

**MASTER PLAN DOCUMENT AND
PLAN DESCRIPTION
FOR
COLLEGE OF THE SISKIYOU'S HEALTH PLAN**

EFFECTIVE DATE

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**COLLEGE OF THE SISKIYOU'S HEALTH PLAN
MASTER PLAN DOCUMENT**

Table of Contents

ARTICLE I	ESTABLISHMENT OF PLAN	1
ARTICLE II	DEFINITIONS	2
ARTICLE III	ELIGIBILITY AND PARTICIPATION	12
ARTICLE IV	UTILIZATION REVIEW ORGANIZATION	24
ARTICLE V	SCHEDULE OF MAJOR MEDICAL BENEFITS /DESCRIPTION OF COVERED CHARGES	26
ARTICLE VI	EXCLUSIONS	45
ARTICLE VII	CLAIMS FILING PROVISIONS	53
ARTICLE VIII	CLAIMS APPEAL PROCEDURES	54
ARTICLE IX	COORDINATION OF BENEFITS WITH OTHER PLANS	56
ARTICLE X	RIGHTS OF EMPLOYEES PARTICIPATING IN THE PLAN	61
ARTICLE XI	RIGHTS OF THE PLAN ADMINISTRATOR	63
ARTICLE XII	AMENDMENT AND TERMINATION OF THE PLAN	65
ARTICLE XIII	ADMINISTRATION	67
ARTICLE XIV	MISCELLANEOUS	69
ARTICLE XV	PLAN IDENTIFICATION	71
AMENDMENTS	PRIVACY STANDARD PURSUANT TO HIPAA	72

ARTICLE I - ESTABLISHMENT OF PLAN

1.1 PURPOSE

The Employer establishes this Plan to provide for the payment or reimbursement of certain medical expenses incurred by Eligible Employees and their Dependents.

1.2 EXCLUSIVE BENEFIT

This Plan is established and shall be maintained for the exclusive benefit of Eligible Employees of the College of the Siskiyous.

1.3 COMPLIANCE

This Plan is established and shall be maintained with the intention of meeting the requirements of all pertinent laws. Should any part of this Plan Document for any reason be declared invalid, such decisions shall not affect the validity of any remaining portion, which remaining portion shall remain in effect as if this document had been executed with the invalid portion thereof eliminated.

1.4 LEGAL ENFORCEABILITY

The Employer intends that terms of this Plan, including those relating to coverage and benefits provided, are legally enforceable by the Participants, subject to the Employer's retention of rights to amend or terminate this Plan as provided elsewhere in this document.

NOTE TO EMPLOYEES: This Master Plan Document and Plan Description describe the circumstances when the Plan pays for medical care. There may be circumstances when an Employee and his Physician determine that medical care which is not covered by this Plan is appropriate. All decisions regarding medical care are up to an Employee and his Physician.

ARTICLE II - DEFINITIONS

- 2.1 **ABORTION** shall mean induced termination of a pregnancy at the election of the Participant. A therapeutic abortion is the induced termination of pregnancy by any acceptable means medically indicated by a diagnosis affecting the mental or physical health of the mother.
- 2.2 **ACCIDENT** shall mean a specific sudden event occurring by chance and resulting in bodily strain or harm.
- 2.3 **ACTIVELY AT WORK** shall mean an Employee who reports to his regular place of employment and performs the usual duties of his position. However, a Participant shall be considered to be Actively At Work on each day of regular paid vacation, or on a regular non-working day on which he is able to perform normal and regular activities and is not Hospital confined, provided he was Actively At Work on the last preceding regular working day.
- 2.4 **ALCOHOLISM TREATMENT FACILITY** shall mean a facility providing Inpatient or Outpatient treatment for alcoholism, which is approved by the Joint Commission on Accreditation of Hospitals, or certified by the Department of Health of the state where it is located. Such a facility must also have in effect a plan for utilization review and a plan for peer review.
- 2.5 **AMBULATORY SURGICAL CENTER** shall mean a licensed public or private facility which is primarily engaged in performing Surgical Procedures and which fully meets every one of the following criteria:
1. Has an organized staff of Physicians;
 2. Has permanent facilities that are equipped and operated primarily for the purpose of performing Surgical Procedures;
 3. Has continuous Physician services and registered professional nursing services whenever a patient is in the facility; and
 4. Does not provide services or other accommodations for patients to stay overnight.
- 2.6 **AMENDMENT** shall mean a formal document that changes the provisions of the Plan Document, duly signed by the authorized person(s) as designated by the Plan Administrator.
- 2.7 **BENEFIT** shall mean the payment or reimbursement by the Plan of a portion of a Medical Expense incurred by a Participant.
- 2.8 **BILATERAL SURGICAL PROCEDURE** shall mean any Surgical Procedure performed on any paired organ whose right and left halves are mirror images of each other, or in which a median longitudinal section divides the organ into equivalent right and left halves. Surgery on both halves is performed during the same operative session and may involve one or two surgical incisions.

- 2.9 BIRTHING CENTER** shall mean a licensed outpatient facility which provides childbirth facilities for low-risk maternity patients. The Birthing Center must meet fully every one of the following tests:
1. Has an organized staff of certified midwives, physicians and other trained personnel;
 2. Has necessary medical equipment;
 3. Has a backup of Physicians;
 4. Has a written agreement to transfer to a Hospital, if necessary; and
 5. Is in compliance with any applicable state or local regulations.
- 2.10 BREAK IN COVERAGE** is defined as a period of sixty-three (63) consecutive days during which an individual did not have Creditable Coverage. Days of Creditable Coverage that occur before a Break In Coverage shall not be counted by the Plan in reducing the Pre-Existing Condition Exclusion. Waiting periods, as defined by HIPAA, shall not be taken into account in determining a Break in Coverage.
- 2.11 CALENDAR YEAR** shall mean a period of twelve (12) consecutive months, commencing January 1 and ending December 31.
- 2.12 CHILD** shall mean only an unmarried Dependent of the Employee, provided the following conditions are met:
1. The child is not eligible as an Employee for group health coverage sponsored by this Employer; and
 2. The child depends on the Employee for support within the meaning of Section 152 of the Code and is one of the following:
 - a) a natural son or daughter of the Employee
 - b) a stepchild who resides with the Employee
 - c) a legally adopted child or a child to whom a court of competent jurisdiction has entered an interlocutory order of adoption.
- The Employee is required to provide health care coverage for the child under a qualified medical support order.
- 2.13 CLAIMS ADMINISTRATOR** shall mean Keenan Health Care, a division of Keenan & Associates.
- 2.14 CODE** shall mean the United States Internal Revenue Code of 1986, as amended.
- 2.15 COINSURANCE** shall mean a percentage of the cost of covered expenses for which each Participant is responsible.
- 2.16 COMMUNITY MENTAL HEALTH FACILITY/CENTER** shall mean a facility approved by a regional health planning agency, or a facility providing services under a community mental health and retardation board established under state law, or certified by the Department of Health of the state where it is located. Such a facility must also have in effect a plan for utilization review and a plan for peer review.

- 2.17 COPAYMENT** shall mean a portion of the cost of covered expenses for which each Participant is responsible.
- 2.18 COSMETIC SERVICE** shall mean a service rendered for the purpose of altering appearance, with no evidence that the service is Medically Necessary.
- 2.19 COVERED PERSON** shall mean an Employee or Dependent who is enrolled in this Plan and satisfies the eligibility and participation requirements specified in this Plan Document.
- 2.20 CREDITABLE COVERAGE** shall mean health care coverage which may be used to reduce a Participant's Pre-Existing Condition Exclusion period as of the Enrollment Date. Creditable Coverage shall only include individual or group health insurance coverage and other health care coverage specifically set forth in HIPAA, including Medicaid (Medi-Cal) and Medicare. Likewise, Creditable Coverage shall not include coverage consisting of excepted benefits as defined by HIPAA. Waiting Period shall not be counted in determining an individual's total amount of Creditable Coverage.
- 2.21 DEDUCTIBLE** shall mean an amount of covered expenses for which each Participant is responsible before the Plan pays benefits as specified in this Plan Document.
- 2.22 DEPENDENT** shall mean:
1. The Spouse of an Employee who is not legally separated or divorced from the Employee.
 2. Each unmarried Child of an Employee who is primarily dependent on Participant for support through 12:00 midnight on the last day of the month in which he attains his nineteenth birthday. Or, if the unmarried Child is age nineteen or over, that Child is eligible until his or her twenty-fourth birthday, provided he or she is enrolled as a full-time student (as defined by the school the Child is attending). An overage Dependent who enters or returns to an eligible status will become eligible for coverage on the first day of the month following the date an enrollment application is filed on their behalf.
 3. Each unmarried Child of an Employee who has attained his nineteenth birthday, who is mentally retarded or physically handicapped, and who is incapable of engaging in self-sustaining employment due to such incapacity. Application for such continuation of Dependent status must be made with the Claims Administrator within thirty-one days of the Child's nineteenth birthday. The Claims Administrator has the right to require proof of the continuation of such incapacity upon attainment of age nineteen or anytime thereafter as deemed necessary by the Claims Administrator.
- 2.23 DISABLED EMPLOYEE** shall mean an Employee who is unable, as the result of his Sickness or Injury, to perform the duties of his occupation.
- 2.24 DURABLE MEDICAL EQUIPMENT** shall mean equipment purchased for treatment of a medical condition which:

1. Is necessary for the medical or surgical treatment of a Sickness or Injury, as certified in writing by the attending Physician; and
2. Serves a therapeutic purpose with respect to a particular Sickness or Injury under treatment in accordance with accepted medical practice; and
3. Is of truly durable nature; and
4. Does not have a value to the patient or members of the patient's family in the absence of the Sickness or Injury for which the equipment is prescribed.

2.25 ELIGIBLE DEPENDENT shall mean a dependent (as defined in Section 2.22 in this Plan Document) of an Eligible Employee (as defined in Section 2.26 in this Plan Document).

2.26 ELIGIBLE EMPLOYEE shall mean any of the following:

1. Full time regular employee;
2. Classified employee working 20 or more hours per week;
3. Faculty employed 50% or greater;
4. Qualified retiree;
5. Qualified board member.

2.27 ELIGIBLE PROVIDER shall mean a medical professional, facility, or institution when duly licensed in the state where providing services, and when rendering services or furnishing supplies within the scope of that license, provided that such expenses are covered under this Plan.

2.28 EMERGENCY shall mean a life-threatening condition, or Injury which may result in permanent bodily harm if treatment is not received.

2.29 EMPLOYEE shall mean an individual for whom the Employer compensates for personal services performed on a regular and continuous basis, and for whom the Employer pays employment taxes as required by the Code.

2.30 ENROLLMENT DATE shall mean the first day of coverage, or if there is a Waiting Period, the first day of the Waiting Period.

2.31 EXTENDED CARE FACILITY/SKILLED NURSING FACILITY shall mean an institution (or distinct part of an institution) that:

1. is primarily engaged in providing accommodations and skilled nursing care on a 24-hour per day basis to Inpatients recovering from Sickness or Injury;
2. is under the full-time supervision of a Physician or Registered Nurse;
3. admits patients only upon the recommendation of a Physician, maintains adequate medical records for all patients, and at all times has available the services of a Physician under an established agreement;
4. has established methods and written procedures for the dispensing and administration of drugs;
5. is not, other than incidentally, a place for rest, a place for the aged, a place for drug addicts, or a place for alcoholics; and

6. is licensed in accordance with all applicable federal, state, and local laws, and is approved by Medicare.

2.32 FAMILY shall mean an Employee and his Dependents.

2.33 FULL-TIME STUDENT shall mean a student at an accredited institution of higher learning who is enrolled for at least twelve (12) credit hours per school term, or who otherwise meets the definition of "full-time" student as established by the institution which he is attending.

2.34 HIPAA shall mean the Health Insurance Portability and Accountability Act of 1996, as presently enacted and as it may be amended from time to time, together with its related rules and regulations. References to any section of HIPAA shall include any successor provision.

2.35 HOME HEALTH CARE AGENCY shall mean a public agency or private organization, or subdivision of an agency or organization that:

1. is primarily engaged in providing skilled nursing services and other therapeutic services such as physical therapy, speech therapy, occupational therapy, medical social services, or at-home health aide services. A public or voluntary nonprofit health agency may qualify by furnishing directly either skilled nursing services or at least one other therapeutic service and by furnishing directly or indirectly (through arrangements with another public or voluntary nonprofit agency) other therapeutic services;
2. has policies established by a professional group associated with the agency or organization (including at least one Physician and at least one Registered Nurse) to govern the services and provides for supervision of the services by a Physician or a Registered Nurse;
3. maintains clinical records on all patients;
4. is licensed in accordance with federal, state, and/or local laws; and
5. meets all conditions of a Home Health Care Agency as required by Medicare.

2.36 HOSPICE FACILITY shall mean a facility other than a Hospital which meets the following criteria:

1. primarily engaged in providing continuous skilled nursing care for Terminally Ill patients during the final stages of their illnesses and is not, other than incidentally, a rest home, home for custodial care, or home for the aged;
2. regularly provides overnight care for patients in a residence or facility;
3. provides twenty-four (24) hour skilled nursing care by licensed nursing personnel under the direction of a full-time registered professional nurse; and
4. maintains a complete medical record for each patient.

2.37 HOSPICE SERVICE shall mean an organization which is recognized by Medicare or which meets the following criteria:

1. Provides in-home nursing care and counseling by licensed professionals under the direction of a full-time registered professional nurse; and
2. Maintains a complete medical record for each patient; and
3. Is primarily engaged in providing nursing care and counseling for Terminally Ill patients during the final stages of their illnesses and does not, other than incidentally, perform housekeeping duties.

