SUMMARY PLAN DESCRIPTION OF
TRINITY HEALTH
VOLUNTARY RETIREE MEDICAL BENEFIT PLAN
AS AMENDED AND RESTATED
EFFECTIVE SEPTEMBER 1, 2005
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Trinity Health
Pre 65 Vol. Retiree Medical HSA

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INTRODUCTION

This booklet or Summary Plan Description includes information describing your plan benefits, first in general, and then specifically, including how each type of service is covered by this plan. Specific services that are not covered are listed in the section titled WHAT IS NOT COVERED?

You will notice that certain words in this Summary Plan Description have been highlighted. These words have a special meaning in this plan and are defined in the section titled WHAT IS MEANT BY...? in this booklet.

This plan is governed by a legal document referred to as the Plan Document. This booklet, referred to as a Summary Plan Description, is written in a manner meant to be easily understood as an explanation of the benefits provided for you in the Plan Document.

Trinity Health may modify, amend or terminate the plan at any time at its discretion. Coverage under this plan, or receipt of any benefit from the plan, does not in any way affect your employment relationship with your employer, or in any way limit your employer's right to terminate your employment.

You will find information on the following pages, which describes your benefits. If you have any questions, please contact the Human Resources Department.

The plan is intended to comply with all provisions of any Federal acts or Supreme Court decisions which set forth precedence. Any provision of this plan found to be in conflict with these acts or Supreme Court precedence is amended to comply.
WHAT IS MEANT BY...?

Whenever one of the following words and phrases appears highlighted, they shall have the meaning explained below unless the context otherwise requires. Please refer to the section titled WHAT ARE THE PLAN SPECIFICS? for information regarding benefits coverage.

**Adverse benefit determination:** a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a participant’s or beneficiary’s eligibility to participate in the plan. This includes a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review (if applicable), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

**Ambulatory surgical center:** a facility that meets all of the following requirements:

- has an organized staff of physicians,
- has permanent facilities that are primarily for surgery,
- provides continuous physician and nursing services,
- does not provide overnight accommodations, and
- does not include a physician's or dentist’s office for the practice of medicine or dentistry.

**Annual open enrollment period:** an annual period during which you may enroll or transfer into any plan maintained by the company for benefits to be effective on the first of January of the following year.

**Authorized representative:** a physician rendering the service for which a bill is submitted, (but not a designee of the physician) or a person who a covered retiree or covered dependent has authorized in writing to act on his/her behalf. If the claim is an urgent care pre-service claim, the plan will consider a health care professional with knowledge of a claimant’s medical condition as an authorized representative.

If a covered retiree or covered dependent wish to authorize another person (e.g., family member) to act on his/her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he/she must first notify the Plan Administrator of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from the [Human Resources Department].

**Cardiac rehabilitation program:** a specialized exercise program conducted at a Medicare approved outpatient hospital department or a freestanding cardiac rehabilitation clinic.

**Claimant:** an eligible retiree, a covered dependent or an authorized representative.
WHAT IS MEANT BY...? (Continued)

Claims Administrator: Your plan has different Claims Administrators based on the type of claim. The Claims Administrator for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an adverse benefit determination. Each is independently, responsible for notifying you of the adverse benefit determination, based on the type of claim, as well as reviewing any appeal you may make. Your Claims Administrators are as follows:

Pre-service claims and post-service claims: (Medical) NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

Post-service claims: (Pharmacy) Trinity Health 34605 Twelve Mile Road, Farmington Hills, MI 48331.

Each Claims Administrator shall have final discretionary authority to construe the terms of the plan, for purposes of final claims determinations, for those pre- and post-service claims listed above for which they are designated as the Claims Administrator.

Company: Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

Concurrent claims decision: a decision by the plan relating to an ongoing course of treatment.

Concurrent hazardous medical condition: a potentially life-threatening condition, substantiated by the patient's attending physician, requiring care with immediate access to hospital equipment. (For the purpose of hospital confinement for dental procedures, conditions such as hemophilia, uncontrollable diabetes and hypertension will be considered concurrent hazardous medical conditions.)

Congenital defect: a physical abnormality existing at birth.

Coverage effective date: the date on which the retiree's and/or his or her eligible dependent's benefits begins. (Please refer to the section titled WHEN WILL COVERAGE BEGIN? for further information.)

Coverage termination date: the date on which the retiree's and/or his or her dependent's eligibility for benefits ends. (Please refer to the section titled HOW YOUR COVERAGE IS AFFECTED WHEN...? for further information.)

Covered individual: an eligible retiree or dependent who is enrolled in the Trinity Health Employee Medical Benefit Plan as Amended and Restated Effective January 1, 2005. (This includes only those people who qualify for enrollment as indicated in the section titled ELIGIBILITY of this booklet.)
WHAT IS MEANT BY...? (Continued)

**Custodial care:** services provided to an individual which are not necessarily medically required, but which primarily help an individual perform daily living activities (example - services normally rendered in a nursing home).

**Deductible:** the specific dollar amount that a **covered individual** must pay (or “satisfy”) in covered expenses each calendar year before the plan pays its share of covered expenses. (Please refer to the section titled WHAT IS THE PLAN DEDUCTIBLE? for further information.)

**Dental:** relating to the teeth or gums.

**Dependent:** people who have the following relationship to a **retiree**:
- an **retiree’s** lawful spouse;
- an **retiree’s** unmarried dependent children.

(This includes only those people who qualify for enrollment as indicated in the section titled ELIGIBILITY of this plan.)

**Diagnosis:** a descriptive statement of a medical or **dental** condition.

**Enrollment form:** the form provided by the employer for your completion and signature to enroll you and your **dependents** in this plan for medical benefits.

**Experimental/investigational:** medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by the plan (at the time it makes a determination regarding coverage in a particular case) to be:

a) not of proven benefit for the particular **diagnosis** or treatment of the covered person’s particular condition as demonstrated by Reliable Scientific Evidence; or

b) not generally recognized by the medical community as effective or appropriate for the particular **diagnosis** or treatment of the covered person’s particular condition as demonstrated by Reliable Scientific Evidence; or

c) except as set forth under Clinical Trials below, subject to review and approval by any Institutional Review Board for the proposed use or the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight or otherwise provided or performed in special settings for research purposes or under a controlled environment or clinical protocol.

d) any technology or any hospitalization in connection with such technology if such technology is obsolete or ineffective and is not used generally by the medical community for the particular **diagnosis** or treatment of the covered person’s particular condition.
WHAT IS MEANT BY...? (Continued)

Experimental/investigational: (Continued)

FDA Approval and Off Label Uses

Any medical device, drug, or biological product must have received final approval to market by the United States Food and Drug Administration (FDA) for the particular diagnosis or condition except as set forth in (a) or (b) below. Any other approval granted as an interim step in the FDA regulatory process, e.g., an Investigational Device Exemption or an Investigational New Drug Exemption, is not sufficient.

a) Once FDA approval has been granted for a particular diagnosis or condition, use of the medical device, drug or biological product for another diagnosis or condition will require that one or more of the following established reference compendia: The American Medical Association Drug Evaluations; The American Hospital Formulary Service Drug Information; or The United States Pharmacopoeia Drug Information, recognize the usage as appropriate medical treatment.

b) As an alternative to such recognition in one or more of the compendia, the usage of the drug will be recognized as appropriate if it is recommended by Reliable Scientific Evidence. A medical device, drug, or biological product that meets the above test will not be considered experimental or investigational.

c) In any event, any drug which the Food and Drug Administration has determined to be contraindicated for the specific treatment for which the drug has been prescribed will be considered experimental and investigational.

Clinical Trials

The plan will cover expenses related to clinical trials only as set forth below if the patient has a current diagnosis that will most likely cause death within one year or less despite therapy with currently accepted treatment.

Covered expenses shall include regular patient care costs in clinical trials (in the same way that the plan reimburses regular care for patient’s not in clinical trials) according to the limitations outlined below. All of the following limitations apply to such coverage:

1. To qualify for coverage, the patient must meet all of the following criteria:

   a) Standard therapies have not been effective in treating the member or would not be medically appropriate; and

   b) The risks and benefits of the experimental or investigational technology are reasonable compared to those associated with the patient’s medical condition and standard therapy based on Reliable Scientific Evidence.

   c) The experimental or investigational technology shows promise of being effective as demonstrated by the member’s participation in a clinical trial satisfying all of the following criteria:
WHAT IS MEANT BY...? (Continued)

Experimental/investigational: (Continued)

i) The experimental or investigational drug, device, procedure, or treatment is under current review by the FDA and has an Investigational New Drug (IND) number or the experimental or investigational study is not conducted under FDA scrutiny, (e.g., new uses of old technologies, new uses of drugs already approved by the FDA (these would not have an IND number)), but would meet all the other criteria below;

ii) The clinical trial has passed review by a panel of independent medical professionals (evidenced by review of the written clinical trial protocols from the requesting institution) who treat the type of disease involved and has also been approved by an Institutional Review Board (IRB) that will oversee the investigation;

iii) The clinical trial is not a single institution or investigator study (NCI designated Cancer Centers are exempt from this requirement); and

iv) The patient must:
   a) Not be treated “off protocol”; and
   b) Must actually be enrolled in the trial.

2. Members must meet any applicable plan requirements for precertification and referrals; and

3. All plan provisions that apply to routine care for patients not in clinical trials will also apply to routine patient care for patient’s in clinical trials; and

4. Covered Expenses include the costs of treating conditions that result as unexpected consequences (complications) of clinical trials.

5. Covered Expenses do not include the following clinical trial costs:
   a) The experimental intervention itself; and
   b) Costs of data collection and record keeping that would not be required but for the clinical trial; and
   c) Other services to clinical trial participants necessary solely to satisfy data collection needs of the clinical trial (i.e., “protocol-induced costs”); and
   d) Items and services provided by the trial sponsor without charge.

Reliable Scientific Evidence

Reliable Scientific Evidence means:

a) Peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

b) Peer-reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health’s National Library of Medicine for indexing in index Medicus, Excerpta Medicus (EMBASE), Medline, or MEDLARS database Health Services Technology Assessment Research (STAR), or

c) Medical journals recognized by the Secretary of Health and Human Services, under Section 1861(t)(2) of the Social Security Act (42 U.S.C. 1395x).
WHAT IS MEANT BY...? (Continued)

Genetic counselor: health care professional with specialized graduate degrees and experience in medical genetics and counseling. It is the genetic counselor’s role to provide information to the individual or family regarding the genetic disorder.

Genetic disorder: a disease caused in whole or in part by a variation or mutation of a gene. Genetic disorders can be passed on to family members who inherit the genetic abnormality.

Health care professional: a physician or other health care professional licensed, accredited, or certified to perform specified health services consistent with state law.

Home health care agency: a public or private agency legally operated in the state in which it is located, that provides nursing services administered in a person's home by a Registered Nurse (RN) or a Licensed Practical Nurse (LPN) or by a home health aide who is employed by the home health care agency.

Hospice: a health care program providing a coordinated set of services rendered at home, in outpatient settings or in institutional settings for covered individuals suffering from a condition that has a terminal prognosis. A hospice must have an interdisciplinary group of personnel that includes at least one physician and one Registered Nurse (RN), and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital: a legally constituted inpatient institution or facility that meets all of the following requirements set forth in either (A), (B) or (C) below:

A • It is accredited by state, national, medical or hospital authorities; or
• It is listed in the American Hospital Association member directory.
• It is open at all times.
• It provides diagnostic services and therapeutic services on the premises for the surgical and/or medical treatment of ill and injured persons.
• The treatment is by or under the direct supervision of a licensed physician(s) or surgeon(s).
• The facility continuously provides 24-hour nursing services by Registered Nurses (RN).
• It is not - other than incidentally - a place for convalescent care, for rest, for the aged, for alcoholics, for drug addicts, for pulmonary tuberculosis or a nursing home.

B • It is a licensed psychiatric or tuberculosis facility recognized by the regulatory authority to provide treatment primarily for mental disorders, substance abuse or tuberculosis treatment.

C • It is an inpatient state licensed facility that provides restorative services to inpatients under the direction of a physician knowledgeable and experienced in rehabilitative medicine.

Hospital confinement: the period of time an individual spends in a hospital as an overnight bed patient (inpatient).
WHAT IS MEANT BY...? (Continued)

Hospital extras: (also known as ancillary services) certain services, supplies and treatment rendered by a hospital for an inpatient, including:

- use of operating, delivery, recovery and treatment rooms;
- laboratory and x-ray services;
- anesthesia and its administration by a hospital employee;
- use of incubators, oxygen, kidney machines and iron lungs;
- physical therapy, chemotherapy and radiation therapy;
- drugs and medicines consumed on the premises; and
- dressings, supplies and casts.

Illness: the condition of being sick or unhealthy as classified in the International Classification of Diseases (ICD-9).

Injury: a sudden, unexpected and unforeseen bodily harm that occurs solely through external bodily contact. (Strains and spasms are considered an illness rather than an injury.)

Inpatient: an individual who is officially admitted to a hospital as a bed patient and occupies a hospital bed while receiving hospital care, which includes room, board and general nursing care.

Life-threatening medical emergency: a condition having symptoms which occur suddenly and unexpectedly and result in an urgent need for immediate medical attention as determined and reported by the physician that the patient's life is endangered, including - but not limited to - heart attacks, acute hemorrhages, strokes and convulsions.

Medically necessary: any service, supply or treatment deemed to be necessary for the treatment of an illness or injury and professionally accepted as the usual, customary and effective means of treating the condition. Diagnostic x-rays and laboratory tests that are performed due to definite symptoms of illness or injury or reveal the need for treatment will be considered medically necessary.

Medicare: a Federal program through the Social Security System that provides benefits for hospital and physician care. This includes a Health Maintenance Organization (HMO) that participates with Medicare and receives payment from Medicare. (It is available on an enrollment basis to individuals receiving hemodialysis treatment beyond 30 months, individuals eligible for Social Security benefits if they are age 65 or older or those individuals who have qualified for Social Security disability benefits and have received such disability benefits for 24 months.)

Mental disorder: a clinically significant behavior or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function and requires psychiatric care for any reason, or an organic or biological condition which requires psychiatric care for any reason.

Network provider: a facility or practitioner who has a signed, effective contract with Trinity Health.

Non-Network provider: a facility or practitioner who does not have a signed, effective contract with Trinity Health.
WHAT IS MEANT BY...? (Continued)

**Nurse:** a Registered Nurse (RN) or Licensed Practical Nurse (LPN) who provides nursing care.

**Out-of-pocket maximum:** the maximum amount of out-of-pocket expenses you have to pay each calendar year for certain covered medical expenses. The limit varies based on your choice of providers. (Please refer to the section titled WHAT IS YOUR OUT-OF-POCKET MAXIMUM EXPENSE? for further information.)

**Outpatient:** an individual who receives medical care, treatment, services or supplies at a clinic, physician's office or at a hospital if not a registered bed patient at that hospital.

Outpatient surgery: surgery performed on an individual, without the individual being admitted to the facility as an inpatient.

**Physical therapy:** physical evaluation (including muscle testing) for a covered individual and certain therapeutic treatments professionally administered by a Registered Physical Therapist (RPT) or a physician, to aid in the recovery from illness or injury, including - but not limited to - diathermy, gait training, hot or cold packs, manual traction, massage, mechanical traction, prosthetic training and whirlpool. Physical therapy activities are designed to help the covered individual attain greater self-sufficiency, mobility and productivity through exercises and externally applied heat, electroshortwave, hydrotherapy and other mechanical modalities intended to improve muscle strength, joint motion, coordination and general endurance.

**Physician:** a qualified Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Chiropractic (DC), Doctor of Podiatry (DPM), Doctor of Optometry (OD), Doctor of Dental Surgery (DDS or DMD) or psychologist, who, within the scope of their licenses, are legally permitted to perform services for which coverage is provided in this plan.

This plan will also cover the services of a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse First Assistant; Physician’s Assistants and Certified Nurse Practitioners who are under the direction of a physician; a Limited Licensed Psychologist (LLP), a Chemical Dependency Counselor, Social Worker (MSW) or a Licensed Clinical Social Worker (LCSW) who are under the direction of a psychiatrist or psychologist; as well as other providers who are not physicians, but who are specifically mentioned as covered providers in the section titled WHAT ARE THE PLAN SPECIFICS?

**Plan Administrator:** Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

**Plan Document:** the legal description of the plan coverage, exclusions and limitations that is the governing document for this plan.

**Plan Supervisor:** NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

**Plan year:** begins on January 1 and ends on December 31.

**Post-service claim:** any claim for a benefit under this plan that is not a pre-service claim. In other words, a claim that is a request for payment under the plan for covered medical services that a claimant has already received.
WHAT IS MEANT BY...? (Continued)

**Prescription drug:** those drugs approved by the Food and Drug Administration of the United States which require a written prescription by a **physician** or dentist and which bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

**Pre-service claim:** any claim for a benefit under this plan where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

- **Urgent Care Claim:** A **pre-service claim** may be an urgent care claim if it is for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the **claimant**; or jeopardize the ability of the **claimant** to regain maximum function; or in the opinion of a **physician** with knowledge of the **claimant’s** medical condition, would subject the **claimant** to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim and the plan conditions receipt of the benefit for the service, in whole or in part, on approval in advance of obtaining medical care.

A **health care professional** with knowledge of the **claimant’s** medical condition may determine if a claim is one involving urgent care. If there is no such **health care professional**, an individual acting on behalf of the plan, applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine, may make the determination.

Please see the plan section titled Pre-Certification of Services for information about **pre-service claims**.

**Prosthetic device:** an artificial part affixed to the body. Most often this attachment is performed during a period of hospitalization, through **surgery**, to remedy a deficiency or defect of the body.

**Psychiatrist:** a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who specializes in the study and treatment of **mental disorders** and psychological diseases.

**Psychologist:** a fully licensed individual who is usually a PhD and is trained in methods of psychological analysis, therapy and research for treatment of psychological and psychoneurological disorders.

**Qualified Medical Child Support Order (QMCSO):** an order of a court or authorized administrative agency requiring medical child support which meets the federal law requirements to be a **Qualified Medical Child Support Order**.

**Reasonable and customary:** for **Network providers**, the fee agreed upon between the plan and participating providers. For **Non-Network providers**, a fee most frequently allowed for a similar service or medical procedure by most similarly qualified **physicians** or other health care providers in the particular geographic area where the service is rendered or a fee that has been negotiated with the provider. It takes into consideration any unusual circumstances and medical complications which may require additional time, skill and experience.
WHAT IS MEANT BY...? (Continued)

**Referral:** If a course of treatment or procedure cannot be performed by a *Network physician*, a written referral may be made to another provider. An approved written referral from a *Network physician* must be obtained prior to receiving the services from a *Non-Network provider*. Failure to obtain an approved referral prior to receiving services will result in benefits being considered at the non-network level, and costs incurred will be the patient’s responsibility.

