements, the Effective Date of Coverage will be delayed. Refer to the section entitled ***Enrollment***.

DEPENDENT(S) EFFECTIVE DATE:

An eligible Dependent(s), as defined in the section entitled ***Eligibility***, will become covered under the Plan on the later of the following dates, provided the Employee has enrolled the Dependent(s) within thirty-one (31) days of meeting the Plan's eligibility requirements. If the Employee does not enroll an eligible Dependent(s) within thirty-one (31) days of meeting the Plan's eligibility requirements, the Dependent(s) Effective Date of Coverage will be delayed. Refer to the section entitled ***Enrollment.***

1. The date the Employee's coverage becomes effective;
2. In the case of marriage***,** the first day of the first calendar month following the Employer's receipt of the completed enrollment form, provided
   a. The Employee requests a Special Enrollment Period; and
   b. The Employee enrolls the spouse within thirty-one (31) days following the date of marriage; and
   c. The Employee makes any required contributions for Dependent coverage;
3. The date the Dependent child(ren) is acquired*****, provided:
   a. The Employee requests a Special Enrollment Period; and
   b. The Employee enrolls the Dependent child(ren) within thirty-one (31) days following the date acquired; and
   c. The Employee makes any required contributions for Dependent coverage;
4. Each newborn child must be enrolled separately at birth. Newborn child(ren)***** will be covered from birth, regardless of Confinement, provided the Employee has applied for Dependent(s) coverage on, before, or within thirty-one (31) days of birth and makes any required contributions for Dependent coverage;
5. Coverage for a newly adopted child(ren)***** will be effective the date the child(ren) is Placed for Adoption provided the Employee requests a Special Enrollment Period and makes any required contributions for Dependent coverage.

****NOTE: The Employee may be required to provide a copy of the birth certificate, decree of adoption, certification of Placement for Adoption, marriage certificate, or any other applicable document before coverage can become effective.***

TERMINATION OF COVERAGE

Except as provided in the Plan's sections entitled ***COBRA Continuation Coverage*** (COBRA), coverage will terminate on the earliest of the following occurrences:

EMPLOYEE(S) TERMINATION DATE:

1. The last day of the month in which the Employer terminates the Plan and offers no other group health plan.
2. The last day of the month in which a lay-off commences.
3. The last day of the month in which the Employee ceases to meet the eligibility requirements of the Plan.
4. The last day of the month in which employment terminates.
5. The last day of the month in which the Employee provides a written request to the Employer to terminate coverage, if the Employee is voluntarily canceling coverage while remaining eligible for coverage under the Plan.
6. The date the Employee becomes a Full-time, active member of the armed forces of any country, other than scheduled drills or other training not exceeding one month in any Calendar Year.
7. The date an Employee fails to return to Full-time employment following an approved Leave of Absence.
8. The end of the period for which the Employee made the required contribution, if the Employee ceases to make the required contribution when due.
9. The date that concludes twelve (12) weeks from the date a leave of absence commences as the result of an Illness or Injury reimbursable under Worker's Compensation Law, if the Employee fails to return to Full-time employment.
10. The date that concludes twelve (12) weeks from the date an approved FMLA Leave of Absence commences, if the Employee fails to return to Full-time employment.
11. The date the Employee fails to make the required contribution during an approved Leave of Absence, FMLA Leave of Absence or Worker's Compensation leave of absence.

DEPENDENT(S) TERMINATION DATE:

1. The last day of the month the Employer terminates the Plan and offers no other group health plan.
2. The date the Employee's coverage terminates, due to change in eligibility or termination of employment. However, if the Employee *remains eligible* for the Plan, but *elects to discontinue* coverage, coverage may be extended for an Alternate Recipient(s).
3. The last day of the month such Dependent(s) ceases to meet the eligibility requirements of the Plan.
4. The last day of the month in which the Employee provides a written request to the Employer to terminate Dependent(s) coverage, if the Employee is voluntarily canceling coverage while the Dependents remain eligible for coverage under the Plan.
5. The last day of the month in which the Dependent(s) reaches the maximum age limit as stated in the section entitled ***Eligibility.***
6. Cessation of Full-time Student Status for a Dependent Child(ren) age nineteen (19) or older will terminate coverage on the earliest of the following dates:
   a. The last day of the month in which the Dependent(s) ceases to be a Full-time Student;
   b. The date the school reconvenes after school vacation, if the Dependent(s) fails to meet the Full-time Student Status criteria;
   c. The last day of the month following graduation;
   d. If the Dependent(s)'s Full-time Student Status ceases due to disability, coverage may continue under this Plan, provided:
      1. The Physician submits a written statement to the Claims Processor; and
      2. The Dependent(s) maintains an acceptable number of credit hours of academic courses as approved by the Employer.

      If approved under #2 above, the coverage will terminate on the first day of the school's next regular session following the date established by a Physician's written statement to the Third Party Claims Processor that the student is capable of Full-time Student Status and full-time school attendance. It is the Employee's responsibility to notify the Employer of cessation of Full-time Student Status.
6. The end of the period for which the Employee made the required contribution for Dependent(s) coverage, if the Employee ceases to make the required contribution when due.
7. The date the Dependent(s) becomes a Full-time active member of the armed forces of any country, other than scheduled drills or other training not exceeding one month in any Calendar Year.

8. The last day of the month in which the Employer discontinues Dependent(s) coverage for any and all Dependent(s) under the Plan.

LEAVE OF ABSENCE:

Coverage under the Plan may be continued for a limited time, ***contingent upon payment of any required contributions***, when the Employee is on an authorized Leave of Absence from the Employer or if full-time work ceases due to an Illness, Injury or disability that does not qualify under the FMLA provisions below. If the covered Employee fails to make the required contribution during an authorized Leave of Absence within thirty (30) days after the date the contribution was due, the Employee's coverage will terminate effective on the date the contribution was due. In no event will coverage continue for more than twelve (12) weeks after the Employee's Active service ends. If an Employee does not return to Active Work after an authorized Leave of Absence or the cessation of the Illness, Injury or disability, this will be considered a qualifying event for the purposes of COBRA. The Employee will incur a COBRA qualifying event on the date the Employee notifies the Employer that he or she will not return to work, or on the date the Employee does not return to work after the Leave of Absence, as scheduled.

FAMILY MEDICAL LEAVE ACT:

Regardless of the established leave policies mentioned above, this Plan will at all times comply with the Family Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

If an Employee does not return to Active Work after an authorized FMLA Leave of Absence, this will be considered a qualifying event for the purposes of COBRA. The Employee will incur a COBRA qualifying event when the Employee notifies the Employer that he or she will not return to work, or when the Employee does not return to work after the leave of absence, as scheduled. The qualifying event is considered to begin on the last day of the FMLA leave.

ELIGIBLE LEAVE:

If an Employee has worked for the Employer for at least twelve (12) months and has performed at least 1250 hours of service for the Employer during the previous twelve (12) month period, the Employee may remain covered under the Plan on an approved Leave of Absence as defined in the Family Medical Leave Act (FMLA), if the Employer is required by law to provide leave under FMLA. Coverage will be continued under the same terms and conditions that would have applied had the Employee continued in Active employment, provided the Employee continues to pay his/her required contributions toward the cost of coverage.

Under the Family Medical Leave Act (FMLA), eligible, enrolled Employees are entitled to a Leave of Absence up to twelve (12) work weeks during any twelve (12) month period, provided the leave is:

1. To care for a child(ren) of the Employee during the twelve (12) months following the birth of the child(ren); or
2. To care for a child(ren) placed with the Employee for adoption or foster care during the twelve (12) months following the placement; or
3. To care for the Employee's spouse, son, daughter, parent of the Employee, or certain other people (as defined in the FMLA) having a "serious health condition"; or
4. Because the Employee has a "serious health condition" and is unable to perform the functions of the Employee's position.

"Serious health condition" is defined in FMLA, but generally means an Illness, Injury, impairment, or physical or mental conditions involving Inpatient care in a Hospital, Hospice, or residential medical care facility, or continuing treatment by a health care provider. If leave continues beyond the twelve (12) weeks, the Employee will be eligible for COBRA Continuation Coverage.

EMPLOYEE NOTICE:

If the leave is foreseeable, the Employee must give the Employer thirty (30) days notice, or as much notice as practical. In cases when such advance notice is not possible, the Employee must give notice within one or two business days of when the Employee learns of the need for the qualifying leave of absence. Notice must be written and state the reason, the timing, and duration of the leave of absence. In emergencies when the Employee is personally unable, because of a serious health condition, to give notice, the Employee's authorized representative may provide such notice.

CONTRIBUTIONS:

During this leave, the Employer will continue to pay the same portion of the Employee's contribution for the Plan. ***The Employee will be responsible to continue payment for the Employee and his/her eligible Dependent(s)'s coverage.*** If the covered Employee fails to make the required contribution during an FMLA Leave of Absence within thirty (30) days after the date the contribution was due, the Employee's coverage will terminate effective on the date the contribution was due.

REINSTATEMENT:

If coverage under the Plan was terminated during an approved FMLA Leave of Absence due to non-payment of the required contributions by the Employee, and the Employee returns to Active employment immediately upon completion of such leave, Plan coverage will be reinstated on the date the Employee returns to Active employment without having to satisfy any waiting period requirement or the Pre-existing Conditions provision of the Plan, provided the Employee makes any necessary contributions and re-enrolls for coverage within thirty (30) days of his/her return to Active employment.

REPAYMENT REQUIREMENT:

The Employer may require an Employee who fails to return from a FMLA Leave of Absence to repay any contributions paid by the Employer on the Employee's behalf during such leave. This repayment will be required only if the Employee's failure to return from such leave is not related to a serious health condition or events beyond the Employee's control.

EMPLOYEE REINSTATEMENT:

In the event an Employee's coverage under the Plan terminates due to a loss of eligibility (termination of employment, reduction of hours, leave of absence, etc.), coverage may be reinstated for the eligible Employee and eligible Dependent(s) provided **ALL** of the following conditions are met:

1. Return to an eligible class occurs within sixty (60) days of the event that caused the loss of coverage under the Plan; **and**
2. The Employee submits the completed application for reinstatement of coverage to the Employer within thirty-one (31) days of becoming eligible for coverage; **and**
3. The Employee and Dependents were covered under the Plan prior to the event that caused the loss of coverage under the Plan.

Coverage will be effective the first day of the month coincident with or next following the date the Employee returns to an eligible class, provided the Employee effects the enrollment. Prior accumulators, such as Deductible, Maximum Benefit, Out-of-Pocket Expenses and Pre-existing Conditions waiting period, will be applied as though no break in coverage had occurred.

Note: this provision does not apply to:

1. An Employee whose coverage terminated due to non-payment of any required contribution;
2. An Employee who voluntarily terminated coverage under the Plan while remaining eligible for coverage;
3. An Employee who does not return to an eligible class or Active, Full-time employment within sixty (60) days of the event that caused the loss of coverage under the Plan. Such an Employee will be considered a new Employee for purposes of eligibility under the Plan, and will be subject to all eligibility requirements, including all requirements relating to Eligibility, Enrollment, Effective Date of Coverage, and the Pre-existing Conditions provision.

PLAN TERMINATION:

The Employer expects this Plan to continue, but reserves the right to terminate this Plan at any time. Termination of this Plan will completely end all obligation of the Employer to provide benefits for incurred expenses after the date of Plan termination. Refer to the section entitled ***General Provisions, Plan Termination***.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), as amended, requires that *most* employers sponsoring group health plans offer employees and their families covered under the employer's health plan the opportunity for a temporary extension of health coverage, called "COBRA Continuation Coverage," in certain instances where coverage under the plan would otherwise end. In order to comply with federal regulations, this document includes a COBRA Continuation Coverage option for certain individuals whose coverage would otherwise terminate.

The following provision is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. This provision serves as notice to the Plan Participants and beneficiaries, ***in summary fashion only,*** of the rights and obligations under the COBRA Continuation Coverage provisions, as amended. This provision is intended to reflect the law, and does not grant, nor take away, any rights under the law. Complete instructions on COBRA Continuation Coverage, as well as election forms and other information, will be provided by the Plan Administrator to a Covered Person who becomes a Qualified Beneficiary under COBRA Continuation Coverage.

THE PLAN OF THIS EMPLOYER:

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

QUALIFIED BENEFICIARIES:

In general, a Qualified Beneficiary is:

1. An individual who, on the day before the Qualifying Event, is covered under the group health plan by virtue of being, on that day, either a covered Employee, the covered spouse of a covered Employee, or a covered Dependent child of an Employee.
2. Any child who is born to or placed for adoption with a covered Qualified Beneficiary during a period of COBRA Continuation Coverage.
3. In the case of bankruptcy proceedings of the Employer under Title 11 of the U. S. Code, a covered Employee who had retired on or before the date of substantial elimination of group health plan coverage is a Qualified Beneficiary, as is the spouse, surviving spouse or Dependent child of such a covered Employee, if, on the day before the bankruptcy Qualifying Event, the spouse, surviving spouse, or Dependent child was a Covered Person under the Plan.
4. An individual who was denied or not offered Plan coverage under circumstances in which the denial or failure to offer plan coverage constituted a violation of applicable law, shall be deemed to have had the Plan coverage on the day before a Qualifying Event, and, therefore, will be considered a Qualified Beneficiary with entitlement to COBRA Continuation Coverage.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION:

A spouse or Dependent child(ren) newly acquired during COBRA Continuation Coverage is eligible to be enrolled as a Dependent(s). The Plan will provide a special thirty (30) day enrollment period to enroll a newly acquired spouse or newly acquired Dependent child(ren) during the COBRA Continuation Coverage. Any child(ren) born to, or adopted by, a covered Employee during a period of COBRA Continuation Coverage will be deemed a Qualified Beneficiary, if properly enrolled in the Plan. Such child(ren) will have all rights of a Qualified Beneficiary, including eligibility for extension of COBRA Continuation Coverage due to a second Qualifying Event. A child born to, or Placed for Adoption, with the *former* spouse of a covered Employee will not be eligible for the Extension of Continuation Coverage due to a second Qualifying Event. However, if a second Qualifying Event occurs *before* the child is born or Placed for Adoption (such as death of the covered Qualified Beneficiary), then the second Qualifying Event also applies to the newborn child or adopted child.

QUALIFYING EVENTS:

Under this provision, the following Covered Persons, whose coverage would otherwise end, may continue coverage under the Plan as a Qualified Beneficiary, provided they were covered under the Plan on the day before the Qualifying Event occurs:

In general, a Qualifying Event is any of the following where Plan coverage would be terminated except for the availability of COBRA Continuation Coverage:

1. The termination of employment (other than termination for gross misconduct) of a covered Employee, or the reduction in hours of a covered Employee to less than the minimum required for coverage under the Plan;
2. The death of a covered Employee;
3. The divorce or legal separation of a covered Employee from the Employee's spouse;
4. A covered Employee becoming entitled for benefits under Medicare under Title XVIII of the Social Security Act;
5. A covered Dependent child(ren) who ceases to be a Dependent of a covered Employee by reason of marriage, attainment of the maximum age at which a Dependent child(ren) may be covered under the Plan, or otherwise becoming ineligible under the Plan's terms because of age or Dependent status;
6. A proceeding in bankruptcy under Title 11 of the U. S. Code with respect to an Employer from whose employment a covered Employee retired at any time.
7. Failure to return to employment at the end of an FMLA leave*****, and all other COBRA Continuation Coverage conditions are present.

If the Qualifying Event causes the covered Employee, covered spouse or covered Dependent child(ren) to cease to be covered under the Plan under the same terms and conditions as immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within twelve (12) months before or after the date of the bankruptcy proceeding commences), the Covered Person losing such coverage becomes a Qualified Beneficiary under COBRA, if all the other conditions of the COBRA law(s) are also met.

***Note:** The taking of leave under FMLA does not in itself constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the approved FMLA leave (or becomes covered under a group health plan during FMLA leave), and all other COBRA Continuation Coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the maximum coverage period is measured from that date. In the case of such a Qualifying Event, the Employer cannot condition the Employee's right to COBRA Continuation Coverage on the Employee's reimbursement of any premiums paid by the Employer to maintain the Employee's group health coverage during the period of FMLA.

SUBSEQUENT QUALIFYING EVENTS:

In general, a secondary Qualifying Event is any of the following where COBRA Continuation Coverage would be terminated except for the availability of COBRA Extension of Continuation Coverage:

If one of these subsequent Qualifying Events occurs during the initial period of COBRA Continuation Coverage, a Qualified Beneficiary may be entitled to a second continuation period. This period will, ***in no event***, continue beyond thirty-six (36) months from the date of the first Qualifying Event.

1. Death of an Employee;
2. Divorce or legal separation from an Employee;
3. Employee's entitlement to Medicare; or
4. The child(ren)'s loss of Dependent status.

Except as provided in the section entitled ***Family Members Acquired During Continuation,*** only a person covered prior to the original Qualifying Event is eligible to extend coverage as the result of a subsequent Qualifying Event.

NOTIFICATION AND ELECTION REQUIREMENTS:

A group health plan can condition the availability of COBRA Continuation Coverage upon the "timely election" of such coverage. An election of COBRA Continuation Coverage is a timely election if it is made during the election period. The election period must begin no later than the date the Qualified Beneficiary would lose coverage due to the Qualifying Event.

The election period must not end before the date that is 60 days after the later of:

1. The date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or
2. The date notice is provided to the Qualified Beneficiary of his/her rights to elect COBRA Continuation Coverage.

In general, the following are the notification and election requirements of the COBRA Continuation Coverage.

1. When eligibility for COBRA Continuation Coverage results from a spouse being divorced or legally separated from a covered Employee, or a child(ren)'s marriage or attainment of the maximum age for coverage under the Plan***, the Employee or Dependent(s) must notify the Employer of that event within sixty (60) days of the event.*** The group health plan is **NOT** required to offer the Qualified Beneficiary an opportunity to elect COBRA Continuation Coverage if the notice is not provided to the Plan Administrator within sixty (60) days after the later of:
   a. The date of the Qualifying Event; or
   b. The date the Qualified Beneficiary would lose coverage due to the Qualifying Event.
   Failure to provide such notice to the Employer will result in the person forfeiting his/her rights to COBRA Continuation Coverage under this provision.
2. Within fourteen (14) days of receiving notice of a Qualifying Event, the Employer will advise the Employee and/or Dependent(s) of their rights to COBRA Continue Coverage.
3. After receiving notice, the Employee and/or Dependent(s) have sixty (60) days to decide whether to elect COBRA Continuation Coverage. The election period must not end before the date that is 60 days after the later of:
   a. The date the Qualified Beneficiary would lose coverage due to the Qualifying Event; or
   b. The date notice is provided to the Qualified Beneficiary of his/her rights to elect COBRA Continuation Coverage.
   If the Employee or Dependent(s) chooses to have COBRA Continuation Coverage, he/she must advise the Employer in writing of this choice. The Employer must receive this written notice no later than the last day of the sixty (60) day period. If the election is mailed, the election must be postmarked on or before the last day of the sixty (60) day period.
4. Within forty-five (45) days after the date the Qualified Beneficiary notifies the Employer that he/she has elected COBRA Continue Coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date COBRA Continuation Coverage health benefits begin to the date the election was made. Thereafter, payments for the COBRA Continuation Coverage are to be made monthly, and are due in advance on the first day each month, but no later than thirty (30) days after the due date. The Employer will not issue any subsequent billing notices.
5. Payments must continue to be made timely for the COBRA Continuation Coverage to remain in full force and effect.

WAIVER OF COBRA CONTINUATION COVERAGE:

If, during the election period, a Qualified Beneficiary waives COBRA Continuation Coverage, the waiver can be revoked at any time before the end of the sixty (60) day election period. Revocation of the waiver is an election of COBRA Continuation Coverage. However, if a waiver is later revoked, COBRA Continuation Coverage need not be provided retroactively, i.e. from the date of the Qualifying Event until the waiver is revoked. Waivers and revocations of waivers are considered made on the date they are sent to the Employer or the Plan Administrator, as applicable.

COST OF COVERAGE:

The Employer requires that Covered Persons pay the entire cost of the COBRA Continuation Coverage, plus the legally permitted administration fee. This must be remitted to the Employer, or the Employer's designated representative, on or before the first day of each month during the COBRA continuation period. The payment must be remitted each month in order to maintain the coverage in force. If the first payment, or any subsequent payment, is not received timely, the Qualified Beneficiary will lose the option to continue coverage. The Employer is **NOT** required to notify the Qualified Beneficiary(ies) of the termination of COBRA Continuation Coverage due to non-payment of premium.

For a Qualified Beneficiary extending coverage under the extension for disabled individuals, the Plan may require the Qualified Beneficiary to pay a contribution for coverage not to exceed 150% of the applicable premium for the continuation coverage month nineteen (19) through month twenty-nine (29).

