SUMMARY PLAN DESCRIPTION
FOR THE
HAMILTON HEALTH CARE SYSTEM, INC.
GROUP BENEFIT PLAN

Group Medical and Dental Benefits

AMENDED AND RESTATED

EFFECTIVE JANUARY 1, 2017

HAMILTON HEALTH CARE SYSTEM, INC.
GROUP BENEFIT PLAN SUMMARY PLAN DESCRIPTION

This Summary Plan Description (SPD) is intended to describe the medical and dental provisions of the Hamilton Health Care System, Inc. Group Benefit Plan, which is sponsored and maintained by Hamilton Health Care System, Inc. The terms of this Summary Plan Description are effective as of January 1, 2017, and they govern the administration and payment of claims Incurred on or after that date. **Please review the following information carefully; it supersedes any prior written information about the medical and dental benefits provided under the Plan.**

TABLE OF CONTENTS

INTRODUCTION

This Plan is maintained for the purpose of providing medical and dental benefits for Eligible Associates, Eligible Retirees and Eligible Dependents who become Covered Persons. In addition, you may be required to pay all or a portion of the cost of your coverage under the Plan (as determined by the Plan Administrator). Your share of the cost is determined annually, or more frequently if deemed appropriate, by the Plan Administrator.

This document, which we refer to as a Summary Plan Description or "SPD", describes the benefits provided under the Plan. This SPD, and the plan document into which this SPD is incorporated, constitute the documents governing the terms of the Plan. We encourage you to read this SPD carefully. Many of the sections of this SPD are related to other sections of the SPD so you may not have all of the information you need by reading just one section. Refer to the Table of Contents when necessary. We encourage you to keep a copy of your SPD for your future reference.

Certain capitalized words and phrases have special meanings. We have defined most of these words in the Definitions section of the SPD. If the capitalized words or phrases are not specifically defined in the Definitions section, the words or phrases may be defined in the section of this SPD in which they are first referenced. If they are not defined in the SPD, they may be defined in the Plan document into which this SPD is incorporated. If they are not defined in the Plan document, the capitalized words and phrases will have their customary and usual meaning.

If you have questions, you may contact the Plan Administrator, or the Claims Administrator, identified in the Plan Information section of this SPD.

Hamilton Health Care System, Inc. (Hamilton), as plan sponsor of group health plans (collectively the "Plan"), complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Hamilton does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. Hamilton also:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact the Civil Rights Coordinator in writing or by phone at the following:

Civil Rights Coordinator
1200 Memorial Drive
Dalton, GA 30720
706.272.6405 (Patient and Guest Services)

If you believe that Hamilton has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with the Coordinator. Please contact the Coordinator as soon as possible for instructions on how to file a grievance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, at:

U.S. Department of Health and Human Services
200 Independence Avenue SW
Room 509F, HHH Building, Washington, DC 20201
1–800–868–1019, 800–537–7697 (TDD)

File complaint electronically at: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf,
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla enspañol, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 706.272.6405	CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 706.272.6405	주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 706.272.6405 번으로 전화해 주십시오 706-272-6405
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 706.272.6405	**સુચના: જો તમે ગુજરાતી બોલતા હો, તો નિ:શુલ્ક ભાષા સહાય સેવાઓ તમારા માટે ઉપલબ્ધ છે. ફોન કરો** 706.272.6405	ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 706.272.6405
706-272-6405- .نمقرب لصتا .لك بالمجا ةغللا،إفنامدخ ا تدعاسملا ةونتة ةيوغللافر ا ملحوظة:اذإ دحتة تنكا ذا ثرك	ध्यान दें: यदि आप □□□□□ बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।	□□□□□: □□□□□□ □□□ □□□□ □□□ □□□□□ □□□□

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ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 706.272.6405	ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 706.272.6405	ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 706.272.6405
ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 706.272.6405	注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。706. 272. 6405	اگر شما زبان فارسی, زبان, کمک, خدمات رایگان هستند 706-در دسترس شما است. تماس 272-6405

DEFINITIONS

For this SPD, the following terms have the meanings given them in this section, unless otherwise specifically defined elsewhere in the SPD or in the Plan document into which this SPD is incorporated. **These definitions are not an indication that charges for particular care, supplies or services are eligible for Benefits under the Plan; please refer to the appropriate sections of this SPD for that information.**

Accident: An unintentional, unforeseeable and undesirable happening that results in bodily Injury for which medical or dental treatment is required.

Affiliate: Any corporation that is a member of a controlled group of corporations (as defined in Internal Revenue Code Section 414(b)) which includes the Employer; any trade or business (whether or not incorporated) which is under common control (as defined in Code Section 414(c)) with the Employer; any organization (whether or not incorporated) which is a member of an affiliated service group (as defined in Code Section 414(m)) which includes the Employer; and any other entity required to be aggregated with the Employer pursuant to Treasury regulations under Code Section 414(o).

Allowable Charge: The following are Allowable Charges under this plan and are agreed to be Reasonable and Customary:

- A contracted rate of a Preferred Provider Organization servicing the Plan with the agreement of the Plan Administrator or Claims Administrator is an Allowable Charge.

- A charge billed by a Non-PPO provider is determined to be an Allowable Charge under the following rules applied in the order of priority as they are listed:

    - If the Claims Administrator determines that the Allowable Charge is a lower amount than is otherwise applicable under the following rules, then that lower amount is the Allowable Charge;

    - If the billed charge is discounted according to an agreement negotiated specifically for the patient by the Claims Administrator (or its designee) directly with the provider, the Allowable Charge is the discounted charge;

    - If the billed charge is for dialysis, the Allowable Charge is the lesser of the billed charge or one-hundred thirty percent (130%) of the Medicare allowable charge;

    - If the billed charge is for chemotherapy drugs obtained through the pharmacy, home health provider, infusion provider, or directly from the pharmaceutical company, the Allowable Charge is the lesser of the billed charge or the average wholesale price of the drug;

    - If the billed charge is for specialty drugs obtained through the pharmacy, home health provider, infusion provider, or directly from the pharmaceutical company, the Allowable Charge is the lesser of the billed charge or the average wholesale price of the drug minus fifteen percent (15%);

    - If the billed charge is for specialty drugs dispensed by a facility on an Inpatient or Outpatient basis, the Allowable Charge is the lesser of the billed charge or 150% of the average wholesale price;

    - If the billed charge is for an implant (including but not limited to knee and hip replacements, pins, rods, cochlear implants, ocular implants), the Allowable Charge is the lesser of the billed charge or one and one-half (1 ½) times the invoice amount of the supplies;

- If the billed charge is discounted according to an agreement with a repricing service that covers the Plan, the Allowable Charge is the discounted amount;

- If the medical or dental service or supply appears on the Reasonable and Customary Table utilized by the Claims Administrator, then the Allowable Charge is the lesser of the billed charge or the amount as listed on the Table;

- If the billed charge is a facility charge that does not appear on the Reasonable and Customary Table utilized by the Claims Administrator, then the Allowable Charge is the lesser of the billed charge or 200% of the Medicare allowable charge; and

- If none of the foregoing applies, the Allowable Charge is the billed charge.

- The Allowable Charge for Out of network emergency care will be determined in a manner consistent with the requirements of the Affordable Care Act.

Approved Clinical Trial: An approved clinical trial means a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition (a disease or condition for which death is probable unless the disease or condition is interrupted) of a Covered Person and is one of the studies or investigations described below:

- The study or investigation is federally funded by one of the federal organizations identified in Section 2709(d)(1)(A) of the Public Health Service Act;
- The study or investigation is conducted under an investigational new drug application reviewed by the Food and Drug Administration;
- The study or investigation is a drug trial that is exempt from having such an investigational new drug application.

In addition, the Plan will not deny Routine Patient Costs solely because they were incurred as part of an approved clinical trial. Routine Patient Costs include all items and services that are typically covered under this Plan for Covered Persons who are not enrolled in an Approved Clinical Trial. Routine Patient Costs do not include:

- The investigational item, device, or service, itself; and
- Items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient.

Associate: Associate means an individual who is a common law Employee of an Employer Company for the purposes of federal income tax withholding.

Benefit: An amount payable by the Plan for a Covered Service in accordance with the terms of the Plan.

Calendar Year: A period of twelve months commencing January 1 and ending December 31 of the same year.

Child: Any individual who is your natural or adopted child or a child placed with you for adoption by a placement agency. Child also includes step-child, which is a natural or adopted child of your current Spouse and an individual for whom you are the court-appointed legal guardian.

Chiropractic Treatment: Skeletal adjustments, modalities, spinal/cerebral manipulation or other treatment in connection with the detection and correction, by manual means, of structural imbalance or subluxation of the human body. Such treatment is done to remove interference resulting from, or related to, distortion, misalignment or subluxation of, or in, the vertebral column.

Claims Administrator: The entity with whom the Employer has contracted to perform certain administrative services for the Plan. See the "Plan Information" section for more details on the Claims Administrator.

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

Coinsurance Amount: The portion of any Allowable Charge for which the Plan and you are obligated under the Plan.

Continuous Period of Confinement: All periods of confinement due to the same or a related cause or condition, unless periods are separated by one continuous month during which the Covered Person was not confined in either a Hospital or an Extended Care Facility or Skilled Nursing Facility.