- 2.38 HOSPITAL** shall mean a licensed facility that provides Inpatient diagnostic, therapeutic, and rehabilitative services for the diagnosis, treatment and care of injured and sick persons under the supervision of a Physician. Such an institution must also meet the following requirements:
1. It must be accredited by the Joint Commission on Accreditation of Hospitals, or be approved by the federal government to participate in federal or state programs;
 2. It must maintain clinical records on all patients;
 3. It must have by-laws which govern its staff of Physicians; and
 4. It must provide nursing care twenty-four (24) hours per day.
- 2.39 HOSPITAL CONFINEMENT** shall refer to a situation in which:
1. a room and board charge is made to a Participant by a Hospital or other Claims Administrative-approved facility; or
 2. a Participant remains in the Hospital or other approved facility for eighteen (18) consecutive hours or longer.
- 2.40 IMMEDIATE RELATIVE** shall mean a Spouse, parent, grandparent, child, grandchild, brother, or sister of a Participant.
- 2.41 INJURY** shall mean physical harm received by an individual as the result of any one Accident. Injury does not include treatment for hernias, ptomaine poisoning, disease, or infection (except pyogenic infection occurring through an accidental cut or wound).
- 2.42 INPATIENT** shall mean the classification of a Participant when that person is admitted to a Hospital, Hospice Facility, or Extended Care Facility for treatment, and charges are made for room and board to the Participant as the result of such treatment.
- 2.43 INTENSIVE CARE UNIT** shall mean an area in a Hospital, established by such Hospital for a formal intensive care program exclusively reserved for critically ill patients requiring constant audiovisual observation as prescribed by the attending Physician, that provides room and board, specialized, registered, professional nursing and other nursing care, and special equipment and supplies immediately available on a standby basis, and that is separated from the rest of the Hospital's facilities.
- 2.44 LATE ENROLEE** shall mean a Participant who enrolls in the Plan after the initial enrollment period.
- 2.45 LICENSED PRACTICAL NURSE** shall mean an individual who has received specialized nursing training and practical nursing experience, and is duly licensed to perform such nursing services by the state or regulatory agency responsible for such licensing in the state in which that individual performs such services.
- 2.46 MASTER PLAN DOCUMENT** shall mean this written description of the Benefits for medical expenses provided by the Employer to its covered Eligible Employees and their covered Eligible Dependents.

- 2.47 MEDICAL EMERGENCY** shall mean a Sickness or Injury that is sudden, life threatening, and unexpected, requiring immediate and urgent medical attention and use of medical facilities.
- 2.48 MEDICAL EXPENSE** shall mean the Reasonable and Customary Charges incurred by the Participant as the result of a Sickness or Injury for Medically Necessary services, treatments, supplies, or drugs. Medical Expenses shall be deemed to be incurred as of the date of the performance of the service or treatment, or the date of purchase of the supply or drug giving rise to the charge.
- 2.49 MEDICALLY NECESSARY** shall mean charges for Medical Expenses which are;
1. consistent with the standards of good medical practice which are generally accepted by the medical-scientific community in the United States of America;
 2. consistent with the symptoms or diagnosis of the condition for which services or supplies are rendered;
 3. not provided solely for the convenience of the patient or Provider;
 4. necessary for the diagnosis or correction of a condition which is threatening to the life, health or physical well being of the Participant, or the source of extreme physical discomfort.
- 2.50 MEDICARE** shall mean the program of medical care benefits provided under Title XVIII of the Social Security Act of 1965, as amended.
- 2.51 MENTAL OR EMOTIONAL DISORDER** shall mean a condition diagnosed as falling within categories 290 through 302, and 305 through 319 of the International Classification of Diseases (ICD-9) of the U.S. Department of Health and Human Services, as amended.
- 2.52 MULTIPLE SURGICAL PROCEDURES** shall mean Surgical Procedures which are performed during the same operative session and which are not incidental or secondary to one primary procedure for which the operative session is undertaken. An "incidental procedure" is a procedure which is not Medically Necessary at the time it is performed. A "secondary procedure" is a procedure which is not part of the primary procedure for which the operative session is undertaken.
- 2.53 NONOCCUPATIONAL** shall mean, with respect to Injury, an Injury that does not arise out of and in the course of any employment for wage or profit; and, with respect to Sickness, means a Sickness in connection with which the person is not entitled to benefits under any workers' compensation law or similar legislation.
- 2.54 OUTPATIENT** shall refer to a person receiving medical care other than as an Inpatient or shall refer to Medical Expenses other than those associated with a Hospital Confinement.
- 2.55 PARTICIPANT** shall mean an Employee or Dependent who is enrolled in the Plan and satisfies the eligibility and participation requirements specified in this Plan Document.
- 2.56 PHARMACY** shall mean any area room, rooms, place of business, department, or portion of any of the foregoing, where prescriptions are filled or where drugs, dangerous drugs or

poisons are compounded, sold, offered, or displayed for sale, dispensed, or distributed to the public. A pharmacy must also meet the following requirements:

1. it must be licensed by the Board of Pharmacy;
2. it must maintain records in accord with federal and state regulations; and
3. it must be staffed with a licensed registered pharmacist.

- 2.57 PHYSICIAN** shall mean a person duly licensed to practice medicine, to prescribe and administer drugs, or to perform surgery. This definition includes doctors of medicine, doctors of osteopathy, dentists, podiatrists, chiropractors, psychologists, and psychiatrists, and midwives, provided that each, under his license, is permitted to perform services covered under this Plan and that the Plan does not exclude the services provided by such Physician. This definition includes any other Physician as determined by the Claims Administrator to be qualified to render the services billed for.
- 2.58 PLAN** shall mean the College of the Siskiyous Health Plan as set forth in this document.
- 2.59 PLAN DOCUMENT** shall mean the Master Plan Document as defined in Section 2.46 of this Article.
- 2.60 PLAN SPONSOR** shall mean the College of the Siskiyous.
- 2.61 PRE-EXISTING CONDITION** shall mean any condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received by a health care provider or practitioner duly licensed to provide such care under state law, and operating within the scope of said license within the six-month period ending on the Enrollment Date.
- 2.62 PREFERRED PROVIDER** shall mean any Hospital, facility, Physician or other provider who has contracted with the Plan Sponsor to provide health care services at a negotiated rate.
- 2.63 PROVIDER** shall mean a duly licensed person or facility that furnishes health care services or supplies pursuant to law, provided that each, under his license, is permitted to perform the medical services covered under this Plan and that the Plan does not exclude the services provided. This definition includes physical therapists, occupational therapists, or any other medical professional or facility as determined by the Claims Administrator to be qualified to render the services billed for.
- 2.64 PSYCHIATRIC SERVICES** shall mean psychotherapy and other accepted forms of evaluation, diagnosis, or treatment of Mental or Emotional Disorders. This includes individual, group and family psychotherapy; electroshock and other convulsive therapy; psychological testing; psychiatric consultations; and any other forms of psychotherapeutic treatment as determined to be Medically Necessary by the Claims Administrator.
- 2.65 PSYCHOTHERAPIST** shall mean a person degreed in counseling or otherwise certified as competent to perform psychotherapeutic counseling. This includes, but is not limited to: a psychiatrist, a psychologist, a pastoral counselor, a person degreed in counseling psychology,

a psychiatrist nurse, and a social worker, when rendering psychotherapy under the direct supervision of a psychiatrist or licensed psychotherapist.

- 2.66 REASONABLE AND CUSTOMARY CHARGES** shall mean charges made by eligible facilities and providers for services which do not exceed the general level of charges for those services in the geographical region where the services are furnished. The Reasonable and Customary charge for each particular service is an amount determined by the use of statistical data received from the Health Insurance Association of America. In determining whether a charge is reasonable, differences in charges which are due to differences in the experience, education, and skill level required for the performance of a particular service because of medical circumstances will be considered.
- 2.67 REHABILITATION FACILITY** shall mean a facility which specializes in physical rehabilitation of injured or sick patients. Such an institution must also meet the following requirements:
1. It must qualify as an Extended Care Facility under Medicare
 2. It must be constituted, licensed, and operated in accordance with the laws of legally authorized agencies responsible for medical institutions.
 3. It must maintain on its premises all the facilities necessary to provide for the medical treatment of Injury or Sickness, for compensation by or under the supervision of Physicians.
 4. It must provide nursing services by registered graduate nurses or licensed practical nurses.
- 2.68 SEMIPRIVATE ROOM ACCOMMODATIONS** shall mean the actual daily rate charged by the Hospital for such accommodations. If the Hospital has no semiprivate rooms, this term shall mean 90% of the actual daily rate charge by the Hospital for a private room. Semiprivate accommodations includes two, three, or four bed wards or rooms.
- 2.69 SICKNESS** shall mean physical disease or illness, including pregnancy.
- 2.70 SPECIALIZED HOSPITAL** shall mean a facility specializing in the treatment of a specific disease or condition. This includes, but is not limited to, hospitals specializing in the treatment of Mental or Emotional Disorders, Alcoholism, Drug Dependence, or tuberculosis.
- 2.71 SPOUSE** shall mean the legally recognized marital partner of an Employee.
- 2.72 SUBSTANCE ABUSE** shall mean:
1. Alcoholism - a condition diagnosed as falling within category 303 of the International Classification of Diseases, of the U.S. Department of Health, as amended.
 2. Drug Dependence (Chemical Dependence) - A condition diagnosed as falling within category 304 of the International Classification of Diseases, of the U.S. Department of Health, as amended.

- 2.73 SURGICAL PROCEDURE** shall mean one or more of the following types of medical procedures performed by a Physician.
1. The incision, excision, or electrocauterization of any part of the body.
 2. The manipulative reduction or treatment of a fracture or dislocation, including the application of a cast or traction.
 3. The suturing of a wound.
 4. Diagnostic and therapeutic endoscopic procedures.
 5. Surgical injection treatments or aspirations.
- 2.74 TERMINALLY ILL** shall mean having a life expectancy of six months or less as certified in writing by the attending Physician.
- 2.75 TOTAL DISABILITY** shall mean a condition caused by Sickness or Injury which renders a Participant unable to engage in any occupation for profit or compensation for which he qualifies by reason of education, training, or experience. In the case of a covered Dependent, the term "occupation" also includes normal activities of a person of the Dependent's age and sex.
- 2.76 URGENT CARE FACILITY** shall mean a facility other than a free clinic providing medical care and treatment of Sick or Injured persons on an Outpatient basis. In addition, it must meet all of the following tests:
1. It is accredited by the Joint Commission on Accreditation of Hospitals, or be approved by the federal government to participate in federal or state programs.
 2. It maintains on-premises diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment by or under the supervision of duly qualified Physicians.
 3. It is operated continuously with organized facilities for operative surgery on the premises.
 4. It is staffed with continuous Physician services and registered professional nursing service whenever a patient attends the facility.
 5. It does not provide services or other accommodations for patients to stay overnight.
- 2.77 WAITING PERIOD** shall mean any period of time imposed by the Plan between the first day of employment and the first day of eligibility for coverage under the Plan.

ARTICLE III

ELIGIBILITY AND PARTICIPATION

3.1 ELIGIBILITY PROVISIONS

3.1.A Employee Eligibility

Any employee of the College of the Siskiyous who meets the provisions of Section 2.26 (Eligible Employee) is eligible to participate in this Plan, subject to the provisions stated in this Article.

3.1.B Dependent Eligibility

Any eligible Dependent of an Eligible Employee may be covered by this Plan if the Employee enrolls for dependent coverage, subject to the provisions stated in this Article

3.1.C Eligibility of Employees Married to Each Other

Eligible Employees who are married to each other will enroll as individuals. Eligible Dependents will enroll as Dependents of both.

3.1.D Verification of Eligibility

The Claims Administrator or the Plan Administrator has the right to request information needed to determine an individual's eligibility for Benefits under this Plan.

3.1.E Notification

The Plan Administrator shall give all Eligible Employees reasonable notification of their eligibility to become Participants under the Plan and of the availability and terms of the Plan.

3.2 ENROLLMENT PROVISIONS

3.2.A Standard Enrollment Period

An Eligible Employee or Dependent may enroll in the Plan within 31 days from his Date of Hire by completing an enrollment form for himself and his Dependents. Coverage, as defined by the Plan, shall become effective on the first day of the month following the completion of the application of enrollment, provided that the Participant pays any required contributions and has completed the enrollment form.

3.2.B Special Enrollment Period - Loss of Coverage

The Plan shall permit Eligible Employees or Dependents who lose other coverage to enroll in the Plan, and shall not impose a preexisting condition exclusion period longer than 12 months with respect to such individuals, if all of the following conditions are met:

1. The Eligible Employee or Dependent was already covered by a group health plan or other health insurance when he declined coverage during the Standard Enrollment Period.
2. The Employee stated in writing at the time of the Standard Enrollment Period that another source of coverage was the reason for declining enrollment.

3. The Eligible Employee or Dependent was covered under COBRA continuation coverage which has been exhausted, or coverage was not under a COBRA continuation provision and has been terminated as a result of a loss of eligibility for the coverage or termination of employer contributions towards such coverage. Loss of eligibility for coverage shall not include a loss of coverage because of failure to pay premiums or participant contributions on a timely basis, or any termination of coverage for cause, including, but not limited to, making a fraudulent claim or an intentional misrepresentation of fact in connection with a plan or policy.
4. The Eligible Employee or Dependent must request the right to enroll for coverage pursuant to Special Enrollment provisions of the Plan in writing within 30 days after the loss of other coverage.

Enrollment under this Special Enrollment Period section is effective on the first day of the first calendar month beginning after the date the valid request for enrollment is received.

3.2.C Special Enrollment Period - New Dependents

The Plan shall permit Eligible Employees the opportunity to enroll in the Plan, and shall not impose a preexisting condition exclusion period longer than 12 months with respect to such individuals, if all the following conditions are met:

1. The Employee is eligible for coverage but is not currently enrolled;
2. The Employee declined enrollment when offered coverage during the Standard Enrollment Period; and
3. An individual became a Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

The Plan shall permit Eligible Dependents the opportunity to enroll in the Plan if one of the following conditions is met:

1. The individual is a Spouse of the Employee and a child becomes a Dependent of the Employee through birth, adoption, or placement for adoption; or
2. The individual becomes a Dependent of the Employee through marriage, birth, adoption, or placement for adoption.

The Special Enrollment Period is 30 days from the date of the marriage, birth, adoption, or placement for adoption. Failure to request enrollment during the Special Enrollment Period shall result in the waiver of the opportunity to enroll in the Plan until another enrollment period, if any, becomes available.

Enrollment under this Special Enrollment Period section is effective:

1. In the case of marriage, the date of marriage;
2. In the case of a Dependent's birth, the date of the birth;
3. In the case of adoption or placement for adoption, the date of the adoption or placement for adoption.

3.2.D Sequence of Coverage

Under no circumstances will coverage for a Dependent become effective prior to an Employee's coverage.

3.3 TERMINATION OF COVERAGE

3.3.A For An Employee

An Employee's coverage under this Plan will terminate at the earliest of the following times:

1. At 12:00 midnight on the last day of the month during which an Employee's employment with the Plan Sponsor terminated.
2. At 12:00 midnight on the last day of the month during which an Employee ceases to be eligible.
3. For any Employee whose coverage has been extended under the provisions set forth in Sections 3.4, 3.5, or 3.6, at 12:00 midnight on the last day that the Employee is eligible for coverage through such an extension of coverage.
4. For any Employee whose coverage has been continued under COBRA, at 12:00 midnight on the last day that the Employee is eligible for such coverage.
5. At 12:00 midnight on the day that an Employee becomes an active member of the armed forces of any country.
6. At 12:00 midnight on the date the Plan is terminated.
7. At the time of the Employee's death.