For purposes of determining monthly costs for continuation coverage, a person originally covered as an Employee, spouse or Dependent child (except a child continuing coverage as part of a family unit continuing coverage) will pay the rate applicable to an Employee if coverage is continued for him/herself alone. Otherwise, a person electing coverage for

him/herself together with either spouse and/or Dependent children, will pay the rate applicable to an Employee with Dependent(s).

WHEN CONTINUATION COVERAGE BEGINS:

When COBRA Continuation Coverage is timely elected and the contributions timely paid, coverage is reinstated back to the date of the loss of coverage, so no break in coverage occurs.

When COBRA Continuation Coverage is waived, and the waiver is subsequently revoked, coverage will be reinstated as of the date the waiver is revoked. In this case, coverage is not required to be provided for the period of time during the election period in which the waiver was in effect.

Coverage for a newly acquired Dependent(s) who is properly and timely enrolled during the COBRA continuation period begins in accordance with the ***Enrollment*** and ***Effective Date of Coverage*** provisions of the Plan, just as those provisions are applied to similarly situated non-COBRA beneficiaries and/or Plan Participants.

END OF CONTINUATION:

Except for an interruption of coverage in connection with a waiver of COBRA Continuation Coverage as described above, COBRA Continuation Coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date that is the later of the date of the Qualifying Event or the date coverage terminated due to the Qualifying Event and ending on the earliest of the following dates:

1. Eighteen (18) months from the date COBRA Continuation Coverage began for a Qualified Beneficiary whose coverage ended because of a reduction of hours or termination of employment of a covered Employee; or
2. Thirty-six (36) months from the date continuation began for a spouse or Dependent child(ren) whose coverage ended because of the death of the Employee, divorce or legal separation from the Employee, or the marriage or attainment of the maximum age of eligibility by a Dependent child(ren); or
3. The end of the period for which contributions are paid if the Qualified Beneficiary fails to make a timely payment on the date specified by the Employer; or
4. The date upon which the Employer ceases to provide any group health plan, including any successor plans, to any Employee; or
5. The date, after the date of the election, the Qualified Beneficiary first enrolls in the Medicare program, either Part A or Part B, whichever occurs earlier; or
6. The date, after the date of the election, the Qualified Beneficiary ***first becomes covered*** under any other group plan not containing any exclusion or limitation with respect to any Pre-existing Conditions, other than such exclusion or limitation does not apply to, or is satisfied by, the Qualified Beneficiary.
7. In the case of a Qualified Beneficiary who is a child born to or Placed for Adoption with a covered Qualified Beneficiary during a period of COBRA Continuation Coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA Continuation Coverage during which the child was born or Placed for Adoption.

EXTENSION FOR DISABLED INDIVIDUALS:

A person who is totally disabled may extend continuation coverage from eighteen (18) months to twenty-nine (29) months, provided the Qualified Beneficiary receives a determination from the Social Security Administration that the Qualified Beneficiary was ***disabled at the time of the Qualifying Event, or within sixty (60) days of the Qualifying Event***. The disabled person and the family members who were covered prior to the Qualifying Event are eligible for up to twenty-nine (29) months of COBRA Continuation Coverage. The Qualified Beneficiary must submit proof of the determination of disability by the Social Security Administration to the Employer within the initial eighteen (18) month COBRA extension period and no later than sixty (60) days after the Social Security Administrations determination in order to be eligible for the additional eleven (11) month extension. For Qualified Beneficiaries whose coverage is continued pursuant to this provision, the Plan may require the Qualified Beneficiaries to pay a contribution for coverage, not to exceed 150% of the applicable premium for the continuation coverage months nineteen (19) through twenty-nine (29).

This COBRA Extension of Coverage for disability will end the on the earlier of:

1. The month that begins thirty days after the person is no longer considered disabled; or
2. The first day following twenty-ninth (29) months after the date of the Qualifying Event, or the date of the termination of coverage, whichever is later.

OTHER TERMINATION PROVISIONS:

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries. For example, the Plan may terminate coverage for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary, but who is receiving coverage under the Plan solely because of the individual's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA Continuation Coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage to the individual who is not a Qualified Beneficiary.

PRE-EXISTING CONDITIONS:

In the event a Qualified Beneficiary becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has a pre-existing conditions limitation or exclusion covered under this Plan, the Covered Person may remain covered under this Plan with COBRA Continuation Coverage and elect coverage under the other employer's group health plan. Coordination of Benefits may occur in certain situations when a benefit limitation, rather than exclusion, applies to the Pre-existing Conditions under the other employer's plan. This Plan will be the primary payor for the Covered Expenses excluded or limited under the other employer sponsored group health plan; however, this Plan will be secondary coverage to the other employer-sponsored group health plan for all other expenses.

CONVERSION PRIVILEGES:

If a Qualified Beneficiary's COBRA Continuation Coverage ends as a result of the expiration of the applicable maximum coverage period, the Plan must, during the one hundred eighty (180) day period that ends on that expiration date, provide the Qualified Beneficiary with the option of enrolling under a conversion health plan, if such an option is otherwise generally available to similarly situated non-COBRA beneficiaries under the Plan***. However, if such a conversion option is not otherwise generally available, it need not be made available to a Qualified Beneficiary.***

MILITARY MOBILIZATION

Employees going into, or returning from, military service will have Plan rights as mandated by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). These rights include the election of continued coverage for a period that is the lesser of eighteen (18) months or a period that ends on the day the Employee fails to apply for or return to a position of Active employment with the Employer. Continuation of coverage is contingent upon coverage upon payment of the entire cost of coverage, plus a legally permitted administration fee (when leave extends beyond 30 days). If the leave is less than thirty-one (31) days, the Employee will not be required to pay more than the Employee's usual contribution to the Plan. Upon the Employee's return to Active employment, coverage will be immediate, with no Pre-existing Conditions provisions being applied in the Plan upon return from service. These rights apply only to Employees and their Dependent(s) covered under the Plan before leaving for military service. Whether or not an Employee on military leave elects continued coverage, no exclusions or waiting periods will be imposed upon the Employee's return from service. Coverage will be immediately reinstated upon return to Active employment meeting the eligibility requirements under this Plan. Restoration of benefits will be at the same level that the Employee would have had if the Employee remained continuously covered. This applies to Employee, spouse and dependent coverage.

Plan exclusions may be imposed for any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, military service.

THIS PLAN AND MEDICARE

The term "Medicare" means the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended. This section is subject to the terms of the Medicare laws and regulations. Any changes in these related laws and regulations will apply to the provisions of this section.

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Ineligible individuals age sixty-five (65) and over may purchase Medicare Part A by making application to the Social Security Administration and paying the full cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage.

1. When an Employee becomes entitled to Medicare coverage and is still Actively at Work, the Employee may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
2. When a Dependent becomes entitled to Medicare coverage and the Employee is still Actively at Work, the Dependent may continue health coverage under this Plan at the same level of benefits and contribution rate that applied before reaching Medicare entitlement.
3. If the Employee or Dependent is also enrolled in Medicare, this Plan will pay as the primary plan; Medicare will pay as the secondary plan.
4. If the Employee and/or Dependent elect to discontinue health coverage under this Plan, and enroll in Medicare, no benefits will be paid under this Plan. Medicare will be the only payer.

END STAGE RENAL DISEASE:

For Covered Persons under age sixty-five who have contracted End Stage Renal Disease, this Plan will be the primary payor of benefits during the first eighteen (18) months of treatment; Medicare will be secondary payor. After the first eighteen-month period, Medicare will permanently become the primary payor.

MEDICAL EXPENSE BENEFIT

Covered Expenses means the expenses actually incurred by, or on behalf of, a Covered Person for the services, supplies and treatments listed in this section, provided the expenses are incurred while such person is covered under this Plan. The Covered Expenses for services, supplies or treatment provided must be recommended by a Physician and be Medically Necessary care and treatment for the Illness or Injury suffered by the Covered Person. Specified preventive care expenses will be Covered Expenses under this Plan. Benefits paid by the Plan for Covered Expenses may subject to applicable Deductibles, Co-payments, Coinsurance, and Maximum Benefits as shown in the section entitled ***Schedule of Benefits***.

CO-PAYMENTS:

The Co-payment is the amount payable by the Covered Person for certain medical treatment or services rendered by a PPO Provider. These services and applicable Co-payments are shown in the section entitled ***Schedule of Benefits***. Under the PPO Plan, the Covered Person pays a Co-payment for specified services. The Plan will then pay its Coinsurance percentage.

The Co-payment will not be applied toward the following:

1. The Calendar Year Deductible; or
2. The maximum Out-of-Pocket Expense Limit; or
3. The common accident Deductible.

DEDUCTIBLES:

INDIVIDUAL DEDUCTIBLE:

The Individual Deductible is the amount of Covered Expenses the Covered Person must incur and pay during each Calendar Year before any Plan benefits are payable for the services, supplies, and treatment rendered by a Provider. Covered Expenses incurred during the last three (3) months of the Calendar Year, and applied to the Individual Deductible of any Covered Person will also be applied to the Individual Deductible for the following Calendar Year. Deductible carry-over does not apply to Family Deductibles.

Only one Deductible will be applied toward the Covered Expenses incurred by a covered newborn Dependent(s)'s mother for a covered Pregnancy and the Covered Expenses for such newborn Dependent(s)'s routine preventive well-baby care incurred while such newborn Dependent(s) is less than five (5) days old and is confined in the birth Hospital or alternative Birthing Center.

FAMILY DEDUCTIBLE:

The Family Deductible amount is three (3) times the Individual Deductible amount. When three (3) covered members of the same family have each met their Individual Deductible amount during a Calendar Year, the Family Deductible amount will be considered satisfied for that Calendar Year and no further Deductible amount will be taken from the expenses of any covered family member for the remainder of that Calendar Year.

COMMON ACCIDENT:

If, as a result of the same accident, two (2) or more Covered Persons within the same family unit sustain Injuries and incur medical charges resulting from such Injuries, only one Individual Deductible amount will be deducted from the total of Covered Expenses relating to the accident for all covered family members. This Deductible feature is applied to Covered Persons for the remainder of the Calendar Year.

PENALTY DEDUCTIBLE:

If the Covered Person fails to obtain Pre-authorization as specified in the section entitled ***Health Care Management***, the Covered Person is responsible for an additional Deductible as specified in the section entitled ***Schedule of Benefits***. The penalty Deductible will be applied to Covered Expenses first, then any applicable Hospital or Calendar Year Deductible will

be applied. Thereafter, the Plan's Coinsurance will apply. This penalty Deductible is waived if the Covered Person is traveling or resides outside the United States.

DEDUCTIBLE EXCLUSIONS:

The following items do not apply toward the satisfaction of the Calendar Year Deductible:

1. Expenses for services or supplies not covered by this Plan;
2. Expenses in excess of the Customary and Reasonable Charge;
3. The Covered Person's Coinsurance share of expenses partially covered by the Plan;
4. The penalty Deductible for failure to obtain Pre-authorization; and
5. Co-payments.

COINSURANCE:

The Coinsurance, otherwise referred to as the benefit percentage, is the percentage of the Customary and Reasonable charge the Plan will pay for Non-Preferred Providers, or the percentage of the Negotiated Rate for Preferred Providers. Once the Deductible or the Co-payment is satisfied, the Plan will pay benefits for incurred Covered Expenses during the remainder of the Calendar Year at the applicable Coinsurance as specified in the section entitled ***Schedule of Benefits***. The Covered Person is responsible for paying the remaining percentage. The Deductible, together with the Covered Person's portion of the Coinsurance represents his/her Out-of-Pocket Expense Limit.

The Non-Preferred Provider of service may charge more than the Customary and Reasonable Charge. The portion of the Non-Preferred Provider's charges in excess of the Customary and Reasonable Charge are not Covered Expenses under this Plan and are the responsibility of the Covered Person.

OUT-OF-POCKET EXPENSE LIMIT:

After the Covered Person has paid an amount equal to the Out-of-Pocket Expense Limit shown in the section entitled ***Schedule of Benefits*** for incurred Covered Expenses, the Plan will pay 100% of Covered Expenses for the remainder of the Calendar Year.

After a covered family has paid a combined amount equal to the family Out-of-Pocket Expense Limit shown in the section entitled ***Schedule of Benefits***, the Plan will pay 100% of Covered Expenses for all covered family members for the remainder of the Calendar Year.

Individual and Family Deductibles will count toward the satisfaction of the applicable Out-of-Pocket maximums.

OUT-OF-POCKET EXPENSE LIMIT EXCLUSIONS:

The following items do not apply toward satisfaction of the Out-of-Pocket Expense Limit:

1. Expenses for supplies, services and treatments not covered by this Plan;
2. Charges for supplies, services and treatments in excess of the Customary and Reasonable amount;
3. Co-payments;
4. Substance Abuse treatment and Chemical Dependency expenses;
5. Expenses incurred as a result of failure to obtain Pre-authorization.

MAXIMUM BENEFIT:

The Lifetime Maximum Benefit payable on behalf of a Covered Person is stated in the section entitled ***Schedule of Benefits.*** This Lifetime Maximum Benefit applies to the entire time he/she is covered under the Plan, either as an Employee, Dependent or Alternate Recipient or under COBRA Continuation Coverage. If the Covered Person's coverage under the Plan terminates and he/she subsequently returns to coverage under the Plan, the Lifetime Maximum Benefit will be calculated on the sum of benefits paid by the Plan during each period of coverage.

The section entitled ***Schedule of Benefits*** contains separate Maximum Benefits for specified conditions. The above provision will also apply to those maximums. Any separate Maximum Benefit is part of, and not in addition to, the medical Lifetime Maximum Benefit.

In the event the Covered Person changes his/her Plan options, the benefits paid on behalf of the Covered Person will apply to the Maximum Benefit limitations of all Plan options. Such accumulation of benefits applies to each Covered Person for the duration the Covered Person is covered by ***any*** Plan or Plan option of the Employer.

PRE-EXISTING CONDITIONS:

"Pre-existing Conditions" means a condition(s) (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment, (including the use of prescription drugs or medicines) was recommended by, or received from, a licensed Physician or a licensed health Practitioner during the six (6) month period prior to the Covered Person's Effective Date of Coverage. Genetic information is not a condition. "Treatment" includes receiving services and supplies, consultations, diagnostic tests or prescribed medicines.

Benefits will be provided for Pre-existing Conditions after the earliest of the following:

1. Twelve***** (12) months continuous coverage under the Plan, if the Employee has no prior creditable coverage; or
2. Eighteen* (18) months continuous coverage under the Plan, if the Employee was a Late Enrollee.

**** This 12 or 18 month period may be reduced or eliminated for periods the employee was covered under other Creditable Coverage, provided there is not more than a sixty-three (63) day break in coverage ("Significant Break in Coverage") until the Enrollment Date of the Covered Person. The Covered Person must submit certification of prior Creditable Coverage to the Employer or the Third Party Claims Processor in order to receive the credit for prior coverage. An eligible Employee may request a Certificate of Creditable Coverage from his/her prior plan and the Employer will assist any eligible Employee in obtaining a certificate of Creditable Coverage from a prior plan.***

The Pre-existing Conditions provision does not apply to pregnancy, to a newborn child(ren) who is covered under this Plan within thirty-one (31) days from the date of birth, or to a child who is adopted, or Placed for Adoption before attaining age eighteen (18) and who, as of the last day of the thirty-one (31) day period beginning on the date of the adoption or Placement for Adoption, is covered under this Plan. Pre-existing Conditions provision may apply to coverage before the date of the adoption or Placement for Adoption. The Plan will provide benefits for an adopted child(ren) the same as a newborn child(ren).

The prohibition on the Pre-existing Conditions provision for newborn, adopted or Placed for Adoption children does not apply to an individual after the end of the first sixty-three (63) day period during all of which the individual was not covered under any Creditable Coverage.

The Pre-existing Conditions provision will **NOT** apply to Pregnancy, even when a Late Enrollee.

Note: Pre-authorization from the Health Care Management Organization does not constitute Plan liability for any Pre-existing Conditions charges during this waiting period.

HOSPITAL/AMBULATORY SURGICAL CENTER:

All Hospital or Facility Inpatient admissions and Outpatient surgeries are subject to Pre-Authorization. Procedures performed in the Physician's office do not require Pre-authorization, unless a Facility fee is involved. Failure to obtain Pre-Authorization will result in a reduction of benefits. Refer to the sections entitled ***Schedule of Benefits*** and ***Health Care Management.***

Covered Expenses will include:

1. Room and board, general or specialized nursing care for treatment in a Hospital, including Intensive Care Units, Cardiac Care Units, and similarly necessary accommodations. Covered Expenses for Room and Board will be the Hospital's average semi-private rate. Covered Expenses for Intensive Care or Cardiac Care Units will be the Negotiated Rate for Preferred Providers and the Customary and Reasonable Charge for Non-preferred Providers. A full private room rate is covered if the private room is necessary for isolation purposes and is not for the convenience of the Covered Person.
2. Miscellaneous Hospital services, supplies, and treatments including, but not limited to:
   a. Admission fees, and other fees assessed by the Hospital for rendering Medically Necessary services, supplies, and treatments;
   b. Use of operating, treatment, recovery, or delivery and labor rooms;
   c. Anesthesia, anesthesia supplies and its administration by an employee of the Hospital;
   d. Surgical services which are generally recognized and accepted procedures for diagnostic or therapeutic purposes in the treatment of an Illness of Injury;
   e. Medical and surgical dressings and supplies; casts and splints;
   f. Blood transfusions, including the cost of whole blood the administration of blood, blood processing, and blood derivatives (to the extent blood or blood derivatives are not donated or otherwise replaced);
   g. Drugs and medicines (except drugs not used or consumed in the Hospital); intravenous injections and solutions;
   h. Routine radiological (X-ray) and non-radiological diagnostic imaging services and supplies; clinical pathology and diagnostic laboratory procedures and services and supplies; services and supplies for EEG's, EMG's, PET's, MRI's, and CAT scans;
   i. Oxygen and other gas therapy and the administration thereof;
   j. Chemotherapy, Radiation therapy, dialysis, respiratory therapy and rehabilitative therapy services.
3. Services, supplies and treatments described above and furnished by an Ambulatory Surgical Center, including follow-up care provided within seventy-two (72) hours of a procedure.
4. Services, supplies and treatments described above and furnished by Facility Providers, if such services would have been covered if performed in a Hospital or Ambulatory Surgical Center.

PRE-ADMISSION TESTING:

Pre-admission Testing enables the Covered Person to have necessary tests done as an Outpatient prior to a scheduled admission or Outpatient Surgery. Pre-admission Testing for Medically Necessary tests will be covered provided **ALL** of the following conditions are met:

1. The tests are ordered by a Physician;
2. The tests are performed on an Outpatient basis;
3. The tests are performed within seven (7) days prior to a Hospital Confinement or Outpatient Surgery; and
4. All tests must be related to the admitting diagnosis.

AMBULANCE:

Covered Expenses will include:

1. Professional ambulance service for air or ground transportation to the nearest Hospital or Ambulatory Surgical Center able to provide the Medically Necessary services;
2. In the event a condition requires specialized treatment not available at a local Hospital, transportation for such Medically Necessary treatment is covered when ordered by a Physician. The transportation must be within the United States of America and Canada only, and be by a regularly scheduled airline, railroad, or by licensed air or ground ambulance. Covered transportation is only from the initial Hospital or Facility to the nearest Hospital or Facility qualified to render the special treatment.
3. Emergency services actually provided by an advance life support unit, even though the unit does not provide transportation.

EMERGENCY SERVICES/EMERGENCY ROOM:

Coverage for Emergency Room treatment and Emergency Services rendered will be paid in accordance with the section entitled ***Schedule of Benefits***. An Emergency is defined as the sudden onset of an Illness or Injury where the symptoms are of such severity that that absence of immediate medical attention could reasonably be assumed to result in:

1. Placing the Covered Person's life in jeopardy; or
2. Causing other serious medical complications; or
3. Causing serious impairment to bodily functions; or
4. Causing serious dysfunction or impairment to any bodily organ or part.