Cosmetic or Cosmetic Surgery: Services or supplies designed to improve appearance, or surgery performed to reshape normal structures of the body in order to improve the patient's appearance and self-esteem.

Covered Dependent: An Eligible Dependent whose enrollment has been approved by the Plan Administrator; however, an Eligible Dependent of more than one Covered Associate may not be a Covered Dependent of more than one Covered Associate.

Covered Associate: An Eligible Associate whose enrollment has been approved by the Plan Administrator, except that no otherwise Eligible Associate may be both a Covered Associate and a Covered Dependent.

Covered Person: A Covered Associate, Covered Retiree and/or Covered Dependent.

Covered Retiree: An Eligible Retiree whose enrollment has been approved by the Plan Administrator except that an otherwise Eligible Retiree may not be simultaneously covered as a Covered Retiree, Covered Associate, or as a Covered Retiree and a Covered Dependent.

Covered Services: Services, supplies or treatments specifically identified as a Covered Service herein for which a Benefit is payable under this Plan, subject to terms of this SPD. Whether a service, supply or treatment qualifies as a Covered Service is determined in accordance with the claims review procedures set forth herein. Unless specifically stated otherwise, an item specifically identified as a Covered Service must also be Medically Necessary.

Custodial or Custodial Care: Care or confinement provided primarily for the maintenance of the Covered Person, essentially designed to assist the Covered Person, whether or not Totally Disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding, preparation of special diets, assistance in walking or getting in and out of bed, supervision over medication which can normally be self-administered and all domestic activities.

Dependent: An individual other than the Associate or Retiree who may become an Eligible Dependent by virtue of the individual's relationship to the Associate or Retiree.

Elective Surgical Procedure: Any non-Emergency surgical procedure which may be scheduled at the convenience of the patient or the surgeon without jeopardizing the patient's life or causing serious impairment to the patient's bodily functions.

Effective Date: The date on which coverage under the Plan becomes effective for a Eligible Person, as set forth herein.

Eligible Associate: An Associate who satisfies the Plan's eligibility requirements for Associates, as set forth herein.

Eligible Dependent: An individual other than the Eligible Associate or Eligible Retiree who satisfies the eligibility requirements for a Dependent as set forth herein.

Eligible Retiree: A Retiree who satisfies the eligibility requirements for Retirees, as set forth herein.

Emergency or Emergency Medical Condition: A severe medical condition of recent onset that would lead a reasonably prudent and knowledgeable layperson to believe that failure to obtain immediate medical attention could result in serious jeopardy to health or serious impairment to bodily function or to any bodily organ or part.

Examples of Emergency medical conditions include but are not limited to::

- Chest pain
- Heart attack
- Head injuries
- Strokes (cerebrovascular accidents)
- Poisoning
- Convulsions
- Severe bleeding
- Fractures
- Vomiting blood
- Extreme difficulty breathing
- Sudden severe pain anywhere in the body
- Threat of bodily harm to self or others

Employer: Hamilton Health Care System, Inc. and any successor thereof.

Employer Company: The Employer and any Affiliate who has adopted the Plan in accordance with the Plan's procedures.

ERISA: The Employee Retirement Income Security Act of 1974, as amended from time to time.

Experimental or Investigational: Any treatment, equipment, new technology, drug, procedure or supply that:

- Is not recognized by the state or national medical communities;

- Does not have final approval from the appropriate government regulatory bodies of the United States;

- Is not supported by conclusive, scientific evidence regarding the effect on health outcome; or

- Is not considered standard medical treatment for the patient's specific condition when compared with established, more conventional or widely recognized treatment alternatives.

Any treatment, equipment, new technology, drug, procedure or supply may be considered Experimental or Investigational within this definition, without regard to whether a Physician has previously prescribed, ordered, recommended or approved such treatment.

Extended Care or Skilled Nursing Facility: A licensed facility operating pursuant to law which is primarily engaged in providing (for compensation from its patients) skilled nursing care on an Inpatient basis during the convalescent stage of Illness or Injury under 24-hour-a-day supervision of a Physician or registered graduate

Nurse, and which maintains permanent facilities for the care of ten or more patients. Such a facility must maintain complete medical records on each patient and have established methods and procedures for the dispensing and administering of drugs. In no event shall the term include a facility that is primarily:

- A rest home, retirement home or home for the aged;
- A school or similar institution;
- Engaged in the care and treatment of Substance Abuse, or of mentally ill or senile persons; or
- Engaged in Custodial Care.

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

Home Health Care Agency: An agency that:

- Is primarily engaged in providing skilled nursing and other therapeutic services to the patient in his home;
- Is duly licensed or approved by the appropriate governmental body if such licensing or approval is legally required;
- Has policies established by a professional group associated with the organization, including at least one Physician and at least one registered Nurse to govern the services provided;
- Provides for full-time supervision of such services by a Physician or by a registered Nurse; and
- Maintains a complete medical record of each patient.

Home Health Care Expenses: The Allowable Charge made by a Home Health Care Agency for the following necessary services or supplies furnished to the Covered Person in such individual's home in accordance with the home health care plan for care for which the patient would otherwise have been hospitalized:

- Part-time or intermittent nursing care by or under the supervision of a registered Nurse;
- Part-time or intermittent home health care aide services that consist primarily of caring for the patient;
- Physical therapy, Occupational Therapy and speech therapy provided by the Home Health Care Agency; and/or
- Medical supplies, drugs and medications prescribed by a Physician and laboratory services by or on behalf of a certified Home Health Care Agency, to the extent such items would have been covered under any other provisions of the Plan had the Covered Associate or Covered Dependent been confined in a Hospital.

Hospice: A licensed service that offers a coordinated program of home care and Inpatient care for a Terminally Ill patient and the patient's family. The program provides supportive care to meet the special needs from the physical, psychological, spiritual, social and economic stresses often experienced during the final stages of life.

Hospital: An institution operated pursuant to law that is accredited by the appropriate national regulatory body for Hospital accreditation. It must be primarily engaged in providing (for compensation from its patients) medical, diagnostic and surgical facilities for the care and treatment of sick and injured persons on an Inpatient basis. It

must also provide such facilities under the supervision of a staff of Physicians and with 24-hour-a-day nursing service by registered graduate Nurses. In addition, the definition of a Hospital shall include the following:

- A surgery center;

- A rehabilitation hospital, if it provides medical supervision by a Physician, 24-hour-a-day nursing services by registered graduate Nurses and treatment programs developed by a staff of professionals who specialize in rehabilitative care, and has transfer arrangements with at least one other Hospital providing acute care and surgical facilities;

- A Substance Abuse treatment center that is licensed by the state or federal government, subject to any exclusions and limitations on such treatment contained in this Plan.

The definition of a Hospital shall not include any institution or part thereof which is used principally as a rest facility, residential treatment facility, Extended Care Facility, nursing facility, facility for the aged or for Custodial Care, or a halfway house.

Illness: A physical or Mental/Emotional Disorder of any kind of any Covered Person. Illness includes pregnancy for the purpose of benefit determinations.

Incurred or Incurred Date: The actual date a specific service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered.

Injury: A bodily injury resulting from an Accident sustained by any Covered Person. All injuries sustained by a Covered Person in one Accident will be considered one Injury.

Inpatient: A person who is confined in a Hospital as a registered bed patient and who is charged at least one day's room and board by the Hospital.

Lifetime Maximum Benefit: The Lifetime Maximum Benefit is the maximum Benefits this Plan will pay with respect to certain services or treatments incurred by a Covered Person, as set forth in this SPD.

Medically Necessary or Medical Necessity: Describes medical or dental services, treatments or supplies that:

- Are appropriate and consistent with the diagnosis;

- In accordance with accepted medical standards, would not have been omitted without adversely affecting the patient's condition or the quality of medical care rendered;

- Not solely for the convenience of the Covered Person; and

- As to institutional care, could not have been provided in a Physician's office, in the Outpatient department of a Hospital or in a lesser facility without adversely affecting the patient's condition or the quality of medical care rendered.

The mere fact that the service is furnished, prescribed or approved by a Physician does not mean that it is “medically necessary.”

With regard to dental services or supplies, the services or supplies, must be essential for the necessary care of the teeth and performed by or under the direction of a licensed dentist.

Medical Judgment: For purposes of the Plan's external review provisions, Medical Judgment means a decision based on the Plan's Medical Necessity requirements, appropriateness of care, level of care or effectiveness of a covered benefit or as otherwise contemplated by 29 C.F.R. § 2590.715-2719(d)(1)(ii)(A), as determined by the Independent Review Organization.

Medicare: All parts of Health Insurance provided by Title XVIII of the Federal Social Security Act of 1965, as now constituted or as hereafter amended.

Mental/Emotional Disorder: Any disorder characterized by abnormal functioning of the mind or emotions and in which psychological, intellectual, emotional or behavioral disturbances is the dominant feature. Mental/Emotional Disorders include mental disorders, mental Illnesses, psychiatric Illnesses, mental conditions and psychiatric conditions, whether organic or non-organic, whether of biological, non-biological, genetic, chemical or non-chemical origin, and irrespective of cause, basis or inducement.

Morbid Obesity: A diagnosed condition in which the body weight exceeds the medically recommended weight by either 100 pounds or is twice the medically recommended weight for a person of the same height, age and mobility as the Covered Person. Morbid Obesity also includes a Body Mass Index which falls above the 95th percentile on the growth chart for a Covered Person who is less than 19 years of age.