**Retiree:** a former employee of Trinity Health who is eligible to participate as described in the section titled WHO IS ELIGIBLE FOR BENEFITS?

**Skilled nursing facility:** a facility approved by *Medicare*, which is primarily engaged in providing 24-hour skilled nursing and related services on an *inpatient* basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of *physicians*. A *skilled nursing facility* is not, other than incidentally, a place that provides:

- Minimal care, *custodial care*, ambulatory care or part-time care services; or
- Care or treatment of *mental disorders*, substance abuse, alcoholism, drug abuse or pulmonary tuberculosis.

**Sound natural teeth:** teeth that are free of active or chronic clinical decay, have at least 50% bony support, are functional in the arch and have not been excessively weakened by multiple *dental* procedures.

**Standby physician:** a *physician* who is present in the event a complication occurs at the time a surgical procedure is performed, but who is not actually assisting the attending *physician* with the surgery.

**Summary Plan Description:** this summary of your benefits.

**Surgery:** a cutting operation, suturing of a wound, treatment of a fracture, relocation of dislocation, radiotherapy (if used in lieu of a cutting operation), diagnostic and therapeutic endoscopic procedures, laser surgery, and injections classified as surgery under the CPT.

**Totally disabled:** an enrolled dependent is totally disabled when he or she is prevented because of injury or disease from engaging in substantially all of the normal activities of a person of like age and sex in good health.

In any case where the *Plan Supervisor* is required to make a determination with respect that an individual is totally disabled, the *Plan Supervisor* shall have the right to require the individual to submit to an examination by a *physician* or medical clinic selected by the *Plan Supervisor*.

**Weekend admissions:** any admission for scheduled, non-emergency surgery where the admission is on Friday or Saturday and, at the time of admission, the surgery is scheduled to be performed the following week.
ELIGIBILITY

WHO IS ELIGIBLE FOR BENEFITS?

When you retire or otherwise terminate from a Trinity Health organization on or after December 31, 2003, you and your spouse can participate in the plan, provided you have met all the following criteria:

- Your are at least age 55 when you leave Trinity Health,
- You have completed 10 or more years of qualifying Benefit Service with Trinity Health,
  Benefit Service – used to determine your accrued benefit under the Trinity Health Pension Plan. You receive one year of Benefit Service when you earn 1800 hours of service or more. Partial benefit service is granted for hours of service worked less than 1800 a year.
- You are not eligible for continued medical benefits as a Trinity Health active employee (for example, as part of a severance package),
- You, your spouse and or dependents that are not enrolled in any other medical benefits plan
- You have exhausted your COBRA benefits through Trinity Health, and
- You are not covered by Medicare.
- Your lawful spouse.
- Your unmarried natural children, stepchildren, legally adopted children, children for which you have been appointed guardianship and children for whom you have been ordered by a court to provide medical coverage. If related by blood, marriage or adoption and for whom you provide at least half their financial support, or a significant amount of support (to be determined by the Plan Administrator). Those children will be covered from the end of the year in which they reach age 19 until the end of the year in which they reach age 24, provided they are not employed on a full-time basis.
- Your unmarried children who are disabled by mental or physical incapacity after the end of the calendar year in which they are 19 years of age. That child will be eligible for enrollment in this plan only if that dependent child was a covered child while they were disabled. Proof that the child is disabled by mental or physical incapacity must be provided upon request.
- An unmarried child who is totally disabled by mental or physical incapacity provided they are enrolled prior to their 19th or 24th birthday. Proof of disability or incapacity will be required.
- A dependent child who has been placed for adoption with a covered retiree, whether or not the adoption is final. The child must be enrolled within 31 days following the date of adoption or the date of placement for adoption and the child may not have reached 18 years of age on such date.
WHO IS ELIGIBLE FOR BENEFITS? (Continued)

- This plan will also provide coverage as described by a Qualified Medical Child Support Order (QMCSO) which assigns a child of a covered retiree the rights of a participant or beneficiary to receive benefits under this health plan. Children assigned benefits by a QMCSO must be enrolled within 31 days following the order. Children assigned benefits by a QMCSO must satisfy the terms and conditions of the plan that apply to other dependents. For further information regarding the plan’s procedures for governing QMCSO, please refer to the section titled APPENDIX C.

DUAL COVERAGE

If both you and your spouse are covered as retiree’s under this plan, only one of you may enroll children as dependents. In addition, if you and your spouse each carry individual coverage as retiree’s, you may carry separate coverage however you are not eligible to be covered as a dependent on the spouse’s policy. If you are covered as a retiree for benefits, you may not be covered as a dependent.

Individuals not added within the 31-day period specified above may only be added as provided in the sections titled SPECIAL ENROLLMENT PERIOD, and CHANGES IN FAMILY STATUS.

WHO IS NOT ELIGIBLE FOR BENEFITS?

You and your dependents, on the end of the month following the date you no longer meet the eligibility requirements in this plan.

- Any individual who does not meet the definition of a retiree or dependent as described in the section titled WHO IS ELIGIBLE FOR BENEFITS?

- You and your dependents that are covered under any other medical benefits plan.

WHAT IS YOUR COST?

The Plan is voluntary, which means you are responsible for paying the full costs of the coverage for you and your eligible family members. The premium rates are per member of the family. Since these rates are subject to change at any time, you’ll need to contact your Trinity Health Retirement Program representative (800) 793-4733.

HOW DO YOU ENROLL FOR COVERAGE?

The Trinity Health Retirement Office will provide you with the appropriate materials. You are not required to begin collecting your Trinity health pension benefits to be eligible to enroll in the Voluntary Retiree Medical Benefit Plan. However, if you elect to postpone your enrollment beyond your initial eligibility date, you will be required to provide proof of continued coverage through another group or individual plan.
HOW DO YOU ENROLL DEPENDENTS?

At the time of your original enrollment you must enroll your eligible dependents in order for them to be covered under this plan.

If you do not enroll your dependents at this time, you will not be given the opportunity to enroll them at a later date. Unless they are covered under another group or individual plan and proof of continued coverage can be provided.

WHEN WILL COVERAGE BEGIN?

Your coverage will begin the 1st of the month following the completion and receipt of your enrollment form. All benefits will be calculated based on the coverage provided to the covered individual on the date a service is rendered.

WHAT CHANGES SHOULD I REPORT?

Whenever any of the information you reported on your enrollment form changes, you should immediately advise the Trinity Health Retirement Office (800) 793-4733. As benefits are administered on the basis of the information provided during enrollment, your records must be kept up to date. Those changes include:

- change of address;
- change of name due to marriage or divorce;
- change in your spouse’s employment status or employer;
- your divorce or legal separation
- changes in the eligibility status of your dependent

WHEN WILL COVERAGE END?

- Coverage under the Trinity Health Voluntary Retirement Medical Plan ends when the retiree and or dependents become eligible for Medicare. If you should die, your dependents can continue coverage (time will be applied to COBRA) by continuing to pay the required premiums provided he or she is enrolled in the plan at the time of your death.

- The coverage of your dependent(s) will end when, as explained in the section titled ELIGIBILITY of this booklet, they are no longer your dependent(s).

- You stop paying premiums.
COBRA CONTINUATION COVERAGE

WHAT IS COBRA?

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

If you should die, your dependents can continue coverage by continuing to pay the required premiums provided he or she is enrolled in the plan at the time of your death. The applicable that is met will be applied to COBRA.

WHEN WOULD I QUALIFY FOR COBRA?

Continuation coverage is available if coverage would otherwise end due to:

• for your dependent spouse – divorce or legal separation from you; or
• for your dependent child(ren), loss of eligibility as a covered dependent (for example, because he or she reaches the maximum age provided by the plan); or
• for a retiree, if the former employer files for bankruptcy under Chapter 11.

WHAT MUST I DO TO NOTIFY MY EMPLOYER OF AN EVENT THAT WOULD TRIGGER COBRA COVERAGE?

If coverage would end because of divorce or legal separation, or because a child is no longer eligible to be a dependent, the employee or covered dependent MUST notify Human Resources in writing. If Human Resources is not notified within 60 days after the coverage would otherwise end, and the person is no longer eligible as a dependent, continuation coverage cannot be offered.

HOW CAN I ELECT COBRA?

When the employer receives notification of one of the above events, or when any other qualifying event occurs, you or the individual losing coverage will be notified of the right to continue coverage. If continuation is desired, the participant must elect to do so within 60 days of the date the notice was sent. Each covered member of the family may individually decide whether or not to continue coverage, but an election of coverage by the employee or spouse will be considered to be an election by all covered individuals, unless another covered individual rejects coverage.

WHAT IS THE COST FOR COBRA COVERAGE?

Continuation is at the participant’s expense. The monthly cost of this continued coverage will be included in the notice. Premiums are the same for all individuals who are in the same type of classification – adult single individuals have the same cost and family groups have the same cost.
WHEN MUST I MAKE PREMIUM PAYMENTS?

For coverage to continue, the first premium must be received by the date stated in the notice. Normally this date will be 45 days after the continuation coverage is elected. Premiums for every following month of continuation coverage must be paid monthly on or before the premium due date stated in the notice. There is a 30 day grace period for these monthly premiums. If the premium is not paid within 30 days after the due date, continuation coverage will end on the first day of that period of coverage. Coverage cannot be reinstated.

HOW LONG CAN I CONTINUE COBRA?

If coverage would otherwise end because employment ends or hours are reduced so you are no longer eligible for group benefits, continuation coverage may continue until the earliest of the following:

- 18 months from the date that the employment ended or the hours were reduced.
- The date on which a premium payment was due but not paid.
- The date the person continuing the coverage becomes covered by another employer’s group health plan and that plan does not contain any exclusion or limitation that affects a covered individual’s pre-existing condition.
- The date, after continuation coverage has been elected, the person becomes eligible for Medicare.
- The date the employer terminates all of its group health plans.

If coverage would otherwise end for a covered dependent (spouse or child) because of divorce, legal separation, death or a child’s loss of dependence status, continuation coverage may continue until the earliest of the following:

- 36 months from the date the covered dependent’s coverage would have otherwise ended.
- The date on which the premium payment was due but not paid.
- The date the person continuing coverage becomes covered by another employer’s group health plan and that plan does not contain any exclusion or limitation that affects a covered individual’s pre-existing condition.
- The date, after continuation coverage has been elected, the person continuing coverage becomes eligible for Medicare.
- The date the employer terminates all of its group health plans.

CAN THE LENGTH OF COBRA COVERAGE BE EXTENDED?

Second Qualifying Event

If continuation coverage was elected by a covered dependent because your employment ended or your hours were reduced and, if during the period of continued coverage, another event occurs which is itself an event which would permit continuation coverage to be offered, the maximum period of continued coverage for the covered dependent is extended for 18 months to a maximum of 36 months from the date of the initial event. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)
CAN THE LENGTH OF COBRA COVERAGE BE EXTENDED? (Continued)

Spouse and Dependents of Medicare-Eligible Employees

If continuation coverage was elected by your spouse or dependent child and you became entitled to Medicare while an employee, the maximum period of continuation coverage for spouse or child is the greater of 36 months from the date you became entitled to Medicare or 18 months from the date you lost coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Disabled Individuals

If a covered individual is disabled, according to the Social Security Act, at the time he or she first becomes eligible for continuation or within 60 days of that date, the maximum period of continuation coverage is extended to 29 months. (Coverage will still end for any other reason listed above, such as failure to pay premiums when due, etc.) The covered individual must notify the employer within 60 days of the date he or she is determined to be disabled under the Social Security Act and within 30 days of the date he or she is finally determined not to be disabled. (Coverage will end on the first day of the month beginning 30 days after the covered individual is determined not to be disabled.) The cost of continuation coverage may increase after the 18th month of continuation coverage, and may be adjusted from time to time when group rates are adjusted.

Trade Act Of 1974

Special COBRA rights apply to employees who have been terminated or experienced a reduction of hours and who qualify for a ‘trade readjustment allowance’ or ‘alternative trade adjustment assistance’ under a federal law called the Trade Act of 1974. These employees are entitled to a second opportunity to elect COBRA coverage for themselves and certain family members (if they did not already elect COBRA coverage), but only within a limited period of 60 days (or less) and only during the six months immediately after their group health plan coverage ended. If you qualify or may qualify for assistance under the Trade Act of 1974, contact Human Resources for additional information. You must contact Human Resources promptly after qualifying for assistance under the Trade Act of 1974 or you will lose your special COBRA rights.

SPECIAL PROVISIONS FOR RETIREES

If your plan provides coverage for retirees, sometimes, filing a proceeding in bankruptcy under Title 1 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the company and that bankruptcy results in the loss of coverage of any retired employee covered under the plan, the retired employee is a qualified beneficiary with respect to the bankruptcy. The retired employee’s spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the plan.
WHAT OTHER FACTS SHOULD I KNOW REGARDING MY RIGHTS UNDER COBRA?

In order to protect your family’s rights, you should keep your employer informed of any changes in the addresses of family members who are or may become eligible for COBRA. You should also keep a copy of any notices you send the Plan Administrator for your records.

WHO SHOULD I CONTACT FOR FURTHER INFORMATION AND TO WHOM SHOULD I PROVIDE NOTICE OF COBRA EVENTS?

If you need more information regarding continuation of coverage, please feel free to contact NGS American, Inc. or contact the Plan Administrator. You may also contact the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

The company is responsible for administering COBRA continuation. The company has contracted with Mongoose Administrators to perform certain administrative functions on its behalf. These functions may include mailing of COBRA notices, collection of premium payments and reporting of paid participants to applicable vendors.
MEDICAL BENEFITS

HOW ARE MEDICAL BENEFITS PROVIDED?

Your benefit plan provides coverage for most medically necessary services, procedures and supplies. Most specific services that are not covered are listed.

When determining payment, the plan will consider the reasonable and customary allowance for each expense.

The plan is designed to provide levels of benefits based on the choices you make. By choosing the services of a Trinity Health or a Network provider, you will receive a higher level of payment. Detailed information about how benefits will be paid can be found in the Plan Provisions.

WHAT IS MEANT BY “REASONABLE AND CUSTOMARY”?  

For Non-Network services, "reasonable and customary" (R&C) is a term that is used to identify fees most frequently allowed for the same or similar services in the geographic area where the service is rendered or a fee that has been negotiated with the provider. R&C allows for any unusual circumstances or complications which may require additional time, skill or experience.

For Network services, "reasonable and customary" (R&C) is the fee agreed upon between the plan and participating providers.

HOW IS R&C DETERMINED?

Our R&C allowances are obtained from independent review companies who collect aggregate and update average charge data from medical providers.

Charges are based on information supplied by claims payers throughout the United States and may be classified by time, complexity, skill and/or geographic area.

HOW WILL YOU BENEFIT FROM CHOOSING A NETWORK PROVIDER?

The company has contracted with certain physician and hospital providers to be the plan's Network provider. This Network provider is an independent contractor. The company does not provide any guarantee concerning the care provided by Network providers. Copies of the PPO provider directories can be obtained, at no charge, from the Human Resources Department.

When you or your covered dependent(s) choose a Trinity Health Network provider the plan will pay at a higher level than if you utilize a Non-Network provider.

You, together with your physician, are ultimately responsible for determining the appropriate treatment regardless of coverage by this plan.
WHAT HAPPENS IF YOU ARE NOT ABLE TO USE A NETWORK PROVIDER?

When you or your covered dependent(s) choose a Trinity Health Network provider, the plan will pay a higher level of benefits for certain services than it normally would.

If you and your covered dependents reside in an area where Network providers are not available, the plan will pay benefits at the Non-Network level.

If you or your covered dependents need emergency treatment for an accidental bodily injury or a life-threatening medical emergency outside the Network area at a provider that is not a Trinity Health or Network provider, the plan will pay benefits at the Network level.

If you or your covered dependents need emergency treatment for an accidental bodily injury or a life-threatening medical emergency and seek treatment (via car or ambulance) at the nearest facility that is not a Trinity Health Network provider, the plan will pay benefits at the Network level.

If a Network provider refers you or your covered dependent to a Non-Network provider and such specialty provider and/or service is not available through a Network provider, the plan will pay benefits at the Network level. Any related laboratory tests, x-rays or follow-up visits by the same Non-Network provider will be paid at the Network level.

If a Network provider refers you or your covered dependent to a Non-Network provider and such specialty provider and/or service is available through a Network provider, the plan will pay benefits at the Non-Network level. Any related laboratory tests, x-rays or follow-up visits by the same Non-Network provider will be paid at the Non-Network level.

If you or your covered dependents use a Trinity Health or a Network facility for inpatient/outpatient services/procedures, but the Trinity Health or a Network facility uses a Non-Network provider for anesthesia, the interpretation of laboratory tests and x-rays and other medically necessary services, the plan will pay benefits at the Network level.

If you or your covered dependents are admitted to a Non-Network hospital through the emergency room, the plan will pay benefits for that confinement at the Network level until you are stable. At that point, the plan will pay benefits at the Non-Network level, unless you are transferred to a Trinity Health or Network facility.

If a covered service or supply (other than Chiropractic services) is not available through a Trinity Health or a Network provider, the plan will pay benefits at the Network level. It is your responsibility to investigate the availability of a needed provider.
**WHAT IS THE PLAN DEDUCTIBLE?**

The plan considers the plan’s *fee schedule* allowance for *medically necessary* services and supplies.

Services that are covered by the plan are payable after the annual *deductible* has been satisfied.

The *deductible* varies depending on where the care is provided. Please see APPENDIX A for detailed information regarding the *deductible* amount.

The *deductible* is satisfied on a calendar year basis with expenses from January through December. Any expense applied toward the *deductible* during the last three months of the calendar year may be applied towards the *deductible* for the following year.

When an individual's coverage becomes effective during a calendar year, the *deductible* will apply only to expenses that are incurred after the *coverage effective date*.

When you enroll as an individual your individual *deductible* will apply. However, when you enroll as a family your family *deductible* will apply. All covered services for all family members will be added together until the family *deductible* is satisfied. No expenses will be paid until the family has met the family *deductible*. Your *deductible* will apply to your out-of-pocket expenses.

No *deductible* for Preventative Care.

Expenses applied toward the Non-Network *deductible* will be used to satisfy the Network *deductible*, and expenses applied to the Network *deductible* will be applied to the Non-Network *deductible*.