PHYSICIAN/PRACTITIONER SERVICES:

Covered Expenses are:

1. Medical and surgical treatment, services and supplies, including, but not limited to: office visits; inpatient visits; diagnostic laboratory and x-ray services for a specific condition, when performed in a Physician's office; laboratory and x-ray services in connection with covered preventive services, when performed in a Physician's office; home visits (not associated with Home Health or Hospice visits); Extended Care/Skilled Nursing Facility visits;
2. Charges of a Physician or Practitioner for medical and/or surgical treatment; procedures for prescribing, administering, directing or supervising medical treatment;
    a. For related operations or procedures performed through the same incision, or in the same operative field, Covered Expenses will include the surgical allowance for the highest paying procedure, plus fifty percent (50%) of the surgical allowance for the second highest procedure, and twenty-five percent (25%) of the surgical allowance for each additional procedure;
    b. When two (2) or more unrelated operations or procedures are performed at the same operative session, but not through the same incision or the same operative field, Covered Expenses will include the surgical allowance for each procedure.
3. Surgical assistance provided by a Physician or Practitioner in connection with a covered Medically Necessary surgical procedure, subject to the following conditions:
    a. Covered services will include the services of no more than one assistant surgeon at one operative session, unless approved in advance by the Health Care Maintenance Organization;
4. Charges of a Physician or professional anesthetist, other than the surgeon or surgeon's assistant, for furnishing and administering general or regional anesthetics; related resuscitative procedures;
5. Consultation charges requested by the attending Physician during a Hospital Confinement. The Plan will pay for one such consultation per Illness or Injury. Consultations do not include staff consultations required by a Hospital's rules and regulations;
6. Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment;
7. Charges of a radiologist or pathologist for diagnosis or treatment, including radiation therapy and chemotherapy;
8. Allergy testing consisting or percutaneous, intracutaneous, patch tests and injections.

SECOND SURGICAL OPINIONS:

The Second Surgical Opinion benefit is designed to supplement the Medical Expense Benefit and, therefore, is not subject to any Deductible.

1. Benefits for a Second Surgical Opinion for an elective surgery (non-emergency surgery) will be payable according to the section entitled ***Schedule of Benefits*** when recommended by the Health Care Management Organization or the Covered Person elects to obtain a Second Surgical Opinion.
2. The Physician rendering the Second Surgical Opinion regarding the Medical Necessity of such surgery must be qualified to render such a service and must not be affiliated in any way with the Physician performing the actual surgery.
3. In the event of conflicting opinions, a request for a third opinion may be obtained. The Plan will consider payment for the third opinion as a Second Surgical Opinion.
4. The Second Surgical Opinion benefit includes Physician services and any diagnostic services as may be required.
5. Benefits will be payable whether or not the elective surgery or Inpatient care is performed.

SECOND SURGICAL OPINION LIMITATIONS:

No payment will be made for expenses incurred for Second Opinions in connection with:

1. Any services, supplies, or treatments not covered under the Plan; or
2. Minor surgical procedures routinely performed in a Physician's office, such as incision and drainage of abscesses or excision of benign lesions; or

TRANSPLANTS:

Transplant procedures are subject to Pre-authorization. Failure to obtain Pre-authorization will result in a reduction of benefits. This Plan may require the Covered Person to obtain transplant procedures at an Approved/Designated Transplant Facility. Once the Covered Person has notified the Health Care Management Organization of a pending transplant procedure, the HCMO's Large Case Manager will be responsible to notify any potential candidate if such a procedure is required to be performed at an Approved/Designated Transplant Facility. Failure to have the Transplant procedure performed at an Approved/Designated Transplant Facility may result in a reduction of benefits.

If a Covered Person is denied a transplant procedure by the Approved/Designated Transplant Facility, the HCMO will refer the Covered Person to a second facility for evaluation. If the second facility determines, for any reason, the Covered Person is an unacceptable candidate for the transplant procedure, benefits will not be paid for further transplant related services and supplies, even if a third Approved/Designated Transplant Facility or any non-designated facility accepts the Covered Person for the procedure.

COVERED TRANSPLANT EXPENSES:

The following human organ transplants will be approved transplant procedures, provided the Covered Person utilizes an Approved/Designated Transplant Facility. Failure to utilize an Approved/Designated Transplant Facility will result in a twenty percent (20%) Coinsurance penalty, not subject to the Out-of-Pocket Expense Limit, unless approved in advance by the Health Care Management Organization:

1. Heart;
2. Lung;
3. Heart/Lung;
4. Kidney;
5. Liver;
6. Kidney/Pancreas;
7. Kidney/Liver
8. Bone Marrow/Peripheral Stem Cell
    a. Autologous: Stem cells collected from the bone marrow of the patient; or
    b. Allogeneic: Stem cells donated by a relative or by an unrelated donor.

Cornea transplants are payable the same as any other Illness, subject to the ***Medical Expense Benefit*** provisions of this Plan, and this Plan's ***Medical Expense Benefit Exclusions*** and ***Plan Exclusions***.

Subject to the following conditions, Covered Expenses for services and supplies in connection with human organ or tissue transplants will be considered:

1. If the recipient is a Covered Person under this Plan, eligible medical expenses incurred by the recipient will be considered for benefits.
2. If the donor is a Covered Person under this Plan, eligible medical expenses incurred by the donor will be considered for benefits, ***provided the recipient is also a Covered Person under this Plan***. Eligible medical expenses incurred by each person will be treated separately for each person.
3. The charges for securing an donated organ from a cadaver or tissue bank, including
    a. The surgeon's charges for removal of the organ, and a Hospital's charges for storage or transportation of the organ, will be Covered Expenses.
    b. Benefits for organ procurement from a non-living donor will include the cost in removing, preserving and transporting the organ;
    c. Benefits for organ procurement from a living donor will include: the cost of screening the potential donor; transporting the donor to and from the site of the transplant; eligible expenses associated with removal of the donated organ; and medical services provided to the donor in the interim and for follow-up care. Medical expenses

of the donor will be covered under this provision to the extent they are not covered elsewhere under this Plan or any other benefit plan, including any government plan, covering the donor, provided the recipient is a Covered Person under this Plan. The donor's expense will be applied to the recipient's Lifetime Maximum Benefits; in no event will benefits be payable in excess of the Lifetime Maximum Benefits still available to the recipient

d. If the transplant procedure is a bone marrow transplant, benefits will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogeneic). Benefits will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion
e. Charges incurred for follow up care, including immuno-suppressant therapy.

If a Covered Person's transplant procedure is not performed as scheduled, due to the intended recipient's medical condition or death, benefits will be paid for organ or tissue procurement costs as described herein.

TRAVEL AND ACCOMMODATION EXPENSES:

If a transplant is performed at a Designated Transplant facility, the Plan will pay for the following:

1. Transportation to and from the Designated Transplant Facility for:
   a. The Covered Person; and
   b. One or two parents of the Covered Person, if the Covered Person is a Dependent child, as defined in this Plan; or
   c. A Close Relative or other person to accompany the Covered Person;
2. Lodging at or near the Designated Transplant Facility for the person(s) listed in (1) above, who accompanied the Covered Person while confined at the Designated Transplant Facility.

subject to the Maximum Benefit as specified in the ***Schedule of Benefits***.

TRANSPLANT LIMITATIONS OR EXCLUSIONS:

1. If an organ or tissue is sold rather than donated, the purchase price of such organ or tissue will **NOT** be considered an eligible medical expense under this Plan.
2. Benefits for travel and accommodations are subject to the Maximum Benefit as specified in the ***Schedule of Benefits***.
3. No benefits are payable for:
   a. Transplant charges related to animal to human transplants;
   b. Transplant charges for artificial or mechanical devices designed to replace human organs;
   c. Charges for organ transplants considered Experimental or Investigational;
   d. Charges for expenses otherwise excluded by this Plan (refer to the sections entitled ***Medical Expense Benefit Exclusions*** and ***Plan Exclusions)***;
   e. For expenses exceeding the Plan's Maximum Benefits.
   f. Transplant procedures performed in a facility not designated by the Health Care Management Organization as an Approved Transplant Facility, unless approved in advance by the HCMO;
   g. Expenses that are entitled to be paid under any private or public research fund, governmental program, or other funding program, whether or not such benefits were applied for;
   h. The acquisition and donor costs related to the removal of an organ from a Covered Person for the purpose of transplantation into a recipient who is not a Covered Person.
4. No benefits will be payable if the Health Care Management Organization does not approve benefits for the procedure, based on established criteria, or if the Health Care Management Organization is not contacted for Pre-authorization prior to referral for transplant evaluation for the procedure.

REHABILITATIVE SERVICES:

Rehabilitative services must be ordered by a Physician to aid restoration of normal function lost due to Illness or Injury, for congenital anomaly, or for prevention of continued deterioration of function. Covered Expenses will include:

INPATIENT:

Inpatient Rehabilitative Services are subject to Pre-authorization. Failure to obtain Pre-Authorization will result in a reduction of benefits. Covered Expenses include, but are not limited to: room and board, including regular daily services and supplies furnished by the Facility, Physician or Practitioner charges, physical therapy, speech therapy, occupational therapy, massage and aquatic therapy, manipulative treatment, bio-mechanical treatment, neurophysiological treatment, physical modalities, and therapeutic procedures, when ordered by a Physician and provided by a qualified therapist as part of the Covered Person's treatment plan to aid in the restoration of function that was previously normal, but lost or impaired due to a covered Illness or Injury; tests and measurements; and monitored cardiac rehabilitation, when authorized by the Health Care Management Organization. Covered Expenses do not include recreational programs.

OUTPATIENT:

Outpatient Rehabilitative Services will include daily services and supplies furnished by the Facility, Physician or Practitioner charges, physical therapy, occupational therapy, speech therapy, massage and aquatic therapy, manipulative treatment, bio-mechanical treatment, neurophysiological treatment, physical modalities and therapeutic procedures when ordered by a Physician and provided by a qualified therapist as part of the Covered Person's treatment plan to aid in the restoration of function that was previously normal, but lost due to a covered Illness or Injury; tests and measurements; and monitored cardiac rehabilitation when authorized by the Health Care Management Program. Covered Expenses do not include recreational programs.

THERAPY SERVICES:

Subject to the Pre-authorization provision for Inpatient admissions, Covered Expenses will include:

1. X-ray, radium or radiotherapy treatment;
2. Chemotherapy;
3. Dialysis therapy or treatment; or
4. Respiratory therapy,

whether rendered as an Inpatient or Outpatient service.

PREGNANCY/OBSTETRICAL SERVICES:

Expenses incurred for medical care and treatment rendered to a Covered Person for Pregnancy and Obstetrical care will be considered for benefits under this Plan, subject to all of the Plan's terms and conditions applicable to medical care and treatment of an Illness.

NORMAL PREGNANCY:

Covered Expenses are:

Expenses arising from a covered condition associated with the treatment of a normal pregnancy. A separate payment will not be made for antepartum and postpartum care.

As mandated by federal law, coverage for a Hospital stay following a normal vaginal delivery may not be limited to less than forty-eight (48) hours for both the mother (if a Covered Person) and the newborn child. Coverage for a Hospital stay in connection with childbirth following a Cesarean section may not be limited to less than ninety-six (96) hours for both the mother (if a Covered Person) and the newborn child. However, federal law does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharge the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours, as applicable). The Plan does not require authorization for a prescribed length of stay not in excess of forty-eight (48) hours, or ninety-six (96) hours, as applicable.

COMPLICATIONS OF PREGNANCY:

Covered Expenses will include any eligible medical expense for the services, supplies, and treatment of the following:

1. Conditions requiring Hospital Confinement (when Pregnancy is not terminated) with diagnoses distinct from pregnancy, but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include, but are not limited to: acute nephritis; nephrosis; cardiac decompensation; hyperemesis gravidarum; puerperal infection; toxemia; pre-eclampsia and eclampsia; and missed abortion.
2. A non-elective Cesarean section.
3. A terminated ectopic Pregnancy.
4. A spontaneous termination of Pregnancy occurring during a period of gestation in which a viable birth is not possible.

"Complications of Pregnancy," as defined above, are covered under the Plan to the same extent as any other Illness.

Complications of Pregnancy does not include:

1. False or premature labor;
2. Occasional spotting;
3. Prescribed rest during the period of pregnancy;
4. Morning sickness;
5. Similar conditions associated with the management of a difficult Pregnancy not constituting a nosologically distinct complication of Pregnancy.

INTERRUPTIONS OF PREGNANCY:

Interruptions of Pregnancy include spontaneous abortion or miscarriage (as covered under Complications of Pregnancy) and therapeutic abortions. The Plan will cover services and supplies for Medically Necessary therapeutic abortions and complications thereof, when:

1. The physical health of the mother would be endangered by continuation of the Pregnancy; or
2. The fetus has a known condition incompatible with life.

No benefits will be payable:

1. For Pregnancy-related care or procedures not certified by a Physician as being Medically Necessary; or
2. For an elective abortion outside the provision above.

BIRTHING CENTER:

Covered Expenses will include services, supplies, and treatment rendered at a Birthing Center, provided there is a Physician in charge acting within the scope of his/her license and the Birthing Center meets all legal requirements. Services of a midwife acting within the scope of her/her license or registration are a Covered Expense, provided the state in which such service is performed has legally recognized midwifery.

ADOPTION BENEFITS:

If the Employee is obligated, as a result of a legal adoption agreement, to pay for the cost of the birth of any child who is in the process of being legally adopted by the Employee, the Plan will pay for Covered Expenses, subject to **ALL** of the following conditions:

1. The child is adopted within one year of birth; **and**
2. The Employee is legally obligated to pay the costs of birth; **and**
3. The Employee has met the terms and conditions of this Plan, including all Deductibles or Co-payments; **and**
4. The Employee notifies the Plan Administrator within sixty (60) days of the Employee's acceptability to adopt the child pursuant to Arizona state law; or
5. In the event the Employee's prior coverage ends and is replaced by this Plan, the Employee notifies the Plan Administrator within sixty (60) days of the Employee's obligation.

The Employee must notify the Plan Administrator of the existence and extent of other coverage. If coverage exists for the child through the natural parent, coverage under this Plan will be considered excess coverage. If other coverage exists, the agency, attorney or individual arranging the adoption will:

1. Advise the Employee and the Plan in writing of the existence and extent of coverage; and
2. Make arrangements for the natural parent's insurance to pay for the Covered Expenses. Confidential information, such as the identity of the natural parent, will not be disclosed.

This Plan is not obligated to pay any costs in excess of the amounts it would have been obligated to pay, had the natural mother and child been Covered Persons under this Plan and eligible to receive Pregnancy and Newborn benefits as normally provided by this Plan.

NEWBORN CARE:

Covered Expenses for newborn well-baby care will include Physician and Hospital charges for Routine Nursery Care, while the mother is confined for delivery, regardless of whether or not an Injury or Illness exists. Benefits for Routine Nursery Care provided up to a Maximum Benefit of five (5) days. Routine care includes charges related to circumcision.

In the event an Illness or Injury exists, benefits are provided for eligible medical expenses, provided the newborn is eligible to be enrolled, and is subsequently enrolled in the Plan within thirty-one (31) days from the date of birth. If an Illness or Injury exists, the newborn will independently establish a claim for benefits separate from the claim of the mother for the expenses incurred for the delivery of the newborn.

STERILIZATION:

Covered Expenses will include elective sterilization procedures for the Covered Employee or covered Dependent spouse of an Employee. Reversal of sterilization is **NOT** a Covered Expense.

PREVENTIVE HEALTH CARE SERVICES:

Subject to all the terms and conditions of this Plan, Covered Expenses for Preventive Health Care Services will include:

1. Charges for services, supplies and treatments rendered for immunizations and vaccinations;
2. Charges for routine physical examinations, gynecological exams, and prostate exams;
3. Charges for Pap smears, PSA's, mammograms, x-rays and laboratory services and general health screening tests not related to the treatment of a specific Illness or Injury;
4. Charges for well child care for a healthy infant or child; office visits for the assessment of the child's state of health; routine laboratory and radiological services rendered in conjunction with a well child care examination; childhood immunizations.

when these services are not related to the treatment of a specific diagnosis. Preventive Health Care Services will be a Covered Expense **ONLY** when rendered by a PPO Provider.

PREVENTIVE HEALTH CARE SERVICES LIMITATIONS:

Mammograms are limited as follows:

1. One Baseline mammogram for a Covered Person between the ages of thirty-five (35) to age thirty-nine (39);
2. One (1) mammogram per Calendar Year for a Covered Person age forty (40) or older;
3. Mammograms in excess of one (1) per Calendar Year for Covered Persons over age forty (40) will be considered only when Medically Necessary.

Child Wellness exams are limited as follows:

1. Well-child checkups to age 2, limited to four (4) visits per Calendar Year;
2. Well-child checkups for ages 2 through 16, limited to two (2) visit per Calendar Year;
3. Benefits include vaccinations, inoculations, immunizations, and related x-ray and laboratory services.

Preventive Health Care Services, except routine mammograms will be subject to an annual Maximum Benefit of $300, as specified in the section entitled ***Schedule of Benefits***. Routine mammograms will be covered as specified in the ***Schedule of Benefits.***

DIAGNOSTIC LABORATORY AND RADIOLOGY:

LABORATORY SERVICES:

Covered Services include prescribed diagnostic clinical and anatomic pathological laboratory services, supplies and materials when Medically Necessary, except as provided in the provision entitled ***Preventive Care.***

RADIOLOGICAL AND NON-RADIOLOGICAL DIAGNOSTIC IMAGING SERVICES:

Covered services will include prescribed diagnostic radiological and non-radiological diagnostic imaging services, supplies and materials, including general radiography, fluoroscopy, mammography, and ultrasound.

OTHER DIAGNOSTIC AND THERAPEUTIC SERVICES:

Covered Expenses include, but are not limited to:

1. Complex diagnostic imaging services, including nuclear medicine, radioisotopic studies, and computerized axial tomography (CAT);
2. Cardiac ultrasonography; cardiographic testing;
3. Magnetic Resonance Imaging (MRI);
4. Non-routine mammograms;
5. Cardiac Catheterization;
6. Arthrography;
7. Complex vascular diagnostic and therapeutic services including Holter monitoring, treadmill or stress testing, percutaneous transluminal coronary angioplasty, and impedance venous plethysmography;
8. Complex neurological diagnostic services, including electroencephalograms (EEG), electromyograms (EEG) and evoked potential;
9. Complex pulmonary diagnostic services, including pulmonary function testing;
10. Complex allergy diagnostic services, including RAST and immunotherapy; and
11. Otological evaluations for the purpose of obtaining information necessary for evaluation of the need for, or appropriate type of, medical or surgical treatment for a hearing deficit or related medical problem resulting from a covered Illness or Injury. However, the purchase of hearing aids is excluded; refer to the section entitled ***Medical Expense Benefit Exclusions***.

SPECIAL EQUIPMENT AND SERVICES:

Covered Expenses will include Medically Necessary special equipment and supplies to include, but not be limited to:

1. Casts, splints, braces, trusses, crutches;
2. Sterile surgical dressings and other medical supplies ordered by a Physician or Practitioner in connection with medical treatment or after surgery but excluding common first aid supplies;
3. The original fitting, adjustment and placement of orthotic appliances, such as braces, splints or other appliances required for support for an injured or deformed part of the body as a result of a disabling congenital condition, Illness, or Injury; cervical collars, head halters, traction apparatus or prosthetic appliances to replace lost body parts or to aid in their function when impaired;
4. Initial artificial limbs and eyes; replacement of artificial eyes and limbs, if required due to a change in the patient's physical condition, or if less expensive than the repair of existing equipment;
5. Pacemakers;

6. Colostomy bags and supplies required for their use; ostomy bags; catheters,
7. Syringes and needles for allergies; glucometers; dextrometers, dextrostix; rental of insulin infusion pumps; other equipment and supplies needed for the self-management of diabetes not covered under the Prescription Drug Program;
8. Allergy serums;
9. Oxygen and the rental equipment necessary for its use, not to exceed the purchase price of such equipment;
10. The initial pair of glasses or contacts needed due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of an Illness or Injury of the eye;
11. Wigs and artificial hairpieces, only following radiation or chemotherapy, or when the baldness is the result of burns or surgery, limited to two (2) per lifetime;
12. Jobst garments, limited to two (2) per Calendar Year;
13. Blood, blood plasma, or blood derivatives and the administration thereof. Donated blood or replaced blood is not a Covered Expense.

DURABLE MEDICAL EQUIPMENT:

Rental or purchase, whichever is less costly, of necessary Durable Medical Equipment for therapeutic use by the Covered Person is a Covered Expense. Equipment ordered prior to the Covered Person's Effective Date of Coverage is not covered, even if delivered after the Effective Date of Coverage. Repair or replacement of Medically Necessary Durable Medical Equipment, due to the normal use or growth of a child(ren) will be provided. Repairs due to misuse or abuse are not Covered Expenses.

Equipment containing features of an aesthetic nature or features of a medical nature not required by the Covered Person's conditions, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment less costly than the equipment furnished, will be covered based on the Customary and Reasonable charge for the equipment meeting the Covered Person's medical needs.

Durable Medical Equipment includes, but is not limited to: equipment for administering oxygen or to aid in breathing, if the equipment has a mouthpiece, hose, and compressor; wheelchairs; hospital beds; dialysis equipment; and infusion pumps. Such equipment will not be covered under the Plan if it could be useful to a person in the absence of an Illness or Injury, and could be purchased without a Physician's prescription.