3.3.B For A Dependent

A Dependent's coverage under this Plan will terminate at the earliest of the following times:

1. At the earliest of any time listed in Section 3.3.A when coverage ceases for the covered Employee.
2. For any Dependent whose coverage has been continued under COBRA, at 12:00 midnight on the last day of the month during which the Dependent is eligible for such coverage.
3. At 12:00 midnight on the last day of the month during which a Dependent Child reaches the limiting age for Dependents.
4. At 12:00 midnight on the date when a Dependent Child is legally married.
5. At 12:00 midnight on the day that a Dependent becomes an active member of the armed forces of any country.
6. At 12:00 midnight on the date when the Employee is relieved of a court-ordered obligation to furnish health care coverage for a Child.
7. At 12:00 midnight on the date when a covered Dependent Spouse is legally separated or divorced from the covered Employee, or their marriage is legally annulled or dissolved.
8. At the time of the Dependent's death.

3.4 EXTENSION OF COVERAGE DURING A QUALIFIED LEAVE OF ABSENCE

If a covered Employee takes a qualified leave of absence as recognized by the Family and Medical Leave Act of 1993, or similar state law, coverage for the Employee and any covered

Eligible Dependents may be continued for the duration of the qualified leave (up to twelve weeks under the Family and Medical Leave Act).

The Employee will be responsible for paying required Plan contributions in a timely manner.

3.5 EXTENSION OF COVERAGE DURING OTHER LEAVES OF ABSENCE

If a covered Employee is granted an approved leave of absence, coverage for the Employee may be continued for a maximum of twelve months. The Employee will be responsible for making timely payments of any required contributions to the Plan.

3.6 EXTENSION OF COVERAGE DUE TO LAYOFF

If a covered Employee is laid off, coverage for the Employee and any covered Eligible Dependents may be continued through the end of the month in which the layoff occurred. The Employee will be responsible for making timely payments of any required contributions to the Plan.

3.7 CONTINUATION OF COVERAGE UNDER COBRA

In order to comply with the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Plan includes a continuation of coverage option, which is available to certain Covered Persons whose health care coverage(s) under the Plan would otherwise terminate. This provision is intended to comply with that law, and if it is found to be incomplete or in conflict in any way with the law or changes to the law, the law will prevail.

Life insurance, accidental death and dismemberment benefits and weekly income or long-term disability benefits (if part of the Employer's Plan) are not eligible for continuation under COBRA.

If retired Employees are eligible and covered under the Plan, such retired Employees are also "Employees" for the purposes of COBRA continuation coverage. Also, certain additional COBRA rights apply to such retirees and their covered Dependents with regard to an Employer's bankruptcy. Anywhere "retirees" are referenced, it means only those retired Employees who were covered under the Plan.

3.7.A Definitions

When capitalized in this COBRA section, the following items will have the meanings shown below:

Qualified Beneficiary - Any individual who meets one of the following requirements:

- (1) An individual who, on the day before a Qualifying Event, is covered under the Plan as either a covered Employee, or the covered Dependent spouse or child of a covered Employee.

- (2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. Such child has the right to immediately elect, under the COBRA continuation coverages the covered Employee has at the time of the child's birth or placement for adoption, the same coverage that a Dependent child of an active Employee would receive. The Employee's Qualifying Event date and continuation coverage period also apply to the child.

If an individual is not covered under the Plan on the day before a Qualifying Event because:

- (3) he was denied Plan coverage or was not offered Plan coverage and such denial or failure to offer constitutes a violation of applicable law, the individual will be considered to have had the Plan coverage and will be a "Qualified Beneficiary" if that individual experiences a Qualifying Event.

Exception: An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which he was a nonresident alien who received no earned income from the Employer that constituted income from sources within the United States. If such an Employee is not a Qualified Beneficiary, then a spouse or Dependent child of the Employee is not a Qualified Beneficiary by virtue of the relationship to the Employee.

Qualifying Event - Any of the following events which would result in the loss of health coverage under the Plan in the absence of COBRA continuation coverage:

- (1) voluntary or involuntary termination of Employee's employment for any reason other than Employee's gross misconduct;
- (2) reduction in an Employee's hours of employment to non-eligible status. In this regard, a Qualifying Event occurs whether or not Employee actually works and may include absence from work due to a disability, temporary layoff or leave of absence where Plan coverage terminates, but termination of employment does not occur. If a covered Employee is on FMLA unpaid leave, a Qualifying Event occurs at the time the Employee fails to return to work at the expiration of the leave, even if the Employee fails to pay his portion of the cost of Plan coverage during the FMLA leave;
- (3) for an Employee's spouse or child, Employee's entitlement to Medicare. For COBRA purposes, "entitlement" means that the Medicare enrollment process has been completed with the Social Security Administration and the Employee has been notified that his or her Medicare coverage is in effect;
- (4) for an Employee's spouse or child, the divorce or legal separation of the Employee and spouse;
- (5) for an Employee's spouse or child, the death of the covered Employee;
- (6) for an Employee's child, the child's loss of Dependent status (e.g., a Dependent child reaching the maximum age limit);

- (7) for retirees and their Dependent spouses and children, loss of Plan coverage due to the Employer's filing of a bankruptcy proceeding under Title 11 of the U.S. Bankruptcy Code. In order for a Qualifying Event to occur, the Employee must have retired on or before the date of substantial elimination of the Plan's benefits and must be covered under the Plan on the day before the bankruptcy proceedings begin. "Substantial elimination" of the Plan's benefits must occur within 12 months before or after the bankruptcy proceedings begin.

NonCOBRA Beneficiary - An individual who is covered under the Plan on an "active" basis (i.e., an individual to whom a Qualifying Event has not occurred).

3.7.B Notification

The Plan Administrator must provide Qualified Beneficiaries with notification of their COBRA continuation coverage rights within 14 days of receipt of notice of a Qualifying Event. Notice to Qualified Beneficiaries must be provided in person or by first-class mail.

Each Qualified Beneficiary, including a child who is born to or placed for adoption with an Employee during a period of COBRA continuation coverage, has a separate right to receive a written election notice when a Qualifying Event occurs that permits him to exercise COBRA coverage continuation rights. However, where more than one Qualified Beneficiary resides at the same address, the notification requirement will be met with regard to all such Qualified Beneficiaries if one election notice is sent to that address, by first-class mail, with clear identification of those beneficiaries who have separate and independent rights to COBRA continuation coverage.

An Employee or Qualified Beneficiary is responsible for notifying the Employer or Plan Administrator within 60 days of a Qualifying Event that is: (1) a Dependent child losing eligibility under the requirements of the Plan, or (2) the divorce or legal separation of the Employee from his/her spouse.

3.7.C Election And Election Period

COBRA continuation coverage may be elected during the period beginning on the date Plan coverage would otherwise terminate due to a Qualifying Event and ending on the later of the following: (1) 60 days after coverage ends due to a Qualifying Event, or (2) 60 days after the notice of the COBRA continuation coverage rights is provided to the Qualified Beneficiary.

If the COBRA election of a covered Employee or spouse does not specify "self-only" coverage, the election is deemed to include an election on behalf of all other Qualified Beneficiaries with respect to the Qualifying Event. However, each Qualified Beneficiary who would otherwise lose coverage is entitled to choose COBRA continuation coverage, even if others in the same family have declined. A parent or legal guardian may elect or decline for minor Dependent children.

An election of an incapacitated or deceased Qualified Beneficiary can be made by the legal representative of the Qualifying Beneficiary or the Qualified Beneficiary's estate, as determined under applicable state law, or by the spouse of the Qualified Beneficiary.

If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage rights, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver will be an election of COBRA continuation coverage. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered to be made on the date they are sent to the Employer or Plan Administrator.

Open Enrollment rights which allow NonCOBRA Beneficiaries to choose among any available coverage options are also applicable to each Qualified Beneficiary. Similarly, the "special enrollment rights" of the Health Insurance Portability and Accountability Act (HIPAA) extend to Qualified Beneficiaries. However, if a former Qualified Beneficiary did not elect COBRA, he does not have special enrollment rights, even though active Employees not participating in the Plan have such rights under HIPAA.

The Plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during the election period.

3.7.D Effective Date Of Coverage

COBRA continuation coverage, if elected within the period allowed for such election, is effective retroactively to the date coverage would otherwise have terminated due to the Qualifying Event, and the Qualified Beneficiary will be charged for coverage in this retroactive period.

See "Election and Election Period" for an exception to the above when a Qualified Beneficiary initially waives COBRA continuation coverage and then revokes his waiver. In that instance, COBRA continuation coverage is effective on the date the waiver is revoked.

3.7.E Level Of Benefits

COBRA continuation coverage will be equivalent to coverage provided to similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. If coverage is modified for similarly situated NonCOBRA Beneficiaries, the same modification will apply to Qualified Beneficiaries.

If the Plan includes a deductible requirement, a Qualified Beneficiary's deductible amount at the beginning of the COBRA continuation period must be equal to his deductible amount immediately before that date. If the deductible is computed on a family basis, only the expenses of those family members electing COBRA continuation coverage are carried forward to the COBRA continuation coverage. If more than one family unit results from a Qualifying Event, the family deductibles are computed separately based on the members in each unit. Other plan limits are treated in the same manner as deductibles.

If a Qualified Beneficiary is participating in a region-specific health plan that will not be available if the Qualified Beneficiary relocates, any other coverage that the Plan Sponsor makes available to active Employees and that provides service in the relocation area must be offered to the Qualified Beneficiary.

3.7.F Cost Of Continuation Coverage

The cost of COBRA continuation coverage will not exceed 102% of the Plan's full cost of coverage during the same period for similarly situated NonCOBRA Beneficiaries to whom a Qualifying Event has not occurred. The "full cost" includes any part of the cost which is paid by the Employer for NonCOBRA Beneficiaries.

The initial payment must be made within 45 days after the date of the COBRA election by the Qualified Beneficiary. Payment must cover the period of coverage from the date of the COBRA election retroactive to the date of loss of coverage due to the Qualifying Event (or date a COBRA waiver was revoked, if applicable). Contributions for successive periods of coverage are due on the first of each month thereafter, with a 30-day grace period allowed for payment. Where an Employee organization or any other entity that provides Plan benefits on behalf of the Plan Sponsor permits a billing grace period later than the 30 days stated above, such period shall apply in lieu of the 30 days. Payment is considered to be made on the date it is sent to the Plan or Plan Sponsor.

The Plan must allow the payment for COBRA continuation coverage to be made in monthly installments but the Plan is also permitted to allow for payment at other intervals. The Plan is not obligated to send monthly premium notices.

The cost of COBRA continuation coverage can only increase if:

- (1) the cost previously charged was less than the maximum permitted by law;
- (2) the increase occurs due to a disability extension (i.e., the 11-month disability extension) and does not exceed the maximum permitted by law which is 150% of the Plan's total cost of coverage; or
- (3) the Qualified Beneficiary changes his coverage option(s) which results in a different coverage cost.

Timely payments which are not significantly less than the required amount are deemed to satisfy the Plan's payment requirement, unless the Plan notifies the Qualified Beneficiary of the deficiency and grants a reasonable period of time (at least 30 days) to make full payment.

Note: For Qualified Beneficiaries who reside in a state with a health insurance premium payment program, the State may pay the cost of COBRA coverage of a Qualified Beneficiary who is eligible for health care benefits from the State through a program for the medically-indigent or due to a certain disability. The Employer's personnel offices should be contacted for additional information.

3.7.G Maximum Coverage Periods

The maximum coverage periods for COBRA continuation coverage are based on the type of Qualifying Event and the status of the Qualified Beneficiary, and are as follows:

- (1) if the Qualifying Event is a voluntary or involuntary termination of employment or reduction of hours of employment, the maximum coverage period is 18 months after the Qualifying Event. With a disability extension (see “Disability Extension” information below), the maximum coverage period is extended to 29 months;
- (2) if the Qualifying Event occurs to a Dependent due to Employee’s enrollment in the Medicare program before the Employee himself experiences a Qualifying Event, the maximum coverage period for the Dependent is 36 months from the date the Employee is enrolled in Medicare;
- (3) in the case of a bankruptcy Qualifying Event with regard to a retiree, the maximum coverage period is to the date of the retired Employee’s death. The maximum coverage period for a Qualified Beneficiary who is the spouse, surviving spouse or Dependent child of the retired Employee ends on the earlier of: (1) 36 months after the death of the retired Employee, or (2) the date of the Qualified Beneficiary’s death;
- (4) for any other Qualifying Event, the maximum coverage period ends 36 months after the Qualifying Event.

If a Qualifying Event occurs which provides an 18-month or 29-month maximum coverage period is followed by a second Qualifying Event that allows a 36-month maximum coverage period, the coverage period will be expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of both Qualifying Events. Thus, a termination of employment following a Qualifying Event that is a reduction of hours of employment or a bankruptcy of the Plan Sponsor following any Qualifying Event will not expand the maximum COBRA continuation period. In no circumstance can the COBRA maximum coverage period be more than 36 months after the date of the first Qualifying Event, except in the case of a bankruptcy Qualifying Event with regard to a retiree where the maximum coverage period is to the date of the retired Employee’s death.

Also, medical continuation of coverage under The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) does not extend the COBRA continuation period but any such Employee and any of his or her covered Dependents shall be treated as any other Qualified Beneficiary for purposes of COBRA.

3.7.H Disability Extension

An 11-month disability extension (an extension from a maximum 18 months of COBRA continuation coverage to a maximum 29 months) will be granted if a Qualified Beneficiary is determined under Title II or XVI of the Social Security Act to have been disabled at the time of the Qualifying Event or at any time during the first 60 days thereafter. To qualify for the disability extension, the Plan Administrator must be provided with notice of the Social

Security Administration's disability determination date which falls within the allowable periods described. The notice must be provided within 60 days of the disability determination and prior to expiration of the initial 18-month COBRA continuation coverage period. The disabled Qualified Beneficiary or any Qualified Beneficiaries in his or her family may notify the Plan Administrator of the determination. The Qualified Beneficiary must also notify the Plan if the Qualified Beneficiary is later determined by Social Security to be no longer disabled, within 30 days of that determination.