**WHAT IS YOUR OUT-OF-POCKET MAXIMUM EXPENSE?**

As outlined previously, this plan shares with you the expense for certain services. Your co-payment is the balance that you must pay of the *reasonable and customary* charge for covered benefits when plan payment is at a percentage other than 100%.

This plan is designed to limit your out-of-pocket. The *out-of-pocket maximum* expense limits are for covered services rendered during each calendar year.

The *out-of-pocket maximum* expense varies depending on the option chosen. Please see the Plan Provisions for detailed information regarding your *out-of-pocket maximum* amount.

When you enroll as an individual your individual *out-of-pocket maximum* will apply. However, when you enroll as a family your family *out-of-pocket maximum* will apply. All covered services for all family members will be added together until the family *out-of-pocket maximum* is satisfied. No expenses will be paid until the family has met the family *out-of-pocket maximum*.

For services rendered during the remainder of the calendar year after a covered individual reaches their *out-of-pocket maximum* expense limit, this plan will pay 100% of the *reasonable and customary* charges for subsequent expenses.
WHAT IS YOUR OUT-OF-POCKET MAXIMUM EXPENSE? (Continued)

Co-payments not included in the out-of-pocket maximum expense limit and not eligible for 100% payment even if the out-of-pocket maximum expense limit is met are:

- Amounts over the usual, customary, and reasonable charges (UCR)
- Applicable Penalties

Expenses applied toward the Non-Network out-of-pocket maximum will be used to satisfy the Network out-of-pocket maximum, and expenses applied to the Network out-of-pocket maximum will be applied to the Non-Network out-of-pocket maximum.

HOW DOES AN HSA WORK?

You may use this Plan in conjunction with a Health Savings Account (HSA). Late in 2003, Congress authorized the creation of the HSA, which is a tax-sheltered vehicle that allows participants enrolled in a “high deductible” medical plan to contribute money to pay for current qualified health care expenses and to save for future qualifying expenses.

The money you elect to contribute to an HSA account – which is professionally managed by an investment company – is allowed to grow tax-free. When you have qualifying medical expenses, you make tax-free withdrawals from your HSA using a special debit card or checking account. Generally, you receive a monthly statement that details deposits, withdrawals, fees (if applicable) and investment earnings.

If you retire from Trinity Health between the ages of 55 and 65 and you elect retiree medical coverage through the Plan, you can contribute tax-free dollars each year to your HSA as follows:

- Single coverage; up to $1,250, (Please note: this amount is indexed for inflation and is likely to increase each year) or
- 2–person or family coverage; up to $2,500 (Please note: this amount is indexed for inflation and is likely to increase each year)

Along with these allowable amounts, individuals who are age 55 or older can make an additional “catch-up contribution” each year. The catch-up limit for 2005 is $600. (Please note: this amount is indexed for inflation and is likely to increase each year.)

The money in an HSA account may be used to pay for out-of-pocket medical expenses such as deductibles and co-payments, doctor’s fees, prescription and nonprescription medicines, or hospital services that are not covered by the Plan.

Unlike other kinds of medical savings accounts the HSA has no “use-it-or-lose-it” rule. Any unspent funds will roll over from year to year, allowing you to build a tax-free nest egg to pay future medical expenses.
**HEALTH MANAGEMENT SERVICES**

The services outlined in this section of the plan are part of NGS’ Health Management Services. Together, they ensure that you receive high quality, cost-effective care.

It is important to remember that this plan covers only those procedures, services, and supplies that are **medically necessary** unless otherwise specified. For a service to be covered it must be considered necessary for the **diagnosis** or treatment of an **illness** or **injury** and the care must be given at the appropriate level. In determining questions of reasonableness and necessity, consideration is given to the customary practices of **physicians** in the community where the service is provided.

Services which are NOT considered to be **medically necessary** include, but are not limited to:

- Procedures of unproven value or of questionable current usefulness.
- Procedures which could be unnecessary when performed in combination with other procedures.
- Diagnostic procedures which are unlikely to provide a **physician** with additional information when used repeatedly.
- Procedures which are not ordered by a **physician** or which are not documented in a timely fashion in the patient’s medical record, or which can be performed with equal effectiveness at a lower level of care facility (e.g., on an **outpatient** basis).

For example, a medically unnecessary **hospital** admission would be one which does not require acute **hospital** bed patient care and could have been provided in a **physician’s office**, **hospital outpatient** department, or lower level of care facility without reduction in the quality of care provided and without harm to the patient. Also, a **hospital** admission primarily for observation, evaluation, or diagnostic study which could be provided adequately and safely on an **outpatient** basis is considered to be medically unnecessary.

**CASE MANAGEMENT**

Case management is a service designed to develop a quality plan of care. NGS’ **nurses** will partner with you and your **physician** to coordinate your care. They will ensure that you receive high quality, cost-effective care by accessing your condition, evaluating your needs, and monitoring your progress.

If you are diagnosed with a serious **illness** or suffer a serious **injury**, a NGS **nurse** will review your treatment plan with your **physician**, and will clarify questions that you may have regarding your treatment. You can contact a NGS **nurse** any time you have a question or concern regarding your treatment. The **nurse** will provide you with information about the treatment and will assist you in evaluating your options.

When the patient chooses to follow the recommendations made through case management, the plan may, at its discretion, cover additional expenses of alternative care and supplies when recommended by medical case managers.

If the **Plan Administrator** determines through case management that the treatment plan submitted is appropriate, then the plan participant must follow this plan of treatment in order to receive benefits under this plan.
PRE-CERTIFICATION OF SERVICES

A hospital stay can be a serious and expensive part of your course of treatment. This plan has a special program, Pre-Certification of Services, to make sure that you are not hospitalized unnecessarily. If you are admitted to (or registered as a patient at) a hospital or a rehabilitation facility, whether for emergency treatment, elective non-emergency treatment, or maternity care in excess of 48 hours for normal deliveries or 96 hours for cesarean delivery, you or a member of your family should call NGS at the number listed on your medical identification card. The call should be made prior to the elective hospital admission. It is your responsibility to obtain Pre-Certification of Services.

NGS’s nurse and your admitting hospital review your inpatient treatment plan before and during your hospitalization. The objective is to help you obtain all the information you need to make informed decisions. The NGS nurse:

- checks medical necessity of the hospital admission and length of stay against generally accepted medical standards, and
- suggests alternative treatment settings, if appropriate.

You will be notified by mail of the approved length of stay. Additional days may be assigned based on medical necessity.

It is important to note that, if you fail to follow these steps, the plan pays your claim at a reduced amount. After the benefits payable under this plan for the facility charges are calculated, those benefits are further reduced by 25%. The reduction of the claim, for which you are responsible, cannot be used to satisfy the annual deductible or the annual out-of-pocket maximum.

The final decision regarding treatment and hospitalization is yours. Maximum allowable plan benefits are paid as long as these steps are followed prior to any inpatient hospitalization.

If you or a covered dependent are admitted to a hospital for any reason without prior approval:

- Contact NGS by telephone within two business days of the admission. The contact may be made by you, a family member, or your physician.

SURGICAL ALTERNATIVES PROGRAM

The Surgical Alternatives Program is a voluntary program of the plan to help you when you make decisions about undergoing surgery. Any time your physician recommends surgery for you or a covered dependent, you may obtain a second opinion, paid for by this plan. To obtain the second opinion, you must select a physician who is not the surgeon originally scheduled to perform the surgery, and ask him or her to review your case. You must also request that the physician who renders the second opinion send a written report of his or her findings to NGS. You can then submit a claim for the expenses you incurred for the second surgical opinion which the plan will cover as described in the Plan Provisions. Based on both the original physician’s recommendations and the second surgical opinion, you should be able to make the appropriate decision for you and your family.
ONCOLOGY CLINICAL TRIALS

It is the plan’s intention to cover regular medical services, such as laboratory tests, x-rays, physician visits, hospital admissions and other services which would otherwise be payable if rendered outside of a clinical trial, when associated with an approved oncology clinical trial. Services will be payable as described in the Plan Provisions.

- A “clinical trial” is a study conducted on a group of patients to determine the effect of a treatment.

- An “approved oncology” clinical trial is a Phase II or III cancer clinical trial that meets the requirements and policies of one of these government agencies:
  1. National Institute of Health
  2. Food and Drug Administration
  3. Department of Defense
  4. Veteran’s Administration
  5. Center for Medicine and Medicaid Services (formerly the Health Care Financing Administration)
  6. Agency for Healthcare Research and Quality
  7. Centers for Disease Control and Prevention

- Phase II Trials are conducted on a large number of patients to determine whether the treatment has a positive effect on the disease or condition as compared to the side effects of the treatment.

- Phase III trials are conducted on a larger group of patients. Phase III compares the results of a new treatment to a conventional or standard treatment, indicating whether the new treatment leads to a better, worse or equal outcome.

NOT COVERED:

Services rendered as a part of a Phase I Clinical Trial.

Services which would not otherwise be payable by the plan if rendered outside of an approved clinical trial.
WHAT ARE THE PLAN SPECIFICS?

The following pages describe more specifically the benefits available for particular services.

Benefits are only payable when they are medically necessary for a covered individual (up to the applicable maximums as described in the Plan Provisions).

Plan payments are always based on the reasonable and customary allowance that is payable.

Plan payment is made according to the plan option you chose and whether you chose to have services rendered by a Network or Non-Network provider. For detailed information regarding the benefit payment, please see the Plan Provisions.

Please note that although some of the exclusions are categorized by type of service, the exclusion or limitation will apply to other services as well.

All services (with the exception of Preventative Care) will apply to deductible first then apply to out-of-pocket. Deductibles and out-of-pockets will cross apply between Network and Non-Network.
AMBULANCE

Professional ambulance, to the nearest point of treatment - including air ambulance, is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Transporting a patient to the first hospital where appropriate treatment is given for an accidental bodily injury or a life-threatening medical emergency

Transporting a patient from the hospital to a skilled nursing facility

Transporting a patient during a hospital confinement to and from another facility when testing or other necessary services cannot be provided at the hospital in which the patient is confined

Transporting a patient from the hospital to the patient's home when home health care is in place

Air ambulance when the aircraft is properly equipped for air transportation for medical patients

Transportation by a regularly scheduled airline or railroad for treatment of an accidental bodily injury or life-threatening medical emergency

NOT COVERED:

Transportation for the convenience of the patient

Transportation by other than a professional ambulance service
ANESTHESIA

Professional charges for the administration of anesthesia are covered as provided below.

If the charge for the anesthetic is included in the charges of the hospital or ambulatory surgical center, it will be covered in the same manner as that facility’s other charges.

If separate bills are received from an anesthesiologist and a Certified Registered Nurse Anesthetist (CRNA), the plan will consider the anesthesiologist and CRNA as practicing as an "anesthesia care team" and will divide the reasonable and customary allowance payment between the providers. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Surgery performed on an inpatient basis

Surgery performed on an outpatient basis

Exams or treatment requiring general anesthesia

NOT COVERED:

Acupuncture or acupressure

Charges for a local anesthetic, when billed independently these services are covered as part of a covered surgical procedure

Charges for anesthesia for procedures that are not covered by this plan

Charges in excess of reasonable and customary by the hospital and practitioner

Charges in excess of reasonable and customary by the physician and Certified Nurse Anesthetist (CRNA)

Services by anyone other than a Doctor of Medicine (MD), Doctor of Osteopathy (DO) or Certified Nurse Anesthetist (CRNA), Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD)
**BLOOD**

Blood and blood products are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

**COVERED:**

Covered surgical procedures performed on an **inpatient** basis

Covered surgical procedures performed on an **outpatient** basis

Blood provided for a **life-threatening medical emergency** or accidental bodily **injury**

Drawing and/or storage of blood for use at a later date for scheduled **surgery**

**NOT COVERED:**

Charges for blood that has been replaced by donation

Charges for blood for procedures that are not covered by the plan
CARDIAC REHABILITATION THERAPY

A cardiac rehabilitation program in a Medicare approved facility is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. The program must be for a patient who is classified as:

- stable, post-myocardial infarction within the prior 12 months,
- stable, angina pectoris controlled on medication and is not a candidate for coronary by-pass surgery, or
- stable, post-cardiac surgery (CABG, valve replacement, PTCA).

Coverage for a cardiac rehabilitation program is provided as follows:

COVERED:

Stress testing that is medically necessary and does not duplicate previous testing

Exercise program, up to 36 sessions

Physical therapy when a diagnosed non-cardiac condition is present

Occupational therapy when a diagnosed non-cardiac condition is present

NOT COVERED:

Psychotherapy and psychological testing

Educational lectures and counseling
CHEMOTHERAPY

Chemotherapy is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Injectable chemicals and administration given on an **inpatient** basis

Injectable chemicals and administration given on an **outpatient** basis, including a **physician’s** office

NOT COVERED:

Chelation therapy, unless for the treatment of heavy metal or lead poisoning

Oral medication (Please refer to the section titled PRESCRIPTION DRUGS for further information)
CHIROPRACTIC CARE

Charges for chiropractic care by a Doctor of Osteopathy (DO) or Doctor of Chiropractic (DC) are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Office visits

Spinal adjustments/manipulations for subluxation

Spinal x-rays

Physical therapy by a Doctor of Chiropractic (DC)

NOT COVERED:

More than one spinal adjustment/manipulation per day

Maintenance or custodial care

Treatment or testing other than spinal adjustments/manipulations or x-rays

Testing more frequently than medically necessary

Myotherapy

Orthomolecular therapy

Thermography

Hair analysis

Nutritional counseling

Injections
CONSULTATIONS

Consultations by a physician other than the attending physician are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. A consultation must be medically necessary because the attending physician's training and background do not enable him or her to properly care for the patient without the assistance of a specialist.

COVERED:

Consultations during a hospital confinement

Outpatient consultations for a second/third surgical opinion

Consultations for treatment of weight management when the patient has been diagnosed as morbidly obese

Consultations in a physician's office for medical conditions (Please refer to the section titled OFFICE VISITS for further information)

NOT COVERED:

Consultations that consist of only a telephone conversation

Consultations with anyone other than a physician

Consultations for procedures that are not covered by this plan
DENTAL SURGERY AND OTHER RELATED CHARGES

Certain dental procedures are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to Appendix A for additional information.

- one pre-surgical examination or consultation,
- certain dental procedures (as outlined below),
- anesthesia for the covered dental procedure, and
- x-rays necessary for the covered dental procedure.

The following is a list of certain dental procedures covered by the plan:

- Incision and drainage of an abscess,
- Vestibuloplasty
- Excision of cyst,
- Resection of benign tumor or soft tissue,
- Sialolithotomy,
- Closure of salivary fistula,
- Extraction of impacted teeth (covered on an outpatient basis only, unless a concurrent hazardous condition is present),
- Gingivectomies
- Alveoectomies/Alveoplasty
- Repair to the jaw, mouth or face or repair/replacement of a dental appliance or sound natural teeth due to an accidental bodily injury
- Surgical treatment of Temporomandibular Joint Syndrome (TMJ), including related x-rays, and
- Dental surgery, not specifically listed, if it would be covered if the same type of procedure were performed on another part of the body

The plan will cover the above surgical procedures performed on the jaw or mouth by a Doctor of Medicine (MD) or Doctor of Osteopathy (DO). The plan will also cover services by a Doctor of Dental Surgery (DDS) or a Doctor of Medical Dentistry (DMD).

Please refer to the section titled CONSULTATIONS, HOSPITAL and OFFICE VISITS of this booklet for information regarding coverage for consultations, hospital services and office visits related to covered dental procedures.

NOTE: Dental procedures that are covered under both this medical benefit plan and a company sponsored dental plan will be processed under this medical benefit plan only. Any remaining charges will be your responsibility.

COVERED:

Physician's charges for surgery and anesthesia
DENTAL SURGERY AND OTHER RELATED CHARGES (Continued)

NOT COVERED:

Manipulations, appliances and other therapies for the treatment of Temporomandibular Joint Syndrome (TMJ)

**Hospital confinements** and **outpatient** facility charges for a covered **dental** procedure, unless necessary due to:

- a **concurrent hazardous medical condition**
- a medical need to utilize the facility

**Dental** x-rays and their interpretation, unless related to and **medically necessary** for the listed covered **dental** procedures

**Dental** services and **dental** prosthesis

Cosmetic **surgery** on the jaw

Excision of pericoronal gingiva
DIALYSIS (USE OF AN ARTIFICIAL KIDNEY MACHINE)

During the waiting period for Medicare benefits, dialysis due to chronic renal failure is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

The plan will cover the rental, lease or purchase of the equipment at its discretion for use in the patient’s home. (Please refer to the section titled MEDICAL EQUIPMENT for further information.)

COVERED:

Dialysis in the outpatient department of a hospital or in a facility recognized by Medicare for dialysis

Medical supplies related to home dialysis when ordered in writing by a physician (these items do not require a prescription)

Installation, maintenance or repair of a dialyzer at the patient's home

Training of the patient and any individual who will be assisting him/her in operating the equipment

Physician's and nurse's services for dialysis treatment provided on an outpatient basis or when medically necessary at the patient's home

NOT COVERED:

Electricity or water used in operating the dialyzer

Installation of electric power, a water supply or a sanitary waste disposal system in conjunction with installing the dialysis equipment

Transfer of the dialyzer to another location of the patient's home

Removal of dialysis equipment when it is no longer necessary
FERTILITY TESTING AND TREATMENT

Fertility testing and treatment is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Testing - lab tests, x-rays and diagnostic surgical procedures to determine the cause of infertility

Surgical procedures to correct infertility

Counseling for infertility

NOT COVERED:

Artificial insemination

In-vitro fertilization

Embryo transfer

Fertility drugs (Refer to the section titled PRESCRIPTION DRUGS)
GENETIC TESTING/SCREENING AND COUNSELING

Genetic testing/screening is done to look for abnormalities in a person’s genes, or the presence/absence of key proteins whose production is directed by specific genes. Please, refer to the Plan Provisions for additional information.

Covered individuals must be referred by a physician to a genetic counselor before testing can occur. You will be asked to sign a consent form before the test is performed. Only one evaluation visit can initially be approved.

Genetic counseling, testing and/or screening is covered when all of the following conditions are met.

1. Covered individual is referred by a physician to a genetic counselor before testing
2. Informed written consent is obtained before and after testing/screening
3. The test has been proven valid (regulatory agency approval).
4. Factors exist to justify that a covered individual is at increased risk.
5. Knowledge of presence or absence of condition would directly affect medical care, where:
   a. the disease is treatable or preventable
   b. the test results will lead to a marked change in the intensity of surveillance/treatment of that disease.