Nurse: A licensed Registered Nurse (RN) or Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) who does not usually live with the patient and is not a member of his family.

Occupational Therapy: The therapeutic use of self-care, work or other therapy activities for the sole purpose of reducing disability and restoring function and motor skills following an Injury or Illness.

Outpatient: A person who is not admitted as an Inpatient but who receives medical care.

Outpatient Surgery: Surgery performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office. An ambulatory surgical facility is defined as a licensed, specialized facility, within or outside the Hospital facility, which meets all the following criteria:

- Is established, equipped and operated in accordance with the applicable laws in the jurisdiction in which it is located and primarily for the purpose of performing surgical procedures;
- Is operated under the supervision of a Medical Doctor (M.D.) who is devoting full time to such supervision;
- Provides at least two operating rooms and one post anesthesia recovery room;
- Provides the full-time service of one or more Registered Nurses for patient care in the operating rooms;
- Maintains a written agreement with at least one or more Hospitals in the area for immediate acceptance of patients who develop complications;
- Maintains an adequate medical record for each patient. The medical record must contain an admitting diagnosis including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or X-rays, an operative report and a discharge summary.

Partial Hospitalization: A structured, Inpatient, Hospital-based program. Patients receive intense treatment usually between the hours of 8 a.m. and 5 p.m., Monday through Friday, and are capable of remaining in their home

environment in the evenings. Individual, group or family therapy is provided a minimum of four hours a day, three times a week.

Physician: A duly licensed Doctor of Medicine (M.D.), Osteopath, Podiatrist, Doctor of Dental Surgery or Dental Medicine (D.D.S. or D.M.D.), Doctor of Optometry, Chiropractor and auxiliary personnel which can include clinical psychologists, board-certified social workers, licensed professional counselors, Family Nurse Practitioners, Physician Assistants, Certified Registered Nurse Anesthetists, Nurse midwives, physical and occupational therapists or any other licensed practitioner of the healing arts if he or she performs a covered service:

- within the scope of the license; and
- applicable state law requires such practitioner to be licensed.

Plan: The Hamilton Health Care System, Inc. Group Medical Plan, as set forth herein, as may be amended from time to time.

Plan Administrator: Hamilton Health Care System, Inc.

Plan Year: The 12 month period identified in the Plan Information section of this SPD.

Preferred Provider Organization or PPO: A network of providers offering discounted fees for services and supplies to Covered Persons. The network will be identified on the Covered Person's Plan identification card.

Qualified Beneficiary: An individual described in 29 U.S.C. 4980B(g)(1) and the applicable regulations issued thereunder, as amended from time to time.

Reconstructive Surgery: Surgery performed to restore function by reshaping abnormal structures of the body caused by Illness, Injury, congenital defects or developmental abnormalities.

Residential Treatment Center: A facility that provides treatment 24 hours a day and can usually serve more than twelve people at a time. Treatment may include individual, group and family therapy; behavior therapy; special education; recreation therapy or medical services. Residential treatment is usually more long-term than Inpatient Hospitalization. Residential treatment is for (1) severe and persistent mental illness that results in the person being unable to maintain independent functioning without support and continued treatment for an indefinite period of time or (2) substance abuse in which the patient is at a high risk for relapse.

Retiree: A former Associate of an Employer Company other than a Qualified Beneficiary.

Routine Dental Exam: Exam by dentist not required because of Illness or Injury.

Routine Physical Exam: Exam by doctor not required because of Illness or Injury.

Second Surgical Opinion: A written report from a qualified Physician, who is not financially or professionally associated with the first Physician, as to the Medical Necessity of a future surgical procedure that was recommended by another Physician. This will include all Outpatient tests and diagnostic procedures Medically Necessary to render such opinion.

Sound, Natural Tooth: Any tooth that is sufficiently supported by its surrounding natural structures and is not decayed or weakened by previous dental work to the extent that it is more susceptible to damage. This susceptibility includes, but is not limited to, a tooth that is restored by a multi-surface restoration or a tooth that has had root canal therapy.

Spouse: A person to whom the Associate or Retiree (as applicable) is legally married in accordance with applicable state law.

Substance Abuse: The regular, excessive and compulsive drinking of alcohol and/or physical, habitual dependence on drugs that results in a chronic disorder affecting physical health and/or personal or social functioning. This does not include dependence on tobacco and ordinary caffeine-containing drinks.

Temporomandibular Joint (TMJ) Syndrome: One or more jaw joint problems including conditions of structures linking the jaw bone and skull and the complex of muscles, nerves and other tissues related to the temporomandibular joint. Care and treatment shall include, but are not limited to orthodontics, crowns, inlays, physical therapy and any appliance that is attached to or rests on the teeth.

Terminally Ill: Someone who has a life expectancy of approximately six months or less, as certified in writing by the Physician who is in charge of the patient's care and treatment.

ELIGIBILITY AND ENROLLMENT

A. Eligibility

Those individuals who satisfy the Plan's eligibility requirements may participate in the Plan provided they satisfy the Plan's enrollment procedures, as described in this SPD. You may be required to pay all or a portion of the cost of coverage for you and your Covered Dependents. Information regarding the cost of coverage will be provided in your enrollment materials.

Any representation of eligibility made by someone other than the Plan Administrator will not be binding on the Plan.

Eligible Associate

The following Associates will be eligible for coverage under the Plan

NOTE: Although an Associate may qualify as an Eligible Associate, the coverage options in which the Associate is eligible to enroll under the Plan may be limited depending the Associate's employment classification designated by the Employer Company:

New Hires

Regular Full-time Associates: A new Associate will generally be considered a Regular Full-time Associate if the Associate is designated by the Employer Company as a Full-time Associate *and* is regularly scheduled by the Employer Company to work 30 or more hours each week. Note: If you change your status from Regular Full-time Employee prior to the start of the Plan's Ongoing Employee Stability Period, you may remain eligible to the extent that the Plan Administrator reasonably determines that you may have 130 Hours of Service in any month following the change in status; however, your coverage options may be limited as described in this SPD.

NOTE: For purposes of clarification, an Associate designated as a PRN employed by Whitfield Staffing Associates is not considered a Regular Full-time Associate.

Qualifying Full-time Associates: Any other Associates, including but not limited to Seasonal Associates, who are not designated by the Employer Company Regular Full-time Associates may become eligible to participate in the Plan to the extent that they average 30 Hours of Service per week over the Associate's applicable Initial Measurement Period. Coverage for such Associates, if properly elected, will be effective on the first day of the Qualifying Full-time Associate's New Associate Stability Period. A Qualifying Full-time Associate will remain eligible throughout the New Associate Stability Period to the extent that the employee remains employed, subject to the Plan's Break in Service rules.

Other: Any other Associate identified as an Eligible Associate in the plan document into which this SPD is incorporated. Coverage for such an Associate will be effective on the date determined by the Plan Administrator.

"Ongoing" Associates

Once an Associate has completed the Plan's Standard Measurement Period without a Break in Service, eligibility will be based solely on the Associate's Hours of Service during the Plan's Standard Measurement Period ("Ongoing Associate"). Any Ongoing Associate who averages 30 Hours of Service per week during the Plan's Standard Measurement Period ("Ongoing Full-time Associates") will be eligible for coverage under the Plan during the Plan's next Ongoing Full-time Associate Stability Period to the extent that the Ongoing Associate remains employed, subject to the Plan's Break in Service rules. Such coverage, if elected, will be effective on the first day of the Plan's Ongoing Associate Stability Period.

Note: If an Associate who is not otherwise in an eligible position transfers during the year to a Regular Full-time Associate position (as determined by the Employer), the Associate will become eligible for the Plan.

Eligible Retiree

The term "Eligible Retiree" shall mean any Retiree who satisfies the eligibility requirements described in the Retiree Appendix to this SPD. Eligibility requirements and benefit provisions applicable to Eligible Retirees are described in more detail in that Appendix.

Eligible Dependent

The term "Eligible Dependent" shall mean any one or more of the following except that no otherwise Eligible Associate shall be eligible for coverage as a dependent and the dependent Child may not be covered as a dependent of another Associate at this company:

1. The Spouse of the Covered Associate. NOTE: See the subsection "Working Spouse Rule" below for more details.

2. Any Child of a Covered Associate who is:

    a. Under the age of 26; or

    b. Incapable of self-sustaining employment due to mental or physical disability, provided such disability commenced prior to attainment of age 26. Such Child must have had continuous coverage as a dependent prior to attainment of such age and have remained covered continuously thereafter.

NOTE: You are required to provide adequate documentation (as determined by the Plan Administrator or its authorized representative) from time to time verifying your Dependent's eligibility. Failure to promptly provide such documentation may result in denial or loss of coverage (including retroactive loss) for you and/or your Dependents. In addition, it is your obligation to ensure that no claims are submitted under this Plan by a provider or other third party for an ineligible individual. If you knowingly submit a claim for an individual who you know is ineligible, or you have reason to believe that a claim will be submitted by a third party for an ineligible individual and you fail to alert the Plan Administrator or the Claims Administrator, you may be deemed to have committed fraud or intentional misrepresentation against the Plan.