Under the Disability extension, the Qualified Beneficiary's cost for continuation coverage for the 19th through 29th month of continued coverage shall increase to 150% of the Plan's cost for similarly situated Non-COBRA Beneficiaries.

If the individual who is eligible for the 11-month disability extension also has family members who are entitled to COBRA continuation coverage, those family members are also entitled to the 29-month COBRA continuation coverage period.

3.7.I Termination Of Continuation Coverage

Except for an initial interruption of Plan coverage in connection with a waiver (see "Election and Election Period" above), COBRA continuation coverage that has been elected by or for a Qualified Beneficiary will extend for the period beginning on the date of the Qualifying Event and ending on the earliest of the following dates:

- (1) the last day of the applicable maximum coverage period – see "Maximum Coverage Periods" above;
- (2) the date on which the Employer ceases to provide any group health plan to any Employee;
- (3) the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes covered under any other plan that does not contain any exclusion or limitation with respect to any pre-existing condition that would reduce or exclude benefits for such condition in the Qualified Beneficiary;
- (4) the date, after the date of the COBRA election, that the Qualified Beneficiary first becomes entitled to Medicare benefits. For COBRA purposes, "entitled" means that the Medicare enrollment process has been completed with the Social Security Administration and the individual has been notified that his or her Medicare coverage is in effect;
- (5) in the case of a Qualified Beneficiary entitled to a disability extension, the later of:
 - (A) 29 months after the date of the Qualifying Event, or the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

- (B) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension;
- (6) the end of the last period for which the cost of continuation coverage is paid, if payment is not received in a timely manner (i.e., coverage may be terminated if the Qualified Beneficiary is more than 30 days delinquent in paying the applicable premium). The plan is required to make a complete response to any inquiry from a healthcare provider regarding a Qualified Beneficiary's right to coverage during any period the Plan has not received payment.

The Plan Sponsor can terminate, for cause, the coverage of any Qualified Beneficiary on the same basis that the Plan may terminate the coverage of similarly-situated NonCOBRA Beneficiaries for cause (e.g., for the submission of a fraudulent claim).

If an individual is receiving COBRA continuation coverage solely because of the person's relationship to a Qualified Beneficiary (i.e., a newborn or adopted child acquired during an Employee's COBRA coverage period), the Plan's obligation to make COBRA continuation coverage available will cease when the Plan is no longer obligated to make COBRA continuation coverage available to the Qualified Beneficiary.

3.8 REINSTATEMENT OF COVERAGE

3.8.A COBRA Participants

An Employee who has elected COBRA continuation of coverage will be considered to have had no lapse of coverage, provided that the coverage is in effect on the day before the Employee returns to eligible employment.

3.8.B Reinstatement of Coverage Following a Military Leave of Absence

Upon return from a military leave of absence, provided the Employee qualifies under the Uniformed Services Employment and Reemployment Rights Act (USERRA), and provided that an enrollment form is submitted, coverage for the Employee and Eligible Dependents will be reinstated on the return-to-work date. Should this paragraph apply, the Employee and any Eligible Dependents will not be subject to a waiting period or Preexisting Condition provisions. Any Deductible or Coinsurance satisfied prior to the leave of absence will be credited if reinstatement takes place during the same Calendar Year in which the expenses were incurred.

3.9 REPLACEMENT OF PRIOR GROUP PLAN

3.9.A Persons Who Are Sick or Injured

This provision applies to Employees or Dependents who:

1. were validly covered under the prior group plan on the date that plan ended;
2. are a member of an eligible class in this Plan;
3. are not covered under this Plan because:
 - a. the Employee is not Actively at Work because of Sickness or Injury; or
 - b. the Dependent is confined because of Sickness or Injury.

This Plan will extend replacement benefits to the Employee or the Employee's Dependents specified above. If the prior plan would have paid benefit, benefits will be paid based upon this Plan. This Plan will reduce benefits by the amount for which the prior plan is liable.

These benefits will cease on the earliest of the following:

1. the date the Employee or Dependents become covered under the Plan;
2. the date the Employee's employment ends;
3. the date the Dependent's status as a Dependent ends;
4. the date this Plan ends; or
5. the end of twelve continuous months under this provision.

3.9.B Persons Who Have Preexisting Conditions

This provision applies to Employees or Dependents who:

1. were validly covered under the prior group plan on the date that plan ended;
2. are a member of an eligible class in this Plan;
3. are covered under this Plan; and
4. have a Preexisting Condition.

For the first 12 months of coverage, this Plan will pay benefits under the lesser of the prior plan or this Plan (without applying the Preexisting Condition limitation).

3.9.B Credit for Prior Period

This Plan will give credit for deductibles and waiting periods to the extent they were met under the prior plan during the same calendar year, or during the 90 days prior to this Plan's effective date, whichever is most beneficial to the Participant.

ARTICLE IV

UTILIZATION REVIEW ORGANIZATION

4.1 GENERAL

The Utilization Review Program requires that the Participant follow certain procedures regarding Inpatient Hospital Confinements and Surgical Procedures. A Participant will be assessed a penalty, as specified in this Article, for not complying with the Utilization Review Program.

The Plan Administrator shall appoint a Utilization Review Organization to administer the Utilization Review Program.

4.2 HOSPITAL PRECERTIFICATION PROCEDURES

A Participant, a member of his family, or his Physician must notify the Utilization Review Organization prior to a non-emergency Hospital Confinement. In the event of an emergency Hospital Confinement, the Participant, a member of his family, or his Physician must notify the Utilization Review Organization within 24 hours following admission, except that for maternity admissions, the Plan does not require precertification of the first 48 hours of a vaginal delivery, or the first 96 hours of a Cesarean delivery. The 48 or 96 hours, as applicable, are counted from the time of actual delivery.

Failure to follow the above specified notification procedures will result in an additional \$250 deductible per confinement. Additional costs paid by the Participant due to this reduction in Benefits will not apply to the accumulation of the Out-of-Pocket Maximum.

4.3 LENGTH OF STAY PENALTY

Upon notification, the Utilization Review Organization will review the Participant's condition and proposed treatment plan and will work with the attending Physician to plan the hospitalization in advance.

The Utilization Review Organization will approve a certain number of days of confinement based upon the information provided. If complications arise during confinement which necessitate a longer period of confinement than initially expected, the Utilization Review Organization must be contacted immediately to approve the additional days of confinement. No Benefits will be payable for facility charges incurred during excess or unauthorized days of confinement. Additional costs paid by the Participant due to this reduction in Benefits will not apply to the accumulation of the Out-of-Pocket Maximum.

4.4 SURGICAL PRECERTIFICATION PROCEDURES

A Participant, a member of his family, or his Physician must notify the Utilization Review Organization prior to a non-emergency Surgical Procedure. In the event of an emergency Surgery, the Participant, a member of his family, or his Physician must notify the Utilization Review Organization within 24 hours following such Surgery.

Failure to follow the above specified notification procedures will result in a \$250 penalty. Additional costs paid by the Participant due to this reduction in Benefits will not apply to the accumulation of the Out-of-Pocket Maximum.

4.5 MANDATORY OUTPATIENT SURGERY REQUIREMENT

Upon notification, the Utilization Review Organization will review the Participant's condition and the proposed surgery and will work with the attending Physician to make sure that the Participant's surgery is performed in the most appropriate setting.

Certain Surgical Procedures can usually be performed safely on an Outpatient basis. If the Utilization Review Organization advises the Participant and/or his Physician that a Surgical Procedure should be performed on an Outpatient basis, no Benefits will be payable for facility charges incurred when such a Surgical Procedure is performed on an Inpatient basis. This penalty will not apply when it is Medically Necessary that the Surgery be performed on an Inpatient basis. Additional costs paid by the Participant due to this reduction in Benefits will not apply to the Out-of-Pocket Maximum.

4.6 WEEKEND ADMISSION PENALTY

No Benefits will be payable for any expenses incurred during the initial weekend confinement for any non-emergency confinement commencing on Friday, Saturday, or Sunday. This penalty will not apply to admissions when surgery is scheduled for the following day. Additional costs paid by the Participant due to this reduction in Benefits will not apply to the accumulation of the Out-of-Pocket Maximum.

ARTICLE V

SCHEDULE OF COMPREHENSIVE MAJOR MEDICAL BENEFITS DESCRIPTION OF COVERED CHARGES

NOTE: See Exclusions (Article VI) for additional exclusions and limitations of the Plan.

5.1 DETERMINATION OF ELIGIBLE EXPENSES

Subject to the exclusions, conditions and limitations stated in this Plan Document, the Plan will pay Benefits to, or on behalf of, a Participant for covered Medical Expenses described in this Article, up to the maximum amounts specified in the Schedule of Benefits.

The Plan will pay Benefits for allowable charges for services and supplies which are ordered by a Physician. Services and supplies must be furnished by an Eligible Provider and be Medically Necessary.

The obligation of the Plan shall be fully satisfied by the payment of allowable expenses in accordance with the Schedule of Benefits. Benefits will be paid for the reimbursement of medical expenses incurred by the Participant if all provisions mentioned in this Plan Document are satisfied.

All payments made under this Plan for covered charges will be limited, as applicable, to negotiated fee schedules (for a Preferred Provider) or Reasonable and Customary charges (for a non-Preferred Provider).

5.2 DETERMINATION OF PAYMENT AMOUNTS

The Plan will pay Benefits for allowable expenses in the percentage specified in the Schedule of Benefits. The Participant is responsible for the remaining portion:

- For a Preferred Provider, the Participant is responsible for the applicable Coinsurance only; (for example, if the Plan pays 90% of the negotiated rate, the Participant shall be responsible for 10% of the negotiated rate)
- For a non-Preferred Provider, the Participant may be responsible for the amount charged by the non-Preferred Provider that is in excess of this Plan's Benefit (for example, if the Plan pays 70% of Reasonable and Customary Charges, the Participant may be responsible for up to the balance of the non-Preferred Provider's *billed* charges).
- Outside the State of California Preferred Provider service area, the Participant may obtain services from a MultiPlan network provider (as described in Section 5.3 below) at the non-Preferred Provider level. The participant shall be responsible for the applicable coinsurance only. For instance, the Plan pays 70% of the MultiPlan provider negotiated rate, and the Participant shall be responsible for 30% of the negotiated rate.

5.3 PREFERRED VS. NON-PREFERRED PROVIDER BENEFITS

Benefits for covered expenses incurred by a Participant will be payable at the Preferred Provider (PPO) level if the service is rendered by a provider who is a member of the PPO network, or at the Non-Preferred (Non-PPO) level if the service is rendered by a provider who is not a member of the PPO network.

Allowable expenses for services incurred outside the contracted service area will be determined in accordance with Section 5.2, above.

The Plan will cover medical and hospital services outside the CA PPO service area, at negotiated rates payable at the Non-Preferred Provider level, if the Covered Person utilizes the MultiPlan network for health care services needed in the event of an accidental Injury or Illness while temporarily away from home and out of the CA service area. The Covered Person may refer to the back of the ID card to contact MultiPlan. This coverage is limited to care which is needed immediately and unexpectedly.

If the Covered Person is admitted to the hospital outside the PPO service area, the Utilization Review Organization (see Article IV) must be notified within one working day following admission to the facility unless extraordinary circumstances (see next paragraph) prevent such notification within that time period. Otherwise, the Covered Person will be subject to the Non-Precertification Penalty.

Extraordinary Circumstances - In determining “extraordinary circumstances”, the Utilization Review Organization may take into account whether or not the condition was severe enough to prevent the Covered Person from notifying the Utilization Review Organization, or whether or not a member of the Covered Person’s family was available to notify the Utilization Review Organization. The Covered Person may have to prove that such “extraordinary circumstances” were present at the time of the admission or procedure.

Continuing or follow-up treatment is limited to services required before the Covered Person can return to the PPO service area without medically harmful consequences. Authorization to continue coverage through the MultiPlan provider may be granted by the Plan after review with the Utilization Review Organization if continued treatment out of the service area is deemed to be Medically Necessary and in the best interest of both the patient and the Plan. In some cases, the Plan will cover medical transportation to return the Covered Person to a participating PPO hospital or provider.

The Plan will cover Medically Necessary elective treatment outside the PPO service area at the Non-Preferred Provider level.

In the case of Retirees and persons on COBRA who are away from the service area and Dependents who are away from the service area while they are attending school, the Plan will provide benefits at the Non-Preferred Provider level for services provided by MultiPlan Providers without balance billed charges. Dependent children

between the ages of 19 and 24 who attend school full-time, Dependent children for whom the Covered Person is required by court order to provide medical coverage, and Dependent children who reside permanently outside the PPO service area may utilize MultiPlan Providers to receive benefits at the Non-Preferred Provider level without balance billed charges.

5.4 OUT-OF-POCKET MAXIMUM AMOUNTS

Preferred Provider:	\$500 per Participant per Calendar Year \$1,000 per Family per Calendar Year
Non-Preferred Provider:	\$1,500 per Participant per Calendar Year \$3,000 per Family per Calendar Year
Out-of-State:	\$500 per Participant per Calendar Year \$1,000 per Family per Calendar Year

The amount which each Participant (or, if applicable, each Family) must pay for covered health care expenses in the form of Coinsurance during any Calendar Year will be limited to the amount stated above as the Out-of-Pocket Maximum Amount. Covered health care expenses in excess of the Out-of-Pocket Maximum which are incurred by any Participant (or, if applicable, any Family) in any Calendar Year will be paid by the Plan in full. Covered expenses for treatment of Substance Abuse will not be credited toward the accumulation of the Out-of-Pocket Maximum Amount, nor paid in full once the Out-of-Pocket Maximum Amount is reached. Non-compliance penalties will also not be credited toward the accumulation of the Out-of-Pocket Maximum Amount.

5.5 MAXIMUM BENEFITS

Lifetime Maximum Benefit:	\$2,000,000 per Participant
Lifetime Maximum Benefit For Speech Therapy	\$5,000 per Participant
Lifetime Maximum Benefit for Temporomandibular Joint Dysfunction (TMJ) Treatment	\$2,000 per Participant
Calendar Year Maximum Benefit For Home Health Care And Hospice Care	\$10,000 per Participant
Calendar Year Maximum Benefit For Inpatient Treatment for Substance Abuse	\$10,000 per Participant
Calendar Year Maximum Benefit	\$1,000 per Participant

For Outpatient Treatment for
Substance Abuse

Calendar Year Maximum Benefit \$2,000 per Participant
For Physical Therapy and Chiropractic

Daily Maximum Benefit for \$175 per Participant
Inpatient expenses incurred in a
Non-PPO Hospital for treatment
Of Substance Abuse

Maximum Benefit for Air Ambulance \$3,500 per year

Maximum Benefit for Ground Ambulance \$1,000 per year

The Maximum Benefit is the maximum amount which will be paid by the Plan for allowable medical expenses incurred by each Participant. Other Maximum Benefits are specified in the applicable sections of this Master Plan Document.

