MERRICK INDUSTRIES, INC.

EMPLOYEE BENEFIT PLAN

PLAN DOCUMENT

AND

SUMMARY PLAN DESCRIPTION

(January 1, 2013)

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ADOPTION

Merrick Industries, Inc. has caused this restated Merrick Industries, Inc. Employee Benefit Plan ***(Plan)*** to take effect as of the first day of January 1, 2013, at Lynn Haven, Florida. This is a revision of the Plan previously adopted January 1, 2012. I have read the document herein and certify the document reflects the terms and conditions of the employee welfare benefit plan as established by Merrick Industries, Inc.

BY:_____ DATE:_____

SUMMARY PLAN DESCRIPTION

- **Name of Plan:** Merrick Industries, Inc. Employee Benefit Plan
- **Name, Address and Phone Number of Employer/Plan Sponsor:**
  Merrick Industries, Inc.
  10 Arthur Drive
  Lynn Haven, Florida 32444
  Phone: (850) 265-3611
- **Employer Identification Number:** 59-3076908
- **Plan Number:** 501
- **Type of Plan:** Welfare Benefit Plan: medical, dental and prescription drug benefits
- **Type of Administration:**
  Contract administration: The processing of claims for benefits under the terms of the Plan are provided through a company contracted by the employer and shall hereinafter be referred to as the claims processor.
- **Name, Address and Phone Number of Plan Administrator, Fiduciary, and Agent For Service of Legal Process:**
  Merrick Industries, Inc.
  10 Arthur Drive
  Lynn Haven, Florida 32444
  Phone: (850) 265-3611
- **Eligibility Requirements:**
  For detailed information regarding a person's eligibility to participate in the Plan, refer to the following sections:
  - Eligibility, Enrollment, Effective Date of Coverage

  For detailed information regarding a person being ineligible for benefits through reaching maximum benefit levels, pre-existing conditions, or termination of coverage, refer to the following sections:
  - Schedule of Benefits, Effective Date of Coverage, Pre-existing Conditions, Termination of Coverage, Plan Exclusions
- **Source of Plan Contributions:**
  Contributions for Plan expenses are obtained from the employer and from the covered employees and their covered dependents. The employer evaluates the costs of the Plan based on projected Plan expenses and determines the amount to be contributed by the employer and the amount to be contributed by the covered employees.
- **Funding Method:**
  The employer pays Plan benefits and administration expenses directly from general assets. Contributions received from covered persons are used to cover Plan costs and are expended immediately.
- **Ending Date of Plan Year:**
  September 30th
- **Procedures for Filing Claims:**
  For detailed information on how to submit a claim for benefits, or how to file an appeal on a processed claim, refer to the section entitled, Claim Filing Procedures. The designated claims processor is:
  Lockard & Williams Insurance Services, P.A.
  PO Box 1688
  Pascagoula, Mississippi 39568-1688
  Phone: (228) 762-2500
- **Statement of ERISA Rights:**
  Participants in the Plan are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all participants shall be entitled to:
  1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, if applicable.
  2. Obtain, upon written request to the plan administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements and copies of the latest annual report (Form 5500 Series) and updated summary plan description, if applicable. The plan administrator may make a 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, if applicable.
  4. Continue health care coverage for the participant, the participant's spouse or dependents if there is a loss of coverage under the Plan as the result of a qualifying event. The participant or dependent may have to pay for such coverage. Review this

summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

5. Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if the participant or dependent has creditable coverage from another plan. The participant or dependent should be issued a certificate of coverage when coverage under the Plan is lost, when the participant or dependent becomes entitled to elect COBRA continuation coverage; when COBRA coverage ceases; if a certificate is requested before losing coverage; or if a certificate is requested within twenty-four (24) months after losing coverage. The participant or dependent may be subject to a pre-existing condition exclusion for twelve (12) months (eighteen (18) months for a late enrollee) after the enrollment date for coverage. The participant or dependent should be provided a certificate of creditable coverage, free of charge, from their group health Plan or health insurance insurer.

- 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 the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of all Plan participants.
- No one, including the employer, a union, or any other person, may fire an employee or discriminate against an employee to prevent the employee from obtaining any benefit under the Plan or exercising their rights under ERISA.
- If claims for benefits under the Plan are denied, in whole or in part, the participant must receive a written explanation of the reason for the denial. The participant has the right to have the Plan review and reconsider the claim.
- Under ERISA, there are steps participants can take to enforce their rights. For instance, if material is requested from the Plan and the material is not received within thirty (30) days, the participant may file suit in a federal court. In such case, the court may require the plan administrator to provide the materials and pay the participant up to $110 a day until the materials are received, unless the materials were not provided for reasons beyond the control of the plan administrator. If a claim for benefits is denied or ignored in whole or in part and after exhaustion of all administrative remedies, the participant may file suit in a state or federal court.
- If it should happen that Plan fiduciaries misuse the Plan's money, or if participants are discriminated against for asserting their rights, participants may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who will pay the costs and legal fees. If the participant is successful, the court may order the person who is sued to pay these costs and fees. If the participant loses, the court may order the participant to pay the costs and fees; for example, if it finds the participant's claim frivolous.
- Participants should contact the plan administrator for questions about the Plan. For questions about this statement or about rights under ERISA, participants should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor listed in their telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. The nearest Regional Office is the Atlanta Regional Office, 61 Forsyth Street, S.W., Suite 7B54, Atlanta, Georgia 30303, Phone: 404/562-2156.

HIPAA PRIVACY STATEMENT

Effective April 14, 2004

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

The Plan will use protected health information (PHI) to the extent of an in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Specifically, the Plan will use and disclose PHI for purposes related to health care treatment, payment for health care and health care operations.

"Payment" includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits that relate to a covered person to whom health care is provided. These activities include, but are not limited to, the following:

1. Determination of eligibility, coverage and coinsurance amounts (for example, cost of a benefit or Plan maximums as determined for a covered person's claim);
2. Coordination of benefits;
3. Adjudication of health benefit claims (including appeals and other payment disputes);
4. Subrogation of health benefit claims;
5. Establishing employee contributions;
6. Risk adjusting amounts due based on enrollee health status and demographic characteristics;
7. Billing, collection activities and related health care data processing;
8. Claims management and related data processing, including auditing payments, investigating and resolving payment disputes and responding to participant inquiries about payments;
9. Obtaining payment under a contract for reinsurance (including stop-loss and excess loss insurance);
10. Medical necessity reviews or reviews of appropriateness of care or justification of charges;
11. Disclosure to consumer reporting agencies related to the collection of premiums or reimbursement; and
12. Reimbursement to the Plan.

"Health Care Operations" include, but are not limited to, the following activities:

- Quality assessment;
- Population-based activities related to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about treatment alternatives and related functions;
- Rating provider and Plan performance, including accreditation, certification, licensing or credentialing activities;
- Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and creating, securing or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess loss insurance);
- Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of payment methods or coverage policies;
- Business management and general administrative activities of the Plan, including, but not limited to:
  (a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements; or
  (b) customer service, including the provision of data analysis for policyholders, plan sponsors or other customers;
- Resolution of internal grievances.

THE PLAN WILL USE AND DISCLOSE PHI TO THE PLAN ADMINISTRATOR AND AS REQUIRED BY LAW AND AS PERMITTED BY AUTHORIZATION OF THE COVERED PERSON

With an authorization, the Plan will disclose PHI to other health benefit plans, health insurance issuers or HMOs for purposes related to the administration of these plans.

The Plan will disclose PHI to the Plan administrator only upon receipt of a certification from the Plan administrator that the Plan documents have been amended to incorporate the following provisions.

WITH RESPECT TO PHI, THE PLAN ADMINISTRATOR AGREES TO CERTAIN CONDITIONS

The Plan administrator agrees to:

- Not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;
- Ensure that any agents, including a subcontractor, to whom the Plan administrator provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan administrator with respect to such PHI;
- Not use or disclose PHI for employment-related actions and decisions unless authorized by a covered person;
- Not use or disclose PHI in connection with any other benefit or employee benefit plan of the Plan administrator unless authorized by the covered person;
- Report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for of which it becomes aware;
- Make PHI available to a covered person in accordance with HIPAA's access requirements;
- Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;
- Make available the information required to provide an accounting of disclosures;
- Make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Health and Human Services Secretary for the purpose of determining the Plan's compliance with HIPAA; and
- If feasible, return or destroy all PHI received from the Plan that the Plan administrator still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

SEPARATION BETWEEN PLAN ADMINISTRATOR AND PLAN

The following employees or classes of employees under the control of the Plan administrator may be given access to PHI by the Plan or a business associate servicing the Plan:

1. Vice President, CFO
2. Manager, Human Resources
3. President, CEO
4. Chairman of the Board

The employees who are included in this description will have access to PHI only to perform the administration functions that the Plan administrator provides to the Plan. Employees who violate this provision will be subject to sanction. The Plan administrator will promptly report any violation of this provision to the Plan and will cooperate with the Plan to remedy or mitigate the effect of such violation.

(PPO) PREFERRED PROVIDER OR NONPREFERRED PROVIDER

Covered persons have the choice of using either a preferred provider or a nonpreferred provider.

- ***PREFERRED PROVIDERS***

  A preferred provider is a physician, hospital or ancillary service provider, which has an agreement in effect with, the Preferred Provider Organization (PPO) to accept a reduced rate for services rendered to covered persons. This is known as the negotiated rate. The preferred provider cannot bill the covered person for any amount in excess of the negotiated rate. Because the covered person and the Plan save money when services, supplies or treatment are obtained from providers participating in the Preferred Provider Organization, benefits are usually greater than those available when using the services of a nonpreferred provider. Covered persons should contact the Human Resources Department for a current listing of preferred providers.

- ***NONPREFERRED PROVIDERS***

  A nonpreferred provider does not have an agreement in effect with the Preferred Provider Organization. This Plan will allow only the customary and reasonable amount as a covered expense. The Plan will pay its percentage of the customary and reasonable amount for the nonpreferred provider services, supplies and treatment. The covered person is responsible for the remaining balance. This results in greater out-of-pocket expenses to the covered person.

- ***REFERRALS***

  Referrals to a nonpreferred provider are covered as nonpreferred provider services, supplies and treatments. It is the responsibility of the covered person to assure services to be rendered are performed by preferred providers in order to receive the preferred provider level of benefits.

- ***EXCEPTIONS***

  The following listing of exceptions represents services, supplies or treatments rendered by a nonpreferred provider where covered expenses shall be payable at the preferred provider level of benefits:

  1. Emergency treatment rendered at a nonpreferred facility. If the covered person is admitted to the hospital after such emergency treatment, covered expenses shall be payable at the preferred provider level.
  2. Nonpreferred anesthesiologist if the operating surgeon is a preferred provider.
  3. Radiologist or pathologist services for interpretation of x-rays and laboratory tests rendered by a nonpreferred provider when the facility rendering such services is a preferred provider.
  4. While confined to a preferred provider hospital, the preferred provider physician requests a consultation from a nonpreferred provider.
  5. Medically necessary services, supplies and treatments not available through any preferred provider.
  6. When a covered dependent resides outside the service area of the Preferred Provider Organization, for example a full-time student, covered expenses shall be payable at the preferred provider level of benefits.
  7. Covered persons who do not have access to preferred providers within thirty-five (35) miles of their place of residence, or for emergency treatment rendered while traveling out-of-area.
  8. Diagnostic laboratory and pathology tests referred to a nonpreferred provider by a preferred provider.

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: Utilization Review, Medical Expense Benefit, Prescription Drug Program, Dental Expense Benefit, Plan Exclusions, Preferred Provider Organization and Exclusive Provider Network.

MAXIMUM BENEFIT FOR ALL COVERED PERSONS FOR ALL BENEFITS

- **Maximum Benefit Per Covered Person Per Calendar Year For:**

Medical	$2,000,000
Extended Care Facility	90 days
Home Health Care	90 days
Chiropractic Care	$500

MERRICK INDUSTRIES

(PPO) Preferred Provider Plan
Wellness Participation/Nicotine Free

- **Calendar Year Deductible: (applies to *preferred* and *nonpreferred providers*)**

	Preferred Provider	***Nonpreferred Provider***
Individual Deductible (Per Person)	$500	$1,000
Family Deductible (Aggregate)	$1,500	$5,000

- **Out-of-Pocket Expense Limit Per Calendar Year: (excludes deductible)**

	Preferred Provider	***Nonpreferred Provider***
Individual (Per Person)	$5,000	$11,000
Family (Aggregate)	$15,000	$33,000

Refer to Medical Expense Benefit, Calendar Year Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit.

- **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 one hundred percent (100%) of incurred covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
Inpatient Hospital	80%	50%
Emergency Room Services	80%	50%
Physician's Services		
Home, Inpatient and Office Visit	80%	50%
Surgery - Outpatient	80%	50%
Surgery - Inpatient	80%	50%
Pathology	80%	50%
Anesthesiology	80%	50%
Radiology	80%	50%

Benefit Description	***Preferred Provider***	***Nonpreferred Provider***
▪ **Diagnostic X-rays & Lab** Inpatient or Outpatient	80%	50%
▪ **Extended Care Facility** Limitation: 90 days maximum benefit per calendar year $150 maximum benefit per day	100%	50%
▪ **Home Health Care** Limitation: 90 days maximum benefit per calendar year $150 maximum benefit per day 1 visit maximum per day	100%	50%
▪ **Hospice Care** Limitation: 180 days maximum benefit while covered by this Plan for inpatient & outpatient combined.	80%	50%
▪ **Durable Medical Equipment** (examples: crutches, wheel chairs, hospital beds, etc.)	80%	50%
▪ **Well Child Care & Immunizations** Limitation: Birth through age 17 (Deductible waived for p*referred provider)*)	100%	Subject to deductible & 50% coinsurance
▪ **Preventive Care** Includes Routine Well Adult Care, Pre-admission Testing and Birthing Center (Deductible waived for a *preferred provider*)	100%	Subject to deductible & 50% coinsurance
▪ **Special Colonoscopy Benefit**	100%	Subject to deductible & 50% coinsurance
▪ **Second Surgical Opinion** (Maximum of $200 for physicians services only)	100%	100%
▪ **Mental & Nervous Disorders**		
Inpatient Services	80%	50%
Outpatient Services	80%	50%
▪ **Chemical Dependency**		
Inpatient Services	80%	50%
Outpatient Services	80%	50%
▪ **Therapy Services** Limitation: $2,000 maximum benefit while covered by this Plan for occupational therapy $2,000 maximum benefit while covered by this Plan for speech therapy	80%	50%
▪ **Chiropractic Care** Limitation: $500 maximum benefit per calendar year	80%	50%
▪ **Transplants**	80%	50%
▪ **All Other Covered Expenses**	80%	50%

(PPO) Preferred Provider Plan
Wellness Participation/Not Nicotine Free

	Preferred Provider	*Nonpreferred Provider*
▪ **Calendar Year Deductible: (applies to *preferred* and *nonpreferred providers*)**		
Individual Deductible (Per Person)	$2,500	$5,000
Family Deductible (Aggregate)	$5,400	$10,000
▪ **Out-of-Pocket Maximum Per Calendar Year: (excludes deductible)**		
Individual (Per Person)	$5,000	$11,000
Family (Aggregate)	$15,000	$33,000

Refer to Medical Expense Benefit, Calendar Year Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit.

▪ **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 one hundred percent (100%) of incurred covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.

Benefit Description	*Preferred Provider*	*Nonpreferred Provider*
▪ **Inpatient Hospital**	75%	50%
▪ **Emergency Room Services**	75%	50%
▪ **Physician's Services**		
Home, Inpatient and Office Visit	75%	50%
Surgery - Outpatient	75%	50%
Surgery - Inpatient	75%	50%
Pathology	75%	50%
Anesthesiology	75%	50%
Radiology	75%	50%
▪ **Diagnostic X-rays & Lab**		
Inpatient or Outpatient	75%	50%
▪ **Extended Care Facility**	100%	50%
Limitation: 90 days maximum benefit per calendar year		
$150 maximum benefit per day		
▪ **Home Health Care**	100%	50%
Limitation: 90 days maximum benefit per calendar year		
$150 maximum benefit per day		
1 visit maximum per day		
▪ **Hospice Care**	75%	50%
Limitation: 180 days maximum benefit while covered by this Plan for inpatient & outpatient combined		
▪ **Durable Medical Equipment**	75%	50%
(examples: crutches, wheel chairs, hospital beds, etc.)		