Working Spouse Rule (not applicable to dental benefits provided under the Plan)

If an Eligible Associate's Spouse works for an employer other than an Employer Company and the Spouse is eligible for group health coverage (medical) through the Spouse's employer that qualifies as Minimum Essential Coverage (as defined in Internal Revenue Code Section 5000A), the Spouse must enroll in his or her employer's health plan to be an Eligible Dependent under this Plan. This rule applies even if the Spouse's employer offers only one option, such as a health maintenance organization. The Spouse's employer's plan will be the "primary" payer (unless otherwise required by Federal law), and this Plan will be the "secondary" payer for the Spouse's Covered Expenses.

B. Enrollment

It is very important for you to timely enroll in the Plan during the applicable enrollment periods. There are three general enrollment periods---the Initial Enrollment Period, Special Enrollment Period, and the Annual Enrollment Period. If you do not timely enroll during the Initial Enrollment Period applicable to you, you will not be able to enroll until the next Annual Enrollment Period unless you experience one of the events described in the "Changes in Enrollment" or Special Enrollment subsection below.

Information regarding enrollment is described in your enrollment packet provided to you at the time you become eligible to enroll. If you have questions, you may contact the Plan Administrator.

Your successful enrollment in the Plan is conditioned on your timely provision of all information requested by the Plan Administrator (or its designee). If you fail to timely provide the requested information, your enrollment in the Plan will be deemed unsuccessful and coverage conditionally provided will be terminated.

In addition, your continued coverage is conditioned on timely payment of the contribution required by the Plan Administrator for such coverage. You will be notified each year in the applicable enrollment materials what the cost is for that year; however, the Plan Administrator reserves the right to change that amount from time to time during the year. NOTE: the cost may be impacted by your participation (or lack thereof) in the wellness program established and maintained by the Employer. The wellness program, which is a component of this Plan, is set forth in separate written materials.

Initial Enrollment Period (applicable to Newly Hired and Newly Eligible Associates)

If you are a newly hired Eligible Associate or you have recently become an Eligible Associate and you wish to participate in the Plan, you must enroll yourself and any Eligible Dependents you wish to cover at that time within 30 days of becoming an Eligible Associate in order for you and your Eligible Dependents to become Covered Persons. You complete your Initial Enrollment by submitting a completed, valid enrollment card which you obtain from the Plan Administrator.

If you timely enroll during the Initial Enrollment Period, coverage will take effect for you and any Eligible Dependent that you enroll at that time on the first day of the month following 30 continuous days as an Eligible Associate. If you fail to timely enroll, you may *not* enroll again until the next Annual Enrollment Period unless you experience one of the events described in the Changes in Enrollment section.

Annual Enrollment Period

Each year, the Employer will conduct an Annual Enrollment Period during which you may enroll yourself or your Eligible Dependents or you may make changes to your current elections. You will be notified in advance of the Annual Enrollment Period each year. If you enroll or make changes during the Annual Enrollment Period, your coverage (or changes) will be effective the following January 1. If you fail to enroll or make any changes during the Annual Enrollment Period, your coverage in effect on the last day of that Plan Year will continue during the next Plan Year.

Changes in Enrollment

Generally, you cannot change your enrollment election under the Plan during the Plan Year except as follows.

First, your election will automatically terminate if you terminate employment or lose eligibility under the Plan, except as otherwise described in the "Coverage Termination" section of this Booklet. **NOTE:** You are still required to provide timely notice of an event that results in loss of eligibility.

Next, you may also voluntarily change your elections to participate (or not to participate) during the Plan Year if you satisfy the following conditions (prescribed by Federal law):

1. You experience one of the Status Changes identified below and the change you wish to make satisfies the Consistency Rule, described below; or

2. You experience a significant Cost or Coverage Change (as defined below);

3. You experience a special enrollment event described below; and

4. You timely complete your enrollment change online. If you do not change your election prior to the enrollment deadline, you will not be permitted to make a change to your benefit elections until the next Annual Enrollment Period.

Status Changes

The following status changes will allow you to change your enrollment election during the Plan Year:

1. *Marital Status*. Your legal marital status changes for reasons such as marriage, divorce, legal separation, annulment, or death of a Spouse. See also HIPAA Special Enrollment below.

2. *Change in Number of Dependents*. Your number of Eligible Dependents changes for reasons such as birth, adoption, placement of a child with you for adoption, or death of a Dependent. See also Special Enrollment.

3. *Change in Dependent Eligibility*. Your Dependent satisfies or ceases to satisfy the eligibility requirements for coverage.

4. *Change in Employment Status that Affects Eligibility*. You, or your Eligible Dependent experiences a change in employment status due to one of the following events:

    a. Termination or commencement of employment;

    b. A strike or lockout;

    c. Commencement or return from an unpaid leave of absence;

    d. A change in employment status, e.g., unpaid leave, part-time to full-time or full-time to part-time, salaried to hourly;

    e. A change in worksite; and

    f. Any other change in employment status that affects benefits eligibility.

5. *Change in Residence that Affects Eligibility*. You or your Eligible Dependent changes residence and as a result of the change, the individual ceases to be eligible for medical coverage or becomes eligible for medical coverage.

You can only change your elections on account of a Status Change if the requested change is on account of and corresponds with the Status Change event, as determined by the Plan Administrator in accordance with Internal Revenue Code Section 125. This is called the "Consistency Rule" and it is a rule imposed by the IRS under the

Internal Revenue Code Section 125 cafeteria plan rules. As a result of the IRS's Consistency Rule, you may experience a Status Change that does not let you change your benefit elections.

In addition, the Status Change must also affect your or your Eligible Dependent's eligibility for medical coverage under an employer's plan. A Status Change also affects eligibility for medical coverage if it results in an increase or decrease in the number of Dependents who may benefit under the Plan. In addition, you must satisfy the following specific requirements in order to alter your election based on a Status Change:

1. *Loss of Dependent Eligibility*. If the event is divorce, legal separation, annulment, death of a Covered Dependent, or a Dependent ceasing to be an Eligible Dependent and you are enrolled in medical coverage, you may only cancel the coverage for the Covered Dependent. Coverage may not be cancelled for you or any other Covered Dependent, unless some other permitted election change applies. In fact, the election associated with the Dependent who ceases to be eligible as a result of one of the events described above ends as of the date described herein; however, you are obligated to provide prompt notice of the event to avoid adverse consequences.

   Example. Pat is unmarried and has one married child. Pat elects Associate Plus 1 medical coverage. Pat's child turns 26 and therefore loses eligibility for medical coverage at the end of the month that the child turns age 26. Although coverage for Pat's child ends under the plan when Pat's child ceases to be an Eligible Dependent, Pat must still notify the Plan Administrator as soon as possible that Pat's child has lost eligibility. Pat cannot cancel coverage for herself.

2. *Gaining Eligibility Under Another Employer Plan*. For a Status Change in which you or your Covered Dependent gains eligibility for coverage under another employer's medical plan as a result of a change in marital status or a change in your Covered Dependent's employment status, an election to cease or decrease coverage for you and/or that Covered Dependent under the Plan would correspond with that Status Change only if the other medical coverage becomes effective or is increased under the other employer's plan.

   Example: Associate Chris elects associate-only medical coverage. Chris marries. Chris's wife elected associate only medical coverage from her employer's medical plan prior to their marriage. Chris may either cancel medical coverage if he certifies that he and his wife will be covered under her employer's plan, or Chris's wife may cancel coverage under her plan and become covered under the Plan. However, due to the Working Spouse Rule, Chris's wife can only be covered as secondary under this Plan.

If you experience a Status Change event and you wish to change your election, you must change your election online within 30 days of the Status Change event.

<u>Cost or Coverage Changes</u>

You may also make changes due to cost or coverage changes. The applicable cost or coverage changes are:

1. *Change in Cost of Coverage*. If your share of the contributions for medical coverage you elected significantly increases, you may choose either to make an increase in contribution, revoke the election and receive coverage under another option (if any) that provides similar coverage, or drop coverage altogether if no similar coverage exists. If the cost of a Plan option significantly decreases, a Covered Associate who elected to participate in another benefit plan option of the Employer may revoke the election and elect to receive coverage provided under the option that decreased in cost. In addition, otherwise Eligible Associates who elected not to participate in the Plan may elect to participate in the

option that decreased in cost. For insignificant increases or decreases in the cost of options, however, your contributions will automatically be adjusted to reflect the minor change in cost. The Plan Administrator will have final authority to determine whether the requirements of this section are met.

2. *Entitlement to or Loss of Entitlement to Medicare or Medicaid*. You or your Eligible Dependent becomes entitled to or loses entitlement to Medicare or Medicaid.

3. *Governmental Plan Coverage Change*. You or your Eligible Dependent loses coverage under a group medical plan sponsored by a governmental or educational institution.

4. *New Benefit Option Added*. You are eligible for a new or improved medical coverage option.

5. *Court Ordered Coverage*. You are an Eligible Associate and you are required by a Qualified Medical Child Support Order ("QMCSO") to provide medical coverage for your Eligible Dependent child; or your Spouse, former Spouse or another individual is required by a QMCSO to provide coverage to a Dependent child you have enrolled in the Plan and such coverage is actually provided.