5.6 LIMITING AGES

Dependent Children: 19

Student Dependents: 24

5.7 HOSPITAL INPATIENT EXPENSES

Preferred Provider: 90% of negotiated rate

Non-Preferred Provider: 70% of Reasonable and Customary Charges

Out-of-State Preferred Provider: 90% of negotiated rate

Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

5.7.A Semiprivate Room and Board Charges

Expenses for Semiprivate Room Accommodations, including general nursing services.

5.7.B Private Room and Board Charges

The maximum amount that the Plan will allow toward charges for private room and board is the average semiprivate room and board rate charged by the Hospital. In the event that the Hospital only provides private room and board accommodations, the Plan will allow ninety percent (90%) of the average room and board rate.

5.7.C Special Care Units

Expenses for special care units, including general nursing services. Special care units include intensive care units, cardiac care units, respiratory care units, step down units, emergency care facilities and other units considered by the Claims Administrator to be special care units.

5.7.D Hospital Service/Supplies

Benefits will be payable for Medically Necessary services and supplies furnished during a covered Hospital Confinement, including the following:

- Meals and special diets
- Operating and recovery rooms
- Drugs and medicines required during a period of confinement
- Oxygen and the use of equipment for its administration
- Laboratory and pathological tissue examinations
- Dressings and casts
- Thyroid function studies
- Blood transfusion services
- X-ray and other radiological examinations
- Electrocardiograms
- Electroencephalograms
- Physical therapy
- Inhalation therapy
- Use of heart-lung equipment
- Kidney dialysis services
- Anesthesia services
- Use of anesthesia equipment
- Radioactive materials and radiation therapy
- Diagnostic services

5.7.E Dental Confinements

Expenses incurred for Hospitalization in connection with dental or oral surgery will be covered if the confinement is certified in writing by a Physician as Medically Necessary to safeguard the life of the patient.

5.8 HOSPITAL OUTPATIENT EXPENSES

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Reasonable and necessary services rendered to a Participant in an Outpatient department of a Hospital. The following services are covered:

- Allergy testing
- Chemotherapy
- Dialysis
- Emergency room services

- Laboratory tests and x-rays
- Pre-admission testing
- Radiation therapy
- Respiratory therapy
- Surgical services

5.9 AMBULATORY SURGICAL CENTER

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Facility charges for procedures performed in an Ambulatory Surgical Center, and associated services and supplies.

5.10 SURGICAL SERVICES (INCLUDING SURGEON, ASSISTANT SURGEON, AND ANESTHESIA EXPENSES)

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

5.10.A Single Surgical Procedures

Surgical services rendered by a qualified Physician to a Participant, in or out of a Hospital. The following are covered surgical services:

1. The performance of generally accepted operative and cutting procedures, including specialized instrumentation, endoscopic examinations, and other invasive procedures.
2. The correction of fractures and dislocations.
3. Usual and related preoperative and postoperative care and follow-up care.
4. Other procedures approved by the Plan.

5.10.B Multiple Surgical Procedures

Multiple Surgical Procedures performed by one or more qualified Physicians during the same operative session will be covered according to the following guidelines:

1. The lesser of the actual charges or the amount stated in the Schedule of Benefits will be allowed for the primary Surgical Procedure.
2. Fifty percent (50%) of the lesser of the actual charges or the amount stated in the Schedule of Benefits will be allowed for each secondary Surgical Procedure.

5.10.C Bilateral Surgical Procedures

Bilateral Surgical Procedures performed by one or more qualified Physicians during the same operative session will be covered according to the following guidelines:

1. Benefits will be allowed for the primary Surgical Procedure.
2. Fifty percent (50%) of the lesser of the actual charges or the amount stated in the Schedule of Benefits will be allowed for each secondary Surgical Procedure.

5.10.D Repair of Multiple Traumatic Injuries

Repair of multiple traumatic injuries by one or more Physicians during the same operative session according to the following guidelines:

1. The lesser of the actual charges or the amount stated in the Schedule of Benefits will be allowed for each procedure performed on a separate bodily area or a separate bodily system.
2. The lesser of the actual charges or the amount stated in the Schedule of Benefits will be allowed for the primary procedure performed on the same bodily area or the same body system.
3. Fifty percent (50%) of the lesser of the actual charges or the amount stated in the Schedule of Benefits will be allowed for each secondary Surgical Procedure performed on the same bodily system.

5.10.E Special Surgical Procedures

1. **Cosmetic Surgery**
Services for cosmetic surgery when required to remedy a condition resulting from an Accidental Injury when sustained while covered under this Plan or to repair a birth defect of a Child who has been covered by this Plan since birth, or for reconstructive surgery following a mastectomy.

Effective March 1, 1999, in compliance with Sec. 2706 of the Public Health Service Act, added by the 1998 Omnibus Budget Bill, the following services complementing medical and surgical benefits for mastectomies, in a manner determined in consultation with the attending Physician and the patient, are covered:

- a. reconstruction of the breast on which the mastectomy was performed;
- b. surgery or reconstruction of the other breast to produce a symmetrical appearance;
- c. prostheses and physical complications with all stages of the mastectomy, including lymphademas.

All relevant Plan Provisions regarding annual Deductibles, Coinsurance and Copayments apply to these additional services.

2. **Dental Surgery**
Dental services for the treatment of a fractured jaw or an Injury to sound, natural teeth sustained while covered under this Plan.

5.10.F Assistant Surgeon

A Physician who actively assists the operating surgeon in rendering a covered surgical service to a Participant. Benefits are payable only if an intern, resident or Hospital staff member is not available. No benefits are payable for surgical assistance rendered by and intern, resident, or Hospital staff member.

5.10.G Postoperative Care

Postoperative care or follow-up care required in connection with covered surgical services.

5.10.H Anesthesia Services

1. Regional or General Anesthesia
The administration of regional or general anesthesia to a Participant by a qualified anesthesiologist in connection with a covered surgical service and not administered by the operating surgeon or surgical assistant.
2. Local or Topical Anesthesia
The administration of local or topical anesthesia is not a covered expense, except in maternity cases.
3. Medical Care in Connection with Anesthesia
Usual related care rendered in connection with the administration of anesthesia.

5.11 SECOND SURGICAL OPINION

Preferred Provider:	\$15 Copayment
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	\$15 Copayment
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Medical Expenses associated with obtaining a second opinion from a Physician regarding the necessity of a surgery or treatment. The Physician rendering an additional opinion must:

1. Be qualified by license or experience to offer such an opinion; and
2. Not be financially related to the Physician rendering the initial opinion.

5.12 PHYSICIAN IN-HOSPITAL VISITS

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Services rendered by a Physician to a Participant who is confined as a registered Inpatient in a Hospital. Consultations are also covered when Medically Necessary.

5.13 PHYSICIAN HOME/OFFICE VISITS

Preferred Provider: \$15 Copayment
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: \$15 Copayment
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Services and supplies provided by a Physician in a professional office, or in the home of the Participant when Medically Necessary.

5.14 OTHER PHYSICIAN SERVICES

Preferred Provider: 90% of negotiated rate
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: 90% of negotiated rate
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Reasonable and necessary services rendered to a Participant by a Physician. The following services are covered:

- Allergy injections
- Allergy testing
- Cardiac rehabilitation
- Chemotherapy
- Dermatology testing
- Dialysis
- Emergency Room services
- Infusion therapy
- Injections
- Interpretation of diagnostic tests
- Radiation therapy
- Respiratory therapy

5.15 DIAGNOSTIC EXPENSES

Preferred Provider: 90% of negotiated rate
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: 90% of negotiated rate
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

5.15.A Lab Expenses for Diagnostic Testing

Diagnostic tests and studies performed on a Participant by a clinic, other laboratory facility, or Physician. To be covered, services must be performed for the express purpose of determining the cause of definite symptoms experienced by the patient, and not in connection with routine physical examinations, except as specified in this Plan Document. Covered services include pathology and radiology expenses.

5.15.B Physician Expenses for Diagnostic Testing

A Physician's interpretation of covered diagnostic tests and studies.

5.16 SPEECH THERAPY EXPENSES

- Limited to a Lifetime Maximum Benefit of \$5,000 per Participant.

Preferred Provider:	\$15 Copayment
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	\$15 Copayment
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Services certified as Medically and/or psychologically Necessary by a Physician or duly licensed speech therapist to treat pathological or organic speech disorders including, but not limited to, cleft palate, cerebral palsy, hearing loss, aphasia, and speech and voice therapy following laryngectomy. Excluded are services to correct non-organic articulatory disorders and services that are otherwise provided by the public schools or other agencies such as Crippled Children's programs.

5.17 PHYSICAL THERAPY EXPENSES

- Limited to a shared Maximum Benefit with Chiropractic Care of \$2,000 per Participant per Calendar Year.

Preferred Provider:	\$15 Copayment
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	\$15 Copayment
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Services rendered by certified or licensed physical therapists provided such services are certified as Medically Necessary by a Physician.

5.18 CHIROPRACTIC CARE

Limited to a shared Maximum Benefit with Physical Therapy Expenses of \$2,000 per Participant per Calendar Year.

Preferred Provider:	\$15 Copayment
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	\$15 Copayment
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Benefits are payable for diagnostic evaluations and treatments by manipulation and other modalities.

5.19 ACUPUNCTURE

Acupuncture is covered up to a maximum benefit of \$250 per Calendar Year.

Preferred Provider: \$15 Copayment
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: \$15 Copayment
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

5.20 EXTENDED CARE FACILITY EXPENSES/ SKILLED NURSING FACILITY EXPENSES

Preferred Provider: 90% of negotiated rate
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: 90% of negotiated rate
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Services and supplies furnished by a Participant who is confined to an Extended Care Facility during a qualified confinement period. A "qualified confinement period" is a period of time which follows a confinement of the Participant in a Hospital for at least three consecutive days for the same or a related cause.

5.21 HOME HEALTH CARE EXPENSES

- Limited to a shared Maximum Benefit with Hospice Care of \$10,000 per Calendar Year per Participant.

Preferred Provider: 90% of negotiated rate
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: 90% of negotiated rate
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Covered charges include the following medical expenses for care of the Participant delivered in the Participant's home by a licensed Home Health Care Agency, provided that:

1. such services follow a confinement of the Participant in a Hospital for at least three consecutive days for the same or a related cause; and
2. services begin within fourteen days following the Participant's discharge from the Hospital.

Covered charges include the following medical expenses incurred through such programs:

- part-time or intermittent home nursing care provided by a Home Health Aide, licensed practical nurse (LPN), registered nurse (RN), or public health nurse
- physical, respiratory, occupational, or speech therapy; and
- medical supplies, drugs, medications prescribed by a Physician and laboratory services by or on behalf of a Hospital to the extent that such items would be covered under the Plan if the Participant had been Hospital confined.

In any event, covered charges will not include medical expenses incurred for the following:

- Home Health Care in excess of the Reasonable and Customary weekly cost for care in a Hospital
- Services provided by or that could be provided by the Participant's family or by a person residing with the Participant
- General household chores and custodial care or child care.

5.22 HOSPICE CARE EXPENSES

- Limited to a shared Maximum Benefit with Home Health Care of \$10,000 per Calendar Year per Participant.
- Limited to six months per Participant

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Covered charges include Medically Necessary Inpatient care and Home Health Care (as described in this Plan Document) delivered to a Terminally Ill Participant by medical personnel and home health aides under a licensed Hospice's administration. Covered charges also include bereavement counseling for the Terminally Ill Participant's Immediate Family.

In any event, covered charges will not include charges in excess of Reasonable and Customary charges that the Participant would exceed if he were Hospital confined.

5.23 PREGNANCY EXPENSES

Preferred Provider:	\$15 Copayment
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	\$15 Copayment
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Regular Plan Benefits (as specified in the applicable sections of this Master Plan Document) are payable for expenses incurred by the Employee, Spouse, or Dependent Daughter.

Covered charges include the following expenses:

1. Normal Pregnancy
Services required for the normal management of pregnancy, including any condition usually associated with the management of a difficult pregnancy, but not considered a complication of pregnancy. Includes antepartum or postpartum care of the mother.
2. Care for Complications of Pregnancy
Services required for the treatment of complications of pregnancy, including any physical effect directly caused by pregnancy, but considered to be an effect of normal pregnancy, conditions related to ectopic pregnancy, or conditions requiring Cesarean section.
3. Care for Miscarriage or Therapeutic Abortion

5.24 ABORTION EXPENSES

Regular Plan Benefits (as specified in the applicable sections of this Master Plan Document) are payable for expenses incurred by the Employee, Spouse, or Dependent Daughter.

Termination of a pregnancy is at the election of the Covered Person. Benefits are payable regardless of Medical Necessity.

5.25 STERILIZATION EXPENSES

Regular Plan Benefits (as specified in the applicable sections of this Master Plan Document) are payable for voluntary sterilization expenses incurred by a Participant.

Covered charges include procedures to bring about, but not reverse, sterilization. Benefits are payable regardless of Medical Necessity.

5.26 NEWBORN CARE EXPENSES

Preferred Provider:	\$15 Copayment
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	\$15 Copayment
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Regular Plan Benefits (as specified in the applicable sections of this Master Plan Document) are payable for Medically Necessary expenses incurred by a newborn

infant during his initial confinement. Such expenses are to be considered separate from expenses of the mother for the purposes of determining benefits, except that, effective April 1, 1997, if a claim is received which does not distinguish between the newborn's and mother's expenses, such claim will be processed as if the submitted expenses were incurred solely by the mother.

The following expenses are covered charges:

1. Hospital Expenses
Services and supplies furnished by a Hospital to care for a newborn infant during his initial confinement in the Hospital.
2. Physician Expenses
Services and supplies furnished by a Physician for the examination of a newborn infant. Inpatient Physician care for a healthy, full-term newborn includes the initial examination and the circumcision of male infants.

5.27 HUMAN ORGAN/TISSUE TRANSPLANT EXPENSES

Regular Plan Benefits (as specified in the applicable sections of this Master Plan Document) are payable for covered expenses related to non-experimental human organ transplants which are Medically Necessary. Covered procedures include, but are not limited to, the following types of transplants:

- Bone marrow
- Cornea
- Heart
- Heart/Lung
- Kidney
- Liver
- Lung
- Pancreas

The Plan will also cover any other types of human organ transplants that become accepted as non-experimental procedures, as determined by the Plan Administrator. Covered charges include acquisition cost and drugs, even if not otherwise covered under this Plan.