▪ **Well Child Care & Immunizations** Limitation: Birth through age 17 (Deductible waived for a *preferred provider*)	100%	Subject to deductible & 50% coinsurance
▪ **Preventive Care** Includes Routine Well Adult Care, Pre-admission Testing and Birthing Center (Deductible waived for *preferred provider*)	100%	Subject to deductible & 50% coinsurance
▪ **Special Colonoscopy Benefit**	100%	Subject to deductible & 50% coinsurance
▪ **Second Surgical Opinion** (maximum of $200 for physicians services only)	100%	100%
▪ **Mental & Nervous Disorders**		
Inpatient Services	75%	50%
Outpatient Services	75%	50%
▪ **Chemical Dependency**		
Inpatient Services	75%	50%
Outpatient Services	75%	50%
▪ **Therapy Services** Limitation: $2,000 maximum benefit while covered by this Plan for occupational therapy $2,000 maximum benefit while covered by this Plan for speech therapy	75%	50%
▪ **Chiropractic Care** Limitation: $500 maximum benefit per calendar year	75%	50%
▪ **Transplants**	75%	50%
▪ **All Other Covered Expenses**	75%	50%

(PPO) Preferred Provider Plan
Wellness Non-Participation

	Preferred Provider	*Nonpreferred Provider*
▪ **Calendar Year Deductible: (applies to *preferred* and *nonpreferred providers*)**		
Individual Deductible (Per Person)	$3,500	No Coverage
Family Deductible (Aggregate)	$7,000	No Coverage
▪ **Out-of-Pocket Maximum Per Calendar Year: (excludes deductible)**		
Individual (Per Person)	$10,000	No Coverage
Family (Aggregate)	$30,000	No Coverage

Refer to Medical Expense Benefit, Calendar Year Out-of-Pocket Expense Limit for a listing of charges not applicable to the out-of-pocket expense limit.

▪ **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 one hundred percent (100%) of incurred covered expenses for the remainder of the calendar year or until the maximum benefit has been reached. Refer to Medical Expense Benefit, Out-of-Pocket Expense Limit, for a listing of charges not applicable to the one hundred percent (100%) coinsurance.

Benefit Description	*Preferred Provider*	*Nonpreferred Provider*
▪ **Inpatient Hospital**	70%	No Coverage
▪ **Emergency Room Services**	70%	No Coverage
▪ **Physician's Services**		
Home, Inpatient and Office Visit	70%	No Coverage
Surgery - Outpatient	70%	No Coverage
Surgery - Inpatient	70%	No Coverage
Pathology	70%	No Coverage
Anesthesiology	70%	No Coverage
Radiology	70%	No Coverage
▪ **Diagnostic X-rays & Lab**		
Inpatient or Outpatient	70%	No Coverage
▪ **Extended Care Facility**	100%	No Coverage
Limitation: 90 days maximum benefit per calendar year		
$150 maximum benefit per day		
▪ **Home Health Care**	100%	No Coverage
Limitation: 90 days maximum benefit per calendar year		
$150 maximum benefit per day		
1 visit maximum per day		
▪ **Hospice Care**	70%	No Coverage
Limitation: 180 days maximum benefit while covered by this Plan for inpatient & outpatient combined		
▪ **Durable Medical Equipment**	70%	No Coverage
(examples: crutches, wheel chairs, hospital beds, etc.)		

▪ **Well Child Care & Immunizations** Limitation: Birth through age 17 (Deductible waived for a *preferred provider*)	100%	No Coverage
▪ **Preventive Care** Includes Routine Well Adult Care, Pre-admission Testing and Birthing Center (Deductible waived for a *preferred provider*)	100%	No Coverage
▪ **Special Colonoscopy Benefit**	100%	No Coverage
▪ **Second Surgical Opinion** (maximum of $200 for physicians services only)	100%	No Coverage
▪ **Mental & Nervous Disorders**		
Inpatient Services	70%	No Coverage
Outpatient Services	70%	No Coverage
▪ **Chemical Dependency**		
Inpatient Services	70%	No Coverage
Outpatient Services	70%	No Coverage
▪ **Therapy Services** Limitation: $2,000 maximum benefit while covered by this Plan for occupational therapy $2,000 maximum benefit while covered by this Plan for speech therapy	70%	No Coverage
▪ **Chiropractic Care** Limitation: $500 maximum benefit per calendar year	70%	No Coverage
▪ **Transplants**	70%	No Coverage
▪ **All Other Covered Expenses**	70%	No Coverage

PRESCRIPTION DRUG PROGRAM

MERRICK INDUSTRIES

- **Participating Pharmacy**
  Prescription Drug Card
  Copay

  *Mandatory Generic unless physician override

  100% after copay;
  Generic: $5 copay
  Brand Name: 20% of prescription cost

- **Nonparticipating Pharmacy**

  Copay, plus the difference in cost between the participating pharmacy and nonparticipating pharmacy.

- **Limitation:** 30 day

- **Mail Order**
  Mail Order Prescriptions
  Copay

  100% after copay;
  Generic: $10 per prescription
  Brand Name: 20% of prescription cost

  ** **Mandatory Mail Order**
  (No more than two (2) fills at retail)

- **Limitation:** 90 day supply

- ***OTC Medications (Prescription required)**
  (CVS/Caremark List)

  100% after $5.00 copay

***Mandatory Generics** – a covered person if required to use generic medications when a generic equivalent is available unless the prescribing physician states in writing that it is medically necessary that the covered person receive the brand medication. Should a covered person choose the brand medication when a generic equivalent is available without the prescribing physician letter then they will be responsible for the brand co-pay plus the cost difference between the generic and brand medication.

****Mandatory Mail Order** – a covered person is required to fill their maintenance medication by mail order. A covered person will be allowed to fill the prescription at a retail facility up to two (2) times. After the second fill the covered person cannot receive their maintenance medication at retail. They must set-up and receive their maintenance medications through mail order.

*****OTC –** Covered medications are limited to proton pump inhibitors and non-sedating antihistamines with a physicians prescription.

DENTAL BENEFITS

MERRICK INDUSTRIES

▪ **Calendar Year Deductible:**	
Individual	$100
Family (Aggregate)	$300
The deductible is waived for diagnostic & preventive dental services.	
▪ **Maximum Benefit Per Covered Person:**	
Preventive, Basic and Major services per calendar year (other than Orthodontics)	$1,500
Orthodontic services for ***dependents*** through age 19 only while covered by this ***Plan***	$2,000
▪ **Percentage of Customary and Reasonable Amount Payable For:**	
Diagnostic & Preventive Dental Services	100%
Basic Dental Services	80%
Major Dental Services	50%
Orthodontic Services	50%

UTILIZATION REVIEW

- Utilization review is the process of evaluating if services, supplies or treatment are medically necessary and appropriate to help ensure cost-effective care. Utilization review can eliminate unnecessary services, hospitalizations, and shorten confinements while improving quality of care and reducing costs to the covered person and the Plan.
- Certification of medical necessity and appropriateness by the Utilization Review Organization does not establish eligibility under the Plan nor guarantee benefits.
- The Plan requires precertification of certain services, supplies or treatment, as specified below. Under this Plan's claim filing procedures, the precertification call is considered to be filing a pre-service claim for benefits. Please see Claim Filing Procedures for details regarding a covered person's rights regarding pre-service claim determinations and appeals.

PRECERTIFICATION

- Hospital/Outpatient Surgery
- All hospital admissions and outpatient surgeries are to be certified in advance of the proposed confinement or outpatient surgery (precertification) by the Utilization Review Organization, except for emergencies. The covered person or their representative should call the Utilization Review Organization at least forty-eight (48) hours prior to admission.
- Covered persons should contact the Utilization Review Organization by calling: 1-800-667-9961
- Emergency hospital admissions are to be reported to the Utilization Review Organization within forty-eight (48) hours following admission, or on the next business day after admission.
- Group health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than forty-eight (48) hours following a normal vaginal delivery, or less than ninety-six (96) hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than forty-eight (48) hours (or ninety-six (96) hours as applicable). In any case, plans may not, under federal law require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.
- Benefits payable for hospital confinement or outpatient surgeries shall be reduced by two hundred and fifty dollars ($250) if precertification is not obtained.
- After admission to the hospital, the Utilization Review Organization will continue to evaluate the covered person's progress through concurrent review to monitor the length of confinement and medical necessity of treatment. If the Utilization Review Organization disagrees with the length of confinement recommended by the physician, the covered person and the physician will be advised. If the Utilization Review Organization determines that continued confinement is no longer necessary, additional days will not be certified. Benefits payable for days not certified as medically necessary by the Utilization Review Organization shall be denied.
- However, in the event that a retrospective review, (a review completed after the event), determines that the hospitalization or surgery did not exceed the amount that would have been approved had the precertification been completed, there will be no penalty assessed and the amount of any deductible and/or coinsurance will count towards the satisfaction of the covered person's maximum out-of-pocket expense.
- Precertification from the Utilization Review Organization does not constitute Plan liability for any pre-existing condition charges during the pre-existing condition waiting period.

PRECERTIFICATION APPEAL PROCESS

In the event certification of medical necessity is denied by the Utilization Review Organization, the covered person may appeal the decision. See Claim Filing Procedures 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 shall 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 mandatory program to the covered person and the Plan will generally provide a greater benefit to the covered person by participating in the program. If the covered person refuses to follow the case management recommendations of the Plan and the result of the refusal would be higher expense to the Plan, then the Plan will reduce the covered persons benefits by the amount of the increased expense. 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.

MEDICAL EXPENSE BENEFIT

This section describes the covered expenses of the Plan. All covered expenses are subject to applicable Plan provisions including, but not limited to: deductible, copay, coinsurance and maximum benefit provisions as shown in the Schedule of Benefits, unless otherwise indicated. Any expenses incurred by the covered person for services, supplies or treatment provided will not be considered covered expenses by this Plan if they are greater than the customary and reasonable amount or negotiated rate, as applicable. The covered expenses for services, supplies or treatment provided must be recommended by a physician or professional provider and be medically necessary care and treatment for the illness or injury suffered by the covered person. Specified preventive care expenses will be covered by this Plan.

DEDUCTIBLES

- ***Hospital Deductible (Applicable to EPO Plan)***
  For each inpatient hospital confinement, the covered person is responsible for an additional hospital deductible as specified on the Schedule of Benefits. The hospital deductible shall be applied to covered expenses first, then any applicable calendar year deductible shall be applied.
- ***Nonpreferred Hospital Deductible (Applicable to PPO Plan)***
  For each inpatient hospital confinement at a nonpreferred facility, the covered person is responsible for an additional hospital deductible as specified on the Schedule of Benefits. The nonpreferred hospital deductible shall be applied to covered expenses first, then any applicable calendar year deductible shall be applied.
- ***Individual Deductible***
  The individual deductible is the dollar amount of covered expense which each covered person must have incurred during each calendar year before the Plan pays applicable benefits. The individual deductible amount is shown on the Schedule of Benefits.
- ***Family Deductible***
  If, in any calendar year, covered members of a family incur covered expenses that are subject to the deductible, equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.
- ***Common Accident***
  If two or more covered members of a family are injured in the same accident and, as a result of that accident, incur covered expenses, only one individual deductible amount will be deducted from the total covered expenses of all covered family members related to the accident for the remainder of the calendar year.
- ***Deductible Carry-Over***
  Amounts incurred during October, November and December and applied toward the deductible of any covered person, will also be applied to the deductible of that covered person in the next calendar year.

COINSURANCE

The Plan pays a specified percentage of covered expenses at the customary and reasonable amount for nonpreferred providers, or the percentage of the negotiated rate for preferred providers or exclusive providers. That percentage is specified in the Schedule of Benefits. The covered person is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the negotiated rate for preferred providers or exclusive providers. For nonpreferred providers, the covered person is responsible for the difference between the percentage the Plan paid and one hundred percent (100%) of the billed amount. The covered person's portion of the coinsurance represents the out-of-pocket expense limit.

CALENDAR YEAR OUT-OF-POCKET EXPENSE LIMIT

- After the covered person has incurred an amount equal to the out-of-pocket expense limit listed on the Schedule of Benefits for covered expenses (after satisfaction of any applicable deductibles), the Plan will begin to pay one hundred percent (100%) for covered expenses for the remainder of the calendar year.
- After a covered family has incurred a combined amount equal to the family out-of-pocket expense limit shown on the Schedule of Benefits, the Plan will pay one hundred percent (100%) of covered expenses for all covered family members for the remainder of the calendar year.
- Out-of-Pocket Expense Limit Exclusions
  The following items do not apply toward satisfaction of the calendar year out-of-pocket expense limit:
  1. Expenses for services, supplies and treatments not covered by this Plan, to include charges in excess of the customary and reasonable amount or negotiated rate, as applicable.
  2. Deductible(s).
  3. Copays.

4. Expenses for treatment of chemical dependency, nor will the Plan's coinsurance be payable at one hundred percent (100%) for these services after the out-of-pocket expense limit has been satisfied.
5. Expense incurred as a result of failure to obtain precertification.

MAXIMUM BENEFIT

The maximum benefit payable on behalf of a covered person is shown on the Schedule of Benefits. The maximum benefit applies to the entire time the covered person is covered under the Plan, either as an employee, dependent, alternate recipient or under COBRA. If the covered person's coverage under the Plan terminates and at a later date he again becomes covered under the Plan, the maximum benefit will include all benefits paid by the Plan for the covered person during any period of coverage.

- The Schedule of Benefits contains separate maximum benefit limitations for specified conditions. Any separate maximum benefit will include all such benefits paid by the Plan for the covered person during any and all periods of coverage under this Plan. All separate maximum benefits are part of, and not in addition to, the maximum benefit. No more than the maximum benefit will be paid for any covered person while covered by this Plan.

HOSPITAL/AMBULATORY SURGICAL FACILITY

Inpatient hospital admissions and outpatient surgeries are subject to precertification. Failure to obtain precertification will result in a reduction of benefits, refer to Utilization Review. Covered expenses shall include:

- Room and board for treatment in a hospital, including intensive care units, cardiac care units and similar necessary accommodations. Covered expenses for room and board shall be limited to the hospital's semiprivate rate. Covered expenses for intensive care or cardiac care units shall be the customary and reasonable amount or negotiated rate, as applicable. In a hospital that has only private rooms, covered expenses for room and board shall be limited to eighty percent (80%) of the hospital's average private room rate.
    1. 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.
- Miscellaneous hospital services, supplies, and treatments including, but not limited to:
    1. Admission fees, and other fees assessed by the hospital for rendering medically necessary services, supplies and treatments;
    2. Use of operating, treatment or delivery rooms;
    3. Anesthesia, anesthesia supplies and its administration by an employee of the hospital;
    4. Medical and surgical dressings and supplies, casts and splints;
    5. 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);
    6. Drugs and medicines (except drugs not used or consumed in the hospital);
    7. X-ray and diagnostic laboratory procedures and services;
    8. Oxygen and other gas therapy and the administration thereof;
    9. Therapy services.
- Services, supplies and treatments described above furnished by an ambulatory surgical facility.

FACILITY PROVIDERS

Services of facility providers if such services would have been covered if performed in a hospital or ambulatory surgical facility.

AMBULANCE SERVICES

Ambulance services must be by a licensed air or ground ambulance.

1. Covered expenses shall include:
    1. Ambulance services for air or ground transportation for the covered person from the place of injury or serious medical incident to the nearest hospital where treatment can be given, unless a longer trip is medically necessary.
    2. Ambulance service is covered in a non-emergency situation only to transport the covered person to or from a hospital or between hospitals for required treatment when such treatment is certified by the attending physician as medically necessary. Such transportation is covered only from the initial hospital to the nearest hospital qualified to render the special treatment.

ACCIDENT EXPENSE BENEFIT

Initial treatment and follow-up care for an injury will be payable subject to any applicable maximum benefit, as specified in the Schedule of Benefits, provided such care is rendered within seventy-two (72) hours of the injury. Covered expenses must not be payable under any other portion of this Plan.

2. Covered expenses shall include charges for the following:
    1. Physician services;
    2. Hospital care and treatment;
    3. Diagnostic x-rays and lab tests;
    4. Local professional ambulance service;
    5. Surgical dressings, splints and casts and other devices used in the reduction of fractures and dislocations;

6. Nursing service;
7. Anesthesia;
8. Covered prescription drugs;
9. Use of a physician's office or clinic operating room.

PHYSICIAN SERVICES

Covered expenses shall include:

- Medical treatment, services and supplies including, but not limited to: office visits, inpatient visits, home visits.
- Surgical treatment. Separate payment will not be made for inpatient pre-operative or post-operative care normally provided by a surgeon as part of the surgical procedure.
  1. If bilateral or multiple surgical procedures are performed by one (1) surgeon, benefits will be determined based on the customary and reasonable amount or negotiated rate that is allowed for the primary procedure; fifty percent (50%) of the customary and reasonable amount or negotiated rate, as applicable, will be allowed for each additional procedure performed through the same incision; and seventy percent (70%) of the customary and reasonable amount or negotiated rate, as applicable, will be allowed for each additional procedure performed through a separate incision. Any procedure that would be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures.
  2. If multiple unrelated surgical procedures are performed by two (2) or more surgeons in separate operative fields, benefits will be based on the customary and reasonable amount or negotiated rate, as applicable, for each surgeon's primary procedure. If two (2) or more surgeons perform a procedure that is normally performed by one (1) surgeon, benefits for all surgeons will not exceed the customary and reasonable amount or negotiated rate, as applicable, allowed for that procedure.
- Surgical assistance provided by a physician if it is determined that the condition of the covered person or the type of surgical procedure requires such assistance. Covered expenses for the services of an assistant surgeon shall be limited to twenty percent (20%) of the surgeon's allowable amount.
- Furnishing or administering anesthetics, other than local infiltration anesthesia, by other than the surgeon or his assistant.
- Consultations requested by the attending physician during a hospital confinement. Consultations do not include staff consultations which are required by a hospital's rules and regulations.
- Radiologist or pathologist services for interpretation of x-rays and laboratory tests necessary for diagnosis and treatment.
- Radiologist or pathologist services for diagnosis or treatment, including radiation therapy and chemotherapy.