6. *Reductions in Coverage*. If coverage under an option is significantly curtailed, you may elect to revoke your election and elect coverage under another option that provides similar coverage, if available. If the significant curtailment amounts to a complete loss of coverage, you may also drop coverage if no other similar coverage is available. Further, if the Plan adds or significantly improves an option during the Plan Year, you may revoke your election and elect to receive, on a prospective basis, coverage provided by the newly added or significantly improved option so long as the newly added or significantly improved option provides similar coverage. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

7. *Change under another Employer Plan*. You may make an election change that is on account of and corresponds with a change made by another employer plan (including another Employer plan), so long as: (a) the other employer plan permits its participants to make an election change permitted under the Treasury Regulations issued under section 125 of the Internal Revenue Code; or (b) the Plan Year for the Plan is different from the plan year of the other employer plan. The Plan Administrator will have final discretion to determine whether the requirements of this section are met.

> *Example*: Associate Jean is married and has two unmarried children. At annual enrollment, Jean elects not to participate in the Plan, because her husband, Tom, has family coverage under his employer's medical plan. In June, the cost of the medical coverage provided by Tom's employer significantly increases and there is no other similar benefit package option available to him. As a result, his employer's plan allows him to cancel his family medical coverage. Because Tom has experienced a Status Change under his employer's plan that allows him to drop his family medical coverage, Jean may elect family medical coverage under the Plan. However, due to the Working Spouse Rule, Tom can only be covered as secondary under this Plan.

If you experience a cost or coverage change and you wish to change your election, you must change your election online within 30 days of the Cost or Coverage Change event.

<u>HIPAA Special Enrollment</u>

You may also change your election mid-year if you experience a special enrollment event. There are three categories of "special enrollment" events under the Health Insurance Portability and Accountability Act ("HIPAA") that will allow a midyear enrollment election change.

1. *New Dependent Special Enrollment*
If an Eligible Associates marries, has a child, adopts a child or a child is placed with the Eligible Associate for adoption (Dependent Event), the Eligible Associate will be permitted to enroll (i) the Eligible Associate only, (ii) the Eligible Associate and an Eligible Spouse only, (ii) the Eligible Associate and the newly acquired Eligible Dependent only, or (iv) the Eligible Associate, Eligible Spouse, and newly acquired Eligible Dependent. If a Covered Associate experiences a Dependent Event, the Covered Associate may enroll (i) an Eligible Spouse only (ii) the newly acquired Eligible Dependent or (iii) an Eligible Spouse and any newly acquired Eligible Dependents. The Eligible Associate or Covered Associate (as applicable) must request enrollment within 30 days of the Dependent Event in order to qualify for special enrollment. If properly enrolled, coverage will begin on the date of the Dependent Event in the case of a birth, adoption or placement for adoption and on the first day of the month following the date the enrollment is processed in the case of marriage.

2. *Loss of Other Coverage Special Enrollment (not applicable to retiree coverage)*
If an Eligible Associate initially refused coverage on behalf of the Eligible Associate and/or his/her Eligible Dependents because of other group health coverage and the Eligible Associate or Eligible Dependent experiences a "loss of eligibility" for that other group health coverage, the Eligible Associate may enroll (i) the Eligible Associate only, (ii) the Eligible Associate and Eligible Dependents who lost eligibility for coverage. If a Covered Associate initially refused coverage for an Eligible Dependent because of other group health coverage and the Eligible Dependent experiences a "loss of eligibility" for that other group health coverage the Covered Associate may enroll any Eligible Dependents who lose eligibility for other coverage. The Eligible Associate or Covered Associate (as applicable) must enroll within 30 days of the date of the loss of eligibility for other group coverage in order to qualify for special enrollment.

   A "loss of eligibility" results if any of the following occurs:

   a. Loss of eligibility for reasons other than failure to pay premiums or fraud. If you elect COBRA continuation coverage, you must exhaust the maximum continuation period in order to qualify for special enrollment.

   b. Cessation of all employer contributions.

   c. Moving out of an HMO service area if the other plan does not offer other coverage.

   d. Ceasing to be a "dependent," as defined in the other plan.

   e. Loss of coverage to a class of similarly situated individuals under the other plan (e.g., part-time Associates).

3. *Loss of Eligibility for CHIP or Medicaid (not applicable to retiree coverage)*
An Eligible Associate may enroll the Eligible Associate and/or an Eligible Dependent child if either of the following conditions is satisfied:

   a. You or your Eligible Dependent child loses eligibility for Medicaid or a state child health plan; or

   b. You or your Eligible Dependent child is determined to be eligible for group health plan premium assistance under a Medicaid plan or a state child health plan.

   NOTE: You must request enrollment within 60 days of this event in order to qualify for this special enrollment.

Effective Date of Enrollment Changes

Except as noted above, enrollment changes are typically effective on the date you make a timely and proper election change.

Notice of Ineligibility

Although coverage ends on the date a Covered Dependent ceases to be an Eligible Dependent, it is your responsibility to notify the Plan Administrator that a Covered Dependent has ceased to be an Eligible Dependent as soon as reasonably possible (but no later than 30 days of the individual ceasing to be an Eligible Dependent). If you fail to timely submit the required documentation, you may be required to repay any claims erroneously paid on such individual's behalf. See the "General Provisions" for more information on the Plan's right of recovery.

In addition, it is your obligation to ensure that no claims are submitted under this Plan for an ineligible individual. If you knowingly submit a claim for an individual who you know is ineligible, or you have reason to believe that a claim will be submitted for an ineligible individual and you fail to alert the Plan Administrator or Claims Administrator, you may be deemed to have committed fraud or intentional misrepresentation against the Plan.

Change in Associate or Dependent Status

If your coverage status changes from Dependent to Associate, or from Associate to Dependent, all individual deductibles, benefit maximums, and out-of-pocket expense amounts applicable to your individual coverage will carry over as if there had been no change in status.

When Both Spouses Are Covered Associates

When both you and your Spouse are Covered Associates and you have family coverage for your Eligible Dependent children, one Spouse will be treated as a Covered Dependent for billing purposes and in calculating the family deductible and out-of-pocket expense amount (when applicable). This provision allows families in which both Spouses are Covered Associates to get the full benefit of their family coverage. The Spouse who was hired last will be the one treated as a dependent for the purposes stated in this section unless the Plan Administrator determines otherwise.

SCHEDULE OF BENEFITS

This is only a summary of the Plan's benefits and is not intended to be all-inclusive. Important information is contained in other sections of this Summary, including but not limited to benefit exclusions, pre-certification requirements and benefit limitations.

For any benefit subject to a Calendar Year and/or Lifetime maximum, Allowable Charges that accumulate towards the benefit limit include any ancillary Allowable Charges associated with that benefit, including but not limited to, office visits, lab tests, x-rays, physician services, etc.

All Deductibles, the Plan's Coinsurance Amounts and Out of Pocket Maximums identified below are based on the Allowable Charges. In some cases, such as services provided by a Non-PPO provider or facility, you may be required to pay amounts over and above the Allowable Charge and such amounts are not applied towards your Deductibles, the Plan's Coinsurance Amounts, and the Out of Pocket Maximums.

There are limited situations in which services provided by a Non-PPO provider or facility are treated as provided by a PPO provider or facility. See Section V. of this SPD for more information.

TRADITIONAL PLAN OPTION

NOTE: This Option is available only for Associates designated as Regular Full-time Associates.

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
ANNUAL MAXIMUM BENEFIT	Unlimited		
MAJOR MEDICAL CALENDAR YEAR DEDUCTIBLE			
• *Physician Charges and PPO facility charges for services not available at a Hamilton Facility*: Allowable Charges for services provided by a PPO Physician, and Allowable Charges for a PPO facility for services not available at a Hamilton facility will be treated for purposes of the Major Medical Deductible as services provided by Hamilton. Consequently, such Allowable Charges will be applied to the Hamilton Major Medical Deductible and will be payable at the applicable PPO coinsurance level once the Hamilton Major Medical Deductible is satisfied. • *PPO Major Medical Deductible*: The PPO Major Medical Deductible is limited to Allowable Charges for PPO facility services otherwise available at a Hamilton facility. • *Application of Major Medical Deductible applied to Covered Persons with Associate Plus Family coverage*: One Covered Person within a family will never be responsible for more than the Associate Only individual deductible amounts. • *Prescription Drug Allowable Charges not included in Major Medical Deductible*. Prescription Drug expenses are subject to a separate deductible. See the Prescription Drug Schedule of Benefits for more information on the deductible applicable to Prescription Drugs.			