NOTE: Tests commonly performed on amniotic fluid by a physician do not require genetic counseling.

Genetic testing/screening is performed:

1. to determine whether a person has a disorder caused by a genetic defect,
2. to determine whether a person is a carrier of a disorder caused by a genetic abnormality,
3. to determine a person’s risk of developing a disease,
4. to predict response to therapy,
5. if there is a history of spontaneous abortions,
6. if a covered individual gave birth to a child with a genetic disorder or chromosomal abnormality,
7. if there is a family history of certain inherited disorders, or the covered individual has symptoms of certain inherited disorders and requires a diagnosis,
8. for a dependent child if there is an increased risk of developing a childhood malignancy,
9. for an adopted child(ren), where the family history is unavailable or unknown, for conditions that manifest themselves during childhood and for which preventive measures or therapy may be undertaken during childhood.
GENETIC TESTING/SCREENING AND COUNSELING (Continued)

NOT COVERED:

Routine, ongoing, or long-term genetic counseling

Genetic testing to determine the paternity of a child

Genetic testing to determine the sex of a child

Genetic testing to determine one’s own genetic predisposition

General population screening for genetic disorders (example-cystic fibrosis)

Prenatal genetic screening undertaken with the intention of aborting the child

Genetic testing or screening in children or adolescents, except as provided

Genetic testing/screening for any individual who is not an eligible retiree or dependent as defined in the section titled ELIGIBILITY of this Plan

Genetic testing for:

- Huntington’s Chorea Disease,
- Li-Fraumeni syndrome,
- Melanoma and melanoma-associated syndromes,
- Ataxia Telangietasaia-associated susceptibilities.

Surgical procedure and related expenses that are performed as a precautionary measure when there is no presence of cancer or other disease (e.g. preventative mastectomy)
HEARING LOSS

This plan will cover certain services rendered to a covered individual, which are related to a hearing loss due to a congenital defect, disease or injury. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Physician and covered facility charges for a covered surgical procedure for hearing loss performed on an inpatient basis

Physician and covered facility charges for a covered surgical procedure for hearing loss performed on an outpatient basis

Audiological testing by an audiologist

Cochlear implant devices, if patient meets all of the following guidelines:

- **Diagnosis** of bilateral severe-to-profound sensorineural hearing impairment with limited benefit from hearing aids
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- No contraindications to surgery
- The device must be accordance with the FDA-approved labeling
- Must be two years of age or older
- Positive Promontory Test Results – A positive test result indicates the claimant would be a good candidate. (A promontory test determines whether the claimant’s nerve fibers serving transmission of sound to the brain are intact.)

Routine hearing exam, limited to one per calendar year

NOT COVERED:

Charges for services rendered to treat degenerative hearing loss

Charges for removal of ear wax, unless necessary due to prior surgical inner ear procedure, after a severe wax impaction, an abscess or infection or due to chronic middle ear infection

Charges for hearing aids, implants and devices
HOME HEALTH CARE

Home health care, by a home health care agency that is Medicare approved and licensed in the state in which it is located, is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

Home health care must be in lieu of a hospital confinement, or in lieu of outpatient services outside of the home, or for a covered individual who is homebound according to Medicare guidelines. To be considered medically necessary, the services cannot be primarily for the comfort or convenience of the member or custodial in nature.

“Your doctor must decide that you need medical care at home; you must need at least one of the following: intermittent skilled nursing care, physical therapy or speech-language therapy, or continue to need occupational therapy, you must be homebound, or normally unable to leave home unassisted. To be homebound means that leaving home takes considerable and taxing effort. A person may leave home for medical treatment or short infrequent absences for non-medical reasons, such as a trip to the barber or to attend religious services.”

Home Health care visits are combined to total less than 8 hours per day and 28 or fewer hours per week.

COVERED:

Part-time or intermittent nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN)

Part-time or intermittent home health aide services (caring for the patient) by an aide who is an employee of the home health care agency

Physical therapy rendered by a Registered Physical Therapist (RPT)

Occupational therapy by a Registered Occupational Therapist (RPT) when necessary to correct a bodily function

Speech therapy by a certified speech pathologist when necessary due to an accidental bodily injury and for victims of stroke and some forms of cancer

Lab tests and medical supplies to the extent they would be covered if the patient were confined in a hospital or skilled nursing facility

Infusion therapy, provided by a home health care agency or a licensed infusion company

Drugs and medicines (Please refer to the section titled PRESCRIPTION DRUGS for further information)
HOME HEALTH CARE (Continued)

NOT COVERED:
Homemaker or housekeeping services
Services of a social worker
Custodial care
HOSPICE

Hospice services, for a patient for whom active treatment to cure a disease has been determined ineffective, is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Inpatient hospice charges

Outpatient hospice charges

Part-time or intermittent nursing care by a Registered Nurse (RN) or Licensed Practical Nurse (LPN) and nurse’s aide

Drugs and medicines supplied by hospice

Physical, occupational or respiratory therapy

Respite care, up to two days per month

Bereavement counseling

Counseling by a Social Worker

Homemaker or caretaker services if solely related to care of the family member

NOT COVERED:

Funeral arrangements

Pastoral counseling

Financial or legal counseling including estate planning or the drafting of a will

Sitter or companion services for either the patient or other members of the patient's family

Transportation

Housecleaning

Maintenance of the house

Any volunteer services
HOSPITAL-EMERGENCY ROOM

Hospital emergency room expenses are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Physician and facility charges for the initial treatment of an accidental bodily injury or life-threatening medical emergency at a hospital emergency room

Physician and facility charges for the initial treatment of an accidental bodily injury or life-threatening medical emergency at an urgent care center

Physician and facility charges for medical conditions not due to an accidental bodily injury or life-threatening medical emergency

NOT COVERED:

Physician and facility charges for follow up visits in the hospital’s emergency room for chronic conditions not requiring repeated visits to the hospital

Physician and facility charges for follow up visits in the hospital’s emergency room for an accidental bodily injury or illness
HOSPITAL-INPATIENT

MEDICAL CONDITIONS

Hospital inpatient charges are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. All inpatient admissions must be pre-certified. Please see the section titled HEALTH MANAGEMENT SERVICES.

COVERED:

Admissions for a covered surgical procedure, an illness or the medical treatment of a life-threatening medical emergency or an accidental bodily injury

Hospital room and board charges for a semi-private room, coronary care unit, intensive care unit, special care unit and isolation

Hospital extras during a covered hospital confinement

Charges of a skin bank, bone bank and other tissue storage banks

Prosthetic appliances, either surgically implanted or external

Hospital confinements for laboratory testing and x-rays when medically necessary due to a concurrent hazardous medical condition

Confinements associated with weight management when the patient has been diagnosed as morbidly obese

NOT COVERED:

Confinements solely for physical therapy for rehabilitation following a hospital confinement for the same illness or injury

Charges for a private room

Rest cures

Charges for patient convenience items, including - but not limited to - telephone, television, guest trays, and guest beds, etc.

Confinements for custodial care or physical check-ups

Services rendered in a hospital operated by the state, U.S. Government or an agency of the U.S. Government
HOSPITAL-INPATIENT (Continued)

MEDICAL CONDITIONS (Continued)

NOT COVERED: (Continued)

Confinements in a Veteran’s Administration Hospital for a service related illness or injury

Hospital hotels

Days charged when the patient is on leave from the hospital

Charges for 23-hour outpatient observation care in excess of the cost of one-day care at the hospital's semiprivate room rate

Hospital confinements for procedures that are not covered by this plan

Weekend admissions for conditions other than a life-threatening medical emergency or accidental bodily injury

Confinements prior to the day before elective surgery

Hospital confinements for a covered dental procedure, unless when necessary due to:

- a concurrent hazardous medical condition
- a medical need to utilize the facility

Confinements in a facility that is not defined as a hospital
HOSPITAL-INPATIENT (Continued)

MENTAL DISORDERS AND/OR SUBSTANCE ABUSE

Hospital inpatient charges are covered as provided below for mental disorders and/or substance abuse in a qualified hospital. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. The hospital confinement must be necessary for the patient's welfare due to the deterioration of his/her condition.

All inpatient admissions must be pre-certified. Please refer to the section titled HEALTH MANAGEMENT SERVICES.

Each two days of intensive outpatient or partial hospitalization treatment will count as one day toward the maximums. If that treatment plan is not completed, then that confinement and any related services will not be covered.

COVERED:

Hospital room and board charges for a semiprivate room, special care units or isolation

Hospital extras during a covered hospital confinement, including counseling by hospital staff

Individual or group therapy

Occupational therapy

Detoxification

Shock therapy

Services for a day care or night care program in a hospital to the same extent that those services would be covered during a hospital confinement

NOT COVERED:

Charges for a private room

Days charged when patient is on leave from the hospital

Confinements when the course of treatment is not completed

Court ordered treatment, unless medically necessary
HOSPITAL-INPATIENT (Continued)

MENTAL DISORDERS AND/OR SUBSTANCE ABUSE (Continued)

NOT COVERED: (Continued)

Charges for patient convenience items, including - but not limited to - telephone, television, guest trays and guest beds

Confinements for custodial care

Services rendered in a hospital operated by the state, U.S. Government or an agency of the U.S. Government

Confinements in a Veteran’s Administration Hospital for a service related illness or injury

Confinements in a facility that is not defined as a hospital
HOSPITAL-OUTPATIENT

Hospital outpatient expenses are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Physician's surgical and facility charges when covered surgery is performed in the outpatient department of a hospital, clinic or an ambulatory surgical center

Laboratory tests and x-rays performed in the outpatient department of a hospital

Occupational, physical, respiratory and speech therapy performed in the outpatient department of a hospital

NOT COVERED:

Hospital outpatient facility charges for a covered dental procedure, unless necessary due to:

- a concurrent hazardous medical condition
- a medical need to utilize the facility

Services rendered in a hospital operated by the state, U.S. Government or an agency of the U.S. Government

Charges for 23-hour outpatient observation room in excess of the cost of one semi-private room per 24 hours, at the hospital’s semi-private room rate
HOSPITAL VISITS

Inpatient medical care (hospital visits) provided by your physician is covered by this plan. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. Hospital visits, unless medically necessary, are limited to one visit per day, per physician, per diagnosis.

COVERED:

Hospital visits during a confinement where surgery is not performed

Hospital visits prior to the date on which the surgery is performed

Counseling by a psychiatrist, psychologist or by a chemical dependency counselor or social worker who are under the direction of a psychiatrist or psychologist and other professional and staff charges billed by the hospital for mental disorders and/or substance abuse, up to the plan maximums

Hospital visits (routine nursery visits) for a well newborn, during a covered hospital confinement

Hospital visits on or after the date on which surgery is performed for a different diagnosis than the surgery and by a different physician than the surgeon

NOT COVERED:

Hospital visits on or after the date on which the surgery is performed when for the same diagnosis as the surgery (these are considered to be included in the surgeon's charge for the surgery)

Hospital visits by anyone other than a psychiatrist, psychologist or by a chemical dependency counselor or social worker who are under the direction of a psychiatrist or psychologist and professional and other staff charges billed by the hospital for a mental disorder and/or substance abuse
IMPLANTS

Implants are covered as provided below, including hospital and physician expenses. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Charges for functional or nonfunctional implants

Breast implant surgery following a mastectomy

Implant surgery for replacement or removal (following a mastectomy if for breast implants) if symptoms indicate a danger to the patient

Physician and facility charges for placement of the covered implants

Cochlear implant devices, if patient meets all of the following guidelines:

- **Diagnosis** of bilateral severe-to-profound sensorineural hearing impairment with limited benefit from hearing aids
- Cognitive ability to use auditory clues and a willingness to undergo an extended program of rehabilitation
- Freedom from middle ear infection, an accessible cochlear lumen that is structurally suited to implantation and freedom from lesions in the auditory nerve and acoustic areas of the central nervous system
- No contraindications to surgery
- The device must be in accordance with the FDA-approved labeling
- Must be two years of age or older
- Positive Promontory Test Results – A positive test result indicates the claimant would be a good candidate. (A promontory test determines whether the claimant’s nerve fibers serving transmission of sound to the brain are intact.)

NOT COVERED:

Penile implants and any related charges unless medically necessary to correct impotence caused by organic disease or injury

Hair and dental implants

Contraceptive implants, unless medically necessary
INJECTIONS

Injections, for the treatment of an illness or injury are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Injections, including the medication and administration of, unless listed as a covered benefit under the prescription drug benefit

Allergy injections, including the medication and administration of, unless listed as a covered benefit under the prescription drug benefit

Preventive inoculations and immunizations (examples - flu shots, shots required for school and/or travel, shots for well baby/child care) - Please refer to the section titled PREVENTIVE CARE BENEFIT for further information

NOT COVERED:

Vitamin injections, unless substitution with over-the-counter medication would endanger the patient's well-being

Injections for cosmetic purposes (example - collagen injections)

Sclerotherapy

Contraceptive injections, unless medically necessary
LABORATORY/PATHOLOGICAL TESTING

Laboratory or diagnostic tests are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Laboratory tests performed during a covered hospital confinement

Laboratory tests performed in the outpatient department of a hospital, at an independent laboratory or in a physician's office

Pre-admission tests performed prior to a covered hospital confinement

NOTE: Those pre-admission tests that are duplicated once the patient is admitted are not covered, except when they are medically necessary to monitor the patient's condition.

Laboratory tests related to outpatient surgery

Allergy testing

Amniocentesis, when medically necessary to determine the condition of the fetus

Pulmonary function testing

Routine testing, routine pap smears and routine PSA tests (Please refer to the section titled PREVENTIVE CARE BENEFIT for further information)

Tests associated with weight management when the patient has been diagnosed as morbidly obese

Genetic testing (Refer to the section titled GENETIC TESTING/SCREENING AND COUNSELING for further information)

NOT COVERED:

Paternity testing

Tests as part of a pre-employment or pre-marital exam or required for school, camp, licensing or other regulatory purpose

Tests associated with smoking cessation programs

Duplicate testing by different physicians

Tests for procedures that are not covered by the plan

Tests performed more frequently than is medically necessary, according to the diagnosis and accepted medical practices

Tests and/or treatment for mercury toxicity
**MEDICAL EQUIPMENT**

Rental of certain durable medical equipment is covered as provided below, if the **physician** prescribes the equipment in writing. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

In order to qualify as durable medical equipment, certain conditions must be met. The equipment must be:

- **medically necessary** to aid in the management or control of a diagnosed **illness** or **injury**,
- able to withstand repeated use,
- not generally useful to a person in the absence of **illness** or **injury**, and
- the type of equipment routinely found in a **hospital**, but appropriate for use in the home.

Examples of durable medical equipment include wheelchairs, traction equipment, walkers, **hospital** beds and mattresses and hemodialysis machines. In certain cases of uncontrolled diabetes, glucometers, dextrometers and portable insulin infusion pumps may be considered durable medical equipment.

**COVERED:**

Rental of durable medical equipment

**NOTE:** This plan may elect to purchase the durable medical equipment if it would be less costly than continued rental. If this occurs, the durable medical equipment is the property of this plan and must be surrendered when the patient for whom it was purchased no longer requires the equipment or becomes ineligible for coverage under this plan.

You (or a responsible person) will be required to sign a purchase agreement if the plan elects to purchase medical equipment.

Repairs of covered durable medical equipment

Whirlpool equipment, when **medically necessary**

**NOT COVERED:**

Charges where rental exceeds the purchase price

Deluxe equipment such as a motor driven wheelchair and bed, unless **medically necessary** for the treatment of the patient's condition and required in order for the patient to operate the equipment him/herself

Exercise equipment, including bicycles, weights, ergometers, and other equipment not generally considered durable medical equipment

Blood pressure kits, diet scales or other similar monitoring devices
MEDICAL EQUIPMENT (Continued)

Home uterine monitoring devices

Environmental control equipment, including - but not limited to - air conditioners, air filters or purifiers, humidifiers, dehumidifiers, vaporizers, heating pads, hot water bottles, water filters, purifiers, toilet seats, shower chairs, whirlpools, water beds, commode chair (except when patient is confined to bed), ultraviolet lighting or similar equipment
MEDICAL SUPPLIES

Certain medical supplies are covered as provided below when ordered by the physician and aid in the management or control of a diagnosed illness or injury. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. The supplies must not be generally useful to a person in the absence of illness or injury.

COVERED:

Medical supplies and dressings such as jobst hose, colostomy supplies, dressing packs, incontinence pads, incontinence briefs (only when patient is confined to bed), crutches, canes, splints, trusses, oxygen and therapeutic gases, syringes and needles

Blood test sticks used by diabetics and prescribed at the same time as insulin needles

NOT COVERED:

Supplies such as cotton balls and swabs, adhesive tape, ace bandages, band-aids, sanitary pads, first aid kits, thermometers, ice packs, heating pads and breast pumps
NURSING

Nursing care is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Services of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), provided on an inpatient basis when the patient cannot be cared for by the hospital staff

Services of a Registered Nurse (RN) or a Licensed Practical Nurse (LPN), provided in your home when it is part of a home health care program (please refer to the section titled HOME HEALTH CARE for further information)

NOT COVERED:

Services rendered by anyone other than a Registered Nurse (RN) or a Licensed Practical Nurse (LPN)

Custodial care
OCCUPATIONAL THERAPY

Occupational therapy necessary to restore a function lost through accidental bodily injury or illness is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. A physician or a Registered Occupational Therapist (OTR) must provide services.

COVERED:

Occupational therapy provided on an inpatient basis

Occupational therapy provided on an outpatient basis

Occupational therapy provided in a skilled nursing facility

Occupational therapy provided in the patient's home through a home health care agency

NOT COVERED:

Services provided by anyone other than a physician or a Registered Occupational Therapist (OTR)
OFFICE VISITS

Office visits are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

Please refer to the section titled PSYCHOTHERAPY - OUTPATIENT for information concerning office visits for mental disorders and/or substance abuse.