Refer to the sections entitled ***Schedule of Benefits*** and ***Definitions*** for further details regarding the type of equipment covered and the benefit percentage limitations.

PROSTHESES:

The initial purchase, fitting, repair and replacement of fitted prosthetic devices (other than dental) provided for functional reasons when replacing all or part of a missing body part, including contiguous tissue, or to replace all or part of the function of a permanently inoperative or malfunctioning body part, will be considered a Covered Expense. No benefits will be provided for *cosmetic* prostheses except for the Covered Person's external breast prostheses and supporting brassiere, and the permanent internal breast prostheses necessary because of a mastectomy. Prostheses ordered prior to the Covered Person's Effective Date of Coverage are not covered, even if delivered after the Effective Date of Coverage. Repair or replacement of a Medically Necessary prosthesis, due to normal use or growth of a child(ren), will be a Covered Expense.

COSMETIC SURGERY/RECONSTRUCTIVE SURGERY:

Charges for Cosmetic Surgery will be a Covered Expense, only when:

1. A Covered Person receives an Injury as a result of an accident and, as a result, suffers bodily damage requiring surgery. Cosmetic Surgery and treatment must be to restore the Covered Person to his/her normal function immediately prior to the accident; or
2. A Covered Person suffers from a covered Illness which results in the damage to or malfunction of a body part(s) or contiguous tissue; or
3. It is required to correct a congenital anomaly, i.e. a birth defect of a child(ren) who is Covered Person under this Plan; or
4. In the case of a Covered Person who is currently receiving Plan benefits in connection with a mastectomy, and who elects breast reconstruction in connection with such mastectomy, coverage will be provided for:

a. Reconstruction of the breast on which the mastectomy has been performed;
b. Surgery and reconstruction of the non-diseased breast to produce a symmetrical appearance; and
c. Prostheses and physical complications for all stages of the mastectomy, including lymphedemas;

in a manner determined in consultation with the attending physician and the patient.

In the absence of Illness or Injury, benefits for Cosmetic surgery will not include the surgical alteration of hard or soft tissue for the improvement of a person's appearance (other than breast reconstructive surgery as noted above), rather than for the improvement or restoration of bodily function.

TEMPOROMANDIBULAR JOINT DYSFUNCTION:

Surgical and non-surgical treatment of Temporomandibular Joint (TMJ), including reduction of dislocations and excision of the temporomandibular joints, and treatment of myofacial pain syndrome will be a Covered Expense, when determined to be Medically Necessary and not a dental or orthodontic procedure. Treatment will **NOT** include orthodontia. Benefits will be paid as shown in the section entitled ***Schedule of Benefits.*** Refer to the section entitled ***Medical Expense Benefit Exclusions*** for excluded treatment and procedures.

PODIATRY SERVICES:

Covered Expenses will include Outpatient surgical podiatry services including, but not limited to incision and drainage of infected tissue of the foot; removal of lesions of the foot; removal or debridement of infected toenails; surgical removal of nail root; treatment of fractures or dislocations of the bones of the foot; and Medically Necessary treatment of metabolic or peripheral-vascular disease. Benefits will be paid as shown in the section entitled ***Schedule of Benefits.*** Refer to the section entitled ***Medical Expense Benefit Exclusions*** for excluded treatment and procedures.

ORTHOTICS:

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

CHIROPRACTIC CARE/SPINAL MANIPULATION:

Covered Expenses include Physician's fees for the initial consultation, diagnostic x-rays and treatment, excluding maintenance care, and manual manipulation for subluxation of the spine (not for reductions of fractures or dislocations), neck or other joints. See the section entitled ***Definitions*** for further definition of treatments and services.

DENTAL SERVICES:

Benefits for services in connection with dental work, dental x-rays, dental examination, or oral surgery, including Hospital Room and Board, necessary services supplies, and charges of a Physician or repair of sound natural teeth or other body tissue, will be paid as All Other Medical Expenses, provided:

1. It is the result of an accidental Injury to sound natural teeth, mouth, gums, jawbones, or surrounding tissues and treatment begins within ninety (90) days of the date of such Injury;
2. It is for the correction of a non-dental, physiological condition resulting in severe impairment of bodily function;
3. It is for the treatment of tumors and cysts requiring pathological examination of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
4. It is for the excision of benign bony growths of the jaw and hard palate;
5. It is for the incision of sensory sinuses, salivary glands or ducts;
6. It is for the removal of impacted wisdom teeth under general anesthesia.

Except as provided above, no benefit will be provided for dental and oral surgical procedures involving preventive or restorative dental care, orthodontic care of the teeth, periodontal disease, or the preparation of the mouth for the fitting of, or continued use of, dentures. Refer to the section entitled ***Dental Expense Benefit*** for coverage for such treatment and procedures.

EXTENDED CARE/SKILLED NURSING FACILITIES:

Charges made by an Extended Care or Skilled Nursing Facility are eligible under the Plan provided:

1. The Covered Person was first confined in a Hospital for at least three (3) consecutive days;
2. The attending Physician recommends extended care Confinement for convalescence from a condition that caused that Hospital confinement, or a related condition;
3. The extended care Confinement begins within fourteen (14) days after discharge from that Hospital Confinement, or within fourteen (14) days after a related extended care Confinement; and
4. The Covered Person is under a Physician's continuous care who certifies the Covered Person must have twenty-four (24) hours-per-day nursing care.

If the Covered Person is discharged from the Extended Care Facility and again becomes an Inpatient in such facility within fourteen (14) days of the original discharge, it is considered one period of Confinement.

Covered Expenses are:

1. Room and Board, including regular daily services and supplies furnished by the Extended Care Facility, limited to seventy-five percent (75%) of the facility's average semi-private room rate; and
2. Other services and supplies, except for Professional Services (Physician or Practitioner Services), ordered by a Physician and furnished by the Extended Care Facility for Inpatient medical care.

Professional services are covered under the Physician/Practitioner Covered Expense Benefit. Extended Care Facility benefits are limited to the number of days shown in the section entitled ***Schedule of Benefits*** and are subject to all the Plan's limitations and exclusions.

HOME HEALTH CARE:

Home Health Care enables the Covered Person to receive treatment in his/her home for an Illness or Injury, instead of being confined in a Hospital or Extended Care Facility. ***All of the following must be satisfied to be covered under this benefit:***

1. The Covered Person's Physician must establish and review a written plan of care that specifically describes the Home Health services and supplies to be provided; and
2. The Covered Person must be homebound, meaning that leaving the home could be harmful to the Covered Person, involves a considerable and taxing effort, and the Covered Person is unable to use transportation without assistance; and
3. The Covered Person's condition must be serious enough to require Confinement in a Hospital or Extended Care Facility in the absence of Home Health Care.

Home Health Care services include:

1. Home visits by a Physician that are in lieu of visits to the Physician's office and that do not exceed the Customary and Reasonable charge to perform the same service in a Physician's office;
2. Nursing care by a registered nurse or licensed practical nurse or license vocational nurse on an intermittent basis;
3. Physical, respiratory, occupational or speech therapy, medical social work, and Home Health Aide Services when receiving nursing or therapy services;
4. Medical appliances and equipment, laboratory services and special meals, if such services and supplies would have been covered by the Plan if the Covered Person had been in a Hospital; and
5. Nutritional guidance by a registered dietitian, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined Medically Necessary;
6. One medical social service consultation per occurrence.

The Plan will not pay for services or supplies excluded under the Plan's limitations and exclusions. Refer to the sections entitled ***Medical Expense Benefit Exclusions*** and ***Plan Exclusions.***

HOSPICE CARE:

Hospice Benefits will be covered only if the Covered Person's attending Physician certifies:

1. The Covered Person is terminally ill; and
2. The Physician has certified the life expectancy is less than six (6) months.

Covered Expenses are:

1. Confinement in a Hospice Facility or at home;
2. Ancillary charges furnished by the Hospice while the Covered Person is confined;
3. Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;
4. Physician services and/or nursing care by a registered nurse, a licensed practical nurse, or a licensed vocational nurse;
5. Home Health Aide Services and Home Health Care by an aide who is employed by the Hospice, or by the Home Health Care Agency, and is provided part-time or as intermittent care under the supervision of a registered nurse or physical therapist. Such care includes ambulation and exercise, assistance with self-administered medications, reporting changes in the Covered Person's conditions and needs, completing appropriate records, and care or services needed to achieve the medically desired results;
6. Nutrition services to include nutritional advice by a registered dietitian, and nutritional supplements, such as diet substitutes administered intravenously or through hyperalimentation, and special meals;
7. Counseling services by a licensed social worker or a licensed pastoral counselor as provided through the Hospice;
8. Respite care for a minimum of four (4) or more hours per day (provides care of the Covered Person to allow temporary relief to the family members or friends from the duties of caring for the Covered Person); and
9. Bereavement counseling as a supportive service to Covered Persons in the terminally ill Covered Person's immediate family. Benefits will be payable up to the bereavement care maximum shown in the section entitled ***Schedule of Benefits***, provided:
    a. On the date immediately before death, the terminally ill person was covered under the Plan and received Hospice care benefits; and
    b. Charges for such services are incurred by the Covered Person's family within six (6) months of the terminally ill person's death.

No benefits are payable for Hospice care or services excluded under the Plan's limitations and exclusions. Any Covered Expense paid under Hospice benefits will not be considered a Covered Expense under any other provision of this Plan. Refer to the sections entitled ***Medical Expense Benefit Exclusions*** and ***Plan Exclusions***.

MENTAL AND NERVOUS DISORDERS/ CHEMICAL DEPENDENCY:

INPATIENT OR PARTIAL CONFINEMENT:

Subject to the Pre-authorization provisions of the Plan, the Plan will pay the applicable Coinsurance as defined in the section entitled ***Schedule of Benefits***, for Confinement in a Hospital or Treatment Center for services and supplies related to the treatment of Mental and Nervous Disorders and/or Chemical Dependency. Two (2) days of Partial Confinement will be considered as one day of Inpatient Confinement. Partial Confinement means treatment for at least three (3) hours, but no more than twelve (12) hours, in any twenty-four (24) hour period.

Covered Expenses will include:

1. Inpatient Hospital Confinement and related ancillary charges;
2. Individual psychotherapy;
3. Group psychotherapy; family counseling to support the therapy of the Covered Person in treatment;
4. Psychological testing;

5. Electro-convulsive therapy (electroshock treatment) or convulsive drug therapy, including anesthesia when administered concurrently with the treatment by the same professional Provider.

OUTPATIENT:

The Plan will pay the applicable Coinsurance as defined in the section entitled ***Schedule of Benefits***, for Outpatient services and supplies related to the treatment of Mental and Nervous Disorders and/or Chemical Dependency.

PRESCRIPTIONS:

Charges for drugs and medicines requiring a written Prescription and dispensed by a Pharmacist will be Covered Expenses. However, if benefits for prescription drugs are provided under the Prescription Drug Service Program of the Plan, payment of medical charges for prescription drugs under the medical benefits of the Plan are limited to such charges made by the Hospital or medical treatment facility for prescription drugs administered to a Covered Person.

MEDICAL EXPENSE BENEFIT EXCLUSIONS

In addition to Plan Exclusions, no benefit will be provided under this Plan for purchase or rental of supplies, services or treatment incurred by a Covered Person for the following:

1. Pre-existing Conditions, except as specifically stated herein;
2. Complications arising from any non-covered surgery or treatment;
3. Elective abortions, except as provided in the section entitled ***Medical Expense Benefit, Pregnancy/Obstetrical Services;*** however, complications arising from a non-covered elective abortion will be considered for benefits;
4. Reversal of surgically performed sterilization or subsequent re-sterilization;
5. Treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, in vitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, low tubal transfers, or gamete intrafallopian transfer ("GIFT"); services or supplies received in connection with a Covered Person acting as, or utilizing the services of, a surrogate mother; family planning counseling, including genetic, sterility, and birth control counseling;
6. Contraceptives, except as provided under the section entitled ***Prescription Drug Program Covered Expenses/Drugs;***
7. Transsexualism, gender dysphoria, or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
8. Hospital admission on Friday, Saturday, or Sunday, unless the admission is an Emergency situation, or surgery is scheduled within twenty-four (24) hours. If neither situation applies, Room and Board charges will only be payable commencing the date of the actual surgery;
9. Inpatient Room and Board charges in connection with a Hospital Confinement primarily for diagnostic tests that could have been performed safely on an Outpatient basis;
10. Professional services billed by a Physician, Registered Nurse, License Practical Nurse, or Licensed Vocational Nurse who is an employee of the Hospital or any other Facility, and who is paid by the Hospital or any other Facility where the services, treatment or supplies were rendered;
11. Biofeedback or educational therapy; milieu therapy; behavior modification therapy; sensitivity training; hypnosis; electrohypnosis; electronarcosis;
12. Marital or family counseling, except as provided in the sections entitled ***Medical Expense Benefit, Mental and Nervous/Chemical Dependency*** and ***Hospice Care;*** social, occupational, religious, or other social maladjustment;
13. Except as provided in the section entitled ***Medical Expense Benefit, Temporomandibular Joint Syndrome*** or ***Dental Services***, expenses for, or in connection with dental splints, dental prostheses, or any treatment on or to the teeth, gums, or jaws, or periodontium, and other services customarily provided by a dentist or orthodontist; charges for the orthodontics including, but not limited to charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia, and intra-oral prosthetic devices and other services customarily provided by an orthodontist or dentist;
14. Optometric services, dispensing optician's services, orthoptics, eyeglasses, and contact lenses, routine eye examinations and eye refractions for the fitting of glasses, except as provided under the section entitled ***Medical Expense Benefit, Special Equipment and Supplies*** or unless such services are necessary to treat a covered Illness or Injury; any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism, or contact lenses or glasses required as a result of this surgery;
15. Except as provided under the section entitled ***Medical Expense Benefit, Podiatry Services,*** routine foot care, including treatment of weak, strained, flat, unstable, or unbalanced feet, metatarsalgia, corns, calluses, fallen arches, and trimming of toenails, except for the removal of nail roots;
16. Purchase of orthopedic shoes, shoe inserts or other devices for support of the feet, except as provided under the section entitled ***Medical Expense Benefit, Orthotics***;
17. Personal comfort or beautification items; television or telephone use;
18. Custodial Care, domiciliary care, convalescent care or rest cures; a place of rest; a place for the aged; a nursing home or institution of like character;
19. Telephone consultations; preparation of medical records, reports, or insurance claim forms; itemized bills, mailing, shipping and handling expenses; sales tax; charges associated with missed appointments;
20. Non-prescription drugs and medicines, such as vitamins, cosmetic dietary aids, nutritional supplements for weight loss, and growth hormones, even through a prescription number has been assigned; amphetamines, even when prescribed as a dietary aid; laetrile; gerovital; drugs and medicines to the extent they are administered for purposes other than those approved by the FDA, regardless of whether or not they are obtained in the United States; non-medical equipment or supplies;

21. Air purifiers, air conditioners, humidifiers, exercise equipment, water purifiers, whirlpools, heating pads, hot water bottles, allergenic pillows or mattresses, or waterbeds;
22. Escalators or elevators, saunas or swimming pools, professional medical equipment, such as blood pressure kits, or supplies or attachments for any of these items or motorized transportation equipment;
23. Therapeutic devices or appliances, including support garments (except Jobst garments) and other non-medical substances, regardless of intended use;
24. Except as provided in the section entitled ***Medical Expense Benefit, Cosmetic/Reconstructive Surgery,*** cosmetic surgery, procedures, and all related services, performed to improve appearance without restoring a physical bodily function, or any procedure utilizing an implant not altering physiological functions, unless Medically Necessary;
25. Removal of breast or other prosthetic implants that were: 1) inserted in connection with an excluded Cosmetic Surgery, regardless of the reason for removal; or 2) not inserted in connection with Cosmetic Surgery, but the removal of which is not currently Medically Necessary;
26. Weight reduction programs or treatment of obesity; enrollment in health, athletic, or similar exercise programs, whether or not recommended, provided, or prescribed by a Physician or Practitioner; special formulas, food supplements or special diets, except as provided in ***Medical Expense Benefit, Home Health Care*** and ***Hospice Care***; This exclusion will not apply to surgical treatment of obesity if:
    a. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and
    b. It has been documented that non-surgical treatments of the obesity have failed.
27. Replacement of casts, splints, or similar devices damaged as a result of negligence; replacement of braces of the leg, arm, back, neck, or replacement of prosthetic limbs, unless there is sufficient physiological change in the Covered Person's physical condition to make the original device(s) nonfunctional;
28. Examinations in connection with a hearing aid or the purchase of a hearing aid, except as specified herein; coverage will be provided for hearing examinations when required to diagnose an Illness or Injury;
29. Additional days of Inpatient Hospital Confinement denied by the Health Care Management Organization;
30. Preventive Care rendered by a Non-Preferred Provider;
31. Third party physical examinations for employment, premarital lab work, licensing, insurance, school camp, sports or adoption purposes; immunizations related to foreign travel;
32. Environmental change or control, even when prescribed by a Physician; ecological or environmental medicine; use of chelation or chelation therapy, orthomolecular substances; use of substances not specifically approved by the FDA as effective for such treatment; electrodiagnosis; Hahnemannian dilution and succussion; magnetically energized geometric patterns;
33. Sports medicine treatment plans intended primarily to enhance athletic ability;
34. Acupuncture;
35. Smoking cessation programs or medicines, including OTC drugs, unless Medically Necessary to treat a severe active lung Illness, such as emphysema or asthma;
36. Non-organic functional speech disorder;
37. Homeopathy or naturopathy; holistic or homeopathic medicine; massage therapy or rolfing;
38. Wigs, artificial hairpieces, artificial hair transplants, or any drug or medication, whether prescribed or not, used to eliminate baldness, except as provided under the section entitled ***Medical Expense Benefit, Special Equipment and Supplies.*** This exclusion does not apply when baldness is the result of burns, chemotherapy, radiation therapy or surgery. Under these circumstances, the purchase of a wig or artificial hairpiece is limited to two per lifetime;
39. Attention deficit disorders; behavior impulse, control or conduct disorders; developmental delay; hyperactivity; learning disorders; mental retardation; autistic disease; personality disorders; organic psychotic disorders; or senile deterioration. However, the initial examination, office visit and diagnostic tests to determine the Illness will be a covered Expense;
40. Educational or recreational therapy; vocational testing; training and work hardening programs, regardless of diagnosis or symptoms; education, training and bed and board while confined to an institution for training; charges for self-help training or other forms of non-medical self-help care, including Lamaze classes;
41. Sleep disorders, apnea, surgical treatment to correct the causes of apnea, unless Medically Necessary;

PRESCRIPTION DRUG PROGRAM

The Prescription Drug Program is provided through a contractor who has contracted pharmacies to participate in the Plan's Prescription Drug Program. ***For purposes of this section only,*** all other provisions in this Plan pertaining to Deductibles, Co-payments and the Out-of-Pocket Expense Limit are not applicable to the Prescription Drug Program. All other Plan provisions, terms, limitations and exclusions will apply.

A prescription drug identification card will be issued to each Employee covered under this Prescription Drug Program.

PARTICIPATING PHARMACIES:

If a Covered Person incurs charges at a pharmacy that participates in the Prescription Drug Program of this Plan for Covered Prescription Drugs, such charges in excess of the applicable prescription drug Co-payment will be payable at 100%. This 100% payment will be in the form of a reimbursement to the participating pharmacy.

When patronizing a participating pharmacy, the Covered Person will present the identification card and the Physician's prescription to the pharmacist. At the time the pharmacist dispenses the medication, the Covered Person will pay the applicable Prescription Drug Co-payment to the pharmacist.***** The pharmacist will require the Covered Person to sign a form (furnished by the pharmacist) as acknowledgment of receipt of the prescription drug. The pharmacist will forward the claim form to the prescription drug contractor and reimbursement for the Covered Prescription Drugs will be made to the pharmacy by the prescription drug contractor.

***Note:** The Prescription Drug Card Benefit utilizes a mandatory generic substitute. This means that Name Brand drugs **MUST** be filled with a Generic Equivalent, as defined below, unless the Physician has designated "Dispense as Written" on the prescription. If the Covered Person requests the Name Brand drug be dispensed, even through the Physician has allowed for a Generic Equivalent, the covered Person will be required to pay the Name Brand Co-payment plus the cost differential between the Name Brand drug and the Generic Equivalent.

For Co-payment amounts under the Prescription Drug Program/Participating Pharmacies, refer to the section entitled ***Schedule of Benefits.***

NON-PARTICIPATING PHARMACIES:

If a Covered Person incurs charges by a pharmacy not participating in the Prescription Drug Program of this Plan for Covered Prescription Drugs, such charges in excess of the Prescription Drug Co-payment will be reimbursed to the Covered Person.