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Associate Only	$700	$1000	$1,900
Associate Plus Family	$2,100	$3,000	$5,700
INPATIENT ADMISSION DEDUCTIBLE			
The Inpatient Admission Deductible is a separate deductible applied to every inpatient admission except in the following cases: • Inpatient admissions at a Hamilton facility • Inpatient admission at a PPO facility for services or treatments not available at a Hamilton facility. All Allowable Charges will be subject to any Major Medical Deductible remaining AFTER the Inpatient Admission Deductible is applied.	$0	$1,250	$1,400
MAJOR MEDICAL OUT-OF-POCKET (OOP) EXPENSE CALENDAR YEAR MAXIMUM			
• *Application of OOP Expense Maximum to Hamilton and PPO Allowable Charges*: The Plan imposes a single, combined OOP Expense Maximum for Hamilton and PPO Allowable Charges. • *Application of OOP Expense Maximum to Covered Persons with Associate plus Family coverage*: One Covered Person in a family will never be responsible for more than the individual Out-of-Pocket Maximum. The Plan pays 100% for Covered Services of any Covered Person in a family once the family Out of Pocket Maximum is satisfied. • *Prescription Drug Allowable Charges not included in Major Medical OOP Expense Maximum*: Prescription Drug Allowable Charges are subject to a separate, OOP Expense Maximum.			
Associate Only	$3,500		Unlimited
Associate Plus Family	$7,000		Unlimited
HEALTH BENEFITS: COPAYMENTS AND BENEFIT PERCENTAGES NOTE: All amounts are subject to the applicable Deductibles (including outpatient services performed at a Hamilton facility), except where specifically noted. All percentages reflect the Coinsurance amount paid by the Plan without regard to subsequent discounts and/or offsets that may be applied			
Ambulance	80%	80%	80%
Anesthesiology-Physician Services	80%	80%	40%

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Bariatric Surgery and services for Morbid Obesity Limited to $30,000 Lifetime maximum. Includes the following treatments if those treatments are determined to be Medically Necessary and appropriate for an individual's Morbid Obesity condition and must be through Hamilton Weight Management up to the limit stated: gastric or intestinal bypasses, stomach stapling, adjustable gastric banding, and charges for diagnostic services, and gastric sleeve. Services related to complications from this surgery are also subject to the $30,000 Lifetime Maximum. Facility Physician	 80% 80%	 Not Covered 80%	 Not Covered Not Covered
Behavioral Health and Substance Use Disorders – Inpatient (See Physician Services for non-facility expenses)	80%	50%	40%
Behavioral Health and Substance Use Disorders – Outpatient (See Physician Services for non-facility expenses)	90%	50%	40%
Blood	80%	50%	40%
Chemotherapy & Radiation Therapy • Facility • Physician	 90% 90%	 50% 90%	 40% 40%
Chiropractic Treatment ($500 Calendar Year maximum) (Office Visit and X-ray charges not included in the Calendar Year maximum)	50%, no deductible	50%, no deductible	50%, no deductible
Colorectal Cancer Screening (includes hemoccult, colonoscopy, Sigmoidoscopy, and barium enemas)	100%, no deductible	100%, no deductible	40%
Dental	Covered under Separate Dental plan		
Diabetes Self-management Training Facility Physician	 80% 80%	 50% 80%	 40% 40%

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Diagnostic Testing - Inpatient (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.)	80%	50%	40%
Diagnostic Testing - Outpatient (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.)	90%	50%	40%
Diagnostic Testing (X-ray, lab) – Inpatient Physician Services	80%	80%	40%
Diagnostic Testing (X-ray, lab) – Outpatient (services other than in a Physician's office or hospital) • Lab • X-ray- Facility • X-ray Physician	 90% 90% 90%	 90% 50% 90%	 40% 40% 40%
Diagnostic Testing (X-ray, Blood work) – Office	80%	80%	40%
Durable Medical Equipment	80%	80%	40%
Emergency Services in an Emergency Room • Facility Charges • All Other ER Charges Copay waived if admitted directly to Hospital from Emergency room.	 $150 copay then 80% 80%	 $150 copay then 80% 80%	 $150 copay then 80% 80%
Extended Care/Skilled Nursing Facility (60 days Calendar Year maximum)	80%	50%	40%
Foot Conditions	80%	80%	40%
Gastric Bypass	Refer to "Bariatric Surgery and services for Morbid Obesity"		
Hearing Screening & Hearing Aids Covered for illness or injury only • Hearing aids & Hearing Screening- Facility • Hearing Screening -Physician	 80% 80%	 50% 80%	 40% 40%

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Home Health Care (60 visits Calendar Year maximum)	80%	50%	40%
Hospice Care	80%	50%	40%
• Bereavement Counseling	100%, no deductible	100%, no deductible	40%
Hospital / Facility Inpatient Room and Board is limited to the semiprivate room rate, or if the Hospital has private rooms only, the private room rate billed. ICU as billed.	80%	50%	40%
Hospital / Facility Outpatient	90%	50%	40%
Infertility/Sterility	Not Covered		
Maternity Maternity related expenses for Covered Children are covered subject to the terms of the plan.			
• Prenatal Care as required by federal law.	See Preventive Care	See Preventive Care	See Preventive Care
• Other Eligible Expenses, including but not limited to Physician's charges	80%	80%	40%
• Facility – Inpatient	Refer to Facility Inpatient	Refer to Facility Inpatient	Refer to Facility Inpatient
• Facility - Outpatient	Refer to Facility Outpatient	Refer to Facility Outpatient	Refer to Facility Outpatient
Newborn Care (routine inpatient) Additional Inpatient deductible does not apply.			
• Facility	80%	50%	40%
• Physician	80%	80%	40%
Non-Surgical Treatment of the Spine Not including any services rendered by a Chiropractor.	80%	50%	40%

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Organ Transplants Donors are covered if they have no other coverage and recipient is covered under this plan. Refer to plan document for further limitations & exclusions			
• Facility	80%	50%	40%
• Physician	80%	80%	40%
Orthotics / Prosthetics	Not Available	80%	40%
Physician Services – Inpatient Visits Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Inpatient Surgeon Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Outpatient Visits Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Outpatient Surgeon Precertification required for outpatient surgery Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Office (includes allergy testing and allergy treatment) Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Office Surgeon Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Prescription Drugs – Inpatient	Refer to **"Hospital / Facility Inpatient"**		
Prescription Drugs – Outpatient	Refer to **"Prescription Drug Benefits schedule and section"**		
Preventive Care Preventive care includes the following once annually: routine office visit, physical exam, immunizations, X-ray & lab, supplies, pap smear, mammogram, and PSA test. Breast pumps are limited to one per calendar year See "Recommended Preventive Treatment and Services" in the Medical Benefits section of this Summary Plan Description.	100%, no deductible	100%, no deductible	40%

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Private Duty Nursing	Not Covered		
Rehabilitation Services for the following categories: **Cardiac Rehab (limited to Phase I & II),** **Occupational,** **Physical,** **Speech,** **Vision.** **Subject to an annual maximum of 30 visits for each category identified above.**	 90% 90% 90% Not available Not available	 50% 50% 50% 80% 80%	 40% 40% 40% 40% 40%
Second/Third Surgical Opinion	80%	50%	40%
Sleep Disorders • Sleep Studies* *$2,000 Lifetime maximum for sleep studies performed outside a Hamilton Health Care facility. • All other Sleep Disorder Expenses	 80% 80%	 80% 80%	 40% 40%
Sterilization/ Vasectomy • Facility • Physician **Female sterilization is covered in accordance with the Plan's guidelines for recommended preventive treatment services. See "Recommended Preventive Treatment" in the Medical Expenses section of this Summary Plan Description for more details.**	 80% 80% See Preventive Care	 50% 80% See Preventive Care	 40% 40% See Preventive Care
Temporomandibular Joint Syndrome	Not Available	80%	40%
Urgent Care Facility (includes all covered charges billed by facility)	80%	80%	40%

BENEFIT DESCRIPTION – TRADITIONAL PLAN	HAMILTON	PPO	NON-PPO
Vision Screening	Not covered		
Wig After Chemotherapy Limited to 1 per lifetime maximum	Not Available	80%	40%
Disease Management Program Includes office visits, labs and cardiovascular and diabetic education when billed with Cardiovascular & Diabetes as the primary diagnosis and participating in the Disease Management Program.	80%	N/A	N/A
Disease Management Program – Diabetes and Cardiovascular (Hamilton only) Proof of Participation Required. Covered Person must be primary under Plan to receive benefit. Supplies and medication must be on approved Disease Management Program Drug List. Any exceptions require approval from the Plan Administrator			
Diabetic Medication and Cardiovascular Medication, except as required by ACA with respect to recommended Preventive Treatment Services.	100%, no deductible and no copay for generic only, (does not apply if generic is not available - The Disease Management medications for Diabetes and Cardiovascular are only available free of charge if obtained at the HMC RX Care Pharmacy.)		
Diabetic Supplies and Cardiovascular Supplies	100%, no deductible and no copay		
Optifast Program and Hamilton Healthier You Program Covered Person must be primary under Plan to receive benefit and also meet program requirements.	50%, no deductible		
Tobacco Cessation (including Office Visits and Tobacco Cessation Supplies**)**	100%, no deductible		