COVERED:

Office visit for illness or injury, other than mental disorders and/or substance abuse

Routine annual physical exams and well child care exams (Please refer to the section titled PREVENTIVE CARE BENEFIT for further information)

Physician’s home visit

Medically necessary treatment of eating disorders

Office visits associated with weight management when the patient has been diagnosed as morbidly obese

NOT COVERED:

Office visits for a pre-employment or pre-marital exam or required for school, camp, licensing or other regulatory purpose

Office visits/treatment for smoking cessation

Marital counseling

Office visits for routine foot care, including treatment (other than surgery) of corns, bunions, toenails, calluses, flat feet, fallen arches, weak feet and chronic foot strain

Office visit at the same time as a surgical procedure, unless:

• for the same diagnosis if the charge for both is recognized under the national coding standards,
• for a different diagnosis than the surgical procedure, or
• for the same diagnosis as the surgical procedure, bundled up to the reasonable and customary allowance of the surgical procedure

Charges for services consisting of only a telephone conversation

Charges for services rendered during an office visit by anyone other than a physician

Treatment and/or tests for mercury toxicity
ORTHOTIC APPLIANCES

Certain orthotic appliances are covered as provided below, when the appliance helps to restore normal every day function. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Prescribed orthotic appliances (example - leg braces)

Orthopedic shoes, when they are an integral part of a corrective brace

Arch supports, when custom molded, limited to one per calendar year unless condition changes to warrant a new prescription

NOT COVERED:

Corrective shoes, dental guards, eyeglasses, orthodontic braces, hearing aids and similar appliances
PHYSICAL THERAPY

Physical therapy is covered as provided below when services are rendered by a Registered Physical Therapist (RPT) or a physician. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Physical therapy provided during on an inpatient basis

Physical therapy provided in the outpatient department of a hospital, in a free-standing physical therapy facility or in a Medicare approved rehabilitation institute

Physical therapy provided in a skilled nursing facility

Physical therapy provided at home as part of home health care program

Massage therapy when applied in conjunction with other physical therapy modalities

Physical therapy provided in a doctor’s office

Physical therapy provided by a Doctor of Chiropractic (DC)

NOT COVERED:

Physical therapy provided in a doctor’s office during an office visit
PREGNANCY RELATED EXPENSES - MOTHER

Pregnancy related expenses are covered as provided below on the same basis as medical expenses for any other illness, for a covered retiree, covered spouse or a dependent child. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

All inpatient admissions must be pre-certified. Please see the section titled HEALTH MANAGEMENT SERVICES.

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

COVERED:

Hospital room, board and hospital extras during a hospital confinement

Hospital charges for the use of an on-site birthing center to the extent those charges do not exceed the cost of similar facility charges within the hospital

Pre-natal and post-natal care

NOTE: All charges for prenatal care must be fully itemized, including the date of each service and the charge for each service. Plan payment will be made as services are billed and rendered up to the reasonable and customary allowance of the global fee.

Delivery charges by a physician

Medically necessary diagnostic testing and x-rays

Services rendered by a Certified Nurse Midwife

NOT COVERED:

Charges by a freestanding birthing center

Ultrasound or amniocentesis, when performed solely to determine the sex of the child
NOT COVERED: (Continued)

Fetal surgery and related charges

Confinement of the mother in excess of the normal recovery period, due solely to a medical condition affecting the baby

Hospital confinement solely for bed rest

Charges for a standby physician, unless ordered by the delivering physician

Charges incurred by a surrogate mother
PREGNANCY RELATED EXPENSES - NEWBORN

Newborn charges are covered as provided below. The newborn must be eligible and enrolled for coverage within 30 days of birth. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

All **inpatient** admissions must be pre-certified. Please see the section titled HEALTH MANAGEMENT SERVICES.

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

**COVERED:**

- **Hospital** room, board and **hospital extras** during a newborn's **hospital confinement**
- Initial examination of a newborn by a **physician** other than the delivering **physician**
- Circumcision of a covered newborn
- Routine care of a covered newborn by a **physician** during the newborn’s **hospital confinement**, limited to one visit per day
- Well baby/child exams (Please refer to the section titled PREVENTIVE CARE BENEFIT for further information)

**NOT COVERED:**

- Confinement of a covered newborn in excess of the mother's normal recovery period following delivery, due solely to a medical or psychological condition affecting the mother
PRESCRIPTION DRUGS

Prescription drugs that are necessary for the treatment of an illness or injury of a covered individual are covered as described below. Drugs furnished during a hospital confinement will be payable as described in the section titled HOSPITAL-INPATIENT.

Prescription drugs purchased in a participating pharmacy are covered by the prescription drug benefit administered by Medco Health Solutions, Inc. The participating pharmacy will fill the prescription with a generic substitute, unless a generic substitute is not available. For each new or refilled prescription, you will be required to meet the applicable deductible. Once the deductible is met you will simply pay the co-payment shown in the PLAN APPENDIX. When drugs are purchased at a pharmacy, the prescription drug program will allow up to a 34-day supply. If you need a brand name drug and a generic equivalent drug is available you will be charged the difference in ingredient cost between the brand and generic drug, in addition to the brand co-pay. The difference between the generic and brand name will not apply to the annual out-of-pocket maximum.

Maintenance drugs (those prescribed to treat long-term or chronic medical conditions) can be obtained by mail through Medco Health Solutions, Inc. After three refills you will be required to have mandatory mail order on all maintenance drugs. This program allows you to save money by receiving a 90-day supply of medication for a low co-payment.

If you or your dependent purchases a drug at a pharmacy that does not participate in the Medco Health Solutions, Inc. program, you or your dependent must pay for the prescription in full and submit a claim for reimbursement to Medco Health Solutions, Inc.. You will be reimbursed the amount that would have been paid to the pharmacy minus the deductible (if applicable) and cash co-payment you would have paid at a participating pharmacy.

NOTE: This plan does not coordinate benefits on prescription drug charges that are provided through Pharmacy Benefit Managers.

COVERED:

Federal legend drugs
State restricted drugs
Compound medications
Insulin (when prescribed)
Injectables
Rhogam
Needles and syringes
Fertility drugs
Diagnosis required medications (except growth hormones)
Immune altering drugs
Imitrix refill vials (up to six injections per 30 days)
PRESCRIPTION DRUGS (Continued)

COVERED: (Continued)

Imitrix auto injector
Diabetic test strips
Diabetic drug (oral)
Diabetic lancets
Bee sting kits
Federal legend vitamins (adult, children and pre-natal)
Anabolic steroids
Retin-A – (pre-authorization required over age 25)
Renova – (pre-authorization required over age 25)
Cough and cold preparation
Cholesterol lowering drugs
Dexedrine ulcer drugs
Mental health drugs
Non steroidal anti-inflammatory drugs
Accutane
Cox inhibitors
Imitrix tablets (up to nine pills per 30 days)
Relenza (up to 20 pills per five days)
Tarnilla (up to 10 pills per five days)
Diet drugs with pre-authorization
Growth hormones with pre-authorization

NOT COVERED:

Nicotine cessation products
Allergy serums
Over the counter drugs
Blood products
Biological sera
Diagnostic agents
Rogaine
PRESCRIPTION DRUGS (Continued)

NOT COVERED: (Continued)

Diaphragms
Yohimbine
Male sexual dysfunction drugs
Ostomy products
Diabetic machine
Intravenous drugs

Contraceptive medications or devices, whether or not dispensed by prescription, which are purchased or prescribed for the sole purpose of preventing contraception
PROSTHETIC DEVICES

Certain artificial devices are covered as provided below when used to replace a functional part of the body (such as an artificial limb) when required due to a congenital defect, an injury or as a result of medically necessary surgery. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Temporary and initial permanent artificial limb or eye

Temporary and initial breast prosthesis following a mastectomy

Repair, fitting and adjustment of a prosthetic device

Replacement of an artificial limb, eye or breast prosthesis when required due to the patient’s growth, or other physiological change

Wigs, when hair loss is due to illness or treatment of an illness and ordered by a physician, up to plan maximum

NOT COVERED:

Specially designed bra for breast prosthesis

Replacement of specially designed bra for breast prosthesis

Eyeglasses, hearing aids, dentures or other similar devices
PSYCHOTHERAPY - OUTPATIENT

Services for the diagnosis, evaluation and treatment due to a mental disorder and/or substance abuse are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

Please refer to the section titled HOSPITAL-INPATIENT for information concerning inpatient care for a mental disorder and/or substance abuse. Services may be provided by a psychiatrist, psychologist or by a chemical dependency counselor or social worker who are under the direction of a psychiatrist or psychologist.

COVERED:

Outpatient counseling and psychotherapy at a physician’s office, a licensed clinic or at a hospital or clinic owned and operated by a hospital

Individual or group therapy

Psychological testing

Therapy associated with weight management when the patient has been diagnosed as morbidly obese

Counseling of a parent when the patient is a covered child under age 19 and in the parent’s custody. These charges will count toward the child’s calendar year and lifetime maximum

Shock Therapy

NOT COVERED:

Occupational therapy

Marital counseling

Therapy for smoking cessation

Hypnotherapy

Biofeedback training

Music therapy

Remedial reading therapy

Recreational therapy

Treatment for learning disabilities

Court ordered treatment, unless medically necessary
RADIATION THERAPY

Radiation therapy is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Radium, radioactive isotopes and other nuclear medicine during a covered hospital confinement
Radium, radioactive isotopes and other nuclear medicine received on an outpatient basis

NOT COVERED:

Ultraviolet or other light therapy, unless for a diagnosed medical condition (example - newborn jaundice, severe psoriasis)
SKILLED NURSING FACILITY

Certain services rendered to a **covered individual** by a **skilled nursing facility** are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

All **inpatient** admissions must be pre-certified. Please see the section titled HEALTH MANAGEMENT SERVICES.

Services in a **skilled nursing facility** will be covered if the admission is in lieu of a covered period of **hospital confinement**.

**COVERED:**

Room and board, up to the semiprivate room rate, and other **medically necessary** covered **hospital extras** even though rendered by a **skilled nursing facility**

**Physician** visits in a **skilled nursing facility**, limited to one visit per day

**Physical therapy**, speech therapy and occupational therapy to restore function lost due to **illness** or **injury**

**NOT COVERED:**

Confinements for **mental disorders** and/or substance abuse

Confinements for **custodial care**

Convenience items, including - but not limited to - telephone, television, guest trays and guest beds

Recreational therapy
SPEECH THERAPY

Speech therapy is covered as provided below when services are rendered to restore speech lost through illness, surgery or injury. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. Services must be provided by a certified speech pathologist.

COVERED:

Speech therapy provided on an inpatient basis for a medical condition

Speech therapy provided in a skilled nursing facility

Speech therapy provided on an outpatient basis for a medical condition

Speech therapy provided at home as part of a home health care program

NOT COVERED:

Speech therapy for a congenital defect, unless following surgery

Speech therapy for learning disabilities
SURGERY

Physician's surgery charges are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

NOTE: When a mastectomy is medically necessary, the plan will provide coverage in the same manner as any other covered surgical procedure. If a mastectomy is performed, the plan will provide coverage for reconstruction of the breast on which the mastectomy was performed. It will also cover reconstruction of the other breast to produce a symmetrical appearance. The plan will provide coverage for breast prosthesis due to a mastectomy as explained in the section titled PROSTHETIC DEVICES.

COVERED:

Surgery and surgical assistance for a covered surgical procedure when performed on an inpatient or outpatient basis or in a physician's office

Removal of warts through repetitive procedures for dissolving warts either by heat or freezing methods

Surgery associated with weight management when the patient has been diagnosed as morbidly obese

NOT COVERED:

Face-lifts, tummy tucks or skin tucks

Eyelid lifts or excision of fatty tissue, unless non-cosmetic

Sterilization reversal

Artificial insemination, in-vitro fertilization or embryo transfer

Hair removal or replacement

Surgery and associated charges for the correction in the size or shape of any part of the body

Breast reduction, unless proven medically necessary and there is removal of 250 grams of tissue per breast

Breast enlargement

Wrinkle removal, including collagen injections

Dermabrasion
SURGERY (Continued)

NOT COVERED: (Continued)

Medical charges incurred for, or in connection with, sexual conversion surgery and other services related to gender reassignment or disturbance of gender identification

Standby physician expenses, unless ordered by the surgeon

Surgical procedures performed by anyone other than a physician

Cosmetic surgery, except when:
- necessary due to an illness or injury
- as a result of a congenital defect which interferes with bodily functions
- for scar revision to correct a deformity caused by an accidental bodily injury or surgery

Sclerotherapy

Abortion procedures and all related charges

Surgical removal of one or both breasts without the current presence of cancer (preventative mastectomy)
TRANSPLANTS

Certain medical expenses associated with a necessary non-experimental human organ transplant, including skin tissue and bone marrow, are covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

Physician’s and facility charges for surgery, anesthesia and medically necessary surgical assistance

Harvesting, storage and transportation costs of the donated organ

Charges for transportation of patient

Donor’s medical expenses when the recipient is a covered individual and the donor has no source of coverage

Expenses of a covered individual who donates an organ if no other source of coverage is available

NOT COVERED:

Fees charges by blood and organ donors

Expenses incurred while waiting for a human organ transplant (Examples - housing, transportation, living expenses)

Services related to obtaining or implanting a non-human, artificial or mechanical organ

Transplant procedures that are considered experimental
VISION SERVICES

Certain services related to vision are covered as provided below when performed by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), or Doctor of Optometry (OD). The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information. The medically necessary treatment of a covered individual must be for the treatment of injury to the eye or the correction of a disease of the eye, but does not include errors of refraction.

Covered vision services include:

- surgical removal of cataracts,
- first pair of eyeglass, lenses or contacts after cataract surgery,
- retinal reattachment,
- implantation of a prosthetic device,
- surgical correction of strabismus (crossed eyes),
- cornea repair,
- medical treatment for eye infections (conjunctivitis) and glaucoma,
- treatment for injury to the eye,
- removal of a foreign body from the eye, and
- other treatment of a medical condition that happens to affect the eye that would be covered by this plan if manifested in any other part of the body (example – excision of cyst).

COVERED:

Physician's and facility charges for a covered surgical procedure performed on an inpatient or outpatient basis

Orthoptic training

NOT COVERED:

Surgical correction of nearsightedness, farsightedness and astigmatism (radial keratotomy, Lasik)

Visual acuity testing (to determine nearsightedness, farsightedness, astigmatism, etc.)

Eyeglasses and contact lenses, except as described

Charges for routine eye exam

Vision therapy
WEIGHT MANAGEMENT

Any expenses, whether surgical, non-surgical, or therapeutic (including prescription drugs) that are related to weight management or the treatment of obesity will not be covered under the plan regardless of the existence of any co-morbid conditions or psychological condition, unless the patient has been morbidly obese (as described below) for at least six months. Refer to APPENDIX A for additional information.

All expenses relating to weight management are limited to one course of treatment per lifetime.

COVERED:

All expenses related to the treatment of morbid obesity that are otherwise payable under the Plan will be considered allowable expenses (e.g. surgery, hospitalization, anesthesia, office visits for a physician, lab testing, psychotherapy, etc. Services will be payable as described in each respective section). For purposes of determining these benefits, the Plan will base the determination of morbid obesity on the patient’s Body Mass Index (BMI) or overweight status. A BMI greater than 40, or more than 80 pounds overweight for a female or more than 100 pounds overweight for a male will be considered indicative of morbid obesity. A BMI > 35 but less than 40 will also be considered indicative of morbid obesity where the patient has one or more of the following co-morbid conditions; severe sleep apnea, Pickwickian syndrome, Congestive heart failure, cardiomyopathy, Insulin dependent diabetes or severe musculoskeletal dysfunction, that are either life threatening or which significantly impair a major life function (e.g. mobility, ability to work, ability to self care). Documentation of the medical treatment of the co-morbid conditions that demonstrates the patient meets these criteria must be provided.

Additionally, the Plan will review patient history for optimal candidacy for any proposed surgical treatment according to current, generally accepted medical practices. For example, this review will consider whether the patient has been unable to lose weight through non-surgical, conventional measures and whether the individual’s ability to manage the surgical intervention and required post operative care has been assessed through a psychological evaluation.

The Plan will review if the patient has undergone a physician supervised nutrition, exercise and weight loss program for a minimum of six months, within the 12 months immediately preceding the proposed surgery, during which the patient was found unable to meet the physician’s weight loss goals. Unsuccessful weight loss attempts and lifestyle changes should be documented by medical office progress notes and a letter from the attending physician as to why non-invasive weight loss attempts are no longer a standard of care for the patient.

If confirmation is obtained from the attending surgeon that the program the patient will be under includes a complete support team with required follow ups, etc. a psychological evaluation is not required.
WEIGHT MANAGEMENT (Continued)

Other limitations include:

1. Appendectomies and cholecystectomies in conjunction with surgical treatment of morbid obesity will be considered incidental and not covered unless the individual has an existing condition that requires the additional surgical treatment.

2. Subsequent panniculectomy [surgery to remove loose skin] resulting from weight loss will be covered only if it is medically necessary as a result a documented history of treatment by a physician for related illnesses for a minimum of six months where the treated condition is no longer controlled through any other means.

NOTE: Please refer to the sections titled CONSULTATIONS, LABORATORY/PATHOLOGICAL TESTING, X-RAY AND X-RAY INTERPRETATION and OFFICE VISITS for information regarding coverage for consultations, laboratory/pathological tests, x-rays and office visits related to covered weight management procedures.

NOT COVERED:

Any expenses, whether surgical, non-surgical, or therapeutic (including prescription drugs) that are related to weight management or the treatment of obesity, regardless of the existence of any co-morbid conditions or psychological condition, unless morbid obesity has persisted for at least six months.
X-RAY AND X-RAY INTERPRETATION

X-ray and x-ray interpretation (medical imaging) is covered as provided below. The benefit payable will vary depending on the option you selected and the provider. Please refer to the Plan Provisions for additional information.

COVERED:

X-rays performed during a covered hospital confinement

X-rays and their interpretation performed in the outpatient department of a hospital, at an independent x-ray facility or in a physician's office

Pre-admission x-rays performed prior to a covered hospital confinement

NOTE: Those pre-admission x-rays that are duplicated once the patient is admitted are not covered, except when they are medically necessary to monitor the patient's condition.

X-rays related to outpatient surgery

X-rays associated with weight management when the patient has been diagnosed as morbidly obese

Routine mammograms and routine x-rays (Please refer to PREVENTIVE CARE BENEFITS for further information)

NOT COVERED:

X-rays as part of a pre-employment or pre-marital exam or when required for school, cam, licensing or other regulatory purpose

X-rays associated with smoking cessation programs

Duplicate x-rays by different physicians

X-rays for procedures not covered by this plan

X-rays performed more frequently than is medically necessary according to the diagnosis and accepted medical practices

X-rays, other than spinal x-rays by a Doctor of Chiropractic (DC)

Dental x-rays, except for a covered dental procedure
WHAT IS NOT COVERED?

There are many situations where benefits may be limited or not provided by this plan. Those situations have been described on the following pages and throughout this plan, as well as in the section of the plan titled WHAT ARE THE PLAN MAXIMUMS? (Please note that although some of the exclusions are categorized by type of service, the exclusion or limitation will apply to other types of services as well.)