Regular Plan Benefits are also payable for covered transplant-related expenses incurred by a living donor, subject to coordination with any other medical benefits covering the donor, and subject to the Participant's Maximum Benefit.

5.28 WELL CHILD CARE

Benefit ends on Child's seventeenth birthday.

Preferred Provider: \$15 Copayment
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: \$15 Copayment
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Routine periodic office visits, including eye and ear screenings, and pediatric immunizations.

5.29 ADULT PREVENTIVE CARE

Preferred Provider: \$15 Copayment
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: \$15 Copayment
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Routine physical examinations and diagnostic tests performed as a part of the examination, routine gynecological examinations, Pap tests, and mammograms.

5.30 EXPENSES FOR TREATMENT OF MENTAL OR EMOTIONAL DISORDERS

Preferred Provider: 90% of negotiated rate
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: 90% of negotiated rate
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Effective January 1, 2000, the limitations specified in Sections 5.30.A and 5.30.B will apply.

5.30.A Inpatient Treatment for Mental or Emotional Disorders

Effective January 1, 2000:

- Limited to thirty days per Participant per Calendar Year
- Coverage for Non-Participating Provider covered charges is limited to a Maximum Benefit of \$175 per day
- Charges which exceed the Maximum Benefit do not apply to the annual Out-of-Pocket Maximum
- Day treatment will be paid as inpatient (4 hours of day treatment = 1/2 day; 8 hours = 1 day)

5.30.B Outpatient Treatment for Mental or Emotional Disorders

Effective January 1, 2000:

- Limited to 10 visits per Participant per Calendar Year

Preferred Provider: \$15 Copayment
Non-Preferred Provider: 70% of Reasonable and Customary Charges

Out-of-State Preferred Provider: \$15 Copayment
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

5.31 EXPENSES FOR THE TREATMENT OF SUBSTANCE ABUSE

Charges which exceed the maximum payable Benefit do not apply to the annual Out-of-Pocket Maximum.

Preferred Provider: 90% of negotiated rate
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: 90% of negotiated rate
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

5.31.A Inpatient Treatment for Substance Abuse

- Limited to a Maximum Benefit of \$10,000 per Participant per Calendar Year
- Limited to thirty days per Participant per Calendar Year
- Expenses incurred in a Non-PPO Hospital are limited to a maximum of \$175 per day.

Covered Hospital charges include semiprivate room accommodations and Medically Necessary services and supplies furnished by the Hospital or facility for diagnosis or treatment of Substance Abuse.

Covered physician charges include inpatient physician visits for the treatment of substance abuse.

5.31.B Outpatient Treatment for Substance Abuse

- Limited to a Maximum Benefit of \$1,000 per Participant per Calendar Year
- Expenses incurred in a Non-PPO Hospital are limited to \$20 per day

Preferred Provider: \$15 Copayment
Non-Preferred Provider: 70% of Reasonable and Customary Charges
Out-of-State Preferred Provider: \$15 Copayment
Out-of-State Non-Preferred Provider: 70% of Reasonable and Customary Charges

Covered charges include Medical Expenses for the Outpatient treatment of Substance Abuse, including the following expenses:

1. Medically Necessary services and supplies provided by a Hospital or other duly licensed facility on an Outpatient basis.
2. Charges for Physician visits in his office or on an Outpatient basis at a Hospital or other licensed facility.

5.32 AMBULANCE EXPENSES

- Air ambulance expenses are limited to a Maximum Benefit of \$3,500 per year
- Ground ambulance expense are limited to a Maximum Benefit of \$1,000 per year

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Transportation by an ambulance service to the nearest Hospital or Urgent Care Facility which would reasonably be expected to render medical treatment for the condition which necessitates emergency care.

5.33 OTHER COVERED SERVICES

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

5.33.A Durable Medical Equipment

The rental or initial purchase (whichever is less expensive; subject to approval by the Claims Administrator) of Durable Medical Equipment, including, but not limited to:

- Respiration equipment
- Hospital beds
- Wheelchairs

5.33.B Medical and Surgical Supplies

Medical and surgical supplies including, but not limited to, dressings, casts, splints, trusses, crutches, braces or supports.

Benefits are also payable for the purchase of prosthetic appliances and for their replacement, if required, because of wear or bodily change.

5.33.C Blood Transfusions, Blood, and Blood Plasma

Services and supplies required for the administration of blood transfusions, including blood, blood plasma, and plasma extenders, when not available to the Participant without charge.

5.33.D Private Nursing Services

Services certified as Medically Necessary by a Physician and provided by a nurse. The nursing services must require the special skill and training of a registered nurse, licensed practical nurse, or professional nurse.

5.34 TEMPOROMANDIBULAR JOINT (TMJ) DYSFUNCTION TREATMENT

- Limited to a Lifetime Maximum Benefit of \$2,000 per Participant.

Preferred Provider:	90% of negotiated rate
Non-Preferred Provider:	70% of Reasonable and Customary Charges
Out-of-State Preferred Provider:	90% of negotiated rate
Out-of-State Non-Preferred Provider:	70% of Reasonable and Customary Charges

Services and supplies certified as Medically Necessary that are required for the treatment of TMJ dysfunction.

5.35 PRESCRIPTION DRUG BENEFITS

NOTE: The prescription drug plan is administered by Advance PCS. The telephone number for Advance PCS is (800) 863-5514.

- All prescriptions filled at a retail pharmacy are limited to a thirty-four day supply or 100 units, whichever is greater.
 - All prescriptions filled through mail order are limited to a ninety day supply.
1. Prescriptions Filled at a Retail Pharmacy
 - Name Brand: \$15 per prescription or refill
 - Generic: \$8 per prescription or refill
 2. Prescriptions Filled Through Mail Order
 - Name Brand: \$15 per prescription or refill
 - Generic: \$8 per prescription or refill
 - (includes regular delivery costs)

The Plan will pay 100% of the cost of a covered prescription drug after a Participant has paid the applicable copayment per prescription or refill.

The Benefits described above are payable for drugs and medicines which require a Physician's prescription and which are dispensed by a licensed pharmacist, except for drugs otherwise excluded under the provisions of this Plan. This Plan also covers insulin, insulin syringes, and insulin devices and blood glucose testing machines, lancets, alcohol swabs, and test strips.

The following drugs are covered only up to age 25:

- ADD Drugs
- Tretinoin Products (Retin A)
- Accutane

Non-covered drugs include, but are not limited to, the following:

- Smoking deterrents
- Fertility drugs
- Growth hormones
- Hyperactivity drugs
- Nutritional supplements
- Prescription vitamins
- Steroids for body building
- Over-the-counter drugs or medicines
- Any prescription refilled in excess of the number specified by the Physician, or any refill dispensed after one year from the Physician's original order
- Any other drugs otherwise excluded under the provisions of this Plan
- Viagra (coverage for Viagra is excluded retroactive to April 1, 1997)
- Norplant
- Drugs used to treat hair loss

ARTICLE VI

EXCLUSIONS

The following are examples of the types of Medical Expenses which are excluded from covered charges under this Plan.

6.1 CHARGES INCURRED WHILE COVERAGE NOT IN EFFECT

Charges for services or supplies provided before a Participant's effective date of coverage under this Plan, or provided after the Participant's termination of coverage under this Plan.

6.2 WORKERS' COMPENSATION

Charges related to any Sickness or Injury for which coverage is available in whole or in part under any Workers' Compensation Act or similar legislation.

6.3 U.S. GOVERNMENT HOSPITALS

Charges for services or supplies provided by the Veterans Administration or in any Hospital or institution owned, operated, or maintained by the United States government for a service-related Sickness or Injury.

6.4 PUBLIC PROGRAMS

Charges made for service or supplies which can be paid for by any government agency, even if the Participant waives his rights to those services or supplies.

6.5 NO CHARGE SERVICES

Charges for any Sickness or Injury for which the service furnished to the Participant was furnished without charge, or would have been furnished without charge if this Plan were not in effect.

6.6 LEGAL OBLIGATION

Charges for which no legal liability would exist had coverage under this Plan not existed.

6.7 OTHER PLAN PROVISIONS

Charges under one coverage of this Plan to the extent that Benefits are payable for the same charges under another coverage provided under this Plan.

6.8 CHARGES NOT MEDICALLY NECESSARY

Charges not Medically Necessary for the diagnosis or treatment of Sickness or Injury.

6.9 CHARGES EXCEEDING REASONABLE AND CUSTOMARY ALLOWANCES

Charges that are in excess of Reasonable and Customary allowable charges.

6.10 PHYSICIAN APPROVAL

Charges for any treatment not recommended or approved by a Physician.

6.11 LICENSED PHYSICIAN

Charges for a Physician or other Provider acting outside the scope of his license.

6.12 WAR-RELATED EXPENSES

Charges for treatment of any Sickness or Injury caused by war, act of war, riot, civil disobedience, nuclear explosion, nuclear accidents, or similar event whether such event be declared or undeclared war.

6.13 MILITARY SERVICE

Charges for treatment of any Sickness or Injury incurred while in the military, naval, or air service of any country.

6.14 LEGAL PROHIBITION

Charges prohibited by any law of the jurisdiction in which the Participant resides at the time the expense is incurred.

6.15 FELONY PARTICIPATION

Charges for a Sickness or Injury sustained during the commission, or attempted commission, of an assault or felony; or Injuries sustained while engaged in an illegal occupation.

6.16 SELF-INFLICTED INJURIES

Charges for an intentionally self-inflicted Sickness or Injury, whether sane or insane.

6.17 EXPERIMENTAL OR INVESTIGATIONAL CHARGES

Charges for treatments, procedures, devices or drugs which the Plan Administrator determines, in the exercise of its discretion, are experimental, investigative, or done primarily for research.

The Plan Administrator shall use the following guidelines to determine that a drug, device, medical treatment or procedure is experimental or investigative:

1. If the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
2. If the drug, device, medical treatment, or procedure, or the patient informed procedure, was reviewed and approved for experimental use by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
3. If Reliable Evidence shows that the drug, device, medical treatment, or procedure is the subject of ongoing Phase I or Phase II clinical trials, is in the research, experimental, study, or investigative arm of ongoing Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with a standard means of treatment or diagnosis; or
4. If Reliable Evidence shows that the 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 efficacy, or its efficacy as compared with a standard means of treatment or diagnosis.

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 informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

6.18 EDUCATION, TRAINING OR INSTRUCTION

Charges for education or training of any kind.

6.19 CUSTODIAL CARE

Charges for custodial care, including institutions that are custodial in nature such as homes for the aged, rest homes, and schools for the mentally retarded.

6.20 DENTAL PROCEDURES

Charges for dental care or treatment, except as specified in this Plan Document.

6.21 COSMETIC SERVICES

Charges for services provided for cosmetic purposes, except as specified in this Plan Document. The term “cosmetic services” includes services which are described in Code Section 212 (d) (9).

6.22 SEXUAL DYSFUNCTIONS

Effective January 1, 2000, charges for services and supplies furnished in connection with sexual dysfunction, sexual inadequacies, or complications arising from any such procedures.

6.23 TRANSSEXUAL SURGERY

Charges for services or supplies furnished in connection with sex reassignment surgery or hormonal treatments, or complications arising from any such procedures.

6.24 VISION EXPENSES

Charges for eyeglasses or contact lenses and examinations for their prescription or fitting, except that, as indicated in Article V, this Plan covers eye screenings for Children to the age of seventeen.

6.25 INFERTILITY TREATMENT/ARTIFICIAL INSEMINATION

Charges for in-vitro fertilization procedures or drugs; GIFT (Gamete Intrafallopian Transfer) procedures; artificial insemination; or other procedures, studies, or drugs related to the treatment of infertility; or any complications arising from such procedures.

6.26 STERILIZATION REVERSAL

Charges in connection with surgery to reverse voluntary sterilization, or any complications arising from such procedures.

6.27 OBESITY/WEIGHT LOSS

Charges for treatment for obesity, including diet control and weight reduction, when not required by a specifically identified condition of morbid obesity and disease etiology.

6.28 SPEECH THERAPY

Charges for speech therapy to correct a non-organic speech defect.

6.29 MILEAGE COSTS/CLAIM FORMS

Charges for mileage costs, completion of claim forms, or preparation of medical reports.

6.30 SALES TAX

Charges for sales tax or other tax imposed by law.

6.31 LUXURY SERVICES

Charges for luxury services and supplies such as mineral baths, massages, telephones, radio and television.

6.32 UNNECESSARY HOSPITAL TREATMENT

Charges for Hospital Services not consistent with and not required in the management and treatment of a Sickness or Injury for which a person is admitted.

6.33 TECHNICAL MEDICAL ASSISTANCE

Charges for technical medical assistance or standby Physician services.

6.34 HEARING AIDS

Charges for hearing aids and examinations for them, except that, as indicated in Article V, the Plan covers ear screenings for Children to the age of seventeen.

6.35 TREATMENT BY AN IMMEDIATE RELATIVE

Charges for services which are self-administered or are rendered by an Immediate Relative.

6.36 TRAVEL EXPENSES

Charges for travel expenses, whether or not recommended by a Physician.

6.37 TELEPHONE CONSULTATIONS

Charges for telephone consultations.

6.38 TREATMENT NOT PROVIDED BY A PHYSICIAN

Charges for treatment not provided by a Physician.

6.39 RADIAL KERATOTOMY

Charges incurred for services or procedures involving radial keratotomy or other eye refractive surgery.

6.40 ROUTINE FOOT CARE

Charges for routine foot care, including: treatment of corns, calluses, trimming or debridement of toenails or other foot tissue, or treatment of mycotic toenails when there is no indication of metabolic disease; treatment of foot weakness or strain; or orthotics or supportive devices.

6.41 VITAMINS/NUTRITIONAL SUPPLEMENTS

Charges for nutritional supplements or vitamins, even if a written prescription is provided.

6.42 OVER-THE-COUNTER DRUGS

Charges for non-legend (over-the-counter) drugs, other than insulin.

6.43 PRESCRIPTION DRUG COPAYMENTS

Prescription drug plan copayments are not covered under Medical Benefits.

6.44 EMPLOYER'S MEDICAL CLINIC

Charges for services provided in a medical department or clinic maintained by an Employer.

6.45 CHELATION THERAPY

Charges for chelation therapy, except for the treatment of heavy metal poisoning.