HIGH DEDUCTIBLE HEALTH PLAN (HDHP) OPTION

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
OVERALL LIFETIME MAXIMUM BENEFIT	Unlimited		
MAJOR MEDICAL CALENDAR YEAR DEDUCTIBLE			
• *Physician Charges and PPO facility charges for services not available at a Hamilton Facility*: Allowable Charges for services provided by a PPO Physician, and Allowable Charges for a PPO facility for services not available at a Hamilton facility will be treated for purposes of the Major Medical Deductible as services provided by Hamilton. Consequently, such Allowable Charges will be applied to the Hamilton Major Medical Deductible and will be payable at the applicable PPO coinsurance level once the Hamilton Major Medical Deductible is satisfied. • *PPO Major Medical Deductible*: The PPO Major Medical Deductible is limited to Allowable Charges for PPO facility services otherwise available at a Hamilton facility. • *Application of Major Medical Deductible applied to Covered Persons with Associate Plus Family coverage*: One Covered Person within a family will never be responsible for more than the Associate Only individual deductible amounts. • *Prescription Drug Allowable Charges not included in Major Medical Deductible*. Prescription Drug expenses are subject to a separate deductible. See the Prescription Drug Schedule of Benefits for more information on the deductible applicable to Prescription Drugs.			
Associate Only	$1,800	$2,100	$4,800
Associate plus Family	$5,400	$6,300	$14,400
INPATIENT ADMISSION DEDUCTIBLE			
The Inpatient Admission Deductible is a separate deductible applied to every inpatient admission except in the following cases: • Inpatient admissions at a Hamilton facility • Inpatient admission at a PPO facility for services or treatments not available at a Hamilton facility. All Allowable Charges will be subject to any Major Medical Deductible remaining AFTER the Inpatient Admission Deductible is applied.	$0	$1,250	$1,400
MAJOR MEDICAL OUT-OF-POCKET (OOP) EXPENSE CALENDAR YEAR MAXIMUM			

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
• *Application of OOP Expense Maximum to Hamilton and PPO Allowable Charges*: The Plan imposes a single, combined OOP Expense Maximum for Hamilton and PPO Allowable Charges. • *Application of OOP Expense Maximum to Covered Persons with Associate plus Family coverage*: One Covered Person in a family will never be responsible for more than the individual Out-of-Pocket Maximum. The Plan pays 100% for Covered Services of any Covered Person in a family once the family Out of Pocket Maximum is satisfied. • *Prescription Drug Allowable Charges not included in Major Medical OOP Expense Maximum*: Prescription Drug Allowable Charges are subject to a separate, OOP Expense Maximum.			
Associate Only	$4,500		Unlimited
Associate Plus Family	$9,000		Unlimited
Covered Services: COPAYMENTS AND BENEFIT PERCENTAGES NOTE: All amounts are subject to the applicable Deductibles (including outpatient services performed at a Hamilton facility), *except where specifically noted.* All percentages reflect the Coinsurance amount paid by the Plan without regard to subsequent discounts and/or offsets that may be applied. See the Prescription Drug section of this Summary Plan Description for a schedule of prescription drug benefits provided by the Plan.			
Ambulance	80%	80%	80%
Anesthesiology-Physician Services	80%	80%	40%
Bariatric Surgery and services for Morbid Obesity Limited to $30,000 Lifetime maximum. Includes the following treatments if those treatments are determined to be Medically Necessary and appropriate for an individual's Morbid Obesity condition and must be through Hamilton Weight Management up to the limit stated: gastric or intestinal bypasses, stomach stapling, adjustable gastric banding, and charges for diagnostic services, and gastric sleeve. Services related to complications from this surgery are also subject to the $30,000 Lifetime Maximum. Facility Physician	 80% 80%	 Not Covered 80%	 Not Covered Not Covered
Behavioral Health and Substance Use Disorders – Inpatient (See Physician Services for non-facility expenses)	80%	50%	40%

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
Behavioral Health and Substance Use Disorders – Outpatient (See Physician Services for non-facility expenses)	90%	50%	40%
Blood	80%	50%	40%
Chemotherapy & Radiation Therapy Facility Physician	 90% 90%	 50% 90%	 40% 40%
Chiropractic Treatment ($500 Calendar Year maximum) (Office Visit and X-ray charges not included in the Calendar Year maximum)	50%, no deductible	50%, no deductible	50%, no deductible
Colorectal Cancer Screening (includes hemoccult, colonoscopy, Sigmoidoscopy, and barium enemas)	100%, no deductible	100%, no deductible	40%
Dental	Covered under Separate Dental plan		
Diabetes Self-management Training Facility Physician	 80% 80%	 50% 80%	 40% 40%
Diagnostic Testing - Inpatient (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.)	80%	50%	40%
Diagnostic Testing - Outpatient (Advanced Imaging – MRI, CAT, PET, nuclear stress tests, etc.)	90%	50%	40%
Diagnostic Testing (X-ray, lab) – Inpatient Physician Services	80%	80%	40%
Diagnostic Testing (X-ray, lab) – Outpatient (services other than in a Physician's office or hospital) Lab X-ray- Facility X-ray Physician	 90% 90% 90%	 90% 50% 90%	 40% 40% 40%
Diagnostic Testing (X-ray, Blood work) – Office	80%	80%	40%
Durable Medical Equipment	80%	80%	40%

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
Emergency Services in an Emergency Room Facility Charges All Other ER Charges *Copay waived if admitted directly to Hospital from Emergency room.	 $150 copay* then 80% 80%	 $150 copay* then 80% 80%	 $150 copay* then 80% 80%
Extended Care/Skilled Nursing Facility (60 days Calendar Year maximum)	80%	50%	40%
Foot Conditions	80%	80%	40%
Gastric Bypass	Refer to "Bariatric Surgery and services for Morbid Obesity"		
Hearing Screening & Hearing Aids Covered for illness or injury only Hearing aids & Hearing Screening- Facility Hearing Screening -Physician	 80% 80%	 50% 80%	 40% 40%
Home Health Care (60 visits Calendar Year maximum)	80%	50%	40%
Hospice Care • Bereavement Counseling	80% 100%, no deductible	50% 100%, no deductible	40% 40%
Hospital / Facility Inpatient Room and Board is limited to the semiprivate room rate, or if the Hospital has private rooms only, the private room rate billed. ICU as billed.	80%	50%	40%
Hospital / Facility Outpatient	90%	50%	40%
Infertility/Sterility	Not Covered		

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
Maternity Maternity related expenses for Covered Children are covered subject to the terms of the plan.			
• Prenatal Care as required by federal law.	See Preventive Care	See Preventive Care	See Preventive Care
• Other Eligible Expenses, including but not limited to Physician's charges	80%	80%	40%
• Facility – Inpatient	Refer to Facility Inpatient	Refer to Facility Inpatient	Refer to Facility Inpatient
• Facility - Outpatient	Refer to Facility Outpatient	Refer to Facility Outpatient	Refer to Facility Outpatient
Newborn Care (routine inpatient) Additional Inpatient deductible does not apply.			
Facility	80%	50%	40%
Physician	80%	80%	40%
Non-Surgical Treatment of the Spine Not including any services rendered by a Chiropractor.	80%	50%	40%
Organ Transplants Donors are covered if they have no other coverage and recipient is covered under this plan. Refer to plan document for further limitations & exclusions			
Facility	80%	50%	40%
Physician	80%	80%	40%
Orthotics / Prosthetics	Not Available	80%	40%
Physician Services – Inpatient Visits Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
Physician Services – Inpatient Surgeon Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Outpatient Visits Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Outpatient Surgeon Precertification required for outpatient surgery Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Office (includes allergy testing and allergy treatment) Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Physician Services – Office Surgeon Services billed by Hamilton Convenient Care Facility ARE subject to the deductible	80%	80%	40%
Prescription Drugs – Inpatient	Refer to **"Hospital / Facility Inpatient"**		
Prescription Drugs – Outpatient	Refer to **"Prescription Drug Benefits schedule and section"**		
Preventive Care Preventive care includes the following once annually: routine office visit, physical exam, immunizations, X-ray & lab, supplies, pap smear, mammogram, and PSA test. Breast pumps are limited to one per calendar year See "Recommended Preventive Treatment and Services" in the Medical Benefits section of this Summary Plan Description.	100%, no deductible	100%, no deductible	40%
Private Duty Nursing	Not Covered		

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
Rehabilitation Services for the following categories: **Cardiac Rehab (limited to Phase I & II),** **Occupational,** **Physical,** **Speech,** **Vision** **Subject to an annual maximum of 30 visits for each category identified above.**	 90% 90% 90% Not available Not available	 50% 50% 50% 80% 80%	 40% 40% 40% 40% 40%
Second/Third Surgical Opinion	80%	50%	40%
Sleep Disorders Sleep Studies* *$2,000 Lifetime maximum for sleep studies performed outside a Hamilton Health Care facility. All other Sleep Disorder Expenses	 80% 80%	 80% 80%	 40% 40%
Sterilization/ Vasectomy Facility Physician **Female sterilization is covered in accordance with the Plan's guidelines for recommended preventive treatment services. See "Recommended Preventive Treatment" in the Medical Expenses section of this Summary Plan Description for more details.**	 80% 80% See Preventive Care	 50% 80% See Preventive Care	 40% 40% See Preventive Care
Temporomandibular Joint Syndrome	Not Available	80%	40%
Urgent Care Facility (includes all covered charges billed by facility)	80%	80%	40%

BENEFIT DESCRIPTION – HDHP PLAN	HAMILTON	PPO	NON-PPO
Vision Screening	Not covered		
Wig After Chemotherapy Limited to 1 per lifetime maximum	Not Available	80%	40%
Disease Management Program Includes office visits, labs and cardiovascular and diabetic education when billed with Cardiovascular & Diabetes as the primary diagnosis and participating in the Disease Management Program.	80%	N/A	N/A
Disease Management Program – Diabetes and Cardiovascular (Hamilton only) Proof of Participation Required. Covered Person must be primary under Plan to receive benefit. Supplies and medication must be on approved Disease Management Program Drug List. Any exceptions require approval from the Plan Administrator			
Diabetic Medication and Cardiovascular Medication, except as required by ACA with respect to recommended Preventive Treatment Services.	100%, no deductible and no copay for generic only, (does not apply if generic is not available - The Disease Management medications for Diabetes and Cardiovascular are only available free of charge if obtained at the HMC RX Care Pharmacy.)		
Diabetic Supplies and Cardiovascular Supplies	100%, no deductible and no copay		
Optifast Program and Hamilton Healthier You Program Covered Person must be primary under Plan and meet program requirements.	50%, no deductible		
Tobacco Cessation (including Office Visits and Tobacco Cessation Supplies**)**	100%, no deductible		

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

The following schedule summarizes amounts paid by the Plan for those enrolled in either the Traditional Plan Option or the High Deductible Health Plan Option. Please refer to the Prescription Drug Benefit section for a description of covered expenses and benefit exclusions and limitations.