Any portion of this plan does not cover the following charges:

Services or supplies that are not medically necessary

Services and supplies not prescribed by a physician

Charges in excess of those considered reasonable and customary

Experimental/investigational care, treatment, services, supplies or drugs

Services and supplies provided through research studies

Any type of travel, whether or not recommended by a physician, except as provided for a transplant procedure

Services rendered by a provider who is not specifically included in the definition of a physician or specifically listed as a covered provider

Charges for medical treatments, consultations or visits that consist of a telephone conversation

Charges that you would not be required to pay if you did not have group health coverage

Charges for which coverage is required by or available through any federal, state, municipal or other governmental body or agency

Charges incurred as a result of war or act of war, whether declared or undeclared

Charges incurred for completion of claim forms

Charges for services or supplies not rendered (including charges for cancelled appointments)

Charges for services or supplies that do not conform to generally accepted medical practices

Claims filed later than one year from the date the charge was incurred

Charges for legal expenses or fees incurred in obtaining medical treatment

Charges in excess of the plan maximums

Covered charges when there has been an incomplete claim submission
WHAT IS NOT COVERED? (Continued)

Services rendered for treatment of any **injury** or **illness** for which benefits are available under Workers' Compensation or Employer Liability Law, and such coverage must be purchased by law, whether or not such coverage is in force, and whether or not such benefits are received by the **covered individual**. Occupational **illness** or **injury** includes those as a result of any work for wage or profit.

Services, care, treatment, and **referrals** rendered by the **covered individual’s** family, including - but not limited to - spouse, mother, father, grandmother, grandfather, in-laws, son, daughter, stepchildren or any person who resides with the **covered individual**

Charges incurred as a result of an intentionally self-inflicted **illness** or **injury**, unless the **illness** or **injury** is a result of a medical condition.

Charges incurred as a result of committing an assault or felony.

Charges incurred as a result of committing any illegal or criminal activity.

Educational training except diabetic counseling, genetic counseling, peritoneal dialysis or other educational services that are **medically necessary**

Charges that are not payable by the **primary** plan covering the patient solely due to the **retiree’s** or patient’s failure to comply with that plan's requirements for cost containment provisions (including - but not limited to - failure to pre-certify, failure to obtain a second opinion, failure to execute subrogation agreements, etc.)

Charges for services that began before the **covered individual** was eligible for benefits.

Services rendered by a Christian Science facility, practitioner or **nurse**.

Charges for contraceptive pills, devices, implants and injections, unless **medically necessary**.

Charges for surgical sterilization and abortion.

Food supplement or augmentation, any form, unless necessary to sustain life in a critically ill person.

GIFT (Gacmete Intrafallopian Transfer), ZIFT.

Impotency treatment, except as described in the section titled IMPLANTS.

Pain management services, unless **medically necessary**.

Sclerotherapy.

Treatment or services resulting from participation in a civil insurrection or riot.
PHYSICAL EXAMINATION

This plan, at its own expense, will have the right and opportunity to have any individual whose treatment is the basis of a claim under this plan, examined by a physician designated by this plan when and as often as it may reasonably require during the review of a claim under this plan.

HOW DO YOU USE YOUR IDENTIFICATION CARD?

Your NGS American, Inc. plastic identification card was designed to assist you in obtaining necessary treatment. It provides health care providers (hospital, physician, laboratory, etc.) with the information they require when treating you.

The NGS American, Inc. card identifies you by name, and includes the status of covered dependents that you may have enrolled in this plan.
HOW WILL THIS PLAN WORK WITH OTHER COVERAGE?

There may be times when this plan is not the only source of benefits for you and your covered dependents. You may have other coverage provided by:

- Another Group Health Plan
- Medicare
- Motor Vehicle Laws

This plan uses established guidelines when there are other sources of benefits in order to determine when it pays first, as the primary source of benefits, or when it pays after other coverage, as the secondary source of benefits. When none of the following guidelines establish which plan is primary, the plan in effect the longest will be primary.

When this plan is primary, it will pay according to plan benefits described in this booklet. When it is secondary the plan supervisor will reduce its payment so that the total benefits paid under both plans do not exceed 100% of the allowable expense.

An allowable expense is an expense for medically necessary care if at least a portion of that expense is covered under one of the plans.

When this plan is secondary, it will subtract the amount paid by the primary plan from the allowable expense. However, even when the plan is secondary, it will never pay more than it would if it were the primary plan.

Example:

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<th>Allowable Expense</th>
<th>$ 75</th>
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</thead>
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<td>Primary Plan Paid</td>
<td>-$ 60</td>
</tr>
<tr>
<td>Balance</td>
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</tr>
</tbody>
</table>

This plan would normally pay $ 60
Payment by this plan as Secondary $ 15

Example:

<table>
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<th>Allowable Expense</th>
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</thead>
<tbody>
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</tr>
<tr>
<td>Primary Plan Payment @ 80%</td>
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<tr>
<td>$1360</td>
<td></td>
</tr>
<tr>
<td>Allowable Expense</td>
<td>$2200</td>
</tr>
<tr>
<td>This Plan’s Deductible Satisfied</td>
<td>-$1200</td>
</tr>
<tr>
<td>$1000 (at 80%)</td>
<td></td>
</tr>
<tr>
<td>This plan would normally pay</td>
<td>$ 800</td>
</tr>
<tr>
<td>Allowable Expense</td>
<td>$2200</td>
</tr>
<tr>
<td>Primary Plan Paid</td>
<td>$1360</td>
</tr>
<tr>
<td>Payment by this plan as Secondary payer</td>
<td>$ 800</td>
</tr>
</tbody>
</table>
HOW THIS PLAN WORK WITH OTHER COVERAGE? (Continued)

COORDINATION WHEN MULTIPLE PREFERRED PROVIDER ARRANGEMENTS ARE UTILIZED

When both this plan, paying as secondary, and the primary plan have a preferred provider arrangement in place, payment will be made up to the preferred provider allowance available to the primary plan.

This Plan will not coordinate with any other coverage. If you or your dependents have any other coverage, your or your dependents are not eligible for this plan as stated in the section titled (ELIGIBILITY).

MEDICARE ELIGIBILITY BY REASON OF END STAGE RENAL DISEASE

A covered individual who is eligible for Medicare solely on the basis of End Stage Renal Disease (ESRD) and who is not eligible for Medicare by reason of age or disability. Such a covered individual is referred to as an “ESRD Medicare eligible individual”.

When a covered individual becomes eligible for Medicare solely on the basis of ESRD, for a period of up to 30 consecutive months, this plan is considered primary.

This 30-month period begins on the earlier of:

a. the first day of the month during which a regular course of renal dialysis starts; and
b. with respect to an ESRD Medicare eligible individual who receives a kidney transplant, the first day of the month during which such covered individual becomes eligible for Medicare.

After the 30-month period ends, if an ESRD Medicare eligible individual incurs a charge for which benefits are payable under Medicare, this plan will not supplement what Medicare pays. The participant will no longer meet the requirements of the section titled ELIGIBILITY. If a covered individual is eligible for Medicare solely on the basis of ESRD, he/she must be covered by both Parts A and B. If the covered individual is not covered by both Parts A and B, he/she must meet the Medicare Alternate Deductible.

COORDINATION WITH AUTOMOBILE INSURANCE COVERAGE

This plan’s liability for automotive accidents is based on the type of automobile insurance act or law enacted in your State. Currently there are two types of state laws that affect how benefits may be paid under your plan.

- Financial responsibility laws
- No-fault automobile insurance coverage or personal injury protection coverage
HOW WILL THIS PLAN WORK WITH OTHER COVERAGE? (Continued)

COORDINATION WITH FINANCIAL RESPONSIBILITY LAW

If you are or your dependent is involved in an automobile accident, this plan may advance payment in order to prevent any financial hardship. You will be asked to provide this plan with information concerning your automobile insurance or automobile coverage of any other party involved. This plan will have an equitable lien against these parties up to the amount of the payment advanced. Please refer to the section titled REIMBURSEMENT OF PLAN PAYMENTS for further information.

If your state does not allow this plan to pay benefits as secondary or advance payment with the intent of subrogation, or recovering an overpayment, this plan will not cover any services related to an automobile accident for you or your dependent.

COORDINATION WITH AUTO NO-FAULT COVERAGE OR PERSONAL INJURY PROTECTION COVERAGE

In the event you or a covered dependent incur medical expenses as a result of an automobile accident, either as an operator of the vehicle, a passenger or a pedestrian this plan will pay for covered services limited to:

- any deductible under the automobile coverage
- any co-payment under the automobile coverage
- any expenses excluded by the automobile coverage that are covered plan benefits

You are or your dependent is considered to be covered under an automobile insurance policy if you are or your dependent is:

- an owner and principle named insured individual of the automobile policy
- a family member or member of the household of the person who is insured by the automobile policy
- a person who would be eligible for medical expense benefits under an automobile insurance policy if this plan did not exist

If you are or a dependent is involved in an automobile accident, this plan may advance plan with payment in order to prevent any financial hardship. You will be asked to provide this plan with information concerning your automobile insurance or automobile coverage of any other party involved. This plan will have an equitable lien against these parties up to the amount of the payment advanced. Please refer to the section titled REIMBURSEMENT OF PLAN PAYMENTS for further information.

Coverage provided by this plan is not intended to reduce the level of coverage that would normally be available through a no-fault automobile insurance or personal injury protection coverage policy nor does this coverage intend to provide benefits as primary in order to reduce any premium cost for no-fault automobile coverage or personal injury protection coverage. Coverage under this plan will be secondary to any no-fault automobile coverage or personal injury protection coverage.

NOTE: If you live in a state that requires no-fault coverage or personal injury protection coverage, and you fail to maintain no-fault automobile coverage or personal injury protection coverage that is required by your state, you and/or your dependents will not be entitled to any benefits that would otherwise be payable.
HOW WILL THIS PLAN WORK WITH OTHER COVERAGE? (Continued)

COORDINATION WITH OTHER AUTOMOBILE LIABILITY INSURANCE

If your state does not have no-fault automobile coverage or personal injury protection coverage or a "financial responsibility law," this plan will be considered secondary and will coordinate payment for covered services with your automobile insurance coverage or with any other party who may have liability for medical expenses.

If you are or your dependent is involved in an automobile accident, this plan may advance payment in order to prevent any financial hardship. You will be asked to provide this plan with information concerning your automobile insurance or automobile coverage of any other party involved. This plan will have an equitable lien against these parties up to the amount of the payment advanced. Please refer to the section titled REIMBURSEMENT OF PLAN PAYMENTS for further information.
FACILITY OF PAYMENT

Whenever payments which should have been made under this plan in accordance with its provisions have been made under any other plans, the plan shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this coordination provision, and any amount so paid shall be deemed to be benefits paid under this plan and to the extent of such payments, the plan shall be fully discharged from liability.

Plan payments will be made to the provider whenever there is no evidence showing that the provider has been paid. If the provider has been paid and the retiree authorizes payment to another individual, the plan will pay that individual upon receipt of the retiree’ signed authorization.

If a retiree dies, the plan will determine payment of claims as follows:

- First, to any providers who have not received payment that would be due under the plan;
- Second, the retiree’s spouse;
- Third, the retiree’s estate.
REIMBURSEMENT OF PLAN PAYMENTS

The plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help a covered person in a time of need, however, the plan may pay covered expenses that may be or become the responsibility of another person, provided that the plan later receives reimbursement for those payments (hereinafter called “Reimbursable Payments”).

Therefore, by enrolling in the plan, as well as by applying for payment of covered expenses, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the plan:

1. **Assignment of Rights (Subrogation).** The covered person automatically assigns to the plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or dental charges, attorney fees, or other costs and expenses. This assignment also allows the plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the plan’s right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. **Equitable Lien and other Equitable Remedies.** The plan shall have an equitable lien against any rights the covered person may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. The equitable lien also attaches to any right to payment from workers’ compensation, whether by judgment or settlement, where the plan has paid covered expenses prior to a determination that the covered expenses arose out of and in the course of employment. Payment by workers’ compensation insurers or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person’s attorney, and/or a trust) as a result of an exercise of the covered person’s rights of recovery (sometimes referred to as “proceeds”). The plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the Plan Administrator, the plan may reduce any future covered expenses otherwise available to the covered person under the plan by an amount up to the total amount of Reimbursable Payments made by the plan that is subject to the equitable lien.
REIMBURSEMENT OF PLAN PAYMENTS (Continued)

This and any other provisions of the plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA that were enunciated in the United States Supreme Court’s decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, ___ US ___ (1/8/2002). The provisions of the plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the “make whole” rule and the “common fund” rule.

3. Assisting in Plan’s Reimbursement Activities. The covered person has an obligation to assist the plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the plan with any information concerning the covered person’s other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the plan’s exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the plan as a co-payee for the amount of the Reimbursable Payments and notifying the plan), (c) sign any document deemed by the Plan Administrator to be relevant to protecting the plan’s subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term “information” includes any documents, insurance policies, police reports, or any reasonable request by the Plan Administrator to enforce the plan’s rights.

4. Overpayments. This plan will have the right to recover any payments that were made to, or on behalf of, a covered individual and which causes an overpayment to be made.

Failure by a covered person to follow the above terms and conditions may result, at the discretion of the Plan Administrator, in a reduction from future benefit payments available to the covered person under the plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the plan.
HIPAA PRIVACY COMPLIANCE

Section 6.17 HIPAA Privacy Compliance. The plan shall comply with applicable requirements of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations found at 45 C.F.R. Parts 160 and 164, as amended from time to time, (collectively “HIPAA”) with respect to the programs under the Plan which meet the definition of a “group health plan” as defined by HIPAA (including the medical, dental, vision, prescription drug, mental health and health care flexible spending account). Accordingly, this Section 6.17 shall apply only to those programs constituting “group health plans” under HIPAA. With respect to the medical, dental, vision, prescription drug, mental health and health care flexible spending account programs under the Plan, such compliance shall include, but not be limited to the following:

A. Plan Sponsor Uses and Disclosures. The Plan shall establish and determine the permitted and required uses and disclosures of protected health information (“PHI,” as defined by HIPAA) by the Plan Sponsor, provided that such permitted and required uses and disclosures may not be consistent with the HIPAA regulations.

B. Plan Sponsor Obligations. The Plan shall disclose PHI to the Plan Sponsor only upon the Plan Sponsor’s agreement that the Plan Sponsor shall:

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

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

3. Not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor;

4. Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by HIPAA of which the Plan Sponsor becomes aware;

5. Make PHI available in accordance with the provisions of HIPAA granting individuals access to their own PHI contained in the Plan’s designated record set;

6. Make PHI available for amendment by the individual who is the subject of the PHI and incorporate any amendments to such person’s PHI in accordance with relevant HIPAA provisions;

7. Make available the information required to provide an accounting of PHI disclosures to an individual covered by the Plan in accordance with relevant HIPAA provisions;

8. Make the Plan Sponsor’s internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA;
HIPAA PRIVACY COMPLIANCE (Continued)

B. Plan Sponsor Obligations (Continued)

9. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and

10. Provide for adequate separation between the Plan and the Plan Sponsor, as set forth below

The Plan Sponsor hereby agrees to abide by the above obligations and to certify to the Plan that it has been amended to incorporate the foregoing provisions.

C. Adequate Separation.

1. Only those employees or classes of employees or other persons under the control of the Plan Sponsor who are responsible for plan administrative functions shall be given access to the PHI to be disclosed, including any employee or person who receives PHI relating to payment under, health care operations of, or other matters pertaining to the Plan in the ordinary course of business.

2. The Plan shall restrict the access to and use by such employees or classes of employees or other persons under the control of the Plan Sponsor to plan administrative functions that the Plan Sponsor performs for the Plan.

3. The Plan shall provide an effective mechanism for resolving any issues of noncompliance with the provisions of this Section 6.17 by such employees and other persons under the control of the Plan Sponsor.

D. Plan Disclosures. The Plan may:

1. Disclose PHI to the Plan Sponsor for purposes of the Plan’s administrative functions that the Plan Sponsor performs consistent with the provisions of this Plan Section 6.17;

2. Not permit a health insurance issuer or health maintenance organization (“HMO”) with respect to the Plan to disclose PHI to the Plan Sponsor except as permitted by this Section 6.17.D;

3. Not disclose, and not permit a health insurance issuer or HMO to disclose, PHI to the Plan Sponsor as otherwise permitted by this Section 6.17.D unless the disclosure is included in the Plan’s Notice of Privacy Practices distributed to Plan Participants; and

4. Not disclose PHI to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.
HIPAA PRIVACY COMPLIANCE (Continued)

E. **Summary Information.** The Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary health information for the purpose of:

1. Obtaining premium bids from health plans for providing health insurance coverage under the Plan; or

2. Modifying, amending or terminating the Plan.

F. **Enrollment Information.** The Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled or has disenrolled from a health insurance issuer or HMO offered by the Plan.
GENERAL PLAN INFORMATION

PLAN NAME
The name of the plan is the Trinity Health Voluntary Retiree Medical Benefit Plan as Amended and Restated Effective September 1, 2005.

TYPE OF PLAN
This plan is a welfare benefits plan providing medical benefits.

PLAN NUMBER
The plan number is 504.

PLAN ADMINISTRATOR AND NAMED FIDUCIARY
The Plan Administrator, named fiduciary and agent for service of legal process is Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI 48331.

EMPLOYER IDENTIFICATION NUMBER
The employer identification number for the Trinity Health is 35-1443425.

COST OF THE PLAN
The Plan is voluntary, which means you are responsible for paying the full costs of the coverage for you and your eligible family members. The premium rates are per member of the family. Since these rates are subject to change at any time, you'll need to contact your Trinity Health Retirement Program representative (800) 793-4733.

PLAN EFFECTIVE DATE
This plan is effective September 1, 2005.

PLAN YEAR
The plan commences on the first day of January and ends on the last day of the following December.

PLAN SUPERVISOR
The Plan Supervisor is NGS American, Inc., 27575 Harper, P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

PLAN IS NOT A CONTRACT OF EMPLOYMENT
Neither this Summary Plan Description nor the plan constitutes or provides a promise or guarantee of employment or continued employment, to any employee of the Plan Sponsor or of any participating employer. Nor do these documents change any such employment relationship to be other than employment "at will."
YOUR RIGHTS UNDER ERISA

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator’s office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan’s annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse or dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Claims Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 31 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court, or bring a civil action under section 502A of ERISA. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that the plan fiduciaries misuse the plan’s money or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration (EBSA), U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.
DESIGNATION OF FIDUCIARY RESPONSIBILITY

Trinity Health is the named fiduciary with respect to this plan, within the meaning of Section 402(a)(1) of ERISA, solely to the extent of its responsibilities specified in the plan and service agreement. Trinity Health shall exercise all discretionary authority and control with respect to management of this plan which is not specifically granted to another fiduciary.