6.46 PRE-EXISTING CONDITIONS

During the first six months from the Enrollment Date, twelve months for a late enrollee, this Plan will not provide Benefits for a Participant for any condition, regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six month period ending on the Enrollment Date by a health care provider or practitioner duly licensed to provide such care under state law and operating within the scope of said license. However, if a Participant receives no medication, care or treatment for a Pre-Existing Condition or another condition related to a Pre-Existing Condition for a continuous period of six months after the Participant's coverage under the Plan begins, the six- or twelve-month exclusionary period, as applicable, shall be waived.

This exclusion shall not apply to a newborn, an adopted child under the age of eighteen, or a child placed for adoption under the age of eighteen, if the child becomes covered within thirty days of birth, adoption, or placement for adoption. Furthermore, this exclusion shall not apply to pregnancy.

The six- or twelve-month Pre-Existing Condition exclusion period may be reduced by the amount of creditable coverage possessed by the Participant. Pursuant to HIPAA, an individual has a right to request a Certificate of Creditable Coverage from prior health plan(s). This Plan will help facilitate, as necessary, in obtaining Certificates of Creditable Coverage.

6.46.A Creditable Coverage

The Plan shall determine the total amount of days of creditable coverage for each Participant by counting all the days during which the Participant had one or more types of creditable coverage. This determination will be made regardless of the specific benefits included in the coverage.

6.46.B Certificates of Creditable Coverage

Within a reasonable time following the receipt of a Certificate of Creditable Coverage, or other evidence of Creditable Coverage, the Plan shall make a determination regarding the length, if any, of the Pre-Existing Condition exclusion period that shall apply to the Participant and provide notice to the Participant of said determination. The Plan shall have the right to reconsider and modify its initial determination if it is later determined that the Creditable Coverage did not exist.

The Plan shall issue a Certificate of Creditable Coverage, automatically and without charge, under the following circumstances:

- For an individual who is a Qualified Beneficiary entitled to elect COBRA coverage, the Certificate of Creditable Coverage shall be issued with the COBRA notice sent after the Qualifying Event.
- For an individual who loses coverage under the Plan, but is not entitled to COBRA coverage, the Certificate of Creditable Coverage shall be issued as soon as reasonably possible after coverage ceases.
- For an individual who is a Qualified Beneficiary and has elected COBRA coverage, the Certificate of Creditable Coverage shall be issued within a reasonable time after the cessation of COBRA coverage or, if applicable, after the expiration of any grace period for the payment of COBRA premiums.
- The Plan shall also issue a Certificate of Creditable Coverage at any time within twenty-four months after coverage ceases, provided that the Plan receives a written request for the Certificate of Creditable Coverage by the former Plan Participant (or by another person authorized by the former Plan Participant).

The Certificate of Creditable Coverage shall be in the form required by HIPAA.

Also upon written request, the Plan shall provide a copy of the Plan Document and other information outlined in the model form established by HIPAA to provide

additional information on categories of benefits for plans that use the Alternative Method of counting Creditable Coverage. The Plan shall charge the requesting entity or individual a fee to cover the reasonable cost of providing this information.

6.47 EATING DISORDERS

Charges for services and supplies relating to eating disorders.

ARTICLE VII

CLAIMS FILING PROVISIONS

7.1 NOTICE OF CLAIM

Written notice of a claim must be given as soon as reasonably possible after the occurrence or commencement of any loss covered by this Plan. Notice given by or on behalf of the claimant to the Claims Administrator – Keenan HealthCare, a division of Keenan & Associates – with information sufficient to identify the claimant, will be considered notice to the Employer.

7.2 CLAIM FORMS

The Employer, upon receipt of a written notice of claim, will furnish to the claimant forms for filing proof of loss. If such forms are not furnished within fifteen days after notice is given, the claimant will be considered to have complied with the requirement of the Plan with respect to proof of loss and written proof covering the occurrence, the character, and the extent of the loss for which the claim is made.

7.3 PROOF OF LOSS

In order to promptly process claims and to avoid errors in processing that could be caused by delays in filing, written proof of loss should be furnished to the Claims Administrator within ninety days after the date of loss. Failure to furnish written proof within ninety days will not invalidate or reduce any claim if it was not reasonably possible to give proof within such time, provided that such proof is furnished as soon as reasonably possible. In no event, except in the absence of legal capacity of the claimant, may proof be furnished later than twelve months from the date upon which an expense was incurred. Except as indicated in the preceding sentence, claims will be barred if proof of loss is not furnished within twelve months from the date incurred.

7.4 TIME OF PAYMENT OF CLAIMS

Benefits for any loss will be paid upon receipt of required proof of loss by the Claims Administrator. The Claims Administrator shall process said claim within sixty days after the receipt of the claim, unless the Claims Administrator requires additional information. If the Claims Administrator requires more than sixty days to process the claim, the claimant will be notified of the delay, the reason for the delay, and the expected date when a decision will be made.

ARTICLE VIII
CLAIMS APPEAL PROCEDURES

8.1 DENIAL OF CLAIM

If a claim is wholly or partially denied, the Claims Administrator shall furnish the claimant with a written explanation for the denial within sixty days after receipt of the written proof of loss. If the Claims Administrator fails to pay Benefits or furnish written explanation of claim denial within such period, then the claim shall be deemed denied for the purpose of the review procedure.

8.2 EXPLANATION OF DENIAL

The written explanation of a claim denial shall set forth, in a manner calculated to be understood by the claimant, the following information:

1. The reason or reasons for the denial.
2. If the claim is denied because the Claims Administrator needs more information to make a decision, a description of any additional information necessary for the claimant to perfect the claim and explanation of why such information is necessary.
3. A statement that the claim and its denial shall be reviewed upon submission of a written report.
4. A statement that the claimant, the claimant's attorney, or other duly authorized representative shall have, as part of the review procedure, a reasonable opportunity to examine pertinent Plan documents and records, and to submit written comments on issues.
5. A statement that the failure to submit a written request for review within sixty days after the receipt of the written explanation of the claim denial shall make the Claim Administrator's decision final.

8.3 REVIEW PROCEDURE

A claim and its denial shall be reviewed if a written request for review is filed within sixty days after receipt of the written explanation of the claim denial by the claimant. Otherwise, the initial decision shall be the final decision of the Plan. As part of the review procedure, the claimant or the claimant's duly authorized representative shall have a reasonable opportunity to examine pertinent Plan documents and records and to submit written comments on the issues.

8.4 DECISION ON REVIEW

The Plan Administrator shall review the information and comments submitted by the claimant or the claimant's duly authorized representative. The Plan Administrator shall furnish the claimant with a written explanation of his decision on review within sixty days after the receipt of a written request for review. If special circumstances

exist that require an extension of time for reviewing the information, the Plan Administrator shall have one-hundred-twenty days after receipt of the written request for review to furnish the claimant with a written decision or review denial, provided the Plan Administrator gives the claimant written notice of the special circumstances within sixty days of the receipt of the written request for review. If the Plan Administrator fails to furnish a written explanation of his decision on review within such time, then the claim shall be deemed denied for purposes of the review procedure.

8.5 EXPLANATION OF DECISION ON REVIEW

The written explanation of the decision on review shall set forth, in a manner calculated to be understood by the claimant, the following information:

1. The specific reason or reasons for the decision, including a response to the information and comments, if any, submitted by the claimant and his duly authorized representative.
2. Specific reference to pertinent Plan provisions and records, if any, on which the decision is based.

8.6 LIMITATION

1. No action at law or in equity can be brought to recover on this Plan until the appeals procedure has been exhausted as described in this Plan.
2. No action at law or in equity can be brought to recover after the expiration of two years after the time when written proof of loss is required to be furnished to the Plan Administrator.

ARTICLE IX

COORDINATION OF BENEFITS WITH OTHER PLANS

9.1 GENERAL

All benefits provided by the Plan are subject to this provision.

9.2 DEFINITIONS

- (1) "Other Plan" means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by:
 - (A) group or blanket insurance coverages;
 - (B) group service plan contract, group practice, group individual practice and other group prepayment coverages;
 - (C) labor-management trustee plans, union welfare plans, employer organization plans or any other arrangement of benefits, not available to the general public, provided for individuals by reasons of their status as members of a particular group; or
 - (D) group coverage under governmental programs or coverage required or provided by any statute, other than coverage under Title XIX of the Social Security Act of 1965, as amended but which includes benefits and services provided by Part A and Part B of Medicare (Title XVIII of the Social Security Act of 1965, as amended).
 - (i) If the Covered Person reaches age 65, who could have coverage under Medicare but is not covered under Part A and Part B of Medicare, then benefits or services that would have been payable under both Part A and Part B of Medicare had the insured made timely application and remained covered for benefits in accordance with provisions of Medicare, shall be included with the benefits or services referred to in this item (D) above.
 - (ii) The premium for the Covered Person age 65 or over shall be adjusted so that the gross premiums paid by or to the Plan shall not exceed that amount of premium on behalf of the Covered Person under age 65.
 - (iii) The term "Other Plan" shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement which reserves the right to take the

benefits of services of other Plans into consideration in determining its benefits and that portion which does not.

- (2) “This Plan” means that portion of the Plan which provides the benefits that are subject to this provision.
- (3) “Allowable Expenses” means any necessary, reasonable, and customary item of expense for medical care, services or supplies, at least a portion of which is covered under at least one of the Other Plan covering the person from whom claim is made, for which payment on account of such Covered Person is legally required.

When the Other Plan provides benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a Benefit paid.

- (4) “Claim Determination Period” means a calendar year except that no Claim Determination Period with respect to any person shall commence prior to the date such person becomes covered under This Plan nor extend beyond the last day such person is covered under This Plan.

9.3 DETERMINATION OF BENEFITS

If an eligible Employee and his spouse are both covered under the Plan as employees, the plan will coordinate benefits so that the total amount paid under the plan is 100% of the allowable expenses up to the maximum benefit. This amount does not include the deductible amount and any applicable copayments for services or supplies provided by This Plan.

When an eligible Employee files a claim, he must state whether he has any other coverage so that the plans can coordinate their benefits. The primary plan will pay its benefits without regard to any Other Plan. The secondary plan will adjust its benefits so that the total benefits available are not more than 100% of the allowable expense. No plan will pay more than it should without the Coordination of Benefits provision. A medical plan will coordinate its benefits with another medical plan. The following rules determine which plan is primary:

- (1) A plan without a Coordination of Benefits provision.
- (2) The plan covering the person as an employee, rather than as a dependent. For example, if a spouse has a claim and is covered under This Plan and his or her employer's plan, the plan covering the spouse as an employee is primary and pays first; This Plan is secondary and pays next. If an eligible Employee has a claim and is covered as a dependent under the spouse's plan, This Plan is primary; then, the spouse's plan will pay secondary.
- (3) If the claim is for a dependent child, the payment order sequence is determined by the parents' birthdays. The plan of the parent whose birthday comes first in the year (not the year of birth) is the primary plan. The other plan is secondary. If the plan

does not have a "birthday rule", the plan of the male parent covering the dependent child will be primary.

- (4) A plan covering a person as an active employee, or his or her dependent, pays benefits before a plan covering the person as a laid-off or retired employee or dependent.
- (5) If the Covered Person is a dependent child whose parents are separated or divorced, the order of benefit determination shall be as follows:
 - (A) If a court orders joint custody without specifying that one parent is responsible for health coverage, the primary plan is the plan of the parent whose birthday is earlier in the year;
 - (B) If a court orders that one parent is responsible for health care coverage, then the plan of that parent will be primary;
 - (C) If a court awards custody to one parent, the order of benefit determination shall be:
 - (i) the plan of the custodial parent;
 - (ii) the plan of the spouse, if any, of the custodial parent;
 - (iii) the plan of the noncustodial parent;
 - (iv) the plan of the spouse, if any, of the noncustodial parent.
- (6) Finally, if none of the rules above will determine the order of payment, the plan that has covered the person the longest will be primary.
- (7) If the Covered Person is eligible for state or federal aid, any charitable sponsored plan, the Plan will pay secondary.

The Plan reserves the right to request and receive information from any other insurance company, or other organization or person as well as to release any necessary information, without consent, in order to operate the Plan. The Plan shall be free from any liability that may arise in relation to these actions. If an eligible Employee is making a claim for benefits under the plan, he will be required to furnish the Plan with all necessary information.

9.4 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For the purposes of determining the applicability of, and implementing the terms of the Coordination of Benefits provision of This Plan or any provision of similar purpose of any Other Plan, This Plan may, without the consent of, or notice to any person, release to or obtain information from any insurance company, other organization, or person with respect to any person, which the Plan deems to be necessary for such purposes, and in so acting, the Plan shall be free from any liability that might arise in relation to such action. Any Covered

Person claiming benefits under This Plan shall furnish to the Plan such information as may be necessary to implement this provision. If this Plan makes a payment and later finds out that it should not have been primary, the Employee must return the excess amount paid to this Plan.

9.5 REINSTATEMENT PROVISIONS

Any benefits that have been paid by this, or any previous District sponsored medical indemnity plan, reduces the individual Lifetime Maximum, as well as all other lifetime and annual maximums applicable to the plan. This will apply to all individuals who return to the District after a termination, a lay-off, an unpaid leave of absence or any other reason coverage may have ended.

9.6 FEDERAL, STATE, AND CHARITABLE SPONSORED PLANS

If the Covered Person has a disability or a diagnosis that would make them eligible for federal, state, or other governmental plans or charitable funded plans, they must first apply to such plan(s) for such aid. If they are accepted by one or more of these plans, that plan will be considered primary and must pay its benefits first. The Plan is considered secondary and will pay after the Other Plan. Payment will be made after the Plan Administrator has received proof of application and a status of benefits to be provided by the federal, state, or other governmental or charitable sponsored agency. If benefits are declined by the agency, a "proof of denial" statement will be required prior to payment under This Plan.

9.7 PAYMENTS

- (1) Whenever payments which should have been made under This Plan in accordance with this provision have been made under any Other Plans, the Plan 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, and amount so paid shall be deemed to be benefits paid under This Plan and, to the extent of such payments, shall be fully discharged from liability under This Plan.
- (2) Whenever payments have been made by the Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Plan Administrator shall have the right, exercisable alone and in its sole discretion to recover such payments, to the extent of such excesses, from among one or more of the following, as the Plan Administrator shall determine: any persons to, or for, or with respect to, whom such payments were made to, any other insurance companies or to any other organizations.

9.8 AUTHORITY

The Plan Administrator reserves the right to delegate its authority to the Claims Administrator for implementing the provisions of this section **Coordination Of Benefits** provision under This Plan.