NOTE: To the extent prescription drugs are components of the recommended preventive treatment services otherwise required to be provided under the Affordable Care Act, such drugs will be covered without any cost sharing requirements. See the "Recommended Preventive Treatment" in the Medical Expenses section of this Summary Plan Description for more details.

Prescription Drug Deductible • Deductible must be satisfied before benefits will be paid • RX drug deductible applies to RX Drug OOP	
Per Participant, per Calendar Year (Applies to retail, mail order, and prescriptions filled at Hamilton Health Care Facilities.)	$100 (Does not apply to Generic drugs)
Prescription Drug Out of Pocket Maximum for the Traditional Plan Option	
Associate Only	$3,100
Associate plus Family	$6,200
Prescription Drug Out of Pocket Maximum for High Deductible Health Plan Option	
Associate Only	$2,100
Associate plus Family	$4,200
Prescription Drug Card Options	**Your Cost Share**
Hamilton Health Care System Facility Pharmacy (30- day supply)	
Prescribed Preventive Medications and Contraceptives in accordance with recommended preventive care treatment guidelines. See the "Recommended Preventive Care Treatments" in the Medical Expenses section of this SPD. Subject to existing brand costs if a generic both exists and is allowed by the physician.	$0 (No Deductible)
Generic drug	$4 copayment (No deductible)
Brand Name drug (when generic is not available)	$25 or 10% of the cost of the drug up to a maximum of $100
Brand Name drug (when brand is not on the Formulary Brand Name drug list)	40% of the cost of the drug
Hamilton Health Care System Facility Pharmacy (90- day supply)	
Prescribed Preventive Medications and Contraceptives in accordance with recommended preventive care treatment guidelines. See the "Recommended Preventive Care Treatments" in the Medical Expenses section of this SPD. Subject to existing brand costs if a generic both exists and is allowed by the physician.	$0 (no deductible)
Generic drug	$8
Brand Name drug (when generic is not available)	$50 or 10% of the cost of the drug (whichever is lesser) up to a maximum of $200
Brand Name drug (when brand is not on the Formulary Brand Name drug list)	40% of the cost of the drug

Retail Pharmacy Option (30-day supply)	
Prescribed Preventive Medications and Contraceptives in accordance with recommended preventive care treatment guidelines. See the "Recommended Preventive Care Treatments" in the Medical Expenses section of this SPD. Subject to existing brand costs if a generic both exists and is allowed by the physician.	$0 (no deductible)
Generic drug	$10 or 10% of the cost of the drug (whichever is lesser) up to a maximum of $100; no deductible
Brand Name drug (when generic is not available)	$40 or 30% of the cost of the drug (whichever is lesser) up to maximum of $150
Brand Name drug (when brand is not on the Formulary Brand Name drug list)	50% of the cost of the drug
Retail Pharmacy Option (90-day supply)	
Prescribed Preventive Medications and Contraceptives in accordance with recommended preventive care treatment guidelines. See the "Recommended Preventive Care Treatments" in the Medical Expenses section of this SPD. Subject to existing brand costs if a generic both exists and is allowed by the physician.	$0 (no deductible)
Generic drug	$20 or 10% of the cost of the drug (whichever is lesser) up to a maximum of $200; no deductible
Brand Name drug (when generic is not available)	$120 or 30% of the cost of the drug (whichever is lesser) up to maximum of $300
Brand Name drug (when brand is not on the Formulary Brand Name drug list)	50% of the cost of the drug
Mail Order Option (90-day supply)	
Prescribed Preventive Medications and Contraceptives in accordance with recommended preventive care treatment guidelines. See the "Recommended Preventive Care Treatments" in the Medical Expenses section of this SPD. Subject to existing brand costs if a generic both exists and is allowed by the physician.	$0 (no deductible)
Generic drug	$20 or 10% of the cost of the drug up to a maximum of $200; no deductible
Brand Name drug (when generic is not available)	$70 or 30% of the cost of the drug up to a maximum of $300
Brand Name drug (when brand is not on the Formulary Brand Name drug list)	50% of the cost of the drug
For members who elect brand drugs when generics are available, the member pays the difference between the brand and generic medication plus the designated copayment amount. *For members whose physician writes a script to dispense brand when generic is available the member would pay the copayment for the brand medication regardless of the pharmacy the member utilizes.*	

Generic drug means a prescription drug that has the equivalency of the Brand Name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration-approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

Formulary Brand Name drug means a list of trade name prescription medications of safe, effective therapeutic drugs specifically covered by this plan.

Non-Formulary Brand Name drug means a trade name prescription medication that is not on the Formulary Brand Name drug list

Schedule of Dental Benefits

The following schedule summarizes amounts paid by the Plan. Please refer to the Dental Benefits section for a description of covered expenses and benefit exclusions and limitations. The Calendar Year deductible for medical benefits does not apply to dental benefits.

DEDUCTIBLES

DENTAL DEDUCTIBLE (waived for Type I expenses)	
Per Covered Person, per Calendar Year	$50, not to exceed $150 per year(for Associate Plus Family)

BENEFIT PERCENTAGES & MAXIMUMS

The Calendar Year maximum is for Type I, II and III benefits combined. The Lifetime maximum is for Type IV benefits only. The chart below details only dollar maximums. See the Dental Benefits section for a list of visit maximums for each type of benefit. All Benefits are subject to the Deductible except as specifically noted.

BENEFIT DESCRIPTION	PERCENTAGE PAYABLE BY PLAN	MAXIMUM BENEFIT
Type I – Preventive	100%, no deductible	$1,500 Calendar Year maximum for Types I, II and III combined.
Type II - Basic Restorative	80% after deductible	
Type III - Major Restorative	50% after deductible	
Type IV – Orthodontics*	50%, no deductible	$1000 Lifetime maximum

*Orthodontics limited to Covered Dependent children to age 19**.**

PREFERRED PROVIDER ORGANIZATION

The Preferred Provider Organization ("PPO") is a network of local Physicians, Hospitals and other health care providers established specifically to provide comprehensive medical services to Plan Covered Persons at reduced rates. As a Covered Person in the Plan, you will receive a list of providers that belong to the PPO network. It is the Covered Person's choice as to which provider to use.

If you choose the PPO option, please follow the procedures for its use carefully. When medical care is needed, be sure the provider is still under contract with the PPO shown on your ID card. When your doctor refers you to another provider, make sure that provider is also under contract with the PPO before services are rendered.

Covered Services rendered in a PPO Hospital by a Non-PPO provider, including, but not limited to, an anesthesiologist, radiologist or pathologist, will be payable at the same benefit percentage level that a PPO provider would be paid for such services if you did not have the option of choosing a PPO provider. All other Allowable Charges by Non-PPO providers for Covered Services will be payable at the Non-PPO benefit percentage shown in the Schedule of Benefits, even if you are referred to the Non-PPO provider by a PPO provider. In addition, Allowable Charges for Covered Services rendered in a Hamilton Health Care facility by a Non-PPO provider, including, and limited to, an anesthesiologist, radiologist or pathologist will be payable at the same benefit percentage level that a Hamilton Health Care Physician would be paid for such services if you did not have the option of choosing a Hamilton Health Care provider.

When you receive care from a Hamilton Health Care or PPO provider as opposed to a Non-PPO Provider, the Benefit percentage payable by the Plan for Allowable Charges is higher except in certain situations described in the Benefits Schedule.

Covered expenses for each confinement in a Hospital will be subject to the per-confinement deductible amount shown in the Schedule of Benefits in addition to the Calendar Year deductible.

Effective January 1, 2014, services received out of network will be treated as in-network only with respect to the following:

- Dependent children residing more than 50 miles outside of the service area and enrolled as a full-time student at a college or university;

- Dependent children residing more than 50 miles outside the service area in which there is a qualified court support order to receive benefits from a non-custodial parent;

- Emergencies

Each Covered Person is able to choose any provider they desire, and the Covered Person, together with his provider, is ultimately responsible for determining the appropriate course of medical treatment, regardless of whether the Plan will pay for all or a portion of the cost of such care. The PPO network providers are independent contractors; neither the Plan nor the Plan Administrator makes any warranty as to the quality of care that may be rendered by any PPO network provider.

DEDUCTIBLES AND OUT-OF-POCKET EXPENSES

Deductibles and out-of-pocket expenses represent the portion that the Covered Person pays of covered expenses. This section describes generally these cost-sharing provisions of the Plan.

Individual Calendar Year Deductible

The Individual Calendar Year Deductible is the amount of Allowable Charges Incurred by a Covered Person during the Calendar Year for