If a Covered Person patronizes a pharmacy not participating in the Prescription Drug Program of this Plan, such person should request the pharmacist complete a direct reimbursement claim form obtainable from the Employer. At the time the pharmacist dispenses the medication, the Covered Person will pay the entire cost of the prescription drug.***** The direct reimbursement claim form should then be mailed by the Covered Person to the Claims Processor. Reimbursement for the Covered Prescription Drugs will be made to the Covered Person by the prescription drug contractor.

***Note:** The Prescription Drug Card Benefit utilizes a mandatory generic substitute. This means that Name Brand drugs **MUST** be filled with a Generic Equivalent, as defined below, unless the Physician has designated "Dispense as Written" on the prescription. If the Covered Person requests the Name Brand drug be dispensed, even through the Physician has allowed for a Generic Equivalent, the Covered Person will be reimbursed for the amount of expense exceeding the Prescription Drug Name Brand Co-payment, less the cost differential between the Name Brand drug and the Generic Equivalent.

PRESCRIPTION DRUG PROGRAM COVERED EXPENSES/DRUGS:

Subject to the exclusions and limitations of the Plan, "Covered Prescription Drugs" will mean the following when prescribed by a Physician:

1. Federal legend drugs: Any medical substance bearing the legend, "Caution: Federal law prohibits dispensing without a prescription."
2. State restricted drugs: Any medicinal substance that may be dispensed by prescription only, according to state law.
3. Compounded medications: A compounded prescription is an extemporaneously prepared dosage form containing at least one Federal legend drug in a therapeutic amount.
4. Insulin: By prescription only;
5. Oral Contraceptives;
6. Insulin syringes and pens, blood and urine test strips, lancets and alcohol swabs; reaction treating products;
7. Aids related drugs;
8. Retain A for Covered Persons to age 26;

GENERIC EQUIVALENT:

A generic equivalent is a drug that:

1. Has been approved by the FDA:
2. Has been manufactured by an FDA approved manufacturer; and
3. Has been shown, through bioequivalent studies, to be equivalent to the name brand product in terms of bioavailability and therapeutic effectiveness.

DISPENSING LIMITATIONS:

Quantities are limited to:

1. Except as provided in the mail-order program, an amount of medication generally recognized as sufficient for a course of therapy, but not to exceed a thirty (30) day supply or a 100 unit dose. Covered Persons must pay the applicable Prescription Drug Co-payment for each thirty (30) day supply or fraction thereof;
2. Refills only up to the number of times specified by a Physician;
3. Refills up to one year from the date of original order by a Physician.

MAIL ORDER PROGRAM:

It is the intent of this Plan to provide coverage for Mail Order Prescriptions; therefore, the Employer has contracted with a company to provide maintenance prescription drugs at a discounted rate through a mail-order program. If the Covered Person requires a maintenance-type drug, the Physician may write the prescription for up to a 100-day supply or 300 units. The Plan will pay 100% of Covered Expenses after satisfaction of the Co-payment. A generic drug will automatically be substituted for a brand name, unless the Physician writes on the prescription "Dispense as Written."

PRESCRIPTION DRUG PROGRAM EXCLUSIONS:

No benefits will be payable under the Prescription Drug Program for the following prescription or non-prescription drugs and/or items:

1. Contraceptive *devices* including, but not limited to, diaphragms, contraceptive jellies ointments, foams, or other contraceptive *devices*;
2. Therapeutic or prosthetic devices or appliances, support garments, and other non-drug substances (refer to the section entitled ***Medical Expense Benefit, Special Equipment and Supplies*** for coverage);
3. Over-the-counter products; Nicorette or other smoking deterrents; weight loss prescriptions; anorectics; any drug, supply, or device that can be purchased without a prescription, unless specifically included herein, even though the Physician or Practitioner has written a prescription;
4. Vitamins and minerals of any type, even though the Physician or Practitioner has written a prescription;
5. Infertility medications or drugs;
6. Impotency medications or drugs;

7. Drugs labeled: “Caution: Limited by Federal law to investigational use”; or experimental drugs, even when charge is made to the Covered Person; prescriptions for non-FDA approved use;
8. Medication for treatment of allergies, except such medication prescribed by a Physician;
9. Covered Prescription Drugs administered to the Covered Person during a period of Confinement or treatment in a Hospital or Facility (these charges will be paid as medical benefits if they otherwise qualify as such);
10. Drugs and medications for the treatment of Pre-existing Conditions;
11. Rogaine and other drugs used to treat or cure baldness; Retin-A for Covered Persons older than twenty-six (26) years of age; any other medications with a cosmetic indication;
12. Immunization agents, biological sera, blood, or blood plasma;
13. Prescription drugs which may be properly received without charge or for which the Covered Person is entitled to receive reimbursement under local, state, or federal programs, including Worker’s Compensation programs;
14. Prescriptions related to any non-covered services or treatment;
15. Charges for the administration of a covered Prescription Drug; any drug or medicine consumed or administered at the place where it is dispensed;
16. Replacement medications resulting from loss, theft or damage;
17. The cost differential between a Generic Drug and Brand Name Drug, when the Physician has not prescribed a Name Brand Drug.

DENTAL EXPENSE BENEFIT

For purposes of this section only, the following will apply to this Plan's Dental Expense Benefit:

All other provisions in this Plan pertaining to Deductibles, Co-payments and Out-of-Pocket Expense Limits are not applicable to the Dental Expense Benefit**.** All other Plan provisions, terms, limitations and exclusions will apply.

DENTAL EXPENSE BENEFIT PROVISIONS:

Benefits are provided for Covered Dental Services a Covered Person incurs, not to exceed the Reasonable and Customary charges, provided the services constitute Medically Necessary treatment and are incurred while the person is covered for benefits under this Plan. Charges are deemed to be incurred on the date the service is performed, except:

1. Charges for full or partial dentures or fixed bridge work are deemed to be incurred when the last impression is taken;
2. Charges for crowns are deemed to be incurred when the tooth or teeth are prepared or filed for crowning;
3. Charges for root canals are deemed to be incurred on the date the pulp chamber is opened;
4. Appliance or modification of appliances on the date the master impression is made;

DENTAL EXPENSE BENEFIT COVERED SERVICES:

Refer to the section entitled ***Schedule of Benefits, Dental Expense Benefit Schedule***, for details regarding Deductibles, annual and Lifetime Maximum Benefits, and the Coinsurance applicable to the following Dental Covered Services. Subject to the Limitations, Exclusions, and other provisions of the Dental Expense Benefit, the following is a complete list of covered dental procedures. Any procedure not listed is excluded. If one or more of the listed procedures would be appropriate according to customary dental practice, the Maximum Covered Charge will be the amount allowable for the lesser charge.

CLASS I - PREVENTIVE SERVICE - INCLUDES:

A. Routine (initial or periodic) oral examinations;
B. Bitewing x-rays;
C. Prophylaxis;
D. Topical application of stannous fluoride, including prophylaxis for a Dependent child(ren) under age sixteen (16);
E. Sealants, for a Dependent child(ren) under age sixteen (16);
F. Emergency palliative treatment for pain;
G. Space Maintainers for Covered Dependent children under age sixteen (16) to replace primary teeth.

CLASS II – BASIC SERVICE - INCLUDES:

A. Visits and Examinations:
    1. Office visits during regular office hours for treatment and observation of injuries to teeth and supporting structure (other than for routine operative procedures); therapeutic injections administered by a Dentist; bacteriological cultures;
    2. Professional visits after hours;
    3. Special consultation by a specialist for case presentation when diagnostic procedures have been performed by a general dentist;
B. Dental X-rays not included in Preventive Service;
C. Oral Surgery:
    1. Extractions:
        a. Uncomplicated (single): each additional tooth; surgical removal or erupted tooth
    2. Impacted Teeth (unless provided in the section entitled ***Medical Expense Benefit/Dental Services***, then coverage is primary under the Medical Expense Benefit):
        a. Removal of tooth (soft tissue)
        b. Removal of tooth (partially bony)
        c. Removal of tooth (completely bony)
    3. Alveolar or Gingival Reconstruction:

a. Alveolectomy (edentulous) per quadrant
b. Alveolectomy (in addition to removal of teeth) per quadrant
c. Alveoplasty with ridge extension, per arch
d. Removal of palatal torus
e. Removal of mandibular tori, per quadrant
f. Excision of hyperplastic tissue, per arch
g. Excision of pericoronal gingiva

4. Odontogenic Cysts and Neoplasms:
   a. Incision and drainage of abscess
   b. Removal of cyst or tumor up to ½ inch
   c. Removal of cyst or tumor over ½ inch
5. Other surgical procedures:
   a. Transplantation of tooth or tooth bud
   b. Maxillary sinusotomy for removal of tooth fragment
   c. Frenectomy
6. Anesthesia: General (only when provided in conjunction with a surgical procedure);
7. Post-operative care.

D. Periodontics:
1. Emergency treatment (periodontal abscess, acute periodontitis, etc.);
2. Scaling;
3. Subgingival curettage, root planning, per quadrant (not prophylaxis);
4. Periodontal prophylaxis considered the same as routine prophylaxis, subject to six (6) month limitation;
5. Correction of occlusion related to periodontal problems, per quadrant;
6. Gingivectomy (including post-surgical visits) per quadrant;
7. Gingivectomy, osseous or mucogingival surgery (including post-surgical visits) per quadrant;
8. Gingivectomy, treatment per tooth (fewer than six (6) teeth;)

E. Restorative Dentistry:
1. Amalgam restorations, primary teeth, cavities involving one, two or three surfaces;
2. Amalgam Restorations, permanent teeth, cavities involving one, two, three or more surfaces;
3. Synthetic Restorations: silicate cement filling, plastic filling; composite filling involving one, two, three or more surfaces;
4. Pins: pin (retention) where part of a restoration used instead of gold or crown restoration;
5. Full and partial denture repairs: broken dentures, not teeth involved; broken denture repairs (metal); replacing missing or broken teeth, each tooth
6. Adding teeth to existing partial denture to replace extracted natural teeth: first tooth; first tooth with clasp; each additional tooth and clasp;
7. Relining of present dentures, but only if they were installed more than six (6) months earlier and if they have not been relined in the past twelve (12) months; Office reline, cold cure, acrylic
8. Rebasing of present dentures, but only if they were installed more than six (6) months earlier and if they have not been rebased in the past thirty-sic (36) months;
9. Denture adjustment once per twelve (12) consecutive months, only if done more than six (6) months after the initial insertion of the denture;

F. Endodontics, as follows:
1. Pulp capping;
2. Pulpotomy;
3. Root canal therapy on permanent teeth only;
4. Apicoectomy;
5. Hemisection;
6. Retrograde fillings.

CLASS III – MAJOR SERVICES - INCLUDES:

A. Restorative: (Cast restorations and crowns are covered only when necessitated by decay or traumatic injury and cannot be restored with a filling material)
1. Inlays: One, two, three or more surfaces; onlay in addition to inlay allowance
2. Crowns: (acrylic; acrylic with gold; acrylic with non-precious metal; porcelain; porcelain with gold; porcelain with non-precious metal; non-precious metal (full cast); gold (full cast); gold (3/4 cast); gold dowel pin), subject to the following limitations:
   a. Covered only when the tooth cannot be restored by a basic restoration, and then only if at least five (5) consecutive years have elapsed since the last placement. Crown used to treat TMJ will not be covered.

b. Plastic or stainless steel crowns will be covered for primary teeth only, and the five (5) year limitation will not apply;
c. Porcelain restorations will be covered only when the tooth cannot be restored by basic restorations, and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth posterior to the first bicuspid are not covered.

B. Prosthodontics:
1. Initial installation of fixed bridge (including abutments) to replace one (1) or more natural teeth extracted while the person is covered under this Plan;
2. Initial installation of a removable bridge (unilateral), partial or complete dentures to replace one (1) or more natural teeth extracted while the person is covered under this Plan;
3. Replacement of an existing partial or full removable denture or fixed bridge, or the addition of teeth to existing bridgework to replace extracted natural teeth; however, only replacement or additions meeting the "Prosthesis Replacement Rule" below will be covered.
4. Initial complete or partial dentures for teeth extracted while covered under this Plan.
a. Fee for dentures or partial dentures includes adjustments and relines *within* six months after installation. Specialized techniques and characterizations are not eligible.
b. Complete upper denture
c. Complete lower denture
d. Partial acrylic upper or lower with gold or chrome cobalt alloy clasps, base, up to four (4) teeth and two (2) clasps;
e. Each additional tooth or clasp
f. Simple stress breakers, extra
g. Stayplate, base
h. Special tissue conditioning, per denture
i. Denture duplication (jump cast), per denture

C. Gold Inlays and Onlays: Covered only when the tooth cannot be restored by basic restoration and then only if at least five (5) consecutive years have elapsed since the last placement. Restorations on teeth anterior to the first bicuspid are not covered.
1. Crown
2. Bridge
3. Repairs, crowns and bridges

D. Post and core on permanent teeth only.

CLASS IV – ORTHODONTIA – INCLUDES:

This treatment is to move teeth by means of appliances to correct a malocclusion of the mouth. These services include preliminary study, including x-rays, diagnostic casts, treatment plans, active treatments and retention appliances.

Payments for comprehensive full-banded orthodontic treatments are made in installments.

Orthodontic procedures shall apply only to eligible a Dependent child(ren) who are age nineteen (19) or less on the date the Orthodontic Procedure begins. Orthodontic benefits shall terminate for a Dependent child(ren) on the date such child is not longer an eligible Dependent as defined by the Plan.

Covered Expenses are:

1. Any dental expense furnished in connection with orthodontic services and treatment;
2. Surgical exposure of impacted or unerupted teeth in connection with orthodontic treatment; includes routine x-rays, local anesthetics, and post-surgical care;
3. Active appliances. Includes diagnostic services, the treatment plan, fitting, making and placing of the active appliance, and all related office visits, including post-treatment stabilization.

PROSTHESIS REPLACEMENT RULE:

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

1. The replacement or addition of teeth is required to replace one (1) or more teeth extracted after the existing denture or bridgework was installed, and while the person was covered under this Plan or a prior plan of the Employer; or
2. The existing denture or bridge cannot be made serviceable and was installed at least five (5) years prior to its replacement.

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

DENTAL EXPENSE BENEFIT LIMITATIONS:

1. Oral exams, bitewing x-rays and prophylaxis are limited to one (1) per six (6)months;
2. A complete mouth x-ray is limited to one (1) each three (3) years;
3. Topical application of stannous fluoride is limited to one (1) per Calendar Year for children under age sixteen (16);
4. Prosthodontic appliances, cast restorations, dentures, individual crowns and jackets will be ***replaced*** only after five (5) years have passed since the last such service was performed. If dental work began prior to the effective date of coverage and within the immediate preceding five (5) year period, there is a twelve (12) month waiting period for benefits to begin.
5. For other than Orthodontic Procedures, the Maximum Annual Benefit is $1,000 per Covered Person;
6. For Orthodontic Procedures, the Lifetime Maximum Benefit is $2,000, and is limited to Dependent children who are age 19 or less on the date the procedure begins.

DENTAL EXPENSE BENEFIT EXCLUSIONS:

In addition to ***Plan Exclusions,*** no benefit will be provided under this Plan for Dental Expenses incurred by a Covered Person for the following:

1. Any service not listed in the section entitled ***Dental Expense Benefit Covered Services***;
2. Any service performed for cosmetic reasons (except if due to accidental injury or congenital disease as specified in the Summary Plan Document). Facings or veneers on crowns or pontics posterior to the second bicuspid are considered cosmetic and, therefore, not covered under this Plan;
3. Installation of, or addition to, full or partial dentures or fixed bridge work are excluded unless:
   a. The installation or addition is an initial one needed because of extraction of one (1) or more injured or diseased natural teeth; and
   b. The denture or bridge work includes replacement of the natural tooth that: 1) is extracted while the Covered Person is covered under this Plan; and 2) was not an abutment to a partial denture or fixed bridge installed with the immediate preceding five (5) years;
4. An appliance or modification of an appliance for which an impression was made before the Covered Person became covered under this Plan; a crown, bridge or gold restoration for which a tooth was prepared before such Covered Person became covered under this Plan; or root canal therapy for which the pulp chamber was opened before such Covered Person became covered under this Plan. X-rays and prophylaxis will not be deemed to start a dental procedure.
5. Appliances, restorations or procedures for the purpose of altering vertical dimension, restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint, except as provided under Orthodontic Services;
6. Crowns for teeth that are restorable by other means or for the purpose of Periodontal Splinting;
7. Replacement of lost or stolen appliances or prosthetic devices; personalization of dentures;
8. Oral hygiene and dietary instructions;
9. Plaque control programs;
10. Bleaching;
11. Athletic mouth guards;
12. Harmful habits appliances;
13. Hospital services;
14. Treatment of Temporomandibular Joint Syndrome or Myofunctional therapy (refer to the section entitled ***Medical Expense Benefit, Temporomandibular Joint Syndrome*** for applicable coverage);

15. Hypnosis;
16. Any operations or service not performed by a physician or dentist, unless that of a licensed dental oral hygienist or denturist under the supervision of a dentist;
17. Surgery required to restore occlusion (refer to the section entitled ***Medical Expense Benefit, Temporomandibular Joint Syndrome*** for applicable coverage);
18. Expenses payable under the Employer's medical plan, HMO Plan, or similar plan;
19. Charges for appointments not kept; charges resulting from changing from one dentist to another while receiving treatment, or from receiving care from more than one dentist for one dental procedure, to the extent the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services;
20. Experimental procedures;
21. Expenses incurred prior to the Covered Person's Effective Date of Coverage or after termination of coverage hereunder, except as specified in the section entitled ***COBRA Continuation Coverage***;
22. Prosthetics to replace teeth missing or extracted prior to the Covered Person's Effective Date of Coverage and not previously replaced;
23. Dentures that have been lost, mislaid, or stolen.
24. Devices ordered while the individual was covered under this Plan, but not delivered or installed within thirty (30) days after termination of coverage;
25. Dental implants;
26. Surgical services with respect to congenital or developmental malformations, including, but not limited to, cleft palate, mandibular prognathism, enamel hypoplasia, flurosis, and anodontia.
27. Replacement of prosthodontics of that could be repaired;
28. Fixed prosthodontics and/or partials for children through the age of sixteen (16);
29. A posterior fixed prosthodontic appliance when done in connection with a removable appliance in the same arch;
30. Charges in excess of the least costly plan of treatment, when there is more than one accepted method of treatment for a dental condition;
31. Porcelain, gold, porcelain veneer, acrylic veneer, and precious metal crowns over primary teeth for children through the age of sixteen (16). An allowance will be made for an acrylic crown.
32. Precision attachments, semi-precision attachments;

PREDETERMINATION OF DENTAL EXPENSE BENEFIT:

Any treatment estimated to be in excess of $300 must be:

1. Part of a Dental Treatment Plan that, before the procedures are performed, has been:
   a. Submitted to the Plan Sponsor or authorized representative; and
   b. Reviewed and returned to the Dentist showing estimated benefits.

Submission of a Dental Treatment Plan will not be required if the services involved are Preventive in nature, $300 or less, or constitute a Dental Emergency.

ALTERNATIVE TREATMENT:

Payment is subject to the following provision:

When a service or supply has an appropriate alternative that is in accordance with accepted standards of dental practice, the service having the lesser charge will be considered as being the Covered Charge.

DENTAL EXPENSE BENEFIT DEDUCTIBLES AND MAXIMUM BENEFIT:

The Individual Deductible is the dollar amount of Covered Expense each Covered Person must incur and pay during each Calendar Year before the Plan pays applicable benefits. The Individual Deductible amount is shown on the ***Schedule of Benefits, Dental Expense Benefits.***

The Maximum Amount Payable will not exceed the applicable Maximum Benefit as stated in the section entitled ***Schedule of Benefits, Dental Expense Benefit.***

HOW TO CLAIM DENTAL EXPENSE BENEFITS:

In the event the Provider of service does not file a claim directly with the Third Party Claims Processor, the Employer will provide the necessary forms for claiming benefits. The completed forms should be forward to the Third Party Claims Processor, in the same manner as described in the section entitled ***Claims Procedure and Payment of Benefits.*** When making a claim for Dental Expense Benefits, the Covered person must furnish proof of each charge, by submission of itemized bills together with the claim form.