9.9 SPECIAL PROVISIONS WITH RESPECT TO MEDICARE

In accordance with the Tax Equity Fiscal Responsibility Act of 1982 (TEFRA – P.L. 97-248) and the Deficit Reduction Act (DEFRA – P.L. 98-369), an active Employee or spouse, who has attained age 65 and is eligible for Medicare, may elect or reject medical coverage under This Plan. Each person may make a separate election. If such person elects medical coverage under This Plan, the benefits of This Plan shall generally be determined before any benefits provided by Medicare (i.e., This Plan will pay its benefits first and then the claims may be submitted to Medicare for consideration). Covered Persons should be certain to enroll in Medicare coverage in a timely manner to assure maximum coverage.

There may be an instance when, in accordance with Federal law, This Plan may assume a secondary position to Medicare (i.e., Medicare will determine its liability first). If this should occur, This Plan reserves the right to assume the secondary carrier position and benefits will be determined in accordance with the **Coordination of Benefits** provision above. When This Plan may lawfully assume a secondary position and an Employee or Dependent becomes eligible for the program of benefits provided under Medicare, he is deemed to be covered by both Medicare parts “A” and “B” for all purposes under The Plan. An Employee or Dependent is considered to be covered by Medicare on the earliest date any coverage under Medicare could have been effective to him had he applied for Medicare in a timely manner.

For covered qualified retirees and dependents, This Plan may assume a secondary position (i.e., Medicare will determine its liability first.)

ARTICLE X

RIGHTS OF EMPLOYEES PARTICIPATING IN THE PLAN

10.1 NON-DISCRIMINATION

In connection with the administration of this Plan, the Plan Administrator or representatives of the Plan Administrator will not discriminate unfairly between individuals in comparison to similar situations at the time of such action.

10.2 CHOICE OF SERVICE

The persons covered under this Plan have the sole right to select their own providers of health care. The Plan will not choose a provider for any Covered Person, or have any liability for any acts, omissions, or conduct of any provider. This Plan's only obligation is to make payments according to the terms of this Plan Document. The payments which the Plan makes are not an attempt to fix the value of any services or supplies provided to a Participant.

10.3 ASSIGNMENT OF BENEFITS

A Participant will have the right to assign the payment of any Benefits for which he is eligible under this Plan to any eligible Provider of services. If a Provider makes a representation to the Claims Administrator that a person covered under this Plan has made an assignment of Benefit payments to the Provider, the Claims Administrator will make payment to the Provider based on that representation.

10.4 RIGHTS OF PLAN PARTICIPANTS

All Plan Participants shall be entitled to:

1. Examine, without charge at the Plan Administrator's office, all Plan documents, including insurance contracts, collective bargaining agreements, and copies of documents, such as detailed annual reports and Plan descriptions.
2. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charges for the copies.

In addition to creating rights for the Plan Participants, the federal law imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate this Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Employee and other Plan Participants and beneficiaries. No one, including the Employer, the union, or other person, may fire the Employee or otherwise discriminate against the Employee in any way to prevent the Employee from obtaining a Benefit or exercising his rights under the law. If a claim for Benefits is denied in whole or in part, the Employee has the right

to have the claim reviewed and reconsidered. There are steps the Employee can take to enforce the above rights. The denial may be reviewed in accordance with the Claims Appeal Procedure provided in Article VIII of this Plan. If the Employee still has a claim for Benefits that is denied or ignored, in whole or in part, after the Claims Appeal Procedure, the Employee may file suit subject to the limitation in Section 8.6 of this Plan.

If it should happen that Plan fiduciaries misuse the Plan's money, or if the Employee is discriminated against for asserting his rights, the Employee may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Employee is successful, the court may order the person sued to pay these costs and fees. If the Employee loses, the court may order the Employee to pay these costs and fees; for example, if it finds the claim is frivolous. If the Employee has any questions about the Plan, he should contact the Plan Administrator.

ARTICLE XI

RIGHTS OF THE PLAN ADMINISTRATOR

11.1 EXAMINATION OF CLAIM

The Plan Administrator or any duly authorized representative of the Plan Administrator will have the right to examine any claim for Benefits under this Plan, whether assigned or unassigned.

11.2 EXAMINATION OF CLAIMANT

The Plan Administrator will, at the Plan's expense, have the right to have the person whose Sickness or Injury is the basis for a claim examined as often as reasonably required during the time a claim is pending under the Plan.

11.3 RIGHT TO DECLINE COVERAGE

The Plan Administrator will have the right to perform an underwriting review of all applicants for coverage under this Plan who are required by the underwriting rules stated in this Plan Document to submit a health statement. The Plan Administrator or Claims Administrator may decline to provide coverage to any applicant based on the underwriting guidelines applied uniformly to each applicant who is required to submit a health statement.

11.4 RIGHT OF SUBROGATION

1. This Plan is subrogated to the right of recovery for covered expenses payable by this Plan, which are the result of Injuries or Sickness suffered from an Accident or the negligent or wrongful conduct of a third party, and which are payable in part or in whole by such third party, another person, an insurance company, or from a judgment or settlement.
2. Before this Plan pays Benefits for such covered expenses, the covered Employee may be required to complete a subrogation reimbursement agreement and supply other reasonable information as requested regarding the Injury.
3. It is not the intent of this Plan that any Covered Person should be reimbursed (considering all sources) for more than 100% of allowable expenses. Therefore, this Plan reserves the right to recover any overpayment it makes on behalf of a Participant that results from the payment by a third party, another person, insurance company, or from a judgment or settlement. To the extent of such payment by this Plan, the covered Employee is required to reimburse this Plan on his behalf or on behalf of his covered Dependents for any benefits so paid out of funds he might recover, however characterized and from whatever source, due to Injury or Sickness caused by a third party. Further, he must provide this Plan with all required information and assistance in the recovery of any such payment or overpayment. The

term “information” includes any instruments and documents as this Plan may reasonably require to enforce its rights.

11.5 RIGHT TO RECEIVE AND RELEASE NECESSARY INFORMATION

For purposes of determining the applicability of the coordination of benefits and subrogation provisions of this Plan, or any provision with a similar purpose of another plan, and implementing those provisions, the Plan Administrator or Claims Administrator may release necessary information to, or obtain necessary information from, any other organization or person.

ARTICLE XII

AMENDMENT AND TERMINATION OF THE PLAN

12.1 RIGHT TO AMEND THE PLAN

The Employer shall have the unlimited right to amend this Plan in any and all respects at any time, and from time to time, without prior notice to any Participant or Eligible Dependent. Any such amendment shall be by a written resolution of the majority of the Board of Directors and shall become effective as of the date specified in the enabling resolution. Any such amendment shall be binding on all Participants (including those Participants on continuation coverage). However, the responsibilities of the named fiduciaries and their delegates shall not be increased or changed by amendment without their written consent.

No change in this Plan will be valid unless it is approved by the Plan Administrator or the duly authorized representative of the Plan Administrator and received in writing by the Claims Administrator. Any such amendment must be endorsed by the Plan Administrator and attached to this Plan Document.

12.2 RETROACTIVE AMENDMENTS

An amendment to the Plan may be retroactively effective, but shall not adversely affect the rights of a Participant under this Plan for covered medical expenses provided after the effective date, but before the amendment is adopted.

12.3 NOTIFICATION OF MATERIAL REDUCTION OF BENEFITS

This Plan shall furnish a summary of material reduction in covered services or benefits to covered Participants within 60 days after the change has been adopted by the Plan.

12.4 MISSTATEMENT OF FACTS

No agent or representative of the Plan will have the authority to legally change this document or waive any of its provisions, either purposely or inadvertently. Any change must be made as stated above. If any relevant facts pertaining to any person's eligibility for benefits under this Plan are found to be misstated, an equitable adjustment of any benefits paid will be made. If such misstatement affects the existence of coverage, the true facts will be used in determining whether coverage is in force under the terms of this Plan, and in what amount.

12.5 RIGHT TO TERMINATE OR MERGE THE PLAN

Notwithstanding that the Plan is established with the intention that it be maintained indefinitely, the Employer reserves the unlimited right to terminate or merge the Plan at any time without prior written notice to any Participant. Such termination

shall be evidenced by a resolution by a majority of the Board of Directors. The date of the merger or termination will be the date specified in the enabling resolution. Termination of the Plan shall apply to all Participants (including those on continuation coverage). Additionally, the employer reserves the right to determine from time to time the level of contribution required from Participants for Plan coverage.

12.6 ENTIRE CONTRACT

The Plan Document, together with any amendments to it, constitutes the entire contract. Any statement made by the Plan Administrator, the Claims Administrator, or any Employee will, in the absence of fraud, be considered a representation and not a warranty. No such statement will void coverage, or reduce benefits, or be used in defense of a claim unless it is in writing.

ARTICLE XIII
ADMINISTRATION

13.1 PLAN ADMINISTRATOR'S RESPONSIBILITIES

The Plan Administrator shall have the authority and responsibility for:

1. calling and attending the meetings at which this Plan's funding policy and method are established and reviewed;
2. establishing the policies, interpretations, practices, and procedures of this Plan and rendering final decisions on review of claims as described in this Plan Document;
3. complying with state and federal reporting and disclosure statements;
4. hiring all persons providing services to the Plan;
5. receiving all disclosures required of fiduciaries and other service providers under any state or federal law;
6. acting as this Plan's agent for the service of legal process; and
7. performing all other responsibilities allocated to the Plan Administrator in the instrument appointing the Plan Administrator.

The Plan Administrator will have the duty, power, and discretion to construe and interpret this Plan, to decide all questions of eligibility, and to determine the amount, manner, and time of payment of any Benefits under this Plan. All interpretations under the Plan and all determinations of fact made in good faith by the Plan Administrator, will be final and binding on the Participants and beneficiaries and all other interested parties.

13.2 CLAIMS ADMINISTRATOR'S RESPONSIBILITIES

The Claims Administrator shall have the authority and responsibility for:

1. interpreting this Plan's provisions relating to coverage except where the Claims Administrator requests an interpretation or a claimant files an appeal with the Plan Administrator, in which case the Plan Administrator shall interpret the Plan and shall communicate in writing to the Claims Administrator the appropriate interpretation of the Plan;
2. administering the Plan's claim procedures;
3. processing checks for Benefits in accordance with Plan provisions;
4. filing claims with insurance companies, if any, who issue stop loss insurance policies to the Employer;
5. transmitting and certifying such information as required by state or federal law; and
6. performing all other responsibilities delegated to the Claims Administrator in the instrument appointing the Claims Administrator.

13.3 ADVISORS TO FIDUCIARIES

A named fiduciary or his delegate may retain the services of actuaries, attorneys, accountants, brokers, employee benefit consultants, and other specialists to render advice concerning any responsibility such fiduciary has under this Plan.

13.4 MULTIPLE FIDUCIARY FUNCTIONS

Any named fiduciary may serve in more than one fiduciary capacity with respect to the Plan.

13.5 NOTICE OF APPOINTMENTS OR DELEGATIONS

A named fiduciary shall not recognize or take notice of the appointment of another named fiduciary, or the delegation of responsibilities of a named fiduciary, unless and until the employer notifies the named fiduciary in writing of such appointment or delegation. The named fiduciaries may assume that an appointment or delegation continues in effect until the named fiduciary receives written notice to the contrary from the Employer.

13.6 WRITTEN DIRECTIONS

Whenever a named fiduciary or delegate must or may act upon the written direction of another named fiduciary or delegate, the named fiduciary or delegate is not required to inquire into the propriety of such direction and shall follow the direction unless it is clear on its face that the actions to be taken under that direction would be prohibited by state or federal law or the terms of this Plan. Moreover, such named fiduciary or delegate shall not be responsible for failure to act without written directions.

13.7 CO-FIDUCIARY LIABILITY

A fiduciary shall not have any liability for a breach of fiduciary duty of another fiduciary, unless he participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach and fails to take action to remedy such breach, or through his negligence in performing his own specific responsibilities, enables such other fiduciary to commit a breach of the latter's fiduciary duty.

13.8 ACTION BY EMPLOYER

Any authority or responsibility allocated or reserved to the Employer under this Plan may be exercised by any duly authorized officer of the Employer.

ARTICLE XIV
MISCELLANEOUS

14.1 STATE LAW

This Plan shall be interpreted, construed, and administered in accordance with applicable state or local laws to the extent such laws are not preempted by federal law.

14.2 STATUS OF EMPLOYEE RELATIONS

The adoption and maintenance of this Plan shall not be deemed to constitute a contract between the Employer and the Employees or to be consideration for, or an inducement or condition of, the employment of an Employee. Nothing in this Plan shall be deemed to:

1. Affect the right of the Employer to discipline or discharge any Employee at any time.
2. Affect the right of any Employee to terminate his employment at any time.
3. Give to the Employer the right to require any Employee to remain in its employ.
4. Give to any Employee the right to be retained in the employ of the Employer.

14.3 WORD USAGE

Whenever words are used in this document in the singular or masculine form, they shall, where appropriate, be construed so as to include the plural, feminine, or neuter form.

14.4 TITLES ARE REFERENCE ONLY

The titles are for reference only. In the event of a conflict between a title and the content of a section, the content of a section shall control.

14.5 COUNTERPARTS

This Plan may be executed in any number of counterparts, each of which may be deemed to be an original, but all of which together constitute an instrument which may be sufficiently evidenced by any counterpart.

14.6 CLERICAL ERROR

No clerical errors made in keeping records pertaining to this coverage, or delays in making entries in such records will invalidate coverage otherwise validly in force, or continue coverage otherwise validly terminated. Upon discovery of any error, an equitable adjustment of any Benefits paid will be made.

ARTICLE XV

PLAN IDENTIFICATION

1. **Name of Plan:** College of the Siskiyou Health Plan
2. **Name and Address of Plan Sponsor:** College of the Siskiyou
800 College Avenue
Weed, CA 96094
3. **Claims Administrator:** Keenan HealthCare
2355 Crenshaw Boulevard
Suite 300
Torrance, CA 90501
1-800-6KEENAN
4. **Sponsor Identification Number:** 94-1614470
5. **Plan Number:** 501
6. **Type of Benefit Provided:** See Schedule of Benefits
7. **Type of Plan Administration:** Self-Funded Third Party
8. **Plan Administrator/Agent for Legal Process/Named Fiduciary:** College of the Siskiyou Health Plan
9. **Contributions to the Plan:** Contributions for the Plan are provided partially by contributions of the Plan Sponsor and partially by contributions of Covered Employees
10. **End of Plan's Fiscal Year:** June 30