Trinity Health may delegate certain of its fiduciary responsibilities under this plan to persons who are not named fiduciaries of the plan. If fiduciary responsibilities are delegated to any other person, except as otherwise required by ERISA, such delegation of responsibility shall be made by written instrument executed by Trinity Health a copy of which will be kept with the records of this plan.

NGS American, Inc. has, by written instrument been designated as the Fiduciary for Final Claims Determination for medical post-service claims and pre-service claims submitted to the plan. By making this designation, it is Trinity Health’s intention that NGS American, Inc. make final claim determinations and have final discretion in construing the terms of the plan with respect to final claim determinations. NGS American, Inc. shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

Each fiduciary under this plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to this plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

Trinity Health, by a duly authorized representative, may modify, amend, or terminate the Plan at any time in its sole discretion.

Any such modification, amendments, or terminations that affect covered individuals in or beneficiaries of the Plan will be communicated to them. If the Plan is terminated, benefits will only be paid for claims incurred before the date of termination up to the time funds are no longer available.
ADMINISTRATION OF THE PLAN

The Plan Administrator, Trinity Health is required to supply you with this booklet and other information and to file various reports and documents with government agencies. In its role of administering this plan, the Plan Administrator also may make rulings, interpret the plan, prescribe procedures, gather needed information, receive and review financial information of the plan, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering this plan.

The Plan Administrator shall have any and all powers of authority which shall be proper to enable him to carry out his duties under this plan, including by way of illustration and not limitation (i) the powers and authority contemplated by the Employee Retirement Income Security Act of 1974 (ERISA) with respect to employee welfare plans, and (ii) full discretionary authority to make regulations with respect to this plan not inconsistent with this plan or ERISA and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons.

The Plan Administrator will determine eligibility for benefits under the Plan. The Plan Administrator has delegated fiduciary responsibility for medical pre-service claims and post-service claim decisions to NGS American, Inc. The plan shall be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not pre-empted by Federal law, the laws of the state of Michigan.

PLAN FUNDING AND ASSET DISTRIBUTION UPON TERMINATION

The Plan is funded through the general assets of Trinity Health and contributions as required. In the event of Plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the Plan should be terminated, only claims incurred prior to the date of such termination would be paid by the Plan up to the time funds are no longer available.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

The Trinity Health Plan is a self-funded plan. Covered individuals in this plan are not insured. In the event this plan does not ultimately pay expenses that are eligible for payment under this plan for any reason, the individuals covered by this plan may be liable for those expenses.

The Claims Administrator, NGS American, Inc., merely processes claims and does not insure that any medical expenses of individuals covered by this plan will be paid.

Complete and proper claims for benefits made by covered individuals will be promptly processed. In the event of a delay in processing, the covered individual shall have no greater right or interest or other remedy against the Claims Administrator, NGS American, Inc., than as otherwise afforded by law.
APPENDIX A

Pre-Medicare Option

### Annual Deductible

<table>
<thead>
<tr>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$1,250 Individual</td>
<td>$1,750 Individual</td>
<td>$2,250 Individual</td>
</tr>
<tr>
<td>$2,500 Family</td>
<td>$3,500 Family</td>
<td>$4,500 Family</td>
</tr>
</tbody>
</table>

NOTE: When you enroll as an individual your individual **deductible** will apply. However, when you enroll as a family your family **deductible** will apply. All covered services for all family members will be added together until the family **deductible** is satisfied. No expenses will be paid until the family has met the family **deductible**.

### Out-Of-Pocket Maximum (annual deductible included)

<table>
<thead>
<tr>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,500 Individual</td>
<td>$5,000 Individual</td>
<td>$10,000 Individual</td>
</tr>
<tr>
<td>$7,000 Family</td>
<td>$10,000 Family</td>
<td>$20,000 Family</td>
</tr>
</tbody>
</table>

### What Are The Co-pays?

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital Co-pay</td>
<td>$250 per admission</td>
<td>$500 per admission</td>
<td>$750 per admission</td>
</tr>
<tr>
<td></td>
<td>after deductible</td>
<td>after deductible</td>
<td>after deductible</td>
</tr>
<tr>
<td>Outpatient Surgical Facility</td>
<td>$50 per admission</td>
<td>$100 per admission</td>
<td>$100 per admission</td>
</tr>
<tr>
<td></td>
<td>after deductible</td>
<td>after deductible</td>
<td>after deductible</td>
</tr>
<tr>
<td>Emergency Room/Urgent Care (waived if admitted)</td>
<td>$75 after deductible</td>
<td>$75 after deductible</td>
<td>$75 after deductible</td>
</tr>
<tr>
<td>Office Visit</td>
<td>$25 after deductible</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Outpatient Mental Health and/or Substance Abuse</td>
<td>$25 after deductible</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

All co-pays are used to satisfy the **out-of-pocket maximum**.
<table>
<thead>
<tr>
<th>What Are The Plan Maximums?</th>
<th>All Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>$400,000 for all covered services</td>
</tr>
<tr>
<td><strong>Chiropractic Care</strong></td>
<td>20 visits in a calendar year.</td>
</tr>
<tr>
<td><strong>Mental Health and/or Substance Abuse</strong></td>
<td><strong>Inpatient Care</strong></td>
</tr>
<tr>
<td></td>
<td>- up to 30 days in a calendar year (120 days in a lifetime) for confinements for mental disorders and/or substance abuse including day and partial hospitalization and up to five days for detoxification. Each two days of intensive outpatient or partial hospitalization treatment will count as one day toward these maximums.</td>
</tr>
<tr>
<td><strong>Mental Disorders</strong></td>
<td><strong>Outpatient</strong> - Up to 30 visits in a calendar year</td>
</tr>
<tr>
<td><strong>Substance Abuse</strong></td>
<td><strong>Outpatient</strong> - Up to 20 visits in a calendar year</td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>120 days in a calendar year</td>
</tr>
<tr>
<td><strong>Home Health Care</strong></td>
<td>100 home health care visits per calendar year</td>
</tr>
<tr>
<td><strong>Temporomandibular Joint Syndrome (TMJ)</strong></td>
<td>$1,000 in a calendar year; $2,500 in a lifetime</td>
</tr>
<tr>
<td><strong>Transplants</strong></td>
<td>• $500,000 in a lifetime for all covered services.</td>
</tr>
<tr>
<td></td>
<td>• $10,000 for organ procurement and acquisition.</td>
</tr>
<tr>
<td></td>
<td>• $10,000 for transportation by ambulance of organ recipient to transplant site and</td>
</tr>
<tr>
<td></td>
<td>• $20,000 for bone marrow matching through a national registry.</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>60 visits in a calendar year</td>
</tr>
<tr>
<td><strong>Speech Therapy</strong></td>
<td>60 visits in a calendar year</td>
</tr>
<tr>
<td><strong>Occupational Therapy</strong></td>
<td>60 visits in a calendar year</td>
</tr>
<tr>
<td><strong>Cardiac Rehabilitation</strong></td>
<td>36 visits per condition in a 12 week period</td>
</tr>
<tr>
<td><strong>Wig</strong></td>
<td>$250 for wigs, when permanent loss of hair results from an illness, accidental injury or chemotherapy treatment</td>
</tr>
</tbody>
</table>
**Schedule of Medical Benefits**

The following tables outline your percentage of coverage as provided by this Plan. Please see the section titled WHAT ARE THE PLAN SPECIFICS? for a detailed description of covered items. If you need to know what the Network is in your area, please contact NGS American at (800) 521-1555.

This plan will pay the applicable percentage for covered services after you pay the applicable **co-pays** and **deductibles**.

<table>
<thead>
<tr>
<th>Hospital Inpatient Services</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard Room &amp; Board</td>
<td>90% of plan’s PPO rate for Semi-Private Room, after hospital co-pay, subject to deductible</td>
<td>80% of plan’s PPO rate for Semi-Private Room, after hospital co-pay, subject to deductible</td>
<td>60% of R&amp;C for Semi-Private Room, after hospital co-pay, subject to deductible</td>
</tr>
<tr>
<td>Extended Skilled Nursing Facility, Room &amp; Board</td>
<td>90% of plan’s PPO rate, after hospital co-pay, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate, after hospital co-pay, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C, after hospital co-pay, subject to deductible, subject to plan maximums,</td>
</tr>
<tr>
<td>Extended Skilled Nursing Facility, Ancillary</td>
<td>90% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C, subject to deductible, subject to plan maximums,</td>
</tr>
<tr>
<td>Intensive Care Room &amp; Board</td>
<td>90% of plan’s PPO rate for Intensive Care, after hospital co-pay, subject to deductible</td>
<td>80% of plan’s PPO rate for Intensive Care, after hospital co-pay, subject to deductible</td>
<td>60% of R&amp;C for Intensive Care, after hospital co-pay, subject to deductible, subject to deductible</td>
</tr>
<tr>
<td>Rehabilitation Room &amp; Board</td>
<td>90% of plan’s PPO rate for Semi-Private Room, after hospital co-pay, subject to deductible</td>
<td>80% of plan’s PPO rate for Semi-Private Room, after hospital co-pay, subject to deductible</td>
<td>60% of R&amp;C for Semi-Private Room, after hospital co-pay, subject to deductible, subject to deductible</td>
</tr>
<tr>
<td>Hospital, Ancillary</td>
<td>90% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
</tbody>
</table>
### Hospital Newborn Care

<table>
<thead>
<tr>
<th>Service</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Newborn Nursery</td>
<td>90% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td>Newborn Ancillary</td>
<td>90% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td>Neo-Natal Room &amp; Board &amp; Ancillaries</td>
<td>90% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
</tbody>
</table>

### Psychiatric & Substance Abuse – Inpatient

<table>
<thead>
<tr>
<th>Service</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Care Room &amp; Board/Ancillary</td>
<td>90% of plan’s PPO rate for Semi-Private Room, after <strong>hospital co-pay</strong>, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate for Semi-Private Room, after <strong>hospital co-pay</strong>, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C for Semi-Private Room, after <strong>hospital co-pay</strong>, subject to deductible, subject to plan maximums</td>
</tr>
<tr>
<td>Substance Abuse Care Room &amp; Board/Ancillary</td>
<td>90% of plan’s PPO rate for Semi-Private Room, after <strong>hospital co-pay</strong>, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate for Semi-Private Room, after <strong>hospital co-pay</strong>, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C for Semi-Private Room, after <strong>hospital co-pay</strong>, subject to deductible, subject to plan maximums</td>
</tr>
<tr>
<td>Psychiatric Care Day Treatment/Partial Hospitalization</td>
<td>90% of plan’s PPO rate for Semi-Private Room, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate for Semi-Private Room, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C for Semi-Private Room, subject to deductible, subject to plan maximums</td>
</tr>
</tbody>
</table>

2 days of treatment equal to 1 **inpatient** day

<table>
<thead>
<tr>
<th>Service</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Substance Abuse Care Day Treatment/Partial Hospitalization</td>
<td>90% of plan’s PPO rate for Semi-Private Room, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate for Semi-Private Room, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C for Semi-Private Room, subject to deductible, subject to plan maximums</td>
</tr>
</tbody>
</table>

2 days of treatment equal to 1 **inpatient** day
### Professional In-Hospital Services

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Hospital</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td><strong>Psychiatric Hospital</strong></td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C, subject to deductible, subject to plan maximums</td>
</tr>
<tr>
<td><strong>Substance Abuse Hospital</strong></td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C, subject to deductible, subject to plan maximums</td>
</tr>
<tr>
<td><strong>Physician Newborn Visit</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
</tbody>
</table>

### Professional Inpatient and Outpatient Services

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Primary Surgeon</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td><strong>Assistant Surgeon</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td><strong>Anesthesia</strong></td>
<td>This plan will pay the applicable percentage for covered services after you pay the applicable <strong>co-pays</strong> and <strong>deductibles</strong> 80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td><strong>Dental Surgery – Accidental Injury</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
</tbody>
</table>

### Professional Diagnostic Interpretation Services Inpatient and Outpatient

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pathologist Fee</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td><strong>Radiologist Fee</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
<tr>
<td><strong>Diagnostic Testing – Interpretation Fee</strong></td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>80% of plan’s PPO rate, subject to deductible</td>
<td>60% of R&amp;C, subject to deductible</td>
</tr>
</tbody>
</table>
## Emergency Room/Urgent Care Services

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient ER facility &amp; physician</strong>: emergency accident and/or life threatening illness</td>
<td>90% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Outpatient ER facility &amp; physician</strong>: non-life threatening illness</td>
<td>90% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Urgent Care facility &amp; physician</strong>: life threatening illness or accident</td>
<td>90% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Urgent Care facility &amp; physician</strong>: non-life threatening illness</td>
<td>90% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
</tr>
</tbody>
</table>

## Outpatient Services Facility

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>CAT Scan</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Clinic Visit – Facility Fee only</td>
<td>90% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>co-pay</strong>, subject to <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Diagnostic Laboratory</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Diagnostic Testing</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Diagnostic X-ray</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Magnetic Resonance Imaging</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Outpatient Hospital Services</strong></td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td><strong>Outpatient Surgery – Benefits are subject to the Outpatient Surgical Facility co-pay</strong></td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Pre-Admission Testing</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Venipuncture</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Sleep Disorder Clinic</td>
<td>90% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
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</tbody>
</table>
### Outpatient Therapy Services

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cardiac Rehabilitation</td>
<td>80% of plan’s PPO rate, after deductible,</td>
<td>80% of plan’s PPO rate, after deductible,</td>
<td>60% of R&amp;C, after deductible, subject to plan</td>
</tr>
<tr>
<td></td>
<td>subject to plan maximums</td>
<td>subject to plan maximums</td>
<td>maximums</td>
</tr>
<tr>
<td>Chemotherapy</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td>Intravenous Therapy</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td>Kidney Dialysis</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td>Occupational Therapy</td>
<td>80% of plan’s PPO rate, after deductible,</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td></td>
<td>subject to plan maximums</td>
<td>subject to plan maximums</td>
<td>maximums</td>
</tr>
<tr>
<td>Osteopathic Manipulation Therapy</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td>Physical Therapy</td>
<td>80% of plan’s PPO rate, after deductible,</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible, subject to plan</td>
</tr>
<tr>
<td></td>
<td>subject to plan maximums</td>
<td>subject to plan maximums</td>
<td>maximums</td>
</tr>
<tr>
<td>Radiation Therapy</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td>Speech therapy</td>
<td>80% of plan’s PPO rate, after deductible,</td>
<td>80% of plan’s PPO rate, after deductible</td>
<td>60% of R&amp;C, after deductible</td>
</tr>
<tr>
<td></td>
<td>subject to plan maximums</td>
<td>subject to plan maximums</td>
<td>maximums</td>
</tr>
</tbody>
</table>

### Outpatient Therapy Services (Continued)

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>60% of R&amp;C after $25 co-pay, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>deductible</td>
<td>deductible</td>
<td></td>
</tr>
<tr>
<td>Second/Third Opinion</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>60% of R&amp;C after $25 co-pay, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>deductible</td>
<td>deductible</td>
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</table>

### Doctor’s Office Services

<table>
<thead>
<tr>
<th></th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visit</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>60% of R&amp;C after $25 co-pay, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>deductible</td>
<td>deductible</td>
<td></td>
</tr>
<tr>
<td>Second/Third Opinion</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>80% of plan’s PPO rate after $25 co-pay,</td>
<td>60% of R&amp;C after $25 co-pay, subject to deductible</td>
</tr>
<tr>
<td></td>
<td>deductible</td>
<td>deductible</td>
<td></td>
</tr>
<tr>
<td>Chiropractic Services-DC only</td>
<td>Trinity Facility</td>
<td>Network</td>
<td>Non-Network</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------</td>
<td>---------</td>
<td>-------------</td>
</tr>
<tr>
<td>Chiropractic office visit</td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C after <strong>deductible</strong></td>
</tr>
<tr>
<td>Adjustment/manipulation</td>
<td>80% of plan’s PPO, after <strong>deductible</strong>, subject to plan maximum</td>
<td>80% of plan’s PPO, after <strong>deductible</strong>, subject to plan maximum</td>
<td>60% of R&amp;C after <strong>deductible</strong>, subject to plan maximum</td>
</tr>
<tr>
<td>Chiropractic x-ray</td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>80% of plan’s PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C after <strong>deductible</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Outpatient Mental Health and Substance Abuse Services</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychiatric Office Visit Outpatient</td>
<td>80% of plan’s PPO rate after the <strong>co-pay</strong>, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>80% of plan’s PPO rate after the <strong>co-pay</strong>, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>60% of R&amp;C, after <strong>deductible</strong>, subject to plan maximums</td>
</tr>
<tr>
<td>Psychiatric Testing and Evaluation</td>
<td>80% of plan’s PPO rate, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>60% of R&amp;C, after <strong>deductible</strong>, subject to plan maximums</td>
</tr>
<tr>
<td>Social Worker Visit (See Plan Definitions)</td>
<td>80% of plan’s PPO rate, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>60% of R&amp;C, after <strong>deductible</strong>, subject to plan maximums</td>
</tr>
<tr>
<td>Substance Abuse Visit, (See Plan Definitions)</td>
<td>80% of plan’s PPO rate after the <strong>co-pay</strong>, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>80% of plan’s PPO rate after the <strong>co-pay</strong>, subject to <strong>deductible</strong>, subject to plan maximums</td>
<td>60% of R&amp;C, subject to <strong>deductible</strong>, subject to plan maximums</td>
</tr>
</tbody>
</table>
PREVENTIVE CARE BENEFITS

Pre-Medicare Option:

- If a Trinity Facility, Network or Non-Network provider renders services, benefits are payable at 100% of the reasonable and customary allowance in a calendar year and not subject to the deductible.