PLAN EXCLUSIONS

No benefit will be provided under this Plan for Medical, Prescription Drug, or Dental expenses incurred by a Covered Person for the following:

1. Charges for services or supplies from any Hospital owned or operated by the United States government or any agency thereof, or charges for services, treatment or supplies furnished by the United States government or any agency thereof, unless payment is legally required;
2. Charges for services or supplies received caused by or contributed to war, or any act of war. "War" means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature.
3. Any condition for which benefits of any nature are recovered, or are found to be recoverable, either by adjudication or settlement, under any Worker's Compensation law, Employer's liability law, or occupational disease law, even though the Covered Person fails to claim rights to such benefits;
4. Charges in connection with any Illness or Injury arising out of, or in the course of, any employment for wage or profit;
5. Charges made for services and supplies not Medically Necessary for the treatment of Illness or Injury, or not recommended and approved by the attending Physician, except as specifically stated herein, or to the extent that the charges exceed the Customary and Reasonable Charge or exceed the Negotiated Rate; charges for services, supplies or treatment not specified as covered under this Plan; charges for services, supplies, or treatment specifically excluded by this Plan;
6. Charges resulting from, or occurring during, the commission of a crime by the Covered Person, while engaged in an illegal occupation, felonious act or aggravated assault;
7. Charges for treatment or services received as the result of an accidental Injury while the Covered Person is engaged in a Hazardous Pursuit;
8. To the extent that payment under this Plan is prohibited by any law of the jurisdiction in which the Covered Person resides at the time the expenses are incurred;
9. Charges for services rendered and/or supplies received prior to the Effective Date of Coverage or after the termination date of a Covered Person's coverage, except as provided herein;
10. Charges covered under any other plan of benefits through the Employer;
11. Any services or supplies for which the Covered Person is not legally required to pay or for which no charge is made to the Covered Person in the absence of coverage;
12. Experimental or investigational services, including transplants, meaning any service so classified by the Food and Drug Administration (FDA), Health Care Finance Administration (HCFA), or any service not generally recognized by the medical profession as tested and accepted medical practice.
13. Charges incurred outside the United States, if the Covered Person traveled to such a location for the sole purpose of obtaining medical services, drugs or supplies, except for an accidental Injury or a Medical Emergency;
14. Charges for services rendered by a Physician or Practitioner, if such professional is a Close Relative of the Covered Person or resides in the same household of the Covered Person;
15. Services rendered by providers beyond the scope of their license;
16. Charges or portion of a charge exceeding the Reasonable and Customary Charge for the geographic area in which the services are rendered;
17. Charges for injuries suffered by a Covered Person due to the negligent conduct of a third party, if the Covered Person fails to provide information as specified in the section entitled ***Subrogation/Third Party Liability***;
18. Charges for services or supplies furnished, paid for, or for which benefits are provided or required by reason of past or present service of any covered family member in the armed forces of a government;
19. Expenses used to satisfy Plan Deductibles;
20. Charges for telephone consultations, completion of claim forms, charges associated with missed appointments;
21. Claims not submitted within twelve (12) months of the Incurred Date, as described in the section entitled ***Claim Procedures and Payment of Benefits***;
22. Intentional self-inflicted Injury, whether the individual treated was sane or insane at the time the incident occurred, including suicide or attempted suicide;
23. Charges for care, services, or treatment required as a result of complications from a treatment not covered under the Plan, except complications from an abortion, as provided in the section entitled ***Medical Expense Benefit***, ***Pregnancy/Obstetrical Services***;
24. Charges for travel or accommodations, whether or not recommended by a Physician, except for ambulance charges as defined in the section entitled ***Medical Expense Benefit, Ambulance*** and travel and accommodations related to a

covered Transplant service, as defined in the section entitled ***Medical Expense Benefit, Transplant, Travel and Accommodation Expenses***;

25. Charges that are payable under any one section of the Plan will not be payable as a benefit under any other section of this Plan. For example, if a benefit is eligible under both the Medical Expense Benefit and the Dental Expense Benefit, the Medical Expense Benefit will prevail, and the remaining unpaid balance of any Covered Expense will not be paid under the Dental Expense Benefit.

CLAIM PROCEDURES AND PAYMENT OF BENEFITS

FILING A CLAIM:

1. A claim form is to be completed on each covered family member upon the initial submission of a claim incurred during the Calendar Year and for each subsequent claim involving an Injury. Appropriate claim forms are available from the Employer.
2. All bills submitted for payment must contain the following information:
   a. Name of patient;
   b. Patient's date of birth;
   c. Name of Employee;
   d. Address of Employee;
   e. Name of Employer;
   f. Name, address and tax ID number of provider;
   g. Employee's Social Security Number;
   h. Date of Service;
   i. Diagnosis;
   j. Description of service and procedure number;
   k. Charge for service;
   l. The nature of the accident, Injury, or Illness being treated.
3. Claims not submitted within twelve (12) months of the date of incurred liability will be denied.

The Covered Person may ask the provider to submit the bill directly to the Claims Processor, or the Covered Person may file the bill with a claim form. If the services of a Preferred Provider are used, the Preferred Provider should file the claim on the Covered Person's behalf. However, it is ultimately the Covered Person's responsibility to make sure the claim has been filed for benefits.

NOTICE OF CLAIM:

A claim for benefits must be submitted to the Third Party Claims Processor within ninety (90) days after the occurrence or commencement of any services covered by the Plan, or as soon thereafter as reasonably possible. Benefits are based on the Plan's provisions at the time the charges were incurred.

Failure to file a claim within the time provided (90 days) will not invalidate or reduce any claim, if it can be shown:

1. It was not reasonably possible to file a claim within that time; and
2. Such claim was furnished as soon as possible, but no later than one (1) year after the loss occurred or commenced, unless the claimant was legally incapacitated.

Notice given by, or on behalf of, a covered Employee or his/her beneficiary, if any, to the Plan Administrator or to any authorized agent of the Plan with information sufficient to identify the Covered Person, will be deemed notice of claim.

PAYMENT OF BENEFITS:

To obtain benefits under this Plan, the Covered Person must submit proof to the Third Party Claims Processor that the Covered Expenses applicable to the Deductible have been incurred. Proof will include an itemized bill on the Provider's letterhead or statement and the diagnosis.

If the services of a Preferred Provider are used, the Plan benefits are payable directly to the provider of service. If the services of a Non-Preferred Provider are used, benefits are payable to the Employee whose Illness or Injury, or whose

Dependent's Illness or Injury, is the basis of claim under this Plan, unless the Employee has made an assignment of benefits to the provider of service.

If additional information is needed for payment of the claim, the Third Party Claims Processor will request the same. The Third Party Claims Processor will approve, partially approve, or deny the claim within ninety (90) days after all necessary information is received to determine the validity of the claim. In the event a claim for benefits under the Plan is not paid in whole or in part, the Employee will receive written notification stating the required information including the review procedure, in the same fashion as reimbursement for a claim, in a manner calculated to be understood by the Employee. The written notice will contain the following information:

1. The specific reason(s) for the denial;
2. The specific reference to those Plan provisions on which the denial is based;
3. A description of any additional information or material necessary to correct the claim and an explanation of why such material or information is necessary; and
4. Appropriate information as to the steps to be taken if a Plan Participant wishes to submit the claim for review.

If special circumstances require an extension of time for processing the claim, the Third Party Claims Processor will send written notice of the extension to the Plan Participant. The extension notice will indicate the special circumstances requiring the extension of time and the date by which the Plan expects to render the final decision on the claim. In no event will the extension exceed a period of ninety (90) days from the end of the initial ninety (90) day period.

APPEALING A CLAIM:

REVIEW PROCEDURE:

In cases where a claim for benefits is denied in whole or in part, a Covered Person, or the Covered Person's representative, may appeal the denial by making written request to the Third Party Claims Processor within sixty (60) days of receipt of the notice of denial of benefits. Written notice for review should:

1. State the reasons the Covered Person feels the claim should not have been denied; and
2. Include any additional information the Covered Person believes supports the claim.

The Covered Person, or his/her authorized representative, may examine all pertinent documents the Third Party Claims Processor may have and submit an opinion in writing of the issues and his/her comments.

Should the Covered Person fail to make a written request for an appeal of a denial of benefits within sixty days of receipt of the notice of denial of benefits, the Covered Person may deem the claim denied.

DECISION ON REVIEW:

Upon receipt of the written request for review of a claim, the Plan Administrator and the Third Party Claims Processor will review the claim and furnish copies of all documents and all reasons and facts relative to the decision. The Plan Administrator will provide the Covered Person with a written response within sixty (60) days of the date the Plan Administrator received the Covered Participant's written request for review. If, because of extenuating circumstances, the Plan Administrator is unable to complete the review process within sixty (60) days, the Plan Administrator will notify the Covered Person of the delay within the sixty (60) day period and will provide a final written response to the request for review within one hundred twenty (120) days of the date the Plan Administrator received the Plan Participant's written request for review. This decision will be delivered to the Covered Person in writing, setting forth specific reasons for the decision and specific references to the pertinent Plan provisions upon which the decision is based.

The Covered Person must exhaust the claims appeal procedure before filing a suit for benefits.

FOREIGN CLAIMS:

In the event a Covered Person incurs Covered Expenses in a foreign country, the Covered Person will be responsible for providing the following to the Third Party Claims Processor before payment of any benefits due are payable:

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

INCAPACITY:

If, in the opinion of the Employer, a Covered Person for whom a claim has been made is incapable of furnishing a valid receipt of payment due him/her and, in the absence of written evidence to the Plan of any qualification of a guardian or personal representative for his estate, the Plan may, at its discretion, make any and all such payments to the provider of medical services or other person providing for the care and support of such Covered Person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment, and the Employer will not be required to see to the application of the money so paid.

LEGAL ACTIONS:

No action at law or in equity will be brought to recover on the Plan prior to the expiration of sixty (60) days after a claim has been filed in accordance with the requirements of the Plan. No such action will be brought after the expiration of three (3) years after the time a claim is required to be furnished.

PHYSICAL EXAMINATION REQUIRED BY THE PLAN:

The Plan, at its own expense, will have the right to require an examination of a Covered Person under this Plan when and as often as it may reasonably require during the pending period of a claim.

RECOVERY OF OVERPAYMENT:

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Employer will have the right to recover these excess payments from the individual or organization to whom such overpayment was made.

COORDINATION OF BENEFITS

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

The Coordination of Benefits provision applies whether or not a claim is filed under the Other Plan(s).

DEFINITIONS APPLICABLE TO COORDINATION OF BENEFITS:

ALLOWABLE EXPENSES:

Means any reasonable, necessary and customary expenses incurred while covered under this Plan, part or all of which would be covered under This Plan. Allowable Expenses do not include excluded expenses defined in the sections entitled ***Medical Expense Benefit Exclusions, Dental Expense Benefit Exclusions***, or ***Plan Exclusions.***

a. When this Plan is secondary, Allowable Expenses will include any Deductible or Coinsurance amounts not paid by the Other Plan(s).
b. If the Other Plan(s) provides benefits in the form of services rather than cash, the reasonable value of the service rendered will be deemed the benefit paid.
c. When this Plan is secondary, Allowable Expenses will **NOT** include any amount that is not payable under the primary plan as a result of a contract between the primary plan and a provider of service in which such provider agrees to accept a reduced payment and not to bill the Covered Person for the difference between the provider's regularly billed charges.
d. In the case of HMO (Health Maintenance Organization) plans, This Plan will **NOT** consider any charges in excess of what an HMO provider has agreed to accept as payment in full. Also, when an HMO is primary and the Covered Person does not use an HMO provider, This Plan will not consider as an Allowable Expense any charge that would have been covered by the HMO, had the Covered Person used the services of an HMO provider.

OTHER PLAN(S):

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

1. Group insurance or any other arrangement for coverage for Covered Persons in a group, whether on an insured or uninsured basis, including, but not limited to, Hospital indemnity benefits and Hospital reimbursement-type plans, franchise or blanket benefit plans;
2. Hospital or medical service organizations on a group basis, group practice, and other group prepayment plans, or on an individual basis, having a provision similar in effect to this provision;
3. Blue Cross and Blue Shield group plans;
4. A licensed Health Maintenance Organization;
5. Any coverage for students sponsored by, or provided through, a school or other educational institution;
6. Any coverage under a government program and any coverage required or provided by any statute, including Medicare;
7. Group automobile insurance;
8. Individual automobile insurance coverage on an automobile owned or leased by the Employee;
9. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
10. Any plans or policies funded, in whole or in part, by an employer, or deductions made by an employer from a Covered Person's compensation or retirement benefits; or
11. Labor/management trustee, union welfare, employer organization, or employee benefit organization plans.

THIS PLAN:

That portion of the Employer's Plan providing benefits that are subject to this provision.

CLAIM DETERMINATION PERIOD:

Means a Calendar Year, or that portion of a Calendar Year, during which the Covered Person for whom a claim is made has been covered under the Plan.

EFFECT ON BENEFITS:

This provision will apply in determining the benefits for a Covered Person for each Claim Determination Period for the Allowable Expenses. If This Plan is secondary, the benefits paid under This Plan may be reduced so the sum of benefits paid by all plans does not exceed 100% of total Allowable Expenses.

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

ORDER OF BENEFIT DETERMINATION:

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

1. **No Coordination of Benefits Provision:** If the Other Plan(s) contains no provision for Coordination of Benefits, then its benefits will be paid before all Other Plan(s).
2. **Employee/Dependent:** The Plan covering the claimant as an Employee (Plan Participant) pays as though no Other Plan(s) exists. Remaining recognized charges are paid under the Plan covering the claimant as a Dependent.
3. **Dependent Children of Parents not Separated or Divorced:** The Plan covering the parent whose birthday (month and day) occurs earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the plan that covered a parent longer pays first. A parent's *year* of birth is *not relevant* in applying this rule.
4. **Dependent Children of Separated or Divorced Parents:** When parents are separated or divorced, the birthday rule does not apply. Instead:
   a. If a court decree has given one parent financial responsibility for the child's health care, the Plan of that parent pays first. The Plan of the stepparent, if any, married to that parent pays second. The Plan of the other natural parent pays third. The Plan of the spouse of the other natural parent pays fourth.
   b. In the absence of such a court decree, the Plan of the parent with custody pays first. The Plan of the stepparent, if any, married to the parent with custody pays second. The Plan of the parent without custody pays third. The Plan of the spouse of the parent without custody pays fourth.
5. **Active/Inactive:** The Plan covering a person as an Active (not laid off or retired) Employee, or as that person's Dependent(s) pays first. The Plan covering that person as a laid off or retired Employee, or as that person's Dependent(s) pays second.
6. **Longer/Shorter Length of Coverage:** If none of the above rules determines the order of benefits, the Plan covering a person longer pays first. The Plan covering that person for a shorter time pays second.
7. **Limited Continuation of Coverage:** If a person is covered under another group health plan, but is also covered under This Plan for COBRA Continuation Coverage due to the Other Plan's limitations for Pre-existing Conditions, the Other Plan will be primary for all Covered Expenses not related to the Pre-existing Conditions. This Plan will be primary for the Pre-existing Conditions only.

COORDINATION WITH AUTOMOBILE INSURANCE:

When medical payments are available under vehicle insurance, This Plan will pay excess benefits only, without reimbursement for vehicle plan deductibles. Where allowed by law, This Plan will be considered the secondary carrier to the automobile insurance carrier.

COORDINATION WITH MEDICARE:

Notwithstanding all other provisions of This Plan, all Covered Persons who are entitled to Medicare benefits will be entitled to benefits under This Plan in addition to Medicare, in accordance with Medicare rules. The benefits of This Plan will be coordinated with Medicare. If any Covered Person entitled to Medicare fails to enroll, benefits will be paid as though he/she had enrolled.

FACILITY OF BENEFIT PAYMENT:

Whenever payments that should have been made under This Plan, in accordance with this provision, have been made under any Other Plan(s), the Plan Administrator will have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments, any amounts it will determine to be warranted in order to satisfy the intent of this provision. Amounts so paid will be deemed to be benefits paid under This Plan and, to the extent of such payments, This Plan will be fully discharged from liability under This Plan.

LIMITATIONS ON PAYMENTS:

In no event will the Covered Person recover under This Plan and all Other Plan(s) combined more than the total Allowable Expenses offered by This Plan and the Other Plan(s). Nothing contained in this section will entitle the Covered Person to benefits in excess of the total Maximum Benefits of This Plan during the Claim Determination Period. The Covered Person will refund to the Employer any excess This Plan may have paid.

RIGHT OF RECOVERY:

This Plan may pay benefits that should be paid by Other Plan(s). In this case, This Plan may recover the amount paid from the Other Plan(s) or the Covered Person. That repayment will count as a valid payment under the Other Plan(s).

Further, This Plan may pay benefits that are later found to be greater than the Allowable Expenses. In this case, This Plan may recover the amount of the overpayment from the individual or organization to which it was paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION:

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

SUBROGATION/RIGHT OF RECOVERY

As a condition to participating in and receiving benefits under this Plan, Covered Persons and their Covered Dependents ("Plan Beneficiary(ies)") agree:

1. To reimburse the Plan for any such benefits paid to, or on behalf of, the Plan Beneficiary when said benefits are recovered, in any form, regardless of how classified or characterized, from any person, corporation, entity, no-fault carrier, uninsured motorist carrier, underinsured motorist carrier, homeowner's or renter's insurance, medical malpractice, other liability policies and any other insurance policies or funds; and that such reimbursement should be made from the first dollars, rather than the last, so recovered; and
2. To refrain from releasing any party, person, corporation, entity, insurance company, insurance policies or funds liable to, or obligated to, the Plan Beneficiary for the Injury, Illness or condition without obtaining the Plan Administrator's written approval; and
3. Without limiting the preceding, to subrogate the Plan to any and all claims, causes of action or rights they have or that may arise against any person, corporation and/or other entity and to any coverage, no-fault coverage, uninsured motorist coverage, underinsured motorist coverage, other insurance policies or funds ("Coverage") for which the Plan Beneficiary claims an entitlement to benefits under this Plan, regardless of how classified or characterized; and
4. To inform the Beneficiary's attorney of the subrogation lien and to make no distributions from any settlement or judgment that will in any way result in the Plan receiving less that the full amount of its lien without the written approval of the Plan.
5. Covered spouses and Covered Dependent children are beneficiaries of this Plan and are party to the obligations of this Plan Document, and, as such, also have full responsibility to reimburse the Plan in the same manner as the Covered Employee.

In the event a Plan Beneficiary settles, recovers or is reimbursed by any third party or Coverage, the Plan Beneficiary agrees to hold any such funds received in trust for the benefit of the Plan, and to reimburse the Plan for all benefits paid or that will be paid as a result of said Injury or condition. The Plan Beneficiary acknowledges the Plan's subrogation rights will be considered a first priority claim and will be paid before any other claims for the Plan Beneficiary as the result of the Illness or Injury, regardless of whether the Plan Beneficiary is made whole. If the Plan Beneficiary fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness or condition, out of any recovery or reimbursement received, the Plan Beneficiary will be liable for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Plan Beneficiary.

The Plan Beneficiary will execute and return a Subrogation Agreement to the Plan Administrator and will supply other reasonable information and assistance as requested by the Plan Administrator regarding the claim or potential claim. If the Subrogation Agreement is not executed and returned, or if information and assistance is not provided to the Plan Administrator upon request, no benefits will be advanced under the Plan with respect to costs incurred in connection with such Illness, Injury or condition, until such time as the Subrogation Agreement is executed and returned to the Plan Administrator or its designee.

If the Plan Beneficiary decides to pursue a third party or any coverage available to him or her as a result of the said Injury or condition, the Plan Beneficiary agrees to include the Plan's Subrogation claim in that action. If there is a failure to do so, the Plan will be legally presumed to be included in such action or recovery. In the event the Plan Beneficiary decides not to pursue any and all third parties or coverage, the Plan Beneficiary authorizes the Plan to pursue, sue, compromise or settle any such claims in his or her name, to execute any and all documents necessary to pursue said claims in her or her name, and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Plan retains the right to enter into litigation but is not obligated to do so in order for the Plan to exercise its rights. The Plan Beneficiary agrees to take no prejudicial actions against the subrogation rights of the Plan, or in any way impede the action taken by the Plan, to recover its subrogation claim. Such cooperation will include a duty to provide information, execute and deliver any acknowledgment and other legal instruments documenting the Plan's subrogation rights, and take such action as requested by the Plan to secure the subrogation rights of the Plan. The Plan will not have any obligation to share the costs of, or pay any part of, the Beneficiary's attorney fees and costs incurred in obtaining any recovery against the person causing the Injury, Illness or condition.

The Third Party Claims Processor will administer and enforce subrogation rights for which there is the potential for collection of amounts paid to, or on behalf of, Participants, and to notify the Plan Administrator of such claims. The Third

Party Claims Processor, upon receipt of the executed Subrogation Agreement, shall advance benefits under the Plan consistent with the terms of the Plan, subject to the determination of the legal liability of the person causing the injury. The Plan Administrator retains discretionary authority with regard to asserting the Plan's right of recovery.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN:

The Plan is administered through the Human Resources Department of the Employer. The Employer is the Plan Administrator. Although the Plan Administrator has retained the services of an independent Third Party Claims Processor experienced in claims review, the Plan Administrator remains responsible for ensuring that required responsibility of the Plan is discharged according to the Plans terms, conditions, provisions, limitations and exclusions.