DIAGNOSTIC SERVICES AND SUPPLIES

Covered expenses shall include services and supplies for diagnostic laboratory, pathology, ultrasound, nuclear medicine, magnetic imaging, x-ray and allergy testing consisting of percutaneous, intracutaneous and patch tests and allergy injections.

TRANSPLANT

Services, supplies and treatments in connection with human-to-human organ and tissue transplant procedures will be considered covered expenses subject to the following conditions:

- When the recipient is covered under this Plan, the Plan will pay the recipient's covered expenses related to the transplant.
- No benefits are payable for charges incurred in obtaining donor organs, including charges for:
  1. evaluating the organ or tissue; or
  2. removing the organ or tissue from the donor; or
  3. transportation of the organ or tissue to the place where the transplant is to take place.

PREGNANCY

Covered expenses for pregnancy or complications of pregnancy shall be provided for a covered female employee or a covered female spouse of a covered employee.

- In the event of early discharge from a hospital or birthing center following delivery, the Plan will cover two (2) Registered Nurse home visits.
- The Plan shall cover services, supplies and treatments for medically necessary abortions when the life of the mother would be endangered by continuation of the pregnancy, or when the pregnancy is the result of rape or incest.
- Complications from an abortion for the covered female employee or a covered female spouse of an employee shall be a covered expense whether or not the abortion is a covered expense.

STERILIZATION

Covered expenses shall include elective sterilization procedures for the covered employee or covered spouse. Reversal of sterilization is not a covered expense.

WELL NEWBORN CARE

The Plan shall cover well newborn care while the mother is confined for delivery not to exceed four (4) days. Covered expenses for services, supplies or treatment of the newborn child shall be considered charges of the child and as such, subject to a separate deductible and coinsurance from the mother.

Such care shall include, but is not limited to: Physician services, Hospital services and Circumcision

WELL CHILD CARE

Covered expenses for well child care shall include charges for the following services provided to covered dependent children, through age sixteen (16): routine physical examinations for a reason other than to diagnose an injury or illness; immunizations; x-rays, laboratory and other tests given in connection with pediatric examinations; patient history; developmental assessment; anticipatory guidance, payable as specified on the Schedule of Benefits.

WELLNESS/PREVENTIVE CARE

Covered expenses shall include the items contained in the definition of Preventative Care in the definitions section of this document.

The Plan will pay for 100% of the allowable expenses as provided under the preferred provider agreement. Use of non-preferred provider will result in additional out-of-pocket cost to the participant.

WOMEN'S PREVENTATIVE SERVICES

To comply with PPACA and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for those Women's Preventative services without cost-sharing as described at www.hrsa.gov/womensguidelines/. Those services generally include: contraception and contraceptive counseling, breastfeeding support, supplies, and counseling, screening and counseling, for interpersonal and domestic violence, counseling and screening for human immune-deficiency virus, counseling for sexually transmitted infections, HPV and DNA testing, screening for gestational diabetes, and well-woman visits.

SPECIAL LABORATORY BENEFIT

Covered expenses for the Nicotine/Cotinine blood test shall be included. The Plan will pay for 100% of the cost of these services at a frequency determined solely by the Plan Administrator.

PREADMISSION TESTING

Covered expenses shall include charges for preadmission testing (x-rays and lab tests) performed within seven (7) days prior to a hospital admission which are related to the condition which is necessitating the confinement. Such tests shall be payable even if they result in additional medical treatment prior to confinement or if they show that hospital confinement is not necessary. Such tests shall not be payable if the same tests are performed again after the covered person has been admitted.

SECOND SURGICAL OPINIONS

Covered expenses shall include charges for a second surgical opinion if an elective surgical procedure (non-emergency surgery) is recommended by the physician. The physician rendering the treatment of the covered person's illness or injury and must not be affiliated in any way with the physician who will be performing the actual surgery.

BIRTHING CENTER SERVICES

Covered expenses shall include services, supplies and treatments rendered at a birthing center provided the physician in charge is acting within the scope of his license and the birthing center meets all legal requirements.

Services of a midwife acting within the scope of his license or registration are a covered expense provided that the state in which such service is performed has legally recognized midwife delivery.

THERAPY SERVICES

Therapy 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 shall include:

- Services of a professional provider for physical therapy. Therapy must be in accord with a physician's exact orders as to type, frequency and duration and to improve a body function.

- Services of a professional provider for occupational therapy to improve a body function, subject to the maximum benefit shown on the Schedule of Benefits. No benefits are payable for recreational programs, maintenance therapy or supplies used in occupational therapy.
- Services of a professional provider for speech therapy, subject to the maximum benefit shown on the Schedule of Benefits. Therapy must be ordered by a physician and follow either:
  1. surgery for correction of a congenital condition of the oral cavity, throat or nasal complex (other than a frenectomy);
  2. an injury;
  3. an illness that is other than a learning or mental and nervous disorder.
- Radiation therapy or chemotherapy and treatment with radioactive substances. The materials and services of technicians are included.
- Dialysis therapy or treatment.
- Infusion therapy.

EXTENDED CARE FACILITY

Extended care facility services, supplies and treatments shall be a covered expense 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 a convalescence from a condition which caused that hospital confinement, or a related condition;
3. The extended care confinement begins within seven (7) days after discharge from that hospital confinement, or within seven (7) days after a related extended care confinement; and
4. The covered person is under a physician's continuous care and the physician certifies that the covered person must have twenty-four (24) hours-per-day nursing care and completes a treatment plan which includes a diagnosis, the proposed course of treatment and the projected date of discharge.

Covered expenses shall include:

1. Room and board (including regular daily services, supplies and treatments furnished by the extended care facility) limited to the facility's average semiprivate room rate; and
2. Other services, supplies and treatment ordered by a physician and furnished by the extended care facility for inpatient medical care.

Extended care facility benefits are limited as shown the Schedule of Benefits.

HOME HEALTH CARE

Home health care enables the covered person to receive treatment in his home for an illness or injury instead of being confined in a hospital or extended care facility. The diagnosis, care and treatment must be certified by the attending physician and must be contained in a home health plan. Covered expenses shall include:

- Part-time or intermittent nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse;
- Physical, respiratory, occupational or speech therapy;
- Part-time or intermittent home health aide services for a covered person who is receiving covered nursing or therapy services;
- Nutritional guidance by a registered dietician and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation as determined to be medically necessary.
- A visit by a member of a home health care team and four (4) hours of home health aide service will each be considered one (1) home health care visit.
- Covered expenses shall be subject to the maximum benefit specified on the Schedule of Benefits.

HOSPICE CARE

Hospice care is a health care program providing a coordinated set of services rendered at home, in outpatient settings, or in facility settings for a covered person suffering from a condition that has a terminal prognosis.

- Hospice benefits will be covered only if the covered person's attending physician certifies that:
  1. The covered person is terminally ill, and
  2. The covered person has a life expectancy of six (6) months or less.
- Covered expenses shall include:
  1. Confinement in a hospice to include ancillary charges and room and board.
  2. Services, supplies and treatment provided by a hospice to a covered person in a home setting.
  3. Physician services and/or nursing care by a Registered Nurse, Licensed Practical Nurse or a Licensed Vocational Nurse.
  4. Nutrition services to include nutritional advice by a registered dietician, and nutritional supplements such as diet substitutes administered intravenously or through hyperalimentation.
  5. Counseling services provided through the hospice.
- Hospice benefits are limited to the maximum benefit as stated in the Schedule of Benefits.
- Charges incurred during periods of remission are not eligible under this provision of the Plan. Any covered expense paid under hospice benefits will not be considered a covered expense under any other provision of this Plan.

DURABLE MEDICAL EQUIPMENT

Rental or purchase, whichever is less costly, of necessary durable medical equipment which is prescribed by a physician and required for therapeutic use by the covered person shall be 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 purchased durable medical equipment, which is medically necessary due to normal use or physiological change in the patient's condition, will be considered a covered expense.
- Equipment containing features of an aesthetic nature or features of a medical nature which are not required by the covered person's condition, or where there exists a reasonably feasible and medically appropriate alternative piece of equipment which is less costly than the equipment furnished, will be covered based on the usual charge for the equipment which meets the covered person's medical needs.

PROSTHESES

The initial purchase of a prosthesis (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 organ shall be a covered expense. A prosthesis 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 a prosthesis, which is medically necessary due to normal use or physiological change in the patient's condition, will be considered a covered expense.

ORTHOTICS

Orthotic devices and appliances (a rigid or semi-rigid supportive device which restricts or eliminates motion for a weak or diseased body part), including initial purchase, fitting and repair shall 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 shall not be covered. Replacement will be covered only after five (5) years from the date of original placement, unless physiological change in the patient's condition necessitates earlier replacement.

DENTAL SERVICES

Covered expenses shall include repair of sound natural teeth or surrounding tissue provided it is the result of an injury. Treatment must be performed within twelve (12) months after the injury. Damage to the teeth as a result of chewing or biting shall not be considered an injury under this benefit.

- Covered expenses shall also include services, supplies and treatment for the following oral surgical procedures:
  1. Excision of tumors and cysts of the jaws, cheeks, lips, tongue, roof and floor of the mouth.
  2. Surgery needed to correct an injury to the jaws, cheeks, lips, tongue, floor and roof of the mouth.
  3. Excision of benign bony growths of the jaw and hard palate.
  4. External incision and drainage of cellulitis.
  5. Incision of sensory sinuses, salivary glands or ducts.
  6. Removal of impacted teeth.
- No benefits shall be paid for dental or oral surgical procedures involving orthodontic care of the teeth, periodontal disease and preparing the mouth for the fitting of or continued use of dentures.

SPECIAL EQUIPMENT AND SUPPLIES

Covered expenses shall include medically necessary special equipment and supplies including, but not limited to: casts; splints; braces; trusses; surgical and orthopedic appliances; colostomy and ileostomy bags and supplies required for their use; catheters; crutches; blood and blood derivatives that are not donated or replaced; intravenous injections and their administration; electronic pacemakers; oxygen and the administration thereof; the initial pair of eyeglasses or contact lenses due to cataract surgery; soft lenses or sclera shells intended for use in the treatment of illness or injury of the eye; the purchase of a wig required due to hair loss following chemotherapy; surgical dressings and other medical supplies ordered by a professional provider in connection with medical treatment, but not common first aid supplies; blood sugar measurement devices; and allergy serums.

COSMETIC/RECONSTRUCTIVE SURGERY

Cosmetic/reconstructive surgery shall be a covered expense provided:

- A covered person receives an injury as a result of an accident and, as a result requires surgery. Cosmetic surgery and treatment must be for the purpose of restoring the covered person to his normal function immediately prior to the accident.
- It is required to correct a congenital anomaly, for example, a birth defect.

MASTECTOMY

Covered expenses shall include the following:

- Medically necessary mastectomy, including complications from a mastectomy, including lymphedemas.
- Reconstructive breast surgery necessary because of a mastectomy.

- Reconstructive breast surgery on the non-diseased breast to make it equal in size with the diseased breast following reconstructive surgery on the diseased breast.
- External breast prosthesis and permanent internal breast prosthesis.

MENTAL AND NERVOUS DISORDERS

- Inpatient
  Subject to the precertification provisions of the Plan, the Plan will pay the applicable coinsurance, up to the maximum benefit as defined in the Schedule of Benefits, for confinement in a hospital or treatment center for services, supplies and treatment related to the treatment of mental and nervous disorders. Physician visits are limited to one (1) per day. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must bill the Plan through these professionals.
- Covered expenses shall include:
  1. Inpatient hospital confinement;
  2. Individual psychotherapy;
  3. Group psychotherapy;
  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.
- Partial Confinement
  Two (2) days of partial confinement will be considered as one (1) day of inpatient confinement.
- Outpatient
  The Plan will pay the applicable coinsurance, up to a maximum benefit as defined in the Schedule of Benefits, for outpatient services, supplies and treatment related to the treatment of mental and nervous disorders. Physician visits are limited to one (1) per day. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must bill the Plan through these professionals.

CHEMICAL DEPENDENCY

The Plan will pay for the treatment of chemical dependency as shown on the Schedule of Benefits. Benefits shall be payable for inpatient or outpatient treatment in a hospital or treatment center by a physician or professional provider.
Physician visits are limited to one (1) per day. Psychiatrists (M.D.), psychologists (Ph.D.) or counselors (Ph.D.) may bill the Plan directly. Other licensed mental health practitioners must bill the Plan through these professionals.

PODIATRY SERVICES

Covered expenses shall include surgical podiatry services, including incision and drainage of infected tissues of the foot, removal of lesions of the foot, removal or débridement of infected toenails, surgical removal of nail root, and treatment of fractures of dislocations of bones of the foot.

PRIVATE DUTY NURSING

Services of a private duty nurse (R.N., L.P.N., or L.V.N.) shall be a covered expense, provided:

- On an inpatient basis, such care will be covered only when medically necessary and not custodial in nature. The hospital's intensive care unit must be full or the hospital must not have an intensive care unit, for services to be covered
- On an outpatient basis, such care must be medically necessary and not custodial in nature. Outpatient private duty nursing on a twenty-four (24) hour shift basis is not covered.

CHIROPRACTIC CARE

Covered expense includes initial consultation, x-rays and treatment (but not maintenance care), subject to the maximum benefit shown on the Schedule of Benefits.

CARDIAC REHABILITATION PROGRAMS

Cardiac rehabilitation is subject to precertification. Failure to precertify may result in a reduction in benefits. Covered expenses shall include charges for medically necessary cardiac rehabilitation programs when rendered:

- under the supervision of a physician;
- in connection with a myocardial infarction, coronary occlusion, or coronary by-pass surgery;
- initiated within twelve (12) weeks after other treatment for the medical condition ends; and
- in a medical care facility as defined herein.

SURCHARGES

Any excise tax, sales tax, surcharge, (by whatever name called) imposed by a governmental entity for services, supplies and/or treatments rendered by a professional provider; physician; hospital; facility or any other health care provider shall be a covered expense under the terms of the Plan.

MEDICAL EXCLUSIONS

In addition to Plan Exclusions, no benefit will be provided under this Plan for medical expenses for the following:

1. Charges for pre-existing conditions as specified in Effective Date of Coverage, Pre-existing Conditions.
2. Charges for services, supplies or treatment for the reversal of sterilization procedures.
3. Charges for services, supplies or treatment related to the diagnosis or treatment of infertility and artificial reproductive procedures, including, but not limited to: artificial insemination, invitro fertilization, surrogate mother, fertility drugs when used for treatment of infertility, embryo implantation, or gamete intrafallopian transfer (GIFT).
4. Charges for services, supplies or treatment for non-congenital transsexualism, gender dysphoria or sexual reassignment or change, including medications, implants, hormone therapy, surgery, medical or psychiatric treatment.
5. Charges for 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, hospital expenses will be payable commencing on the date of actual surgery.
6. Charges for services, supplies or treatments which are primarily educational in nature; charges for services for educational or vocational testing or training and work hardening programs regardless of diagnosis or symptoms; charges for self-help training or other forms of non-medical self-care.
7. Charges for routine vision examinations and eye refractions; orthoptics; eyeglasses or contact lenses, except as specifically stated under Medical Expense Benefit, Special Equipment and Supplies; dispensing optician's services.
8. Charges for any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia) and astigmatism including radial keratotomy by whatever name called; contact lenses and eyeglasses required as a result of such surgery.
9. Except as medically necessary for the treatment of metabolic or peripheral-vascular illness, charges for routine, palliative or cosmetic foot care, including, but not limited to: treatment of weak, unstable, flat, strained or unbalanced feet; subluxations of the foot; treatment of corns or calluses; non-surgical care of toenails.
10. Charges for services, supplies or treatment which constitute personal comfort or beautification items, whether or not recommended by a physician, such as: television, telephone, air conditioners, air purifiers, humidifiers, electric heating units, orthopedic mattresses, blood pressure instruments, scales, elastic bandages or stockings, non-hospital adjustable beds, exercise equipment.
11. Charges for nonprescription drugs, such as vitamins, cosmetic dietary aids, and nutritional supplements.
12. Expenses for a cosmetic surgery or procedure and all related services, except as specifically stated in Medical Expense Benefit, Cosmetic Surgery.
13. Charges incurred as a result of, or in connection with, cosmetic surgery or any procedure or treatment excluded by this Plan which has resulted in medical complications, except for complications from a non-covered abortion, as specified herein.
14. Charges incurred as a result of, or in connection with, the pregnancy or complications of pregnancy of a dependent child.
15. Charges for services provided to a covered person for an elective abortion. However, complications from such procedure shall be a covered expense for a covered female employee or the covered female spouse of an employee.
16. Charges for services, supplies or treatment primarily for weight reduction or treatment of obesity, including, but not limited to: exercise programs or use of exercise equipment; special diets or diet supplements; appetite suppressants; Nutri/System, Weight Watchers or similar programs; and hospital confinements for weight reduction programs, even if part of a treatment plan for another illness or injury.
17. Charges for surgical weight reduction procedures and all related charges, even if resulting from morbid obesity or as part of a treatment plan for another illness or injury.
18. Charges for services, supplies and treatment for smoking cessation programs, or related to the treatment of nicotine addiction, including smoking deterrent patches, unless medically necessary due to a severe active lung illness such as emphysema or asthma.
19. Charges for examination to determine hearing loss or the fitting, purchase, repair or replacement of a hearing aid or a cochlear implant.
20. Charges for routine or periodic physical examinations, such as employment physical, or any related charges, such as premarital lab work, and other care not associated with treatment or diagnosis of an illness or injury, except as specified herein.
21. Charges for treatment of temporomandibular joint syndrome and myofacial pain syndrome including, but not limited to: charges for treatment to alter vertical dimension or to restore abraded dentition, orthodontia and intra-oral prosthetic devices.
22. Charges for custodial care, domiciliary care or rest cures.
23. Charges for travel or accommodations, whether or not recommended by a physician, except as specifically provided herein.
24. Charges for wigs, artificial hair pieces, artificial hair transplants, or any drug - prescription or otherwise -used to eliminate baldness, except as specified under Medical Expenses Benefit, Special Equipment and Supplies.
25. Charges for any services, supplies or treatment not specifically provided herein.