The Plan will cover: one (1) complete physical examination annually for adults age 18 and over. [For dependents from birth to age 17, refer to the Well Baby/Child Benefit.] This benefit will cover the following related laboratory tests, x-rays and immunizations, which are performed in conjunction with the routine exam including but not limited to:

- Pap smear
- Breast exam
- Mammogram (a baseline age 35 to 39, and annually thereafter)
- Prostatic specific antigen screening (PSA)
- Urine test or urinalysis
- Hct (Hematocrit) or HGB (Hemoglobin)
- Sickle cell
- TB testing
- CBC (Complete Blood Count)
- PPD (Purified Protein Derivative)
- Fasting glucose
- Cholesterol screening
- CRP (C Reactive Protein) Diagnostic Test
- Creatinine
- EKG (Electrocardiogram)
- Digital rectal examination
- Chest x-ray
- SMA-17 (Sequential Multi-channel Analysis)
- TSH (Thyroid Stimulating Hormone)
- PFT (Pulmonary Function Test)
- Osteoporosis screening
- Routine Hearing Exam (as needed, but no more than one per calendar year)
- Routine colonoscopy (once in a ten-year period beginning at age 50)
- One routine eye exam each calendar year

If there is an illness that necessitates any of the above tests being performed more frequently, the test will be covered under the regular plan benefits. Where frequency limits are not recorded above, services performed in conjunction with the annual physical examination are subject to the standards recommended by the American Medical Association.

The following summarizes covered preventive care services and the frequency limits of each, based on recommendations and guidelines established by several leading national health-related organizations:
WELL BABY/CHILD BENEFIT PROVISIONS

The Plan will follow the American Academy of Pediatrics recommendations regarding a well baby check up and vaccines consistent with the following schedule:

- Six (6) visits from birth through 12 months will be covered
  - Recommended at the following intervals: birth, 2 months, 4 months, 6 months, 9 months and 12 months
- Three (3) visits from 13 months through 24 months will be covered
  - Recommended at the following intervals: 15 months, 18 months, and 24 months
- Annual visits from age 3 through 17 will be covered

Recommended Immunization Schedule:

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccines</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>Hepatitis B (HepB #1) vaccine</td>
</tr>
<tr>
<td>2 months</td>
<td>Hepatitis B (HepB #2) vaccine</td>
</tr>
<tr>
<td></td>
<td>Diphtheria and tetanus toxoids and acellular pertussis (DTaP #1) vaccine</td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenzae type b (Hib #1) conjugate vaccine</td>
</tr>
<tr>
<td></td>
<td>Inactivated Poliovirus vaccine (IVP #1)</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal (PCV #1) vaccine</td>
</tr>
<tr>
<td>6 months</td>
<td>Hepatitis B (HepB #3) vaccine</td>
</tr>
<tr>
<td></td>
<td>Diphtheria and tetanus toxoids and acellular pertussis (DTaP #3) vaccine</td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenzae type B (Hib #3) conjugate vaccine</td>
</tr>
<tr>
<td></td>
<td>Inactivated Poliovirus vaccine (IVP #3)</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal (PCV #3) vaccine</td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td>12 months</td>
<td>Measles, Mumps, Rubella (MMR #1) vaccine</td>
</tr>
<tr>
<td></td>
<td>Varicella (Chickenpox) vaccine</td>
</tr>
<tr>
<td></td>
<td>Haemophilus influenzae type B (Hib #4) conjugate vaccine</td>
</tr>
<tr>
<td></td>
<td>Pneumococcal (PCV #4) vaccine</td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td>15 months</td>
<td>Diphtheria and tetanus toxoids and acellular pertussis (DTaP #4) vaccine</td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td>2 years</td>
<td>Hepatitis A (Hep A)**</td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td>4 years</td>
<td>Diphtheria and tetanus toxoids and acellular pertussis (DTaP #5) vaccine</td>
</tr>
<tr>
<td></td>
<td>Inactivated Poliovirus vaccine (IVP #5)</td>
</tr>
<tr>
<td></td>
<td>Measles, Mumps, Rubella (MMR #2) vaccine</td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine</td>
</tr>
<tr>
<td>11-12 years</td>
<td>Tetanus/Diphtheria Booster (Td)</td>
</tr>
<tr>
<td></td>
<td>Influenza vaccine</td>
</tr>
</tbody>
</table>
### Ages 13 – 39

<table>
<thead>
<tr>
<th>Covered Benefit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Serum Cholesterol* and all Lab Tests listed above</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
</tr>
<tr>
<td>- Diphtheria and Tetanus Toxoids (DT)</td>
<td>One (1) in a ten year period</td>
</tr>
<tr>
<td>- Mumps, Measles and Rubella Virus Vaccine (MMR)</td>
<td>One (1) time from age 19 to 39</td>
</tr>
<tr>
<td>- Rubella Virus Vaccine</td>
<td>One (1) time from age 19 to 39</td>
</tr>
</tbody>
</table>

* Cholesterol screening for a child under age 18 is covered where the weight of the child is in the 100th percentile range for their age group

#### Female only

<table>
<thead>
<tr>
<th>Covered Benefit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram</td>
<td>One (1) time from age 35 to 39</td>
</tr>
<tr>
<td>Rubella Titer</td>
<td>One (1) time from age 19 to 39</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Breast Exam</td>
<td>One (1) per calendar year</td>
</tr>
</tbody>
</table>

### Ages 40 – 64

<table>
<thead>
<tr>
<th>Covered Benefit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Rectal Exam</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Sigmoidoscopy</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Stool Occult Blood</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Colonoscopy</td>
<td>One (1) every 10 year period at age 50</td>
</tr>
<tr>
<td>Serum Cholesterol and all Lab Tests listed above</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Colorectal Cancer test</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Diabetes Screen</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Depression Screen</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Immunizations</td>
<td></td>
</tr>
<tr>
<td>Diphtheria and Tetanus Toxoids (DT)</td>
<td>One (1) in a ten year period</td>
</tr>
</tbody>
</table>

#### Female only

<table>
<thead>
<tr>
<th>Covered Benefit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mammogram</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Pap Smear</td>
<td>One (1) per calendar year</td>
</tr>
<tr>
<td>Breast Exam</td>
<td>One (1) per calendar year</td>
</tr>
</tbody>
</table>

#### Male only

<table>
<thead>
<tr>
<th>Covered Benefit</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prostatic specific antigen screening (PSA)</td>
<td>One (1) per calendar year</td>
</tr>
</tbody>
</table>
### Other Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy Care (extract and injection)</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Allergy Tests</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Ambulance – Air Transportation</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Ambulance – Ground Transportation</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Durable Medical Equipment</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Home Health Care Services</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Hospice</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Hospice – Physician</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Injections</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Orthotics</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Prosthetics</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>RN &amp; LPN Services – Outpatient</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
<tr>
<td>Sleep Disorder clinics</td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>80% of plan's PPO rate, after <strong>deductible</strong></td>
<td>60% of R&amp;C, after <strong>deductible</strong></td>
</tr>
</tbody>
</table>

### Prescription Drug Co-pays

<table>
<thead>
<tr>
<th>Prescription Drug Card:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RETAIL (34 day supply)</td>
</tr>
<tr>
<td>• Generic</td>
</tr>
<tr>
<td>• Formulary</td>
</tr>
<tr>
<td>• Non-formulary</td>
</tr>
<tr>
<td>MAIL ORDER (100 day supply)</td>
</tr>
<tr>
<td>• Generic</td>
</tr>
<tr>
<td>• Formulary</td>
</tr>
<tr>
<td>• Non-formulary</td>
</tr>
</tbody>
</table>

**Note:** Prescriptions are subject to the In-Network **deductible** level.

The Rx program has a mandatory generic component. When a brand name is selected and a generic is available, the member will have to pay the generic copay plus the difference between the generic and brand drugs. The difference between the generic and brand name will not apply to the annual **out-of-pocket maximum**.
<table>
<thead>
<tr>
<th>Replacement of Organs/Tissues (Benefits are subject to the annual deductible and Hospital Co-pay and Plan Maximums)</th>
<th>Trinity Facility</th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Transplant Procedure</td>
<td>90% of plan’s PPO rate after hospital co-pay, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate after hospital co-pay, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C after hospital co-pay, subject to deductible, subject to plan maximums</td>
</tr>
<tr>
<td>Organ procurement and acquisition</td>
<td>90% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C, subject to deductible, subject to plan maximums</td>
</tr>
<tr>
<td>Transportation of recipient to Transplant Facility</td>
<td>90% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>80% of plan’s PPO rate, subject to deductible, subject to plan maximums</td>
<td>60% of R&amp;C, after hospital co-pay, subject to deductible, subject to plan maximums</td>
</tr>
</tbody>
</table>
APPENDIX B

HOW TO FILE A CLAIM

Following is a description of how the plan processes claims for benefits. A claim is defined as any request for a plan benefit, made by a **claimant** that complies with the plan’s reasonable procedure for making benefit claims.

There are different types of claims. Reasonable claim filing procedures, which are different for each type of claim, are described below. Each type of claim has a specific timetable for approval, payment, and request for further information, denial of the claim and for review of any **adverse benefit determination**.

The times listed below for response and appeals are maximum times only. A period of time begins at the time the claim is received, as explained in the claim filing procedures for each type of claim. Decisions will be made within a reasonable period of time appropriate to the circumstances. “Days” means calendar days.

WHAT YOU SHOULD KNOW ABOUT PRE-SERVICE CLAIMS

Where the plan requires advance approval of a service or treatment, the purpose of a **pre-service claim** is to provide the **claimant** with a determination of whether or not the approval process will prevent payment of the claim and to give you the opportunity to appeal any **adverse benefit determination** made during the pre-approval process. However, the claim determination made on a **pre-service claim** review does not guarantee payment of any **post-service claim**.

**Plan Procedures For Filing A Pre-Service Care Claim**

A **claimant** may file a **pre-service claim** by telephone, mail or electronic media. The plan may have specific requirements associated with notification of **pre-service claims**. See the Pre-Certification of Services section of the plan for further information.

The following information should be provided to the **Claims Administrator** for medical **pre-service claims**.

- The retiree’s name, name of the employer and four-digit division code; this information is embossed on your NGS American, Inc. identification card.
- The retiree’s social security number.
- The name of the patient and relationship to the retiree’s.
- The proposed date of service.
- The **diagnosis** and type of service to be provided.

The **Claims Administrator** must reply to the claim request within a certain time period. The **claimant** must also respond to the request from the **Claims Administrator** within certain time periods.
WHAT YOU SHOULD KNOW ABOUT PRE-SERVICE CLAIMS (Continued)

Urgent Care Pre-Service Claims

If the claim is an urgent care pre-service claim, the Claims Administrator must notify the claimant, orally or in writing, within 24 hours if proper claims filing procedure were not followed. The claimant must respond to that notification within 72 hours. If the claimant does not properly file the claim within 72 hours, the claim will be denied. If the claimant properly files the claim within 72 hours, the Claims Administrator will notify the claimant of a decision within 48 hours of receipt of the properly filed claim.

If the claim is filed following the proper claims filing procedures and no additional information is needed, the Claims Administrator will notify the claimant of a decision within 72 hours.

If additional information is needed the Claims Administrator will notify the claimant within 24 hours. The claimant will have up to 48 hours from the request to supply the needed information. When the information is received, the Claims Administrator will notify the claimant of a decision within 48 hours from the receipt of the response. If the claimant does not respond to the request for information, the claim will be denied within 48 hours after the request for information.

If an adverse benefit determination is given, the claimant may appeal the decision in writing via mail, fax or electronically. The Claims Administrator will provide a decision regarding the appeal within 72 hours. Refer to the section titled APPEALS for further information.

Non-Urgent Care Pre-Service Claims

If the claim is a non-urgent care pre-service claim, the Claims Administrator must notify the claimant, orally or in writing, within 5 days proper claims filing procedures were not followed. The claimant must respond to that notification within 15 days. If the claimant does not properly file the claim within this 15 days, the claim will be denied.

When the claim is filed following the proper claims filing procedures and no additional information is needed, the Claims Administrator will notify the claimant of a decision within 15 days.

If additional information is needed, or there are matters that prevent a decision and they are beyond the control of the plan, the Claims Administrator will notify the claimant within 15 days. The claimant will have up to 45 days from the request to supply the needed information. When the information is received, the Claims Administrator will notify the claimant of a decision within 15 days from the receipt of your response. If the claimant does not respond to the request for information, the claim will be denied within 60 days after the request for information.

If an adverse benefit determination is given, the claimant may appeal that decision. The appeal must be in writing. It should be addressed to the Claims Administrator. The appeal must be made within 180 days from the receipt of the notification. The Claims Administrator will review the appeal and respond within 30 days. Please see the section titled APPEALS for further information.
WHAT YOU SHOULD KNOW ABOUT POST-SERVICE CLAIMS

Plan Procedures For Filing A Medical Post-Service Claim

The claimant may file a post-service claim by mail or electronic media directly with the Claims Administrator. The plan does not require filing a claim form. When a provider files a claim, they will be considered the authorized representative.

The Claims Administrator for medical post-service claims is NGS American, Inc.

Original bills and/or receipts with the complete claims information listed below should be sent to NGS American, Inc. In the case of a bill from a Network provider where the Network requires claims be submitted through them, the bill will not be considered a claim until it is received by the Network. In addition to bills filed by hard copy, NGS American, Inc. will consider claims filed electronically as original claims.

When submitting a medical claim, the following information must be presented:

- The retiree’s name, name of the employer and four-digit division code; this information is embossed on your NGS American, Inc. identification card.
- The retiree’s social security number.
- The name of the patient and relationship to the retiree.
- The date of service.
- The provider’s name and degree.
- The medical condition for which treatment was provided.
- The charge for each specific service.

Unless you submit proof that you have paid for the services billed, payment will be made to the provider as your authorized representative.

Additional information provided at the time of the claim will help in making a determination. For example, if the bill is for your covered dependent who has other medical coverage, send a copy of the other coverage’s proof of payment or denial.

If the bill is for services rendered due to an accidental bodily injury, please provide the following details:

- How the accident happened?
- When the accident happened?
- The name and address of anyone who was responsible for the injury.

Things you need to know...

For medical claims, your Claims Administrator is NGS American, Inc., P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.
Plan Procedures For Filing A Medical Post-Service Claim (Continued)

This plan intends, through NGS American, Inc., to promptly acknowledge and make a claims determination on claims submitted. In order to do this, the plan needs your cooperation. In most cases when a bill is sent to NGS American Inc. directly by the provider, the claims information listed above will be on the bill. If you send a bill or receipt to NGS American, Inc., you should be sure the above claim information is given.

For Pharmacy Claims, your Claims Administrator is Trinity Health, 34605 Twelve Mile Road, Farmington Hills, MI, 48331.

For a prescription drug claim, present your identification card at a participating pharmacy with the prescription(s) to be filled or refilled. Your eligibility under the prescription drug program and your copay will be verified on-line by the pharmacy at the time the prescription is filled.

To obtain prescriptions through the mail order program, obtain forms and envelopes from your Human Resource Department, then fill out the forms and submit them with 1) the new prescription, and 2) the appropriate mail order copay, to the address on the envelope.

To obtain prescriptions from a pharmacy that does not participate in the participating Network provider program you must pay for the prescription in full and submit a claim for reimbursement to the participating Network provider. You will be reimbursed the amount that would have been paid to the pharmacy minus the cash co-payment you would have paid at a participating pharmacy.

The Claims Administrator must reply to a claim request within a certain time period. The claimant must also respond to the request for additional information from the Claims Administrator within certain time periods.

When a post-service claim is filed, and all information needed to make a claim determination is present, the Claims Administrator must notify the claimant of a claim decision within 30 days from the date the claim is received.

If a post-service claim is filed and additional information is needed, the Claims Administrator must notify the claimant within 30 days.

The claimant will have up to 45 days from the request to supply the needed information. When the information is received, the Claims Administrator will notify the claimant of a decision within 15 days from the receipt of the response. If the claimant does not respond to the request for information, the claim will be denied within 60 days after the request for information.

If an adverse benefit determination is given, the claimant may appeal that decision. The appeal must be in writing. It should be addressed to the Claims Administrator. The appeal must be made within 180 days from the receipt of the notification. The Claims Administrator will review the appeal and respond within 60 days. Please see the section titled APPEALS for further information.
NOTICE OF AN ADVERSE BENEFIT DETERMINATION

Except with Urgent Care Claims, when the notification may be given orally followed by written or electronic notification within three days of the oral notification, the Claims Administrator shall provide written or electronic notification of any adverse benefit determination. The notice will state, in a manner calculated to be understood by the claimant:

1. The specific reason or reasons for the adverse benefit determination.

2. Reference to the specific plan provisions on which the determination was based.

3. A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary.

4. A description of the plan’s review procedures and the time limits applicable to such procedures. This will include a statement of the claimant’s right to bring a civil action under section 502 of ERISA following an adverse benefit determination on review.

5. A statement that the claimant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

6. If the adverse benefit determination was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion which was relied on will be provided free of charge to the claimant upon request.

7. If the adverse benefit determination is based on medical necessity or experimental or investigational treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the claimant’s medical circumstances, will be provided free of charge to the claimant upon request.

APPEALS

If a claimant receives an adverse benefit determination for a non-urgent pre-service claim or a post-service claim, the claimant may appeal the decision within 180 days of date of the adverse benefit determination. The claimant may submit written comments, documents, records, and other information relating to the claim. If the claimant requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the plan. This timing is without regard to whether all the necessary information accompanies the filing.
A document, record, or other information shall be considered relevant to a claim if it:

1. was relied upon in making the benefit determination;

2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan Documents and plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by an individual employed by the Claims Administrator who is neither the individual who made the adverse benefit determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Claims Administrator shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the plan in connection with a review on appeal will be identified.
APPENDIX C

PROCEDURES RELATING TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Upon receipt of a Qualified Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the Plan Administrator shall take the following steps, within 20 business days:

1. Determine if the Notice or Order conforms to the requirements of a QMCSO,
2. Reply to the issuing agency if the individual is no longer employed, falls into a class of retiree’s who are ineligible for coverage or if dependent coverage is not provided,
3. Notify the issuing agency if the Notice or Order is determined to not meet the requirements of a QMCSO,
4. Notify the issuing agency of the coverage options available under the plan and any waiting periods which exist for coverage under the plan (if applicable),
5. Determine if federal withholding limits or prioritization rules permit the withholding from the retiree’s income of the amount required to obtain coverage for the children specified,
6. If appropriate, withhold from the retiree’s income any contributions required,
7. Notify the retiree of any contributions to be withheld from future pay,
8. Notify plan supervisors/vendors about enrollment, and
9. Notify the issuing agency of the date of enrollment and date coverage under the plan will begin.

The participant and each Alternate Recipient shall have the right to request in writing, within 60 calendar days after being notified of the Plan Administrator’s decision, that the Plan Sponsor again reviews the status of the Notice or Order. The participant and each Alternate Recipient may present additional materials to the Plan Sponsor for review. The Plan Sponsor may request additional information or material from the participant or Alternate Recipient. The Plan Sponsor must provide sufficient information to understand available options and to assist in appropriately completing the Notice or Order.