The Plan is a legal entity. Legal notices may be filed with, and legal process served, upon the Employer.

The Employer is the Named Fiduciary of the Plan. As fiduciary, the Employer maintains discretionary authority to review all denied claims for benefits under the Plan with respect to which it has been designated Named Fiduciary, including, but not limited to, the denial of certification of the Medical Necessity of Hospital or medical treatment, to interpret the terms of the Plan and to determine eligibility for and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made pursuant to such discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

ASSIGNMENT:

The Plan will pay benefits under this Plan to the Employee, unless payment has been assigned to a Hospital, Physician, or other provider of service furnishing the services for which benefits are provided herein. No assignment, however, will be binding on the Plan unless the Third Party Claims Processor is notified in writing of such assignment prior to payment hereunder.

Preferred Providers normally bill the Plan directly. If service has been received from a Preferred Provider, benefits are automatically paid to that provider. Any balance due after the Plan payment will then be billed to the Covered Person by the Preferred Provider.

BENEFITS NOT TRANSFERABLE:

No person other than an eligible Covered Person is entitled to receive benefits under this Plan. Such right to benefits is not transferable.

CLERICAL ERROR:

No clerical error on the part of the Employer or Third Party Claims Processor will operate to defeat any of the rights, privileges, services, or benefits of any Employee or any Dependent(s) hereunder, nor create or continue coverage that would not otherwise validly become effective or continue in force hereunder. An equitable adjustment of contributions and/or benefits will be made when the error or delay is discovered.

CONFORMITY WITH STATUTES:

Any provision of the Plan in conflict with statutes applicable to this Plan is hereby amended to conform to the minimum requirements of said statute(s).

CONSTRUCTION:

Wherever any words are used in this Plan document in the masculine gender, they shall be construed as though they were also in the feminine or neuter gender in all situations where they would so apply, and wherever any words are used in the Plan document in the singular form, they shall be construed as though they were also used in the plural form in all situations where they would so apply and wherever any words are used in this Plan in the plural form, they shall be construed as though they were also used in the singular form in all situations where they would so apply.

EFFECTIVE DATE OF THE PLAN:

The original Effective Date of this Plan is October 1, 1999.

FALSE STATEMENTS/MISREPRESENTATION:

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

FREE CHOICE OF HOSPITALS AND PHYSICIAN:

Nothing contained in this Plan shall, in any way or manner, restrict or interfere with the right of any Covered Person entitled to service and care hereunder to select a Hospital or to make a free choice of the attending Physician. However, benefits will be paid in accordance with the provisions of this Plan and the Covered Person will be Out-of-Pocket more if the Covered Person uses the services of a Non-Preferred Provider.

INCONTESTABILITY:

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

LIMITS ON LIABILITY:

Liability hereunder is limited to the services and benefits specified, and the Employer will not be liable for any obligation of the Covered Person incurred in excess thereof.

The Employer will not be liable for the negligence, wrongful act, or omission of any Physician, Provider, Practitioner, Hospital, or other institution, or their employees, or any other person. The liability of the Plan will be limited to the reasonable cost of Covered Expenses and will not include any liability for pain and suffering or general damages.

MEDICAID ELIGIBILITY AND ASSIGNMENT OF RIGHTS:

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

MEDICAL NECESSITY (MEDICALLY NECESSARY):

The benefits of this Plan are provided only for services that are Medically Necessary. The services must be ordered by the attending Physician for the direct care and treatment of a covered Illness or Injury, except for routine care as specifically

stated herein. They must be standard medical practice where received for the Illness or Injury being treated, and must be legal in the United States. When an Inpatient Confinement is necessary, services are limited to those that could not have been performed on an Outpatient basis.

PLAN IS NOT A CONTRACT:

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

PLAN MODIFICATION AND AMENDMENT:

The Employer may modify or amend the Plan from time to time at its sole discretion, and such amendments or modifications affecting the participants will be communicated to the participants. Any such amendments will be in writing, setting forth the modified provision of the Plan, the Effective Date of the modifications, and will be signed by the Employer's designee.

PLAN TERMINATION:

The Employer reserves the right to terminate the Plan at any time. Upon termination, the rights of the Covered Persons to benefits are limited to claims incurred up to the date of termination. Any termination of the Plan will be communicated to the participants.

Upon termination of this Plan, all claims incurred prior to termination, but not submitted to either the Employer or the Third Party Claims Processor within three (3) months of the effective date of termination of this Plan, will be excluded from any benefit consideration.

PROTECTION OF COVERAGE:

The Employer will not have the right to cancel or terminate coverage of any individual Employee hereunder, while this Plan remains in effect and while said Employee remains eligible for coverage as defined.

TERMS OF COVERAGE:

In order for a person to be entitled to benefits under this Plan, both the Plan and the person's coverage under the Plan must be in effect on the date the expenses giving rise to a claim for benefits is incurred.

The benefits a Covered Person may be entitled to will depend on the terms of coverage in effect on the date the expense giving rise to a claim for benefits is incurred. An expense is incurred on the date the Covered Person received the service or supply for which a charge is made.

TIME EFFECTIVE:

The effective time, with respect to any dates used in this Plan, will be 12:01 a.m. (midnight) Standard Time as may be legally in effect at the address of the Plan Administrator, or the Employee, as appropriate.

WORKERS COMPENSATION NOT AFFECTED:

This Plan is not in lieu of, and does not affect any requirement for, coverage by Workers' Compensation Insurance.

DEFINITIONS

Certain words and terms used in this Plan Document are herein defined as follows and are shown in capital letters throughout the document.

ACTIVE, ACTIVE EMPLOYEE OR ACTIVELY AT WORK:

The active expenditure of time and energy in the service of the Employer. An Active Employee is one who is on the regular payroll of the Employer and who is scheduled to perform the duties of his/her job with the Employer on a Full-time basis.

ALTERNATE RECIPIENT:

Any child(ren) of the Employee or the spouse of the Employee who is recognized in a Qualified Medical Child Support Order (QMCSO) issued by any court judgment, decree, or order, as being entitled to enroll for coverage under this Plan.

AMBULATORY SURGICAL CENTER:

A facility, other than a medical or dental office, whose main function is performing surgical procedures on an Outpatient basis. It must be licensed as an Outpatient clinic according to state and local laws and must meet all requirements of an Outpatient clinic providing surgical services.

BASELINE:

The initial test results to which the results in future years will be compared in order to detect abnormalities.

BIRTHING CENTER:

A facility that meets professionally recognized standards and all of the tests that follow:

1. It mainly provides an Outpatient setting for childbirth following a normal, uncomplicated Pregnancy.
2. It has:
   a. At least two (2) delivery rooms;
   b. All the medical equipment needed to support the services furnished by the facility;
   c. Laboratory diagnostic facilities; and
   d. Emergency equipment, trays, and supplies for use in life threatening events.
3. It has a medical staff that:
   a. Is supervised full-time by a Physician; and
   b. Includes a registered nurse at all times when patients are in the facility.
4. If it is not part of a Hospital, it has a written agreement(s) with a local Hospital(s) and a local ambulance company for the immediate transfer of patients who require greater care than can be furnished at the facility.
5. It admits only patients who:
   a. Have undergone an educational program to prepare them for the birth; and
   b. Have records of adequate prenatal care.
6. It schedules Confinements of not more than twenty-four (24) hours for a birth.
7. It maintains a medical record for each patient.
8. It complies with all licensing and other legal requirements that apply.
9. It is not the office or clinic of one or more Physicians or a specialized facility other than a Birthing Center.

CALENDAR YEAR:

A twelve (12) month period starting each January 1st at 12:01 a.m. Standard Time as may be in effect at the address of the Employer.

CHEMICAL DEPENDENCY/SUBSTANCE ABUSE:

A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is further characterized by frequent or intense patterns of pathological use to the extent the user exhibits a loss of self-control over the amount and circumstances of use; develops symptoms of tolerance or physiological and/or psychological withdrawal if the use of the controlled substance or alcoholic beverage is reduced or discontinued; and the user's health is substantially

impaired or endangered or his/her social or economic function is substantially disrupted. Diagnosis of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) criteria. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

CHIROPRACTIC CARE/SPINAL MANUAL MANIPULATION:

The diagnosis, treatment, or maintenance by a licensed Chiropractor, M. D., or D. O. to include treatment of:

1. Musculoskeletal strain surrounding vertebra, spine, neck or joints; or
2. Skeletal adjustments, spinal manipulation or other treatment in connection with the detection and correction by manual or mechanical means of structural imbalance or subluxation in the human body; or
3. Nerve interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.
4. Adjunctive therapy, necessary x-rays, and other treatments of the spinal column, neck, extremities, or other joints, other than for fractures or surgery.

CLOSE RELATIVE:

The Employee's spouse, children, siblings, half siblings, step siblings, parents, step parents, grandparents or step grandparents; or the children, siblings, step siblings, half siblings, parents, step parents, grandparents, or step grandparents of the Employee's spouse;

COBRA:

The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.

COINSURANCE:

The benefit percentage of Covered Expenses or charges billed, whichever is less, payable by the Plan for benefits provided under the Plan. The Coinsurance is applied to Covered Expenses after the Co-payments or Deductibles have been met.

COMPLICATIONS OF PREGNANCY:

1. Conditions requiring Hospital Confinement (when Pregnancy is not terminated) with diagnoses distinct from pregnancy, but adversely affected by Pregnancy or caused by Pregnancy. Such conditions include: acute nephritis, nephrosis, cardiac decompensation, hyperemesis gravidarum, puerperal infection, toxemia, eclampsia, and missed abortion and miscarriage;
2. A non-elective Cesarean section;
3. A terminated ectopic Pregnancy;
4. A spontaneous termination of Pregnancy occurring during a period of gestation in which a viable birth is not possible.

"Pregnancy Complications, " as defined above, are covered under the Plan to the same extent as any other Illness.

CONCURRENT REVIEW:

Concurrent Review occurs during the Covered Person's Hospital Confinement to determine if continued Inpatient care is Medically Necessary.

CONFINEMENT:

A continuous stay in a Hospital, Extended Care Facility, or at home, due to an Illness or Injury diagnosed by a Physician. Later stays will be deemed part of the original confinement, unless there was either a complete recovery during the interim from the Illness or Injury causing the initial stay, or unless the later stay results from a cause or causes unrelated to the Illness or Injury causing the initial stay.

CO-PAYMENT:

A cost sharing arrangement whereby a Covered Person pays a set amount for a specific service at the time that service is provided. Co-payments are not applied toward the satisfaction of Deductibles or to the Out-of-Pocket Expense Limit.

COSMETIC SURGERY:

The surgical alteration of hard and soft tissue for the improvement of a person's appearance, rather than the improvement or restoration of bodily functions.

COVERED EXPENSES (ELIGIBLE MEDICAL EXPENSES)/COVERED SERVICES:

Medically Necessary services, supplies, or treatments that are recommended or provided by a licensed Physician, Practitioner, or covered facility for the treatment of an Illness or Injury and that are not specifically excluded from coverage herein. Covered Expenses will include specified preventive care services.

COVERED PERSON/EMPLOYEE/DEPENDENTS:

A Employee or Dependent, as described in the section entitled ***Eligibility***, designated as being eligible for coverage under this Plan Document, whose enrollment form has been received and accepted by the Employer in accordance with the enrollment requirements of this Plan Document, and for whom the Employee's portion of the premiums have been received by the Employer.

CREDITABLE COVERAGE:

Coverage of an individual under any of the following:

1. Group health plans, including governmental plans and church plans.
2. Health insurance, either group or individual, including COBRA Continuation of Coverage.
3. Health Maintenance Organization coverage;
4. Part A or B of Title XVIII of the Social Security Act (Medicare).
5. Title XIX of the Social Security Act (Medicaid), other than coverage consisting solely of benefits under Section 1928 of the Social Security Act (the program for distribution of pediatric vaccines).
6. Title 10 U.S.C. Chapter 55 (medical and dental care for members and certain former members of the uniformed services, and for their dependents; for purposes of Title 10 U.S.C. Chapter 55, "uniformed services" means the armed forces and the Commissioned Corps of the National Oceanic and Atmospheric Administration and of Public Health Service.
7. A medical care program of the Indian Health Service or of a tribal organization.
8. A state health benefits risk pool.
9. The Federal Employee Health Benefits Plan (FEHBP).
10. A public health plan as defined in HCFA regulations.
11. Any health benefit plan under Peace Corps Act δ 5(e).
12. A short-term limited duration policy issued on an individual basis.

CUSTODIAL CARE:

Care that does not require the continuing services of skilled medical or allied health professionals and that is designed primarily to assist the Covered Person in activities of daily living, including institutional care that is primarily to support self-care and provide Room and Board. Custodial Care includes, but is not limited to, help in walking, getting into and out of bed, bathing, dressing, feeding and preparation of special diets, and supervision of medications that are ordinarily self-administered.

Room and Board and skilled nursing services are not, however, considered Custodial Care if:

1. Provided during Confinement in an institution for which coverage is available under this Plan; and
2. Combined with other necessary therapeutic services, under accepted medical standards, that can reasonably be expected to substantially improve the person's medical condition.

CUSTOMARY AND REASONABLE CHARGES/USUAL AND CUSTOMARY (UCR):

1. *Customary* is the fee that falls within the range of prevailing fees charged by Physicians of similar training or experience for a procedure in a given geographic region.
2. *Reasonable* is the fee that meets the requirements of customary and is justified considering the complexity or the severity of treatment for a specific case.

Covered Persons who use the services of Non-Participating Providers will receive no benefit payments or reimbursement for charges in excess of the Customary and Reasonable charges for any Covered Services. The Plan will reimburse the actual charge billed if it is less than the Customary and Reasonable charge. The Plan Administrator has the discretionary authority to decide whether a charge is Customary and Reasonable.

DATE OF ONSET:

The date the Covered Person first had a symptom or condition that a Provider could have used to identify the Illness or Injury or other condition with reasonable accuracy.

DEDUCTIBLE:

The accumulated amount of Covered Expenses incurred throughout the Calendar Year the Covered Person must pay before any Coinsurance applies.

DEPENDENTS:

For a complete definition of "Dependent," refer to the section entitled ***Eligibility, Dependent Eligibility.***

DURABLE MEDICAL EQUIPMENT:

Medical equipment which:

1. Can withstand repeated use;
2. Is not disposable;
3. Is primarily and customarily used to serve a medical purpose;
4. Is generally not used in the absence of Illness or Injury; and
5. Is appropriate for used in the home.

Such equipment includes, but is not limited to, wheelchairs, kidney dialysis machines, and hospital beds.

EFFECTIVE DATE:

The date of this Plan, or the date on which the Covered Person's coverage commences, whichever occurs last.

ELECTIVE SURGICAL PROCEDURE:

A surgical procedure that need not be performed on an Emergency basis because reasonable delay will not cause life endangering complications.

EMERGENCY/EMERGENCY SERVICES:

The sudden onset of an Illness or Injury requiring immediate medical attention. The Medically Necessary services received in connection with an unforeseen Injury or Illness requiring surgical or medical attention within seventy-two (72) hours after onset; and, in the absence of such care, the Covered Person could reasonably expect to suffer serious physical impairment or death. **IMPORTANT NOTE:** See also the definition of *Mental Health Emergency* and *Substance Abuse Emergency*.

EMERGENCY ADMISSION:

An Emergency Admission occurs when a Covered Person is admitted to the Hospital as an Inpatient due to an Emergency, as defined.

EMPLOYEE:

For a complete definition of Employee, refer to the section entitled ***Eligibility, Employee Eligibility.*** This definition does not include temporary or seasonal employees, or independent contractors or consultants who are paid on other than a regular wage or salary by the Employer.

EMPLOYER:

Employer will mean Eldorado Claims Services, Inc. and Eldorado Computing, Inc.

ENROLLMENT DATE:

1. For other than a Late Enrollee, the first day of coverage, or the first day of the Waiting Period, if any.
2. For an individual who enrolls on a special enrollment period, the Enrollment Date is the first day of coverage.
3. For a Late Enrollee, the Enrollment Date is the first day of the first month following an Open Enrollment Period.

ERISA:

The Employee Retirement Income Security Act of 1974, as amended.

EXPERIMENTAL/INVESTIGATIONAL PROCEDURES:

Experimental procedures are:

1. Those that have not yet been used frequently enough to establish a track record;
2. Procedures that have not yet achieved a success rate high enough to be considered safe or effective; or
3. Procedures that have progressed to limited use on humans, but that are not widely accepted as proven and effective by the Health Care Financing Administration.

Services, supplies and treatment not constituting accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.

The Plan Administrator must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The Plan Administrator will be guided by a reasonable interpretation of Plan provisions. The decisions will be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The Plan Administrator will be guided by the following principles:

1. If the drug or device cannot be lawfully marketed without approval of the U. S. Food and Drug Administration, and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment or procedure, or the Covered Person's informed consent document utilized with the drug, device, treatment or procedure, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
3. If "reliable evidence" shows the drug, device, medical treatment or procedure is the subject of on-going Phase I or Phase II clinical trials, is in the research, experimental, study, or investigational arm of on-going Phase II clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If "reliable evidence" shows prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trails are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with standard means of treatment or diagnosis.

"Reliable evidence" will mean only publishes reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

A service, supply or treatment may be considered Experimental or Investigational even if the Provider has performed, prescribed, recommended, ordered or approved it, or if it is the only available procedure or treatment for the condition.

EXTENDED CARE FACILITY:

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

1. It is licensed to provide, and is engaged in providing, on an Inpatient basis for persons convalescing from Illness or Injury, professional nursing services rendered by a graduate registered nurse or by a licensed practical nurse under the direction of a graduate registered nurse, and physical restoration services to assist patient to reach a degree of body functioning to permit self-care in essential daily living activities.
2. Its services are provided for compensation from its patients while under the full-time supervision of a Physician or graduate registered nurse.
3. It provides twenty-four (24) hours per day nursing services by a licensed nurse while under the direction of a full-time graduate registered nurse.

4. It maintains a complete medical record on each patient.
5. It is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, a place for the mentally retarded, a place for custodial or educational care, or a place for care of mental disorders.
6. It is approved and licensed by Medical.

This term will also apply to expenses incurred in an institution referring to itself as a Skilled Nursing Facility, Convalescent Nursing Facility, or any such other similar designations.

FACILITY:

A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis facility, a lithotritor center, or an outpatient imaging center.

FAMILY DEDUCTIBLE:

The accumulated amount of Covered Expenses incurred throughout the Calendar Year the family must pay before any Coinsurance applies.

FULL-TIME:

Employees regularly scheduled to work not less than thirty (30) hours per workweek. This definition does not include temporary or seasonal employees, or independent contractors or consultants who are paid on other than a regular wage or salary by the Employer.

FULL-TIME STUDENT STATUS:

An Employee's Dependent child(ren) who is enrolled in, and regularly attends, high school, an accredited college, university, or institution of higher learning for the minimum number of credit hours required by that institution in order to maintain Full-time Student Status.

GENERIC DRUG:

A drug that is generally equivalent to a higher-priced brand name drug and meets all FDA bioavailability standards.

GENETIC INFORMATION:

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

HAZARDOUS PURSUIT:

An activity involving or exposing an individual to risk of a degree or nature not customarily undertaken in the course of a person's normal leisure time activities and commonly considered as involving unusual or excessive risks.

Such activities include, but are not limited to: hang gliding, bungee jumping, base jumping; sky diving,; use of explosives; automobile, motorcycle or speedboat racing in a designated competition or meet; and travel to countries with advisory warnings.

HEALTH CARE MANAGEMENT:

A process of evaluating if services, supplies, or treatment are Medically Necessary to help ensure cost-effective care.

HEALTH CARE MANAGEMENT ORGANIZATION:

The individual or organization designated by the Employer to authorize Hospital admissions and surgeries and to determine the Medical Necessity of treatment for which Plan benefits are claimed.

HOME HEALTH CARE AGENCY:

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

1. It is primarily engaged in, and duly licensed (if such licensing is required by the appropriate licensing authority), providing skilled nursing and other therapeutic services.
2. It has a policy established by a professional group associated with the agency or organization to govern the services provided. This professional group must include at least one Physician and at least one graduate registered nurse. It must provide for full-time supervision of such services by a Physician or graduate registered nurse.
3. It maintains a complete medical record on each patient.
4. It has a full-time administrator.
5. It qualifies as a reimbursable service under Medicare.