26. Charges for professional services billed by a physician or Registered Nurse, Licensed Practical Nurse or Licensed Vocational Nurse who is an employee of a hospital or any other facility and who is paid by the hospital or other facility for the service provided.
27. Charges for exercise programs for treatment of any condition, except for physician-supervised cardiac rehabilitation, occupational or physical therapy which is covered by this Plan.
28. A charge for replacement of braces of the leg, arm, back, neck, or artificial arms or legs, unless there is sufficient change in the covered person's physical condition to make the original device no longer functional.
29. Charges for care and treatment for sleep disorders, unless deemed medically necessary.
30. Charges for prescription drugs that are covered under the Prescription Drug Program or for the Prescription Drug copay applicable thereto.
31. Charges for environmental change including hospitalization or physician charges connected with prescribing an environmental change.
32. Charges for room and board in a facility for days on which the covered person is permitted to leave (a weekend pass, for example.)
33. Charges for treatment or surgery for sexual dysfunction.
34. Charges for inpatient room and board in connection with a hospital confinement primarily for diagnostic tests, unless it is determined by the Plan that inpatient care is medically necessary.
35. Charges for biofeedback therapy.
36. Charges for marital counseling.
37. Except as specifically stated in Medical Expense Benefit, Dental Services, charges for or in connection with: treatment of injury or disease of the teeth; oral surgery; treatment of gums or structures directly supporting or attached to the teeth; removal or replacement of teeth; or dental implants.
38. Charges for orthopedic shoes (except when they are an integral part of a leg brace and the cost are included in the orthotist's charge) or shoe inserts.
39. Charges related to acupuncture treatment.
40. Charges for expenses related to hypnosis.
41. Charges for chelation therapy, except as treatment of heavy metal poisoning.
42. Charges for massage therapy, sex therapy, diversional therapy or recreational therapy.
43. Charges for procurement and storage of one's own blood, unless incurred within three (3) months prior to a scheduled surgery.
44. Charges for holistic medicines or providers or naturopathy.
45. Charges for or related to the following types of treatment: primal therapy, rolfing, psychodrama, megavitamin therapy; visual perceptual training.
46. Charges for structural changes to a house or vehicle.

PRESCRIPTION DRUG PROGRAM

PHARMACY OPTION

Participating pharmacies have contracted with the Plan to charge covered persons reduced fees for covered prescription drugs.

- **COPAY**

  The copay is applied to each covered pharmacy drug charge and is shown on the Schedule of Benefits. The copay amount is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a (30) day supply.

  1. If a drug is purchased from a nonparticipating pharmacy or a participating pharmacy when the covered person's ID card is not used, the covered person the amount payable in excess of the copay will be the ingredient cost and dispensing fee.

MAIL ORDER OPTION

The mail order drug benefit option is available for maintenance medications (those that are taken for long periods of time, such as drugs sometimes prescribed for heart disease, high blood pressure, asthma, etc.). Because of volume buying, the mail order pharmacy is able to offer covered person's significant savings on prescriptions.

- **COPAY**

  The copay is applied to each covered mail order prescription charge and is shown on the Schedule of Benefits. It is not a covered expense under the Medical Expense Benefit. Any one prescription is limited to a ninety day (90) supply.

COVERED PRESCRIPTION DRUGS

- All drugs prescribed by a physician that require a prescription either by federal or state law, except injectables (other than insulin and/or injectable contraceptives) and drugs excluded by the Plan.
- All compounded prescriptions containing at least one prescription ingredient with a therapeutic quantity.
- Insulin when prescribed by a physician.
- Oral contraceptives and/or injectable contraceptives.

LIMITS TO THIS BENEFIT

This benefit applies only when a covered person incurs a covered prescription drug charge. The covered drug charge for any one prescription will be limited to:

- Refills only up to the number of times specified by a physician.
- Refills up to one year from the date of order by a physician.

EXPENSES NOT COVERED

- A drug or medicine that can legally be purchased without a written prescription. This does not apply to injectable insulin and the specific categories of medications listed in the Schedule of Benefits.
- Devices of any type, even though such devices may require a prescription. These include, but are not limited to: therapeutic devices, artificial appliances, braces, support garments, or any similar device.
- Immunization agents or biological sera; blood or blood plasma.
- A drug or medicine labeled: "Caution - limited by federal law to investigational use."
- Experimental drugs and medicines, even though a charge is made to the covered person.
- Any charge for the administration of a covered prescription drug.
- Any drug or medicine that is consumed or administered at the place where it is dispensed.
- A drug or medicine that is to be taken by the covered person, in whole or in part, while hospital confined. This includes being confined in any institution that has a facility for dispensing drugs.
- A charge for prescription drugs which may be properly received without charge under local, state or federal programs.
- A charge for hypodermic syringes and/or needles, injectables or any prescription directing administration by injection (other than insulin and injectable contraceptives).
- A charge for infertility medication.
- A charge for contraceptives or contraceptive materials other than oral or injectable contraceptives.
- A charge for any drug not approved by the Food and Drug Administration.

DENTAL EXPENSE BENEFIT

Subject to all the terms of the Plan, the Plan will pay a dental benefit for covered dental expenses incurred by a covered person. The dental benefit is a percentage of the customary and reasonable amount for incurred covered dental expenses, as shown on the Schedule of Benefits.

DEDUCTIBLE

- **Individual Deductible**
  The individual deductible is the dollar amount of covered expense which each covered person must incur during each calendar year before the Plan pays applicable benefits. The individual deductible amount is shown on the Schedule of Benefits.
- **Family Deductible**
  If, in any calendar year, covered members of a family incur covered expenses that are subject to the deductible, equal to or greater than the dollar amount of the family deductible shown on the Schedule of Benefits, the family deductible will be considered satisfied for all family members for that calendar year. Any number of family members may help to meet the family deductible amount, but no more than each person's individual deductible amount may be applied toward satisfaction of the family deductible by any family member.

COINSURANCE

The Plan pays a specified percentage of the customary and reasonable amount for covered expenses. That percentage is listed on the Schedule of Benefits. The covered person is responsible for the difference.

MAXIMUM BENEFIT

The maximum calendar year benefit payable on behalf of a covered person for covered dental expense is stated on the Schedule of Benefits. If the covered person's coverage under the Plan terminates and he subsequently returns to coverage under the Plan during the calendar year, the maximum benefit will be calculated on the sum of benefits paid by the Plan.

- The maximum benefit for orthodontic treatment while a covered person is covered by this Plan is also shown on the Schedule of Benefits.

ALTERNATIVE TREATMENT

In the event the dentist recommends a particular course of treatment and a lower-cost alternative would be as effective, benefits shall be limited to the lower-cost alternative. Any balance remaining, as a result of the covered person's choice to obtain the higher-cost treatment will be the covered person's responsibility.

DENTAL INCURRED DATE

A dental procedure will be deemed to have commenced on the date the covered dental expense is incurred, except as follows:

- For installation of a prosthesis, other than a bridge or crown, on the date the impression was made;
- For a crown, bridge or gold restoration, on the date the tooth or teeth are first prepared;
- For endodontic treatment, on the date the pulp chamber is opened.

There are times when one overall charge is made for all or part of a course of treatment. In this case the claims processor will apportion that overall charge to each of the separate visits or treatments. The pro rata charge will be considered to be incurred as each visit or treatment is completed.

COVERED DENTAL EXPENSES

Subject to the limitations and exclusions, covered dental expenses shall include the necessary services, supplies, or treatment listed below and on the following pages. No dental benefit will be paid for any dental service, supply or treatment which is not on the following list of covered dental expenses.

Diagnostic and Preventive Dental Services

1. Routine oral examination: Initial or periodic, limited to twice per calendar year.
2. Prophylaxis: Scaling and cleaning of teeth, limited to twice per calendar year.
3. Dental x-rays as follows:
   - Bite-wing x-ray series, limited to one (1) every two (2) calendar years.
   - Full mouth x-ray series, limited to one (1) every five (5) calendar year.
4. Topical application of fluoride for dependent children under the age of nineteen (19), limited to one (1) treatment per calendar year.
5. Space maintainers, fixed appliance (not made of precious metals), designed to preserve the space between teeth caused by the premature loss of a primary tooth (also called a baby tooth) including all adjustments within six (6) months of installation, limited

to dependent children under the age of nineteen (19). This does not include space maintainers used in orthodontics to create a space between teeth.

6. Emergency palliative treatment primarily for relief of dental pain, not cure. Only paid as a separate benefit when no other treatment (except x-rays) is rendered during the visit.

Basic Dental Services

1. Dental x-rays not included in Class A.
2. Oral surgery. Oral surgery is limited to removal of teeth, preparation of the mouth for dentures and removal of tooth-generated cysts of less than 1/4 inch.
3. Periodontics (gum treatments).
4. Endodontics (root canals).
5. Extractions. This service includes local anesthesia and routine post-operative care.
6. Recementing bridges, crowns or inlays.
7. Fillings, other than gold.
8. General anesthetics, upon demonstration of medical necessity.
9. Antibiotic drugs.

Major Dental Expenses

1. Gold restorations, including inlays, onlays, and foil fillings. The cost of gold restorations in excess of the cost for amalgam, synthetic porcelain or plastic materials will be included only when the teeth must be restored with gold.
2. Installation of crowns.
3. Installing precision attachments for removable dentures.
4. Installing partial, full or removable dentures to replace one (1) or more natural teeth that were extracted. This service also includes all adjustments made during a six (6) month period following installation.
5. Addition of clasp or rest to existing partial removable dentures.
6. Initial installation of fixed bridgework to replace one (1) or more natural teeth which were extracted.
7. Repair of crowns, bridgework and removable dentures.
8. Re-basing or relining of removable dentures.
9. Replacing an existing removable partial or full denture or fixed bridgework; adding teeth to an existing removable partial denture; or adding teeth to existing bridgework to replace newly extracted natural teeth. However, this item will only apply if one of the following tests is met:
   - The replacement or addition of teeth is required because of one or more natural teeth being extracted;
   - The existing denture or bridgework was installed at least five (5) years prior to its replacement and it cannot currently be made serviceable;
   - The existing denture is of an immediate temporary nature. Further, replacement by permanent dentures is required and must take place within twelve (12) months from the date the temporary denture was installed.

Orthodontic Services (for dependent children under age 19 only)

1. Any dental expense furnished in connection with the orthodontic 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, the fitting, making and placing of the active appliance, and all related office visits including post-treatment stabilization.
4. Comprehensive full-banded and bracketed orthodontic treatment.
5. Fixed or cemented appliance to control harmful habits.

DENTAL EXCLUSIONS

In addition to the Plan Exclusions, no benefit will be provided under this Plan for dental expenses incurred by a covered person for the following:

- Replacement of lost, missing or stolen appliances or prosthetic devices.
- Charges for all services, supplies and treatment related to dental implants, including any appliances and/or crowns and the surgical insertion or removal of implants.
- Any procedure not listed under Covered Dental Expense.
- Services, supplies or treatment that is cosmetic in nature, including charges for personalization or characterization of dentures. Veneers or coverings placed on teeth except when used to return the tooth to normal form and function are considered cosmetic in nature.
- Appliances, restoration 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, except as specified under Orthodontic Services.
- Charges in excess of the least costly plan of treatment when there is more than one accepted method of treatment for a dental condition.
- Charges for services or supplies related to orthognathic surgery.
- Charges for instruction in oral hygiene, plaque control programs or dietary instructions.

- A charge for crowns for teeth that are restorable by other means or for the purpose of periodontal splinting.
- Charges for adjustments of new dentures within six (6) months of installation.
- Any procedure which began before the date the covered person's dental coverage started to include a service which is:
  1. An appliance, or modification of an appliance, for which an impression was made before such person became covered, or
  2. A crown, bridge or gold restoration, for which a tooth was prepared before such person became covered, or
  3. Root canal therapy, for which the pulp chamber was opened before such person became covered.
  4. X-rays and prophylaxis shall not be deemed to start a dental procedure.
- A service not furnished by a dentist, except:
  1. That performed by a licensed dental hygienist under a dentist's supervision;
  2. X-rays ordered by a dentist; and
  3. Denturist.
- Replacement of a prosthetic which in the dentist's opinion can be repaired or does not need replacement.
- 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 that the total charges billed exceed the amount that would have been billed if one dentist had performed all the required dental services.
- Charges for services or supplies related to diagnosis of, or treatment of temporomandibular joint syndrome, by whatever name called.

PLAN EXCLUSIONS

The Plan will not provide benefits for any of the items listed in this section, regardless of medical necessity or recommendation of a physician or professional provider.

1. Charges for services, supplies or treatment from any hospital owned or operated by the United States government or any agency thereof or any government outside the United States, or charges for services, treatment or supplies furnished by the United States government or any agency thereof or any government outside the United States, unless payment is legally required.
2. Charges for an injury sustained or illness contracted while on active duty in military service, unless payment is legally required.
3. Charges for services, supplies or treatment for treatment of illness or injury which is caused by or attributed to by war or any act of war, participation in a riot, civil disobedience or insurrection. "War" means declared or undeclared war, whether civil or international, or any substantial armed conflict between organized forces of a military nature.
4. 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 or fails to enroll or purchase such coverage.
5. Charges in connection with any illness or injury arising out of or in the course of any employment intended for wage or profit, including self-employment.
6. Charges made for services, supplies and treatment which are not medically necessary for the treatment of illness or injury, or which are 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 amount or exceed the negotiated rate as applicable.
7. Charges in connection with any illness or injury of the covered person resulting from or occurring during the covered person's commission or attempted commission of a criminal battery or felony. Claims shall be denied if the plan administrator has reason to believe, based on objective evidence such as police reports or medical records, that a criminal battery or felony was committed by the covered person.
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 expense is incurred.
9. Charges for services rendered and/or supplies received prior to the effective date or after the termination date of a person's coverage.
10. Any services, supplies or treatment for which the covered person is not legally required to pay; or for which no charge would usually be made; or for which such charge, if made, would not usually be collected if no coverage existed; or to the extent the charge for the care exceeds the charge that would have been made and collected if no coverage existed.
11. Charges for services, supplies or treatment that is considered experimental/investigational.
12. Charges for services, supplies or treatment rendered by any individual who is a close relative of the covered person or who resides in the same household as the covered person.
13. Charges for services, supplies or treatment rendered by physicians or professional providers beyond the scope of their license; for any treatment, confinement or service which is not recommended by or performed by an appropriate professional provider.
14. Charges for illnesses or injuries suffered by a covered person due to the action or inaction of any party if the covered person fails to provide information as specified in Subrogation.
15. Claims not submitted within the Plan's filing limit deadlines as specified in Claim Filing Procedures.
16. Charges for services, supplies or treatment to a covered person for an injury which occurred as a result of that covered person's illegal use of alcohol. Eligible expenses will be covered for injured covered persons other than the person illegally using alcohol.
17. Charges for services, supplies or treatment to a covered person for injury resulting from that covered person's voluntary taking of or being under the influence of any controlled substance, drug, hallucinogen, or narcotic not administered on the advice of a physician, except as specified herein. Eligible expenses will be covered for injured covered persons other than the person using controlled substances.
18. Charges for e-mail or telephone consultations, completion of claim forms, charges associated with missed appointments, and medical records or information required to adjudicate a claim.
19. If the primary plan has a restricted list of healthcare providers and the covered person chooses not to use a provider from the primary plan's restricted list, this Plan will not pay for any charges disallowed by the primary plan due to the use of such provider, if shown on the primary carrier's explanation of benefits.
20. This Plan will not pay for any charge which has been refused by another plan covering the covered person as a penalty assessed due to non-compliance with that plan's rules and regulations, if shown on the primary carrier's explanation of benefits.
21. Benefits which are payable under any one section of this Plan shall 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 section and the Dental Expense Benefit section, and is paid under the Medical Expense Benefit, the remaining balance will not be paid under the Dental Expense Benefit.
22. Charges incurred outside the United States if the covered person traveled to such a location for the sole purpose of obtaining services, supplies or treatment.

ELIGIBILITY

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

EMPLOYEE ELIGIBILITY

All full-time employees regularly scheduled to work at least thirty- five (35) hours per work week shall be eligible to enroll for coverage under this Plan. This does not include temporary or seasonal employees.

DEPENDENT(S) ELIGIBILITY

The following describes dependent eligibility requirements. The employer will require proof of dependent status.

- The term "spouse" means the spouse of the employee under a legally valid existing marriage in the state in which the employee resides, unless court ordered separation exists.
- The term "child" means the employee's natural child or stepchild, legally adopted child, foster child, and a child for whom the employee has been appointed legal guardian, provided:
  a. The child is less than twenty six (26) years of age, and;
  b. The child is not eligible to enroll for Health Coverage through their employer.
- An eligible child shall also include any other child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan, even if the child is not residing in the employee's household. Such child shall be referred to as an alternate recipient. Alternate recipients are eligible for coverage regardless of whether the employee elects coverage for himself. An application for enrollment must be submitted to the employer for coverage under this *Plan. The employer/plan administrator shall establish written procedures for determining whether a medical child support order is* a QMCSO or NMSN and for administering the provision of benefits under the Plan pursuant to a valid QMCSO or NMSN. Within a reasonable period after receipt of a medical child support order, the employer/plan administrator shall determine whether such order is a Qualified Medical Child Support Order (as defined in Section 609 of ERISA) or a National Medical Support Notice (NMSN) as defined in Section 401 of the Child Support Performance and Incentive Act of 1998.
- The employer/plan administrator reserves the right, waivable at its discretion, to seek clarification with respect to the order from the court or administrative agency which issued the order, up to and including the right to seek a hearing before the court or agency.
- Upon written notice to the employer, a child who is unmarried, 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'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:
  1. Cessation of the mental and/or physical disability;
  2. Failure to furnish any required proof of mental and/or physical disability or to submit to any required examination.
- 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. Eligible children may be enrolled as dependents of one spouse, but not both.

ENROLLMENT

APPLICATION FOR ENROLLMENT

An employee must file a written application with the employer for coverage hereunder for himself and his eligible dependents within thirty-one (31) days of becoming eligible for coverage; and within thirty-one (31) days of marriage or the acquiring of children or birth of a child, if dependent coverage is not already in place at the time of birth. The employee shall have the responsibility of timely forwarding to the employer all applications for enrollment hereunder.

- The employer must be notified of any change in eligibility of dependents, including the birth of a child that is to be covered and adding or deleting any other dependents. Forms are available from the employer for reporting changes in dependents' eligibility as required.

SPECIAL ENROLLMENT PERIOD (OTHER COVERAGE)

An employee or dependent who did not enroll for coverage under this Plan because he was covered under other group coverage or had health insurance coverage at the time he was initially eligible for coverage under this Plan, may request a special enrollment period if he is no longer eligible for the other coverage. Special enrollment periods will be granted if the individual's loss of eligibility is due to:

- Termination of the other coverage (including exhaustion of COBRA benefits)
- Cessation of employer contributions toward the other coverage
- Legal separation or divorce
- Termination of other employment or reduction in number of hours of other employment
- Death of covered person.

The end of any extended benefits period, which has been provided due to any of the above, will also be considered a loss of eligibility.

- However, loss of eligibility does not include a loss due to failure of the individual to pay premiums or contributions on a timely basis 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.)

The employee or dependent must request the special enrollment and enroll no later than thirty-one (31) days from the date of loss of other coverage.

- The effective date of coverage as the result of a special enrollment shall be the first day of the first calendar month following the Plan administrator's receipt of the completed enrollment form.

SPECIAL ENROLLMENT PERIOD (DEPENDENT ACQUISITION)

An employee who is not covered under the Plan, but who acquires a new dependent may request a special enrollment period. For the purposes of this provision, the acquisition of a new dependent includes:

- marriage
- birth of a dependent child
- adoption or placement for adoption of a dependent child

The employee must request the special enrollment within thirty-one (31) days of the acquisition of the dependent.

- The effective date of coverage as the result of a special enrollment shall be:
  1. in the case of marriage, the first day of the first calendar month following the Plan administrator'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 placement for adoption, the date of such adoption or placement for adoption.

OPEN ENROLLMENT

Open enrollment is the period designated by the employer during which the employee may change benefit plans or enroll in the Plan if he did not do so when first eligible or does not qualify for a Special Enrollment Period. An open enrollment will be permitted once in each calendar year during the month of December. A covered employee who fails to make an election or to change enrollment during the open enrollment period will automatically retain his or her present coverage.

- During this open enrollment period, an employee and his dependents who are covered under this Plan or covered under any employer sponsored health plan may elect coverage under this Plan for himself and his eligible dependents. An employee must make written application as provided by the employer during the open enrollment period to change benefit plans.
- Any person enrolling in this Plan for the first time at open enrollment (not transferring from another employer-sponsored health plan) will be treated as a late enrollee.
- The effective date of coverage as the result of an open enrollment period will be the following January 1.
- Except for a status change listed below, the open enrollment period is the only time an employee may change benefit options or modify enrollment. Status changes include:
  1. Change in family status. A change in family status shall include only:
     - Change in employee's legal marital status;
     - Change in number of dependents;
     - Termination or commencement of employment by the employee, spouse or dependent;

- Change in work schedule;
- Dependent satisfies (or ceases to satisfy) dependent eligibility requirements;
- Change in residence or worksite of employee, spouse or dependent locating them outside the service area of the Preferred Provider Organization or Exclusive Provider Organization.

2. Change in the cost of coverage under the employer's group medical plan.
3. Cessation of required contributions.
4. Taking or returning from a leave of absence under the Family and Medical Leave Act.
5. Significant change in the health coverage of the employee or spouse attributable to the spouse's employment.
6. A Special Enrollment Period as mandated by the Health Insurance Portability and Accountability Act.
7. A court order, judgment or decree.
8. Entitlement to Medicare or Medicaid.
9. A COBRA qualifying event.

EFFECTIVE DATE OF COVERAGE

EMPLOYEE(S) EFFECTIVE DATE

Eligible employees, as described in Eligibility, are covered under the Plan the first day of the month coincident with or following their full time employment date of hire.

DEPENDENT(S) EFFECTIVE DATE

Eligible dependent(s), as described in Eligibility, will become covered under the Plan on the later of the dates listed below, provided the employee has enrolled them in the Plan within thirty-one (31) days of meeting the Plan's eligibility requirements.

- The date the employee's coverage becomes effective.
- The date the dependent is acquired, provided any required contributions are made and the employee has applied for dependent coverage within thirty-one (31) days of the date acquired.
- Newborn children shall be covered from birth, regardless of confinement, provided the employee has applied for dependent coverage within thirty-one (31) days of birth. However, if dependent coverage is in place when a child is born, the newborn shall be automatically added for coverage and no additional enrollment is required.
- Coverage for a newly adopted child shall be effective on the date the child is placed for adoption.

PRE-EXISTING CONDITIONS

Benefits will be provided for pre-existing conditions after the completion of a period of twelve (12) months (eighteen (18) months for a late enrollee) from the covered person's date of enrollment for coverage under this Plan. For the purpose of this provision, the date of enrollment shall mean the first day of any applicable service waiting period or the date of hire. In the case of an employee or dependent that enrolls as the result of a Special Enrollment Period or Open Enrollment Period, the enrollment date shall mean the first day of coverage.

- This ***pre-existing condition*** limitation shall not apply to 1) a child born to or ***placed for adoption*** after the ***employee's effective date*** of coverage under this ***Plan,*** 2) a person covered under this ***Plan*** that is 19 years of age or less, nor to 3) ***pregnancy*** under any circumstances.
- Precertification from the Utilization Review Organization does not constitute Plan liability for any pre-existing condition charges during this waiting period.
- For the purpose of determining whether this pre-existing condition provision of the Plan will be applied to claims for any individual, the Plan administrator will look not only to the period of time the individual has been covered under this Plan, but also to any period of previous creditable coverage the individual has earned. Creditable coverage shall include, but is not limited to, coverage the individual may have had under a prior employer's benefit plan or COBRA, individual or group insurance, Medicare or Medicaid, a state risk pool, or CHAMPUS. Other types of coverage may also be considered creditable coverage. However, creditable coverage will only be applied to this Plan's pre-existing condition time periods if there has been no break in coverage of the individual for more than sixty-three days. If there has been a break in coverage of more than sixty-three days, the Plan administrator will not apply previous coverage towards this Plan's pre-existing condition limitation. Waiting periods for coverage do not count as a break in coverage.
- It is the employee's responsibility to provide the Plan administrator with evidence of creditable coverage. Such evidence may be in the form of a Certificate of Coverage or in any other form acceptable to the Plan administrator.

TERMINATION OF COVERAGE

Except as provided in the Plan's Continuation of Coverage (COBRA) provision, coverage will terminate on the earliest of the following dates:

EMPLOYEE(S) TERMINATION DATE

- The date the employer terminates the Plan and offers no other group health plan.
- The date the employee ceases to meet the eligibility requirements of the Plan.
- The date employment terminates.
- The date the employee becomes a full-time, active member of the armed forces of any country.
- The date the employee ceases to make any required contributions.

DEPENDENT(S) TERMINATION DATE

- The date the employer terminates the Plan and offers no other group health plan.
- The date the employee's coverage terminates. However, if the employee remains eligible for the Plan, but elects to discontinue coverage, coverage may be extended for alternate recipients.
- The date such person ceases to meet the eligibility requirements of the Plan.
- The date the employee ceases to make any required contributions on the dependent's behalf.
- The date the dependent reaches the maximum age limit as stated in Eligibility.
- The date the dependent becomes a full-time, active member of the armed forces of any country.
- The date the Plan discontinues dependent coverage for any and all dependents.
- The date the dependent becomes eligible as an employee.

LEAVE OF ABSENCE

Coverage may be continued for a limited time, contingent upon payment of any required contributions for employees and/or dependents, when the employee is on an authorized leave of absence from the employer. In no event will coverage continue beyond the date the employer ends the continuance.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

- **Eligible Leave**
  An employee who is eligible for unpaid leave and benefits under the terms of the Family and Medical Leave Act of 1993, as amended, has the right to continue coverage under this Plan for up to twelve (12) weeks during any twelve (12) month period.
- **Contributions**
  During this leave, the employer will continue to pay the same portion of the employee's contribution for the Plan. The employee shall be responsible to continue payment for eligible dependent's coverage and any remaining employee contributions. If the covered employee fails to make the required contribution during a FMLA leave within thirty (30) days after the date the contribution was due, the coverage will terminate effective on the date the contribution was due.
- **Reinstatement**
  If coverage under the Plan was terminated during an approved FMLA leave, and the employee returns to active work immediately upon completion of that leave, Plan coverage will be reinstated on the date the employee returns to active work as if coverage had not terminated, provided the employee makes any necessary contributions and enrolls for coverage within thirty-one (31) days of his return to active work.
- **Repayment Requirement**
  The employer may require employees who fail to return from a leave under FMLA to repay any contributions paid by the employer on the employee's behalf during an unpaid 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," as defined in FMLA, or events beyond the employee's control.

CERTIFICATES OF COVERAGE

The Plan administrator shall provide each terminating covered person with a Certificate of Coverage, certifying the period of time the individual was covered under this Plan. For employees with dependent coverage, the certificate provided may include information on all covered dependents. This Plan will at all times comply with the provisions of the Health Insurance Portability and Accountability Act of 1996.

CONTINUATION OF COVERAGE

In order to comply with federal regulations, this Plan includes a continuation of coverage option for certain individuals whose coverage would otherwise terminate. The following is intended to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended.

- The coverage, which may be continued under this provision, consists of health coverage. It does not include life insurance benefits, accidental death and dismemberment benefits, or income replacement benefits. Health coverage includes medical, prescription drug and dental benefits as provided under the Plan.

QUALIFYING EVENTS

Qualifying events are any one of the following events that would cause a covered person to lose coverage under this Plan, even if such coverage is not lost immediately, and allow such person to continue coverage beyond the date described in Termination of Coverage:

- Death of the employee.
- The employee's termination of employment (other than termination for gross misconduct), or reduction in work hours to less than the minimum required for coverage under the Plan.
- Divorce or legal separation from the employee.
- The employee's entitlement to Medicare benefits under Title XVIII of the Social Security Act, if it results in the loss of coverage under this Plan.
- A dependent child no longer meets the eligibility requirements of the Plan.
- The last day of leave under the Family Medical Leave Act of 1993.
- The call-up of an employee reservist to active duty.

NOTIFICATION REQUIREMENTS

- When eligibility for continuation of coverage results from a spouse being divorced or legally separated from a covered employee, or a child's loss of dependent status, the employee or dependent must notify the employer of that event within sixty (60) days of the event. The employee or dependent must advise the date and nature of the qualifying event and the name, address and Social Security number of the affected individual. Failure to provide such notice to the employer will result in the person forfeiting their rights to continuation of coverage under this provision.
- Within fourteen (14) days of a qualifying event, or within fourteen (14) days of receiving notice of a qualifying event, the employee or dependent will be notified of his rights to continuation of coverage, and what process is required to elect continuation of coverage.
- After receiving notice, the employee or dependent has sixty (60) days to decide whether to elect continued coverage. Each person who was covered under the Plan prior to the qualifying event, has the right to elect continuation of coverage on an individual basis, regardless of family enrollment. If the employee or dependent chooses to have continued coverage, he 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. This sixty (60) day period begins on the latter of the following:
  1. The date coverage under the Plan would otherwise end; or
  2. The date the person receives the notice from the employer of his or her rights to continuation of coverage.
- Within forty-five (45) days after the date the person notifies the employer that he has chosen to continue coverage, the person must make the initial payment. The initial payment will be the amount needed to provide coverage from the date continued benefits begin, through the last day of the month in which the initial payment is made. Thereafter, payments for the continued coverage are to be made monthly, and are due in advance, on the first day each month.
- The employee or dependent must make payments for the continued coverage.

COST OF COVERAGE

- The employer requires that covered persons pay the entire costs of their continuation coverage. This must be remitted to the employer or the employer's designated representative, by or before the first day of each month during the continuation period. The payment must be remitted each month in order to maintain the coverage in force.
- For purposes of determining monthly costs for continued coverage, a person originally covered as an employee or as a spouse will pay the rate applicable to an employee if coverage is continued for himself alone. Each child continuing coverage independent of the family unit will pay the rate applicable to an employee.

WHEN CONTINUATION COVERAGE BEGINS

When continuation coverage is elected and the contributions paid within the time period required, coverage is reinstated back to the date of the loss of coverage, so that no break in coverage occurs. Coverage for dependents acquired and properly enrolled during the continuation period begins in accordance with the enrollment provisions of the Plan.

FAMILY MEMBERS ACQUIRED DURING CONTINUATION

A spouse or dependent child newly acquired during continuation coverage is eligible to be enrolled as a dependent. The standard enrollment provision of the Plan applies to enrollees during continuation coverage. A dependent acquired and enrolled after the original qualifying event, other than a child born to or placed for adoption with a covered employee during a period of COBRA continuation coverage, is not eligible for a separate continuation if a subsequent event results in the person's loss of coverage.

SUBSEQUENT QUALIFYING EVENTS

- Once covered under continuation coverage, it is possible for a second qualifying event to occur, including:
  1. Death of an employee.
  2. Divorce or legal separation from an employee.
  3. Employee's entitlement to Medicare.
  4. The child's loss of dependent status.
- If one of these subsequent qualifying events occurs, a dependent 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.
- Only a person covered prior to the original qualifying event or a child born to or placed for adoption with a covered employee during a period of COBRA continuation is eligible to continue coverage again as the result of a subsequent qualifying event. Any other dependent acquired during continuation coverage is not eligible to continue coverage as the result of a subsequent qualifying event.

END OF CONTINUATION

Continuation of coverage under this provision will end on the earliest of the following dates:

- Eighteen (18) months from the date continuation began because of a reduction of hours or termination of employment of the employee.
- Thirty-six (36) months from the date continuation began for dependents whose coverage ended because of the death of the employee, divorce or legal separation from the employee, or the child's loss of dependent status.
- The end of the period for which contributions are paid if the covered person fails to make a payment on the date specified by the employer.
- The date coverage under this Plan ends and the employer offers no other group health benefit plan.
- The date the covered person first becomes entitled to Medicare after the date of election of COBRA continuation coverage.
- The date the covered person first becomes covered under any other group health plan after the date of election of COBRA continuation coverage, with exception of the pre-existing provision below.

PRE-EXISTING CONDITIONS

In the event that a covered person becomes eligible for coverage under another employer-sponsored group health plan, and that group health plan has an exclusion or pre-existing limitation on a condition that is covered by this Plan, the covered person may remain covered under this Plan with continuation of coverage and elect coverage under the other employer's group health plan. This Plan shall be primary payor for the covered expenses that are excluded or limited under the other employer sponsored group health plan and secondary payor for all other expenses.

EXTENSION FOR DISABLED INDIVIDUALS

A person who is totally disabled may extend continuation coverage from eighteen (18) months to twenty-nine (29) months. The person must be disabled for Social Security purposes at the time of the qualifying event or within sixty (60) days thereafter. The disabled person must submit proof of the determination of disability by the Social Security Administration to the employer within the initial eighteen (18) month continuation coverage period and no later than sixty (60) days after the Social Security Administration's determination. The employer may charge 150% of the contribution during the additional eleven (11) months of continuation of coverage.

MILITARY MOBILIZATION

If an employee or an employee's dependent is called for active duty by the United States Armed Services (including the Coast Guard), the National Guard or the Public Health Service, the employee or the employee's dependent may continue their health coverages, pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA).

- When the leave is less than thirty-one (31) days, the employee or employee's dependent may not be required to pay more than the employee's share, if any, applicable to that coverage. If the leave is more than thirty-one (31) days, then the employer may require the employee or employee's dependent to pay no more than 102% of the full contribution.
- The maximum length of the continuation coverage required under the Uniformed Services Employment and Reemployment Rights Act (USERRA) is the lesser of:
  1. Eighteen (18) months beginning on the day that the leave commences, or

2. A period beginning on the day that the leave began and ending on the day after the employee fails to return to employment within the time allowed.

- The employee or the employee's dependent coverage will be reinstated without exclusions or a waiting period.

TRADE ADJUSTMENT ASSISTANCE

If a covered person's coverage under this Plan terminates due to circumstances which would qualify that covered person for trade adjustment assistance (TAA) under the terms of the Trade Act of 1974 (19 U.S.C. 2101 et seq.) which covers workers whose employment has been adversely affected by international trade – increased imports or a shift in production to another county, and that covered person did not elect to continue coverage under the Continuation of Coverage provisions of this Plan during his or her initial sixty (60) day election period as specified herein, a second sixty (60) day election period will be granted. This second sixty (60) day election period shall begin on the first day of the month in which the covered person is determined to be a TAA-eligible individual. However, the election to continue coverage under this provision of the Plan cannot be made more than six (6) months after the date of the TAA-related loss of coverage.

- If continued coverage is elected under this provision of the Plan, such coverage shall begin on and any applicable COBRA time frames shall be measured from the first day of the second election period and not on the date of the original qualifying event. All other requirements for continued coverage under the COBRA provisions of this Plan shall apply.
- Any time between the date of the original qualifying event and the first day of the second election period shall NOT count towards any determination of whether the individual has experienced a "break in coverage" (See Effective Date of Coverage, Pre-existing Conditions.)

CLAIM FILING PROCEDURE

A claim for benefits is any request for a benefit, which is provided by this Plan made by a covered person or the authorized representative of a covered person, which complies with the Plan's procedures for making claims. Claims for health care benefits are one of two types: pre-service claims or post-service claims.

- Pre-service claims are claims for services for which preapproval must be received before services are rendered in order for benefits to be payable under this Plan, such as those services listed in the section Utilization Review. A pre-service claim is considered to be filed whenever the initial contact or call is made by the covered person, provider or authorized representative to the Utilization Review Organization, as specified in Utilization Review.
- Post-service claims are those for which services have already been received (any claims other than pre-service claims).
- If the covered person would like the Plan administrator/claims processor to deal with someone other than them regarding a claim for benefits then the covered person must provide the Plan administrator with a written authorization in order for an authorized representative (other than the employee) to represent and act on behalf of the covered person. The covered person must consent to release information related to the claim to the authorized representative.

FILING A PRE-SERVICE CLAIM

A pre-service claim begins when the covered person, provider, or the covered person's authorized representative makes a call to the Utilization Review Organization to precertify specified services, supplies or treatment. See Utilization Review for specific details regarding the services which require precertification, the number to call, and time frames for making the precertification call.

- If a call is made to the Utilization Review Organization that fails to follow the precertification procedure as specified in Utilization Review, but at least identifies the name of the patient, a specific medical condition or symptom and the specific treatment, service or product for which precertification is being requested, the covered person or the covered person's authorized representative will be orally notified (in writing, if requested) within five (5) calendar days (twenty-four (24) hours in the case of Urgent Care Claims) of the failure to follow correct procedures.
- Pre-service claims fall into three categories: Precertification Claims, Urgent Care Claims or Concurrent Care Claims.
    1. A Precertification Claim is a claim for any services for which the Plan requires precertification, however the services which are required are not services which would qualify as Urgent Care Claims, as defined below.
    2. Urgent Care Claims are claims for services which require precertification, however, the services are of such a nature such that the application of the longer time periods for making Precertification Claim determinations could seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function, or – in the opinion of a physician with knowledge of the patient's medical condition – would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.
    3. Concurrent Care Claims are claims for continuing care for which additional services are being requested or claims for which benefits for additional care are being reduced or terminated.

TIME FRAME FOR BENEFIT DETERMINATION OF A PRE-SERVICE CLAIM

When a pre-service claim has been submitted to the Plan (call made to the Utilization Review Organization) and no additional information is required, the Plan will generally complete its determination of the claim within the following timeframes:

- Precertification Claims – within a reasonable time frame, but no later than fifteen (15) calendar days from receipt of claim;
- Urgent Care Claims – within a reasonable time frame, but no later than seventy-two (72) hours following receipt of claim;
- Concurrent Care Claims – if a request for an extension of an on-going course of treatment is received, determination will be made as follows:
    1. If the request for additional care is of an urgent care nature and the request is made at least twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within twenty-four (24) hours of the request. If the request is made less than twenty-four (24) hours prior to the end of the course of treatment, the determination must be made within seventy-two (72) hours of the request;
    2. For non-urgent care, the determination must be made within fifteen (15) calendar days after the request is received.
- When a pre-service claim has been submitted to the Plan and additional information is needed in order to determine whether and to what extent, services are covered or benefits are payable by the Plan, then the Plan administrator or its designee (Utilization Review Organization), shall notify the covered person as follows:
    1. If the pre-service claim is for care of an urgent care nature, the Plan administrator or its designee shall notify the covered person as soon as possible, but no later than twenty-four (24) hours after the initial call, of the specific information necessary to complete the claim. The covered person or authorized representative will have forty-eight (48) hours to provide the requested information and the Plan administrator or its designee will complete the claim determination no later than forty-eight (48) hours after receipt of the requested information. Failure of the covered person to respond in a timely and complete manner will result in a denial of the precertification request.
    2. If the pre-service claim is for non-urgent care or if an extension of time is required due to reasons beyond the control of the Plan administrator or its designee, the Plan administrator or its designee will, within fifteen (15) calendar days from the date

of the initial call, provide the covered person or the covered person's authorized representative with a notice detailing the circumstances and the date by which the Plan administrator, or its designee, expects to render a decision. If additional information is required, the notice will provide details of what information is needed and the covered person will have forty-five (45) days to provide the requested information. The Plan administrator, or its designee, will complete its determination of the claim no later than fifteen (15) calendar days following receipt of the requested information. Failure to respond in a timely and complete manner will result in a denial of the precertification request.

NOTICE OF PRE-SERVICE CLAIM BENEFIT DENIAL

If the pre-service claim for benefits is denied, the Plan administrator or its designee shall provide the covered person or authorized representative with a written notice of benefit denial within the time frames listed above.

- The notice will contain the following:
  1. Explanation of the denial, including:
     - The specific reasons for the denial;
     - Reference to the Plan provisions on which the denial is based;
     - A description of any additional material or information necessary and an explanation of why such material or information is necessary;
     - A description of the Plan's review procedure and applicable time limits;
     - A statement that if the covered person's appeal (See "Appealing a Denied Claim" below) is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
  2. If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either
     - A copy of that criterion, or
     - A statement that such criterion was relied upon and will be supplied free of charge, upon request
  3. If denial was based on medical necessity, experimental treatment or similar exclusion or limit, the Plan will supply either
     - An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person's medical circumstances, or
     - A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED PRE-SERVICE CLAIM

The Named Fiduciary for purposes of an appeal of a pre-service claim as described in U. S. Department of Labor Regulations 2560.503-1 is the Utilization Review Organization.

- A covered person, or the covered person's authorized representative, may request a review of a denied claim by making written (for any claim involving urgent care, the request may be verbal) request to the Named Fiduciary within one hundred eighty (180) calendar days from receipt of notification of the denial. The written request should state the reasons the covered person feels the claim should not have been denied. The following describes the review process:
  1. The covered person has a right to submit documents, information and comments
  2. The covered person has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information.
     - Relied on in making the benefit determination; or
     - That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon; or
     - That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions; or
     - That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person's diagnosis, even if not relied upon.
  3. The review shall take into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
  4. The review by the Named Fiduciary will not afford deference to the original denial.
  5. The Named Fiduciary will not be
     - The individual who originally denied the claim, nor
     - Subordinate to the individual who originally denied the claim
  6. If the original denial was, in whole or in part, based on medical judgment:
     - The Named Fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
     - The professional provider utilized by the Named Fiduciary will be neither
     - An individual who was considered in connection with the original denial of the claim, nor
     - A subordinate of any other professional provider who was considered in connection with the original denial.
     - If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR PRE-SERVICE CLAIMS ON APPEAL

The Named Fiduciary shall provide the covered person or authorized representative with a written notice of the appeal decision within the following timeframes:

- Urgent Care Claims or Concurrent Care Claims involving urgent care – as soon as possible, but not later than seventy-two (72) hours from receipt of appeal;
- Precertification Claims or Concurrent Care Claims involving non-urgent care – as soon as possible, but not later than fifteen (15) calendar days from receipt of appeal;

If the appeal is denied, the notice will contain the following:

- Explanation of the denial including:
  1. The specific reasons for the denial
  2. Reference to specific Plan provisions on which the denial is based
  3. A statement that the covered person has the right to access, free of charge, information relevant to the claim for benefits.
  4. A statement that if the covered person's appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
- If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:
  1. A copy of that criterion, or
  2. A statement that such criterion was relied upon and will be supplied free of charge, upon request
- If the denial was based on medical necessity, experimental treatment or similar exclusion or limit, the Notice will supply either:
  1. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person's medical circumstances, or
  2. A statement that such explanation will be supplied free of charge, upon request

FILING A POST-SERVICE CLAIM

A claim form is to be completed on each covered family member at the beginning of the calendar year and for each claim involving an injury. Appropriate claim forms are available from the Human Resources Department.

- Claims should be submitted to:
  Lockard & Williams Insurance Services, P.A.
  PO Box 1688
  Pascagoula, MS 39568-1688
- All bills submitted for benefits must contain the following:
  1. Name of patient.
  2. Patient's date of birth.
  3. Name of employee.
  4. Address of employee.
  5. Name of employer.
  6. Name, address and tax identification number of provider.
  7. Employee Social Security number.
  8. Date of service.
  9. Diagnosis.
  10. Description of service and procedure number.
  11. Charge for service.
  12. The nature of the accident, injury or illness being treated.
- Properly completed claims not submitted within one (1) year 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. However, it is ultimately the covered person's responsibility to make sure the claim has been filed for benefits.

TIME FRAME FOR BENEFIT DETERMINATION OF A POST-SERVICE CLAIM

When a completed claim has been submitted to the claims processor and no additional information is required, the claims processor will generally complete its determination of the claim within thirty (30) calendar day of receipt of the completed claim, unless an extension of time is necessary due to circumstances beyond the Plan's control.

- When a completed claim has been submitted to the claims processor and additional information is required for determination of the claim, the claims processor will provide the covered person or authorized representative with a notice detailing the information needed.
- This notice will be provided within thirty (30) calendar days of receipt of the completed claim and will indicate the date when the claims processor expects to make a decision, if the requested information is received.
- The covered person will have forty-five (45) calendar days to provide the information requested, and the claims processor will complete its determination of the claim within fifteen (15) calendar days of receipt of the requested information.
- Failure to respond in a timely and complete manner will result in a denial of benefit payment.

NOTICE OF POST-SERVICE CLAIM BENEFIT DENIAL

If the post-service claim for benefits is denied, the Plan administrator or their designee shall provide the covered person or authorized representative with a written notice of benefit denial within thirty (30) calendar days of receipt of a completed claim, or if the Plan had requested additional information from the covered person or authorized representative, within fifteen (15) calendar days of receipt of such information. The notice will contain the following:

- Explanation of the denial, including:
  1. The specific reasons for the denial;
  2. Reference to the Plan provisions on which the denial is based
  3. A description of any additional material or information necessary and an explanation of why such material or information is necessary
  4. A description of the Plan's review procedure and applicable time limits
  5. A statement that if the employee's appeal (See "Appealing a Denied Claim" below) is denied, the employee has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
- If an internal rule, guideline, protocol or other similar criterion was relied upon, the Notice will contain either
  1. A copy of that criterion, or
  2. A statement that such criterion was relied upon and will be supplied free of charge, upon request
- If the denial was based on medical necessity, experimental treatment or similar exclusion or limit, the Plan will supply either
  1. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the covered person's medical circumstances, or
  2. A statement that such explanation will be supplied free of charge, upon request

APPEALING A DENIED POST-SERVICE CLAIM

The "Named Fiduciary" for purposes of an appeal of a post-service claim as described in U. S. Department of Labor Regulations 2560.503-1 (issued November 21, 2000) is the claims processor.

- A covered person, or the covered person's authorized representative, may request a review of a denied claim by making written request to the "Named Fiduciary" within one hundred eighty (180) calendar days from receipt of notification of the denial. The request for review should state the reasons the covered person feels the claim should not have been denied.
- The review process is as follows:
  1. The covered person has a right to submit documents, information and comments
  2. The covered person has the right to access, free of charge, information relevant to the claim for benefits. Relevant information is defined as any document, record or other information:
     - Relied on in making the benefit determination, OR
     - That was submitted, considered or generated in the course of making a benefit determination, whether or not relied upon, OR
     - That demonstrates compliance with the duties to make benefit decisions in accordance with plan documents and to make consistent decisions, OR
     - That constitutes a statement of policy or guidance for the Plan concerning the denied treatment or benefit for the covered person's diagnosis, even if not relied upon.
  3. The review takes into account all information submitted by the covered person, even if it was not considered in the initial benefit determination.
  4. The review by the Named Fiduciary will not afford deference to the original denial.
  5. The Named Fiduciary will not be
     - The individual who originally denied the claim, nor
     - Subordinate to the individual who originally denied the claim
  6. If original denial was, in whole or in part, based on medical judgment,
     - The Named Fiduciary will consult with a professional provider who has appropriate training and experience in the field involving the medical judgment.
     - The professional provider utilized by the Named Fiduciary will be neither
     - An individual who was considered in connection with the original denial of the claim, nor
     - A subordinate of any other professional provider who was considered in connection with the original denial.
     - If requested, the Named Fiduciary will identify the medical or vocational expert(s) who gave advice in connection with the original denial, whether or not the advice was relied upon.

NOTICE OF BENEFIT DETERMINATION FOR POST-SERVICE CLAIM APPEAL

The Plan administrator or their designee shall provide the covered person or authorized representative with a written notice of the appeal decision within sixty (60) calendar days of receipt of a written request for the appeal. If the appeal is denied, the notice will contain the following:

- An explanation of the denial including:
  1. The specific reasons for the denial
  2. Reference to specific Plan provisions on which the denial is based
  3. A statement that the covered person has the right to access, free of charge, information relevant to the claim for benefits.
  4. A statement that if the covered person's appeal is denied, the covered person has the right to bring a civil action under section 502 (a) of the Employee Retirement Income Security Act of 1974.
- If an internal rule, guideline, protocol or other similar criterion was relied upon the Notice will contain either:
  1. A copy of that criterion, or
  2. A statement that such criterion was relied upon and will be supplied free of charge, upon request
- If the denial was based on medical necessity, experimental treatment or similar exclusion or limit, will supply either
  1. An explanation of the scientific or clinical judgment, applying the terms of the Plan to the patient's medical circumstances, or
  2. A statement that such explanation will be supplied free of charge, upon request.

EXTERNAL REVIEW PROCESS

- **Scope**
  1. The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.
  2. The Federal external review process applies only to:
     (a) An Adverse Benefit Determination (including a final internal Adverse Benefit Determination) by a plan or issuer that involved medical judgement (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is experimental or investigational), as determined by the external reviewer; and
     (b) A rescission of coverage (whether or not the rescission has any effect on any particular benefit at the time).

- **Standard external review**

  Standard external review is external review that is not considered expedited (as described in paragraph B of this section).

  1. Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within four (4) months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. IF there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.
  2. Preliminary review. Within five (5) business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
     (a) The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
     (b) The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
     (c) The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations; and
     (d) The claimant has provided all the information and forms required to process an external review.

  Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

  3. Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims

Processor to contract with, on its behalf) at least three (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

4. Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or final internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

- **Expedited external review**

1. Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   (a) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   (b) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continue stay, or health care item or service for which the claimant received emergency services, but has not been discharged from a facility.
2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth in paragraph A.2 above for standard external review. The Plan will immediately send a notice that meets the requirements set forth in paragraph A.2 above for standard external review to the claimant of its eligibility determination.
3. Referral to independent review organization. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth in paragraph A.3 above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or final internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.
4. Notice of final external review decision. The Plan's (or Claim Processor's) contract with the assigned IRO will require the IRO will require the IRO to provider notice of the final external review decision, in accordance with the requirements set forth in paragraph A.3 above, as expeditiously as the claimant's medical condition or circumstances required, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

FOREIGN CLAIMS

In the event a covered person incurs a covered expense in a foreign country, the covered person shall be responsible for providing the following to the claims processor before payment of any benefits due are payable:

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

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 Plan(s). 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 secondary plan, 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). If another plan provides benefits in the form of services rather than cash, the reasonable value of the service rendered shall be deemed the benefit paid.

DEFINITIONS APPLICABLE TO THIS PROVISION

"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 expenses contained in the "Exclusions" sections of this Plan.

- When this Plan is secondary, "Allowable Expense" will include any deductible or coinsurance amounts not paid by the Other Plan(s).
- When this Plan is secondary, "Allowable Expense" shall 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 contracted amount and the provider's regular billed charge.
- "Other Plan" means any plan, policy or coverage providing benefits or services for, or by reason of medical, dental or vision 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;
    2. Hospital or medical service organization 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. A licensed Health Maintenance Organization (HMO);
    4. Any coverage under a government program and any coverage required or provided by any statute;
    5. Group automobile insurance;
    6. Individual automobile insurance coverage based upon the principles of "No-fault" coverage;
    7. Any plan or policies funded in whole or in part by an employer, or deductions made by an employer from a person's compensation or retirement benefits;
    8. Labor/management trusteed, union welfare, employer organization, or employee benefit organization plans.
- "This Plan" shall mean that portion of the employer's Plan which provides 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 this Plan.

EFFECT ON BENEFITS

This provision shall 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 that the sum of benefits paid by all plans does not exceed 100% of total Allowable Expense.

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

AUTOMOBILE LIMITATIONS

When medical payments are available under vehicle insurance, the Plan shall pay excess benefits only, without reimbursement for vehicle plan deductibles. The Plan shall always be considered the secondary carrier regardless of the individual's election under personal injury protection with the auto insurance carrier.

ORDER OF BENEFIT DETERMINATION

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

- No Coordination of Benefits Provision
- If the Other Plan contains no provisions for coordination of benefits, then its benefits shall be paid before all Other Plan(s).
- Member/Dependent
- The plan which covers the claimant as a member (or named insured) pays as though no Other Plan existed. Remaining covered expenses are paid under a plan which covers the claimant as a dependent.
- 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.

- Dependent Children of Separated or Divorced Parents
- When parents are separated or divorced, the birthday rule does not apply, instead:
  1. 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 married to that parent, if any, pays second. The plan of the other natural parent pays third. The plan of the spouse of the other natural parent pays fourth.
  2. In the absence of such a court decree, the plan of the parent with custody pays first. The plan of the stepparent married to the parent with custody, if any, pays second. The plan of the parent without custody pays third. The plan of the spouse of the parent without custody pays fourth.
- Active/Inactive

  The plan covering a person as an active (not laid off or retired) employee, or as that person's dependent pays first. The plan covering that person as a laid off or retired employee, or as that person's dependent pays second.
- Limited Continuation of Coverage

  If a person is covered under another group health plan, but is also covered under this Plan for continuation of coverage due to the Other Plan's limitation for pre-existing conditions or exclusions, the Other Plan shall be primary for all covered expenses which are not related to the pre-existing condition or exclusions. This Plan shall be primary for the pre-existing condition only.
- Longer/Shorter Length of Coverage

  If none of the above rules determine the order of benefits, the plan covering a person longer pays first. The plan covering that person for a shorter time pays second.

LIMITATIONS ON PAYMENTS

In no event shall 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 shall entitle the covered person to benefits in excess of the total maximum benefits of this Plan during the claim determination period. The covered person shall refund to the employer any excess it may have paid.

RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

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

FACILITY OF BENEFIT PAYMENT

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

SUBROGATION

The Plan maintains the right to seek reimbursement on its own behalf: the right of subrogation. The Plan also reserves the right to reimbursement upon a covered person's (a covered employee or a covered dependent) receipt of settlement, judgment, or award: the right of reimbursement. The Plan reserves the right of recovery, either by subrogation or reimbursement, for covered expenses payable by the Plan which are a result of illness or injury. The Plan shall be reimbursed from the first monies recovered as the result of judgment, settlement or otherwise. (This is known as "Pro tanto" subrogation.) This right includes the Plan's right to receive reimbursement from uninsured or underinsured motorist coverage and no-fault coverage.

- Accepting benefits from this Plan automatically assigns to it any rights the covered person may have to recover benefits from any party, including an insurer or another group health program. This right of recovery allows the Plan to pursue any claim which the covered person may have against any party, group health program or insurer, whether or not the covered person chooses to pursue that claim. This includes a right to recover from no-fault auto insurance carriers in a situation where no third party may be liable, or from any uninsured or underinsured motorist coverage where the recovery was triggered by the actions of a party which caused or contributed to the payment of benefits under this Plan. This also includes a right to recover from amounts the covered person received from workers' compensation, whether by judgment or settlement, where the Plan has paid benefits prior to a determination that the medical expenses arose out of and in the course of employment. Payment by workers' compensation will be presumed to mean that such a determination has been made.
- If a covered person is involved in an automobile accident, or suffers an illness or injury that was due to the action or inaction of any party, the Plan may advance payment in order to prevent any financial hardship to the covered person. Acceptance of Plan benefits acknowledges (1) the obligation of the covered person to help the Plan to recover benefits it has paid out on behalf of the covered person, and (2) to provide the Plan with information concerning: any automobile insurance, any other group health program which may be obligated to pay benefits on behalf of the covered person, and the insurance of any other party involved. The covered person is required to cooperate fully in the Plan's exercise of its right to recovery and the covered person cannot do anything to prejudice those rights. Such cooperation is required as a condition of receiving benefits under the Plan. The Plan administrator may refuse to pay benefits, or cease to pay benefits, on behalf of a covered person who fails to sign any document deemed by the Plan administrator to be relevant to protecting its subrogation rights or fails to provide relevant information when requested. The term information includes any documents, insurance policies, police reports, or any reasonable request by the claims processor or Plan administrator to enforce the Plan's rights.
- Whether the covered person or the Plan makes a claim directly against any party, group health program or insurance company for the benefit payments made on behalf of a covered person by the Plan, the Plan has a lien on any amount the covered person recovers or could recover from any party, insurance company, or group health program whether by judgment, settlement, or otherwise, and whether or not designated as payment for medical expenses. This lien shall remain in effect until the Plan acknowledges and agrees upon payment to the Plan and releases its lien. The lien may not be for an amount greater than the amount of benefits paid under the Plan.
- The Plan administrator has delegated to the claims processor the right to perform ministerial functions required to assert the Plan's rights; however, the Plan administrator shall retain discretionary authority with regard to asserting the Plan's right of recovery.

THIS PLAN AND MEDICARE

Individuals who have earned the required number of quarters for Social Security benefits within the specified time frame are eligible for Medicare Part A at no cost. Participation in Medicare Part B is available to all individuals who make application and pay the full cost of the coverage. 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.

- 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.
- 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.
- If the employee and/or dependent are also enrolled in Medicare, this Plan shall pay as the primary plan. Medicare will pay as secondary plan.
- If the employee and/or dependent elect to discontinue health coverage under this Plan and enroll under the Medicare program, no benefits will be paid under this Plan. Medicare will be the only payor.

GENERAL PROVISIONS

ADMINISTRATION OF THE PLAN

The Plan is administered through the Human Resources Department of the employer. The employer is the Plan administrator. The Plan administrator shall have full charge of the operation and management of the Plan. The employer has retained the services of an independent claims processor experienced in claims review.

- The employer is the named fiduciary of the Plan for all purposes except claim appeals, as specified in Claim Filing Procedure. As fiduciary, the employer maintains discretionary authority with respect to those responsibilities for which it has been designated named fiduciary, including, but not limited to, interpretation of the terms of the Plan, and determining 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 shall 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 of benefits shall be binding on the Plan unless the claims processor is notified in writing of such assignment prior to payment hereunder.

- Preferred providers or exclusive providers normally bill the Plan directly. If services, supplies or treatment has been received from such a provider, benefits are automatically paid to that provider. The covered person's portion of the negotiated rate, after the Plan's payment, will then be billed to the covered person by the preferred provider or exclusive provider.
- This Plan will pay benefits to the responsible party of an alternate recipient as designated in a qualified medical child support order.

BENEFITS NOT TRANSFERABLE

Except as otherwise stated herein, 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 claims processor shall operate to defeat any of the rights, privileges, services, or benefits of any employee or any dependent(s) hereunder, nor create or continue coverage which 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. However, if more than six (6) months has elapsed prior to discovery of any error, any adjustment of contributions shall be waived. No party shall be liable for the failure of any other party to perform.

CONFORMITY WITH STATUTE(S)

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

EFFECTIVE DATE OF THE PLAN

The original effective date of this Plan was October 1, 1997. The effective date of the modifications contained herein is October 1, 2003.

FREE CHOICE OF HOSPITAL AND PHYSICIAN

Nothing contained in this Plan shall in any way or manner restricts or interferes with the right of any person entitled to benefits hereunder to select a hospital or to make a free choice of the attending physician or professional provider. However, benefits will be paid in accordance with the provisions of this Plan, and the covered person will have higher out-of-pocket expenses if the covered person uses the services of a nonpreferred provider.

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 and in the absence of written evidence to the Plan of the qualification of a guardian or personal representative for his estate, the employer may on behalf of the Plan, at his discretion, make any and all such payments to the provider of services or other person providing for the care and support of such person. Any payment so made will constitute a complete discharge of the Plan's obligation to the extent of such payment.

INCONTESTABILITY

All statements made by the employer or by the employee covered under this Plan shall be deemed representations and not warranties. Such statements shall not void or reduce the benefits under this Plan or be used in defense to a claim unless they are contained in writing and

signed by the employer or by the covered person, as the case may be. A statement made shall 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.

LEGAL ACTIONS

No action at law or in equity shall be brought to recover on the benefits from the Plan prior to the expiration of sixty (60) days after all information on a claim for benefits has been filed and the appeal process has been completed in accordance with the requirements of the Plan. No such action shall be brought after the expiration of two (2) years from the date the expense was incurred, or one (1) year from the date a completed claim was filed, whichever occurs first.

LIMITS ON LIABILITY

Liability hereunder is limited to the services and benefits specified, and the employer shall not be liable for any obligation of the covered person incurred in excess thereof. The employer shall not be liable for the negligence, wrongful act, or omission of any physician, professional provider, hospital, or other institution, or their employees, or any other person. The liability of the Plan shall be limited to the reasonable cost of covered expenses and shall not include any liability for suffering or general damages.

LOST DISTRIBUTEES

Any benefit payable hereunder shall be deemed forfeited if the Plan administrator is unable to locate the covered person to whom payment is due, provided, however, that such benefits shall be reinstated if a claim is made by the covered person for the forfeited benefits within the time prescribed in Claim Filing Procedure.

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") either in enrolling that individual as a covered person or in determining or making any payment of benefits to that individual. 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 which provides that the State has acquired the rights with respect to such individual to payment for such services, supplies or treatment under the Plan.

MISREPRESENTATION

If the covered person or anyone acting on behalf of a covered person makes a false statement on the application for enrollment, or withholds information with intent to deceive or affect the acceptance of the enrollment application or the risks assumed by the Plan, or otherwise misleads the Plan, the Plan shall be entitled to recover its damages, including legal fees, from the covered person, or from any other person responsible for misleading the Plan, 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.

PHYSICAL EXAMINATIONS REQUIRED BY THE PLAN

The Plan, at its own expense, shall have the right to require an examination of a person covered under this Plan when and as often as it may reasonably require during the pendency of a claim.

PLAN IS NOT A CONTRACT

The Plan shall not be deemed to constitute a contract between the employer and any employee or to be a consideration for, or an inducement or condition of, the employment of any employee. Nothing in the Plan shall be deemed to give any employee the right to be retained in the service of the employer or to interfere with the right of the employer to 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 which affect covered persons will be communicated to the covered persons. Any such amendments shall be in writing, setting forth the modified provisions of the Plan, the effective date of the modifications, and shall be signed by the employer's designee.

Such modification or amendment shall be duly incorporated in writing into the master copy of the Plan on file with the employer, or a written copy thereof shall be deposited with such master copy of the Plan. Appropriate filing and reporting of any such modification or amendment with governmental authorities and to covered persons shall be timely made by the employer.

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 covered persons.

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

PRONOUNS

All personal pronouns used in this Plan shall include either gender unless the context clearly indicates to the contrary.

RECOVERY FOR OVERPAYMENT

Whenever payments have been made from the Plan in excess of the maximum amount of payment necessary, the Plan will have the right to recover these excess payments. If the company makes any payment that, according to the terms of the Plan, should not have been made, the Plan may recover that incorrect payment, whether or not it was made due to the Company's own error, from the person or entity to whom it was made or from any other appropriate party.

STATUS CHANGE

If an employee or dependent has a status change while covered under this Plan (i.e. dependent to employee, COBRA to Active) and no interruption in coverage has occurred, the Plan will provide continuance of coverage with respect to any pre-existing condition limitation, deductible(s), coinsurance and maximum benefit.

TIME EFFECTIVE

The effective time with respect to any dates used in the Plan shall be 12:00 a.m. (midnight) as may be legally in effect at the address of the Plan administrator.

WORKERS' COMPENSATION NOT AFFECTED

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

DEFINITIONS

- ***Alternate Recipient***
  Any child of an employee or their spouse who is recognized in a Qualified Medical Child Support Order (QMCSO) or National Medical Support Notice (NMSN) which has been issued by any court judgment, decree, or order as being entitled to enrollment for coverage under this Plan.
- ***Ambulatory Surgical Facility***
  A facility provider with an organized staff of physicians which has been approved by the Joint Commission on the Accreditation of Healthcare Organizations, or by the Accreditation Association for Ambulatory Health, Inc. or by the Plan, which:
  1. Has permanent facilities and equipment for the purpose of performing surgical procedures on an outpatient basis;
  2. Provides treatment by or under the supervision of physicians and nursing services whenever the covered person is in the ambulatory surgical facility;
  3. Does not provide inpatient accommodations; and
  4. Is not, other than incidentally, a facility used as an office or clinic for the private practice of a physician.
- ***Authorized Representative***
  An individual who the covered person has authorized (in writing) to represent or act on their behalf with regards to a claim. An assignment of benefits does not constitute a written authorization for a provider to act as an authorized representative of a covered person.
- ***Birthing Center***
  A facility that meets professionally recognized standards and all of the following tests:
  1. It mainly provides an outpatient setting for childbirth following a normal, uncomplicated pregnancy, in a home-like atmosphere.
  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 situations.
  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 covered persons are at the facility.
  4. If it is not part of a hospital, it has written agreement(s) with a local hospital(s) and a local ambulance company for the immediate transfer of covered persons who develop complications or who require either pre or post-natal care.
  5. It admits only covered persons who: (a) have undergone an educational program to prepare them for the birth; and (b) have medical records of adequate prenatal care.
  6. It schedules confinements of not more than twenty-four (24) hours for a birth.
  7. It maintains medical records for each covered person.
  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.
- ***Chemical Dependency***
  A physiological or psychological dependency, or both, on a controlled substance and/or alcoholic beverages. It is characterized by a frequent or intense pattern 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 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.
- ***Chiropractic Care***
  Services as provided by a licensed Chiropractor, M.D., or D.O. for manipulation or manual modalities in the treatment of the spinal column, neck, extremities or other joints, other than for a fracture or surgery.
- ***Claims Processor***
  The company contracted by the employer which is responsible for the processing of claims for benefits under the terms of the Plan and other ministerial services deemed necessary for the operation of the Plan as delegated by the employer.
- ***Close Relative***
  The employee's spouse, children, brothers, sisters, or parents; or the children, brothers, sisters or parents of the employee's spouse.
- ***Coinsurance***
  The benefit percentage of covered expenses payable by the Plan for benefits that are provided under the Plan. The coinsurance is applied to covered expenses after the deductible(s) have been met, if applicable.
- ***Complications of Pregnancy***
  A disease, disorder or condition which is diagnosed as distinct from pregnancy, but is adversely affected by or caused by pregnancy. Some examples are:
  1. Intra-abdominal surgery (but not elective Cesarean Section).
  2. Ectopic pregnancy.
  3. Toxemia with convulsions (Eclampsia).
  4. Pernicious vomiting (hyperemesis gravidarum).

5. Nephrosis.
6. Cardiac Decompensation.
7. Missed Abortion.
8. Miscarriage.

These conditions are not included: false labor; occasional spotting; rest during pregnancy even if prescribed by a physician; morning sickness; or like conditions that are not medically termed as complications of pregnancy.

- ***Concurrent Review***

  A review by the Utilization Review Organization which occurs during the covered person's hospital confinement to determine if continued inpatient care is medically necessary.
- ***Confinement***

  A continuous stay in a hospital, treatment center, extended care facility, hospice, or birthing center due to an illness or injury diagnosed by a physician. Later stays shall be deemed part of the original confinement unless there was either complete recovery during the interim from the illness or injury causing the initial stay, or unless the latter stay results from a cause or causes unrelated to the illness or injury causing the initial stay.
- ***Copay***

  A cost sharing arrangement whereby a covered person pays a set amount to a provider for a specific service at the time the service is provided.
- ***Cosmetic Surgery***

  Surgery for the restoration, repair, or reconstruction of body structures directed toward altering appearance.
- ***Covered Expenses***

  Medically necessary services, supplies or treatments that are recommended or provided by a physician, professional provider or covered facility for the treatment of an illness or injury and that are not specifically excluded from coverage herein. Covered expenses shall include specified preventive care services.
- ***Covered Person***

  A person who is eligible for coverage under this Plan, or becomes eligible at a later date, and for whom the coverage provided by this Plan is in effect.
- ***Custodial Care***

  Care provided primarily for maintenance of the covered person or which is designed essentially to assist the covered person in meeting his activities of daily living and which is not primarily provided for its therapeutic value in the treatment of an illness or injury. Custodial care includes, but is not limited to: help in walking, bathing, dressing, feeding, preparation of special diets and supervision over self-administration of medications. Such services shall be considered custodial care without regard to the provider by whom or by which they are prescribed, recommended or performed. Room and board and skilled nursing services are not, however, considered custodial care (1) if provided during confinement in an institution for which coverage is available under this Plan, and (2) if combined with other necessary therapeutic services, under accepted medical standards, which can reasonably be expected to substantially improve the covered person's medical condition.
- ***Customary and Reasonable Amount***

  The fee assessed by a provider of service for services, supplies or treatment which shall not exceed the general level of charges made by others rendering or furnishing such services, supplies or treatment within the area where the charge is incurred and is comparable in severity and nature to the illness or injury. Due consideration shall be given to any medical complications or unusual circumstances which require additional time, skill or experience. The customary and reasonable amount is determined from a statistical review and analysis of the charges for a given procedure in a given area. The term "area" as it would apply to any particular service, supply or treatment means a county or such greater area as is necessary to obtain a representative cross-section of the level of charges.
- ***Dentist***

  A licensed doctor of dental medicine (D.M.D.) or a licensed doctor of dental surgery (D.D.S.), other than a close relative of the covered person.
- ***Dependents***

  For a complete definition of dependent, refer to Eligibility, Dependent Eligibility.
- ***Durable Medical Equipment***

  Medical equipment which:
  1. Can withstand repeated use;
  2. Is primarily and customarily used to serve a medical purpose;
  3. Is generally not used in the absence of an illness or injury;
  4. Is appropriate for use in the home.

  All provisions of this definition must be met before an item can be considered durable medical equipment. Durable medical equipment includes, but is not limited to: crutches, wheel chairs, hospital beds, etc.
- ***Effective Date***

  The date of this Plan or the date on which the covered person's coverage commences, whichever occurs later.

- ***Emergency***

  The sudden onset of an illness or injury where the symptoms are of such severity that the absence of immediate medical attention could reasonably result in:
  1. Placing the covered person's life in jeopardy, or
  2. Causing other serious medical consequences, or
  3. Causing serious impairment to bodily functions, or
  4. Causing serious dysfunction of any bodily organ or part.
- ***Employee***

  A person directly involved in the regular business of and compensated for services by the employer, who is regularly scheduled to work not less than thirty (30) hours per work week on a full-time status basis.
- ***Employer***

  The employer is Merrick Industries, Inc.
- ***Exclusive Provider***

  A physician, hospital, or other health care provider which has an agreement in effect with the Exclusive Provider Organization at the time services are rendered. Exclusive providers agree to accept the negotiated rate as payment in full.
- ***Exclusive Provider Organization***

  The Exclusive Provider Organization is MultiPlan.
- ***Experimental/Investigational***

  Services, supplies, and treatment which does not constitute accepted medical practice properly within the range of appropriate medical practice under the standards of the case and by the standards of a reasonably substantial, qualified, responsible, relevant segment of the medical community or government oversight agencies at the time services were rendered.
  1. The claims processor, Named Fiduciary, Plan administrator or their designee must make an independent evaluation of the experimental/non-experimental standings of specific technologies. The claims processor, Named Fiduciary, Plan administrator or their designee shall be guided by a reasonable interpretation of Plan provisions and information provided by qualified independent vendors who have also reviewed the information provided. The decisions shall be made in good faith and rendered following a factual background investigation of the claim and the proposed treatment. The claims processor, Named Fiduciary, Plan administrator or their designee will be guided by the following principles:
     - 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
     - If the drug, device, medical treatment or procedure, or the covered person 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
     - If "reliable evidence" shows that the drug, device, medical treatment or procedure is the subject of on-going phase I or phase II clinical trials, is in the research, experimental, study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety its efficacy as compared with a standard means of treatment or diagnosis; or
     - If "reliable evidence" shows that prevailing opinion among experts regarding the drug, device, medical treatment or procedure is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, or its efficacy as compared with standard means of treatment or diagnosis.
  2. "Reliable evidence" shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.
- ***Extended Care Facility***

  An institution or distinct part thereof, operated pursuant to law and one which meets 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, and physical restoration services to assist covered persons to reach a degree of body functioning to permit self-care in essential daily living activities. Such services must be rendered by a Registered Nurse or by a Licensed Practical Nurse under the direction of a registered nurse.
  2. Its services are provided for compensation from its covered persons and under the full-time supervision of a physician or Registered Nurse
  3. It provides twenty-four (24) hour-a-day nursing services.
  4. It maintains a complete medical record on each covered person.
  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 custodial or educational care, or a place for the care of mental and nervous disorders.
  6. It is approved and licensed by Medicare.

  This term shall also apply to expenses incurred in an institution referring to itself as a skilled nursing facility, convalescent nursing facility, or any such other similar designation.

- ***Facility***
  A healthcare institution which meets all applicable state or local licensure requirements, such as a freestanding dialysis facility, a lithotriptor center or an outpatient imaging center.
- ***Full-time***
  Employee's regularly scheduled work not less than thirty (30) hours per work week.
- ***Generic Drug***
  A prescription drug that is generally equivalent to a higher-priced brand name drug with the same use and metabolic disintegration. The drug must meet all Federal Drug Administration (FDA) bioavailability standards and be dispensed according to the professional standards of a licensed pharmacist or physician and must be clearly designated by the pharmacist or physician as generic.
- ***Home Health Aide Services***
  Those services which may be provided by a person, other than a Registered Nurse, which are medically necessary for the proper care and treatment of a person.
- ***Home Health Care Agency***
  An agency or organization which meets fully every one of the following requirements:
  1. It is primarily engaged in and duly licensed, if licensing is required, by the appropriate licensing authority, to provide 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 Registered Nurse. It must provide for full-time supervision of such services by a physician or Registered Nurse.
  3. It maintains a complete medical record on each covered person.
  4. It has a full-time administrator.
  5. It qualifies as a reimbursable service under Medicare.
- ***Hospice***
  An agency that provides counseling and medical services and may provide room and board to a terminally ill covered person and which meets all of the following tests:
  1. It has obtained any required state or 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 covered person.
  9. It is licensed, if licensing is required.
- ***Hospital***
  An institution, which meets the following conditions:
  1. It is licensed and operated in accordance with the laws of the jurisdiction in which it is located which 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 covered person's expense.
  3. It maintains on its premises all the facilities necessary to provide for the diagnosis and medical and surgical treatment of an illness or injury; and such treatment is provided by or under the supervision of a physician with continuous twenty-four (24) hour nursing services by or under the supervision of Registered Nurses.
  4. It qualifies as a hospital and is accredited by the Joint Commission on the Accreditation of Healthcare Organizations.
  5. It must be approved by Medicare.

  Under no circumstances will a hospital be, other than incidentally, a place for rest, a place for the aged, or a nursing home.
  1. Hospital shall include a facility designed exclusively for rehabilitative services where the covered person received treatment as a result of an illness or injury.
  2. The term hospital, when used in conjunction with inpatient confinement for mental and nervous conditions or chemical dependency, will be deemed to include an institution which is licensed as a mental hospital or chemical dependency rehabilitation and/or detoxification facility by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located.
- ***Illness***
  A bodily disorder, disease, or physical sickness. Pregnancy of a covered employee or their covered spouse shall be considered an illness.
- ***Incurred or Incurred Date***
  With respect to a covered expense, the date the services, supplies or treatment are provided.
- ***Injury***
  A physical harm or disability which is the result of a specific incident caused by external means. 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 of a covered person in a hospital, hospice, or extended care facility as a registered bed patient, for twenty-three (23) or more consecutive hours and for whom charges are made for room and board.
- ***Intensive Care***
  A service which is reserved for critically and seriously ill covered persons requiring constant audio-visual surveillance which is prescribed by the attending physician.
- ***Intensive Care Unit***
  A separate, clearly designated service area which is maintained within a hospital solely for the provision of intensive care. It must meet the following conditions:
  1. Facilities for special nursing care not available in regular rooms and wards of the hospital;
  2. Special life saving equipment which is immediately available at all times;
  3. At least two beds for the accommodation of the critically ill; and
  4. At least one Registered Nurse in continuous and constant attendance twenty-four (24) hours-per-day.

  This term does not include care in a surgical recovery room.
- ***Layoff***
  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. Layoffs 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 which is of stated duration after which time the employee is expected to return to active work.
- ***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 for a particular covered expense during amount a specified period of time, such as a calendar year.
  2. The maximum number the Plan acknowledges as a covered expense. The maximum number relates to the number of:
     - Treatments during a specified period of time, or
     - Days of confinement, or
     - Visits by a home health care agency
- ***Medically Necessary (Medical Necessity)***
  Service, supply or treatment which, as determined by the claims processor, Named Fiduciary, employer/Plan administrator or their designee, to be:
  - Appropriate and consistent with the symptoms and provided for the diagnosis or treatment of the covered person's illness or injury and which could not have been omitted without adversely affecting the covered person's condition or the quality of the care rendered;
  - Supplied or performed in accordance with current standards of good medical practice within the United States; and
  - Not primarily for the convenience of the covered person or the covered person's family or professional provider; and
  - Is an appropriate supply or level of service that safely can be provided; and
  - It is recommended or approved by the attending professional provider.

  The fact that a professional provider may prescribe, order, recommend, perform, or approve a service, supply or treatment does not, in and of itself, make the service, supply, or treatment medically necessary. In making the determination of whether a service or supply was medically necessary, the claims processor, employer/Plan administrator, or its designee, may request and rely upon the opinion of a physician or physicians. The determination of the claims processor, employer/Plan administrator or its designee shall be final and binding.
- ***Medicare***
  The programs established by Title XVIII known as the Health Insurance for the Aged Act, which includes: Part A, Hospital Benefits For The Aged; Part B, Supplementary Medical Insurance Benefits For The Aged; and Part C, Miscellaneous provisions regarding both programs; and including any subsequent changes or additions to those programs.
- ***Mental and Nervous Disorder***
  An emotional or mental condition characterized by abnormal functioning of the mind or emotions. Diagnosis and classifications of these conditions will be determined based on standard DSM-III-R (diagnostic and statistical manual of mental disorders) or the current edition of International Classification of Diseases, published by the U.S. Department of Health and Human Services.
- ***Negotiated Rate***
  The rate the preferred providers or exclusive providers have contracted to accept as payment in full for covered expenses of the Plan.
- ***Nonparticipating Pharmacy***
  Any pharmacy, including a hospital pharmacy, physician or other organization, licensed to dispense prescription drugs which do not fall within the definition of a participating pharmacy.

- ***Nonpreferred Provider***
  A physician, hospital, or other health care provider which does not have 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.
- ***Outpatient***
  A covered person shall be considered to be an outpatient if he is treated at:
  1. A hospital as other than an inpatient;
  2. A physician's office, laboratory or x-ray facility; or
  3. An ambulatory surgical facility; and
  4. The stay is less than twenty-three (23) consecutive hours.
- ***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. Psychiatric services.
  2. Treatment of mental and nervous disorders.
  3. Chemical dependency treatment.

  It may include day, early evening, evening, night care, or a combination of these four.
- ***Participating Pharmacy***
  Any pharmacy licensed to dispense prescription drugs, which is contracted within the Pharmacy Organization.
- ***Pharmacy Organization***
  The Pharmacy Organization is CVS Caremark.
- ***Physician***
  A Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is practicing within the scope of his license.
- ***Placed For Adoption***
  The date the employee assumes legal obligation for the total or partial financial support of a child during the adoption process.
- ***Plan***
  "Plan" 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 is the employer.
- ***Post-service Claim***
  Post-service claims are those for which services have already been received (any claims other than pre-service claims).
- ***Pre-existing Conditions***
  An illness or injury which existed within six (6) months before the covered person's enrollment date for coverage under this Plan. An illness or injury is considered to have existed when the covered person:
  1. Sought or received professional advice for that illness or injury, or
  2. Received medical care or treatment for that illness or injury, or
  3. Received medical supplies, drugs, or medicines for that illness or injury.
- ***Preferred Provider***
  A physician, hospital or other health care facility who has an agreement in effect with the Preferred Provider Organization at the time services are rendered. Preferred providers agree to accept the negotiated rate as payment in full.
- ***Preferred Provider Organization***
  An organization who selects and contracts with certain hospitals, physicians, and other health care providers to provide covered persons services, supplies and treatment at a negotiated rate. The Preferred Provider Organization is Evolutions Healthcare.
- ***Pregnancy***
  The physical state which results in childbirth or miscarriage.
- ***Pre-service Claim***
  A pre-service claim is a claim for services for which preapproval must be received before services are rendered in order for benefits to be payable under this Plan, such as those services listed in the section Utilization Review. A pre-service claim is considered to be filed whenever the initial contact or call is made by the covered person, provider or authorized representative to the Utilization Review Organization, as specified in Utilization Review.
- ***Preventive Care***
  "Preventive Care" shall mean certain preventive care services.
  This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention; and
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here:
http://www.healthcare.gov/center/regulations/prevention/recommendations.html.
For more information, you may contact the Claim Administrator at (ph) 228-762-2500 or (e) susanne@lockardandwilliams.com.

- ***Professional Provider***
  A person or other entity licensed where required and performing services within the scope of such license. The covered professional providers are: Certified Addictions Counselor, Certified Registered Nurse Anesthetist, Certified Registered Nurse Practitioner, Chiropractor, Clinical Laboratory, Clinical Licensed Social Worker (A.C.S.W., L.C.S.W., M.S.W., R.C.S.W., M.A., M.E.D.), Dental Hygienist, Dentist , Dietician, Dispensing optician, Nurse (R.N., L.P.N., L.V.N.), Occupational Therapist, Optician, Optometrist , Physical Therapist, Physician, Physician's Assistant, Podiatrist, Psychologist, Respiratory Therapist, Speech Therapist.
- ***Retrospective Review***
  A review by the Utilization Review Organization after the covered person's discharge from hospital confinement to determine if, and to what extent, inpatient care was medically necessary.
- ***Room and Board***
  Room and linen service, dietary service, including meals, medically necessary special diets and nourishments, and general nursing service. Room and board does not include personal items.
- ***Semiprivate***
  The daily room and board charge which a facility applies to the greatest number of beds in its semiprivate rooms containing two (2) or more beds.
- ***Treatment Center***
  1. An institution which does not qualify as a hospital, but which does provide a program of effective medical and therapeutic treatment for chemical dependency or mental and nervous disorders, and
  2. 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, or
  3. 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 services:
        - Room and board
        - Evaluation and diagnosis
        - Counseling
        - Referral and orientation to specialized community resources.
- ***Utilization Review***
  A process of evaluating if services, supplies or treatment are medically necessary to help ensure cost-effective care.
- ***Utilization Review Organization***
  The individual or organization designated by the employer for the process of evaluating whether the service, supply, or treatment is medically necessary. The Utilization Review Organization is Rehab Review.
- ***Well Child Care***
  Preventive care rendered to dependent children through the age of sixteen (16).