HOME HEALTH CARE PLAN:

A plan of care that must meet these all of the following requirements:

1. It must be a formal written plan made by the Covered Person's attending Physician and is reviewed at least every thirty (30) days; and
2. It must state the diagnosis; and
3. It must certify the Home Health Care is in lieu of Hospital Confinement; and
4. It must specify the type and extent of Home Health Care required for the treatment of the Covered Person.

HOME HEALTH CARE SERVICES AND SUPPLIES:

Part-time or intermittent nursing care by or under the supervision of a Registered Nurse (R.N.); part-time or intermittent home health aide services provided through a Home Health Care Agency, not to include general housekeeping services; physical, occupation and speech therapy; medical supplies and laboratory services by or on behalf of the Hospital.

HOSPICE AGENCY:

An agency that provides counseling and medical services, may provide Room and Board to a terminally ill patient, and meets all of the following requirements:

1. It has obtained any required state governmental Certificate of Need approval.
2. It provides service twenty-four (24) hours per day, seven (7) days a week
3. It is under the direct supervision of a Physician.
4. It has a nurse coordinator who is a registered nurse.
5. It has a social service coordinator who is licensed.
6. It is an agency that has as its primary purpose the provision of Hospice services.
7. It has a full-time administrator.
8. It maintains written records of services provided to the patient.
9. It is licensed, if licensing is required.

HOSPICE CARE PLAN:

A plan of terminal patient care established and conducted by a Hospice Agency and supervised by a Physician; is designed to provide non-curative and support care to a terminally ill Covered Person; and includes an assessment of the medical and social needs, and a description of the care needed to meet those needs.

HOSPICE CARE SERVICES AND SUPPLIES:

Those services and supplies provided through a Hospice Agency and under a Hospice Care Plan, including inpatient care in a Hospice Unit or other licensed facility, home care, and family counseling during the bereavement period.

HOSPITAL:

An institution meeting the following conditions:

1. It is considered licensed and operated in accordance with the laws of jurisdiction in which it is located that pertain to Hospitals.
2. It is engaged primarily in providing medical care and treatment to ill and injured persons on an Inpatient basis, at the patient's expense.

3. It maintains on its premises all the facilities necessary to provide for diagnosis and medical or surgical treatment of an Illness or Injury, with such treatment being provided by, or under the supervision of, a Physician, with continuous, twenty-four (24) hour nursing services by graduate registered nurses.
4. It qualifies as a Hospital, or psychiatric Hospital, and is accredited by the Joint Commission on the Accreditation of Health Care Organizations.
5. It is approved by Medicare.

Under no circumstances will a Hospital be, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, a place for alcoholics, or a nursing home.

ILLNESS:

An abnormal state of health resulting from bodily malfunction, disease, physical sickness, congenital malformation which causes functional impairment, Pregnancy or Complications of Pregnancy of a Covered Person; the bodily condition requiring obstetrical delivery, sterilization, or circumcision. 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, due to the same or related causes, will be considered one Illness.

INCURRED DATE:

With respect to a Covered Expense, the date the services or supplies are provided.

INFERTILITY OR FERTILITY TREATMENT:

Services, tests, supplies, devices, or drugs that are intended to promote fertility; achieve a condition of pregnancy; or treat an Illness causing an infertility/fertility condition which such treatment is done in an attempt to bring about a pregnancy.

For purposes of this definition, Infertility/Fertility treatment includes, but is not limited to:

1. Fertility tests and drugs;
2. Tests and exams done to prepare for, or follow through with, induced conception;
3. Surgical reversal of a sterilized state which was a result of a previous surgery;
4. Sperm enhancement procedures;
5. Direct attempts to cause pregnancy by any means, including, but not limited to, hormone therapy or drugs, artificial insemination; in vitro fertilization, GIFT or ZIFT, embryo transfer, and freezing or storage of embryo, eggs, or semen.

INJURY:

A physical harm or disability that is the result of a specific, unexpected incident caused by an external force, foreign object, temperature, or corrosive chemical. The physical harm or disability must have occurred at an identifiable time and place. Injury does not include Illness or infection of a cut or wound.

INPATIENT:

A Confinement in a Hospital, Hospice, or Extended Care Facility as a registered bed patient for which charges are made for Room and Board to the Covered Person as a result of admission.

INTENSIVE CARE/INTENSIVE CARE UNIT:

A service reserved for critically and seriously ill patients requiring constant audiovisual surveillance as prescribed by the attending Physician. Additionally, Intensive Care Units provides Room and Board and care by a graduate registered nurse or other highly trained Hospital personnel utilizing special equipment and supplies immediately available on a standby basis. Services are rendered at a location segregated from the rest of the Hospital's facilities. This term does not include care in a surgical recovery room.

LATE ENROLLEE:

An Employee or Dependent who: 1) does not enroll for coverage under the Plan when first eligible for coverage; or 2) terminated coverage under the Plan and desires to re-enroll; and 3) does not meet the provisions of the Special Enrollment. An Alternate Recipient is not a Late Enrollee.

LAYOFF/REDUCTION IN FORCE:

A period of time during which the Employee, at the Employer's request, does not work for the Employer, but which is of a stated or limited duration and after which time the Employee is expected to return to Full-time, Active work. Layoff/Reductions in Force will otherwise be in accordance with the Employer's standard personnel practices and policies.

LEAVE OF ABSENCE:

A period of time during which the Employee does not work, but is of stated duration, after which time the Employee is expected to return to Active Work. Leaves of Absence will otherwise be in accordance with the Employer's standard personnel practices and policies.

LEGAL GUARDIAN:

A person recognized by a court of law as having the duty of taking care of, and managing the rights of, a minor child.

LIFETIME:

A word that appears in this Plan in reference to benefit maximum and limitations. Lifetime is understood to mean while covered under this Plan, or any other prior Plan of the Employer. Under no circumstances does *Lifetime* mean during the lifetime of the Covered Person.

MAXIMUM BENEFIT:

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

1. The maximum amount paid by this Plan for any one Covered Person during the entire time he/she is covered by this Plan; or
2. The maximum amount paid by this Plan for any one Covered Person for a particular Covered Expense. This maximum amount can be for:
   a. The entire time the Covered Person is covered under this Plan; or
   b. A specified period of time, such as a Calendar Year.
3. The "maximum number" the Plan acknowledges as a Covered Expense. The maximum number relates to the number of:
   a. Treatments during a specified period of time; or
   b. Days of Confinement: or
   c. Visits by a Home Health Care agency.

MEDICALLY NECESSARY (MEDICAL NECESSITY):

Health care service, supply, or treatment which is determined by the Health Care Maintenance Organization, the Employer, or the Plan Administrator to be:

1. Appropriate and consistent with the symptoms and provided for diagnosis or treatment of the Covered Person's Illness or Injury in accordance with generally accepted medical standards, and which could not have been omitted without adversely affecting the Covered Person's condition or the quality of medical care rendered.
2. In accordance with current standard of good medical practice within the organized medical community and is medically proven to be effective treatment of the Illness or Injury.
3. The most appropriate supply or level of service that can safely be provided to the Covered Person. When applied to an Inpatient admission, this further means the Covered Person requires acute care as a be patient due to the nature of the services rendered, or the Covered Person's Illness or Injury and the Covered Person cannot receive safe or adequate care as an Outpatient.

A service, supply, or treatment will not be considered Medically Necessary if:

1. It is provided only as a convenience to the Covered Person or Provider; or
2. It is part of a plan of treatment that is experimental, unproven, or related to a research protocol.

The fact that any particular Physician may prescribe, order, recommend, or approve a service or supply does not, in and of itself, make the service or supply Medically Necessary. In making the determination of whether a service or supply was

Medically Necessary, The Health Care Management Organization, the Plan Administrator, the Employer, or its designees may request and rely upon the opinion of a Physician(s).

MEDICARE:

The programs established by Title XVIII, known as the Health Insurance for the Aged Act, including:

1. Part A: Hospital Benefits for the Aged;
2. Part B: Supplementary Medical Insurance Benefits for the Aged; and
3. Part C: Miscellaneous provisions regarding both programs; and also including any subsequent changes or additions to those programs.

MENTAL AND NERVOUS DISORDER(S):

An emotional or mental condition characterized by abnormal functioning of the mind or emotions, and in which psychological, intellectual, emotional or behavioral disturbances are the dominating factor. A pathological state of mind producing clinically significant psychological or physiological symptoms together with impairment in one or more major areas of functioning, wherein improvement can reasonably be anticipated with therapy. Diagnosis of these conditions will be determined based on standard SM-III-R (Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association) or the current edition of International Classification of Diseases, published by the U. S. Department of Health and Human Services.

Mental and Nervous Disorder(s) does not include the following when they represent the primary need for therapy:

1. Marital or family problems;
2. Social, occupational, religious or other social maladjustment;
3. Behavior disorders;
4. Chronic situational reactions;
5. Transsexualism, psychosexual identity disorder, psychosexual dysfunction, or gender dysphoria;
6. Chronic organic brain syndrome;
7. Personality disorder;
8. Learning disability;
9. Mental retardation;
10. Impulse control disorders.

MENTAL HEALTH EMERGENCY:

A situation in which a Covered Person with a Mental and Nervous Disorder displays behavior that represents a clear and present danger to self, or danger to others. "Danger to self" means attempting or threatening to commit suicide, or committing acts in furtherance of a threat to commit suicide, if there exists a reasonable probability the person will commit suicide unless admitted to a Mental Health Facility. "Danger to Others" indicates inflicting or attempting to inflict serious bodily harm on any other person or making threats to inflict harm and committing acts in furtherance of those threats, if there exists a reasonable probability the person will do so again unless the person is admitted to a Mental Health Facility.

MIDWIFE:

Any licensed professional (or a professional person deemed by state law to be the same as a legally qualified Midwife) who assists in the delivery of newborns.

MORBID OBESITY:

A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight in the most recent Metropolitan Life Insurance Company tables (or similar actuarial tables) for a person of the same height, age, and mobility as the Covered Person.

NEGOTIATED RATE:

The rate Preferred Providers have contracted to accept as payment in full for Covered Expenses of the Plan.

NEWBORN CARE:

The normal care rendered on behalf of a newborn child(ren) not relating to an Illness or Injury, but to the care and general health maintenance required during the mother's Confinement for delivery including, but not limited to, circumcision, pediatrician's charges, and Routine Nursery Care.

NON-PREFERRED PROVIDER:

A Physician, Hospital, or other health care facility not having an agreement in effect with the Preferred Provider Organization at the time services are rendered.

NURSE:

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

OCCUPATIONAL:

With respect to any Injury or Illness, means any Injury or Illness arising out of, or in the course or, employment for pay or profit.

OUTPATIENT/OUTPATIENT CARE:

A Covered Person will be considered to be an "Outpatient" if treated at:

1. A Hospital as other than a registered bed patient;
2. A Physicians office; or
3. A laboratory or X-ray facility;
4. The Covered Person's home; or
5. An Ambulatory Surgical Center; and

Confinement is less than eighteen (18) consecutive hours.

OUTPATIENT SURGERY:

Elective Surgical Procedures performed in a surgical facility other than Confinement in a Hospital as a registered bed patient.

PARTIAL CONFINEMENT:

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

1. Alcoholism treatment;
2. Chemical Dependency treatment;
3. Psychiatric services;
4. Treatment of mental disorders.

The treatment periods may include day, early evening, evening, night care, or a combination of these four periods.

PART-TIME:

Employees regularly scheduled to work not less than an average of twenty (20) hours per workweek (1000 hours per year).

PHYSICIAN/PRACTITIONER/PROFESSIONAL PROVIDER:

1. A Doctor of Medicine (M. D.) or a Doctor of Osteopathy (D. O.) who is licensed to practice medicine or osteopathy where the care is provided; or
2. One of the following providers, but only when the provider is licensed to practice where the care is provided, who is rendering a service within the scope of that license, and is providing a service for which benefits are specified in this Plan and to whom benefits would be payable if the services were provided by a Physician, as defined in (1) above:
   a. A Dentist (D. D. S. or D. M. D.);

b. An Optometrist (O. D.);
c. A dispensing optician;
d. A podiatrist or chiropodist (D. P. M., D. S. P., or D. S. C.);
e. A psychologist;
f. A chiropractor (D. C.).

3. A Physician or person acting within the scope of applicable state licensing/certification requirements and holding the degree of Certified Nurse Midwife (C. N. M.), Certified Registered Nurse Anesthetists (C. R. N. A.), Registered Physical Therapist, Physician's Assistant, Registered or Certified Respiratory Therapist, Occupational Therapist, Registered Speed Therapist, Registered Nurses (R. N.), Licensed Practical Nurse (L. P. N.), Nurse Practitioner, or Accredited Registered Nurse Practitioner (A. R. N. P.), pathologist, and lab technicians.

   Licensed health service providers in psychology, when acting within the scope of their license or state certification, are included in this definition for services covered under this Plan. The following are those providers who fall under this definition: Certified Social Workers (M. S. W.), Certified Mental Health Counselors (M. A., M. E., M. C., L. C. S. W., or R. C. S.), and Licensed Clinical Psychologists (PSY).

The Physician may not be a Close Relative of the Covered Person.

PHYSICIAN VISIT:

A personal interview between a Covered Person and a Physician, including during Hospital Confinement, but not including telephone calls or interviews in which the Physician does not see the Covered Person.

PLACED FOR ADOPTION:

The date the Employee assumes legal obligation for the total or partial support of the child(ren).

PLAN/PLAN DOCUMENT:

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

PLAN ADMINISTRATOR:

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

PLAN PARTICIPANT:

Any Employee or Dependent covered under this Plan.

PLAN SPONSOR:

The Employer.

PLAN YEAR:

The twelve (12) month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

PRE-ADMISSION TESTING:

Testing prescribed by a Physician in connection with a planned Hospital Confinement or Outpatient Surgery. The testing must be:

1. Performed in a covered facility; and
2. Necessary to diagnose and treat the condition for which Confinement is planned.

Confinement or surgery must actually start within seven (7) days after the test is performed.

PRE-EXISTING CONDITIONS:

A condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment, including the use of prescription drugs or medicines was recommended by or received from a licensed Physician or licensed health practitioner during the six (6) month period prior to the Covered Person's Enrollment Date.

PREFERRED PROVIDER:

A Physician, Hospital, or other health care facility having an agreement in effect with the Preferred Provider Organization at the time the services are rendered. Preferred Providers agree to accept the Negotiated Rate as payment in full.

PREFERRED PROVIDER ORGANIZATION (PPO):

An organization that selects and contracts with several Hospitals, Physicians, and other health care providers to provide services and supplies at a reduced rate to a Covered Person.

PREGNANCY:

The physical state resulting in childbirth or miscarriage and any medical complication arising our of or resulting from such state.

PRESCRIPTION DRUG:

A Food and Drug Administration-approved drug or medicine that, under Federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription."; injectable insulin; such medicine or drugs appearing in a formulary approved by the Employer, obtainable only by prescription (except insulin), dispensed by a licensed pharmacist, and Medically Necessary in the treatment of an Illness or Injury.

PRIOR AUTHORIZATION:

A process through which services are screened, prior to the rendering of such services to determine if the service is Medically Necessary, the appropriate level of care, and the appropriate site for health care delivery.

PROFESSIONAL SERVICES:

Reasonable and necessary services that are consistent with the Physician's diagnosis, for treatment or improvement of a Covered Person's Illness or Injury. Professional Services include charges made by a Physician for x-ray and laboratory examinations.

PROVIDER:

A Hospital, Skilled Nursing Facility, Extended Care Facility, Urgent Care Facility, Ambulatory Surgical Facility, Home Health Care Agency, Physician, Practitioner, or other individual or organization duly licensed to provide medical or surgical supplies, services, treatment and accommodations.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO):

The QMSCO creates or recognizes the right of a child(ren) who is recognized under the order as having a right to be enrolled under the Plan, to receive benefits for which the Employee is entitled under the Plan, and includes:

1. The name and last known address of the Employee and of each such child(ren);
2. A reasonable description of the type of coverage to be provided by the Plan;
3. The period for which coverage must be provided; and
4. Each Plan to which the order applies.

NOTE: A QMCSO cannot require the Plan to provide any type or form of benefit that is not already offered.

REHABILITATION FACILITY:

A facility designed exclusively for rehabilitative services where the Covered Person receives treatment as a result of catastrophic Illness or Injury.

RETROSPECTIVE REVIEW:

Retrospective Review occurs after the Covered Person's discharge to determine if, and to what extent, Inpatient Care was Medically Necessary.

ROOM AND BOARD:

The Hospital's most common semi-private Room and Board charge for room and linen service, dietary service, including meals, special diets and nourishment, and general nursing service. Room and Board does not include personal items.

ROUTINE NURSERY CARE:

Hospital charges for Room and Board and supplies, if applicable, for a newborn child(ren) while the mother is Hospital-confined due to delivery.

SCHEDULE OF BENEFITS:

This Plan's brief summary of Covered Services, benefit limitations, applicable Co-payments, Coinsurance, and Deductibles provided by the Plan.

SECOND SURGICAL OPINION:

A surgical consultation by a specialist who is not affiliated with the surgeon to confirm the medical advisability of proposed elective surgery.

SEMI-PRIVATE:

The daily Room and Board charge a health care institution applies to the greatest number of beds in its semi-private rooms containing two (2) or more beds. If the institution has no semi-private rooms, the semi-private room rate will be the daily Room and Board rate most commonly charged for semi-private rooms with two (2) or more beds by similar institutions in the area. The term "area" means a city, a county, or any greater area necessary to obtain a representative cross section of similar institutions.

SIGNIFICANT BREAK IN COVERAGE:

A period of more than sixty-three (63) consecutive days during all of which a person does not have any Creditable Coverage. A Waiting Period is not counted in determining a Significant Break in Coverage.

SKILLED NURSING FACILITY:

A facility meeting all of these tests:

1. It is licensed in accordance with state and local laws pertaining to such institutions to provide continuous skilled nursing services, and recognized as a Skilled Nursing Facility by the Secretary of Health and Human Services of the United States for participation under the Medicare Act. The services must be rendered twenty-four (24) hours per day by a registered nurse (R.N.) or by as licensed practical nurse (L.P.N.) under the direction of a registered nurse. Services to help restore patients to self-care in essential daily living activities must be provided.
2. Its services are provided for compensation and under the full-time supervision of a Physician;
3. It maintains a complete medical record on each patient;
4. It has an effective utilization review plan; and
5. 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 and Nervous Disorders.

SUBSTANCE ABUSE EMERGENCY:

A situation in which an intoxicated Covered Person with a substance abuse disorder displays behavior representing a clear and present danger to self, or danger to others. "Danger to self" means attempting or threatening to commit suicide, or committing acts in furtherance of a threat to commit suicide, if there exists a reasonable probability the person will commit suicide unless admitted to a Mental Health Facility. "Danger to Others" indicates inflicting or attempting to inflict serious bodily harm on any other person or making threats to inflict harm and committing acts in furtherance of those threats, if there exists a reasonable probability the person will do so again unless the person is admitted to a Substance Abuse Facility.

SUBSTANCE ABUSE TREATMENT CENTER:

An institution not qualifying as a Hospital, but provides a program of effective medical and therapeutic treatment for Chemical Dependency, and:

1. Where coverage of such treatment is mandated by law, has been licensed and approved by the regulatory authority having responsibility for such licensing and approval under the law;
2. Where coverage of such treatment is not mandated by law, meets all of the following requirements:
   a. It is established and operated in accordance with the applicable laws of the jurisdiction in which it is located.
   b. It provides a program of treatment approved by the Physician.
   c. It has or maintains, a written, specific, and detailed regimen requiring full-time residence and full-time participation by the Covered Person.
   d. It provides at least the following basic service:
      1. Room and Board;
      2. Evaluations and diagnoses;
      3. Counseling;
      4. Referral and orientation to specialized community resources.

TERMINAL ILLNESS (TERMINALLY ILL):

A life expectancy of six (6) months or less.

TEMPOROMANDIBULAR JOINT:

TMJ Syndrome is the treatment of jaw joint disorders including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the TMJ.

THIRD PARTY CLAIMS PROCESSOR:

The firm contracted by the Employer responsible for the processing of claims and other services deemed necessary for the operation of the Plan.

TOTAL DISABILITY (TOTALLY DISABLED):

Total Disability will mean the Employee is prevented from engaging in his regular, customary occupation, or for an occupation for which he/she becomes qualified by training or experience, and is performing no work of any kind for compensation or profit. Total Disability also means a Dependent(s) who is prevented from engaging in all the normal activities of a person of like sex and age in good health, by reason of mental or physical handicap.

WAITING PERIOD:

A period of time that must pass before coverage begins for the Employee or the Employee's Dependent(s) who enrolls under this Plan.

URGENT CARE FACILITY:

A facility, other than a Hospital Emergency Room, equipped and operated mainly to render immediate treatment for an acute Illness or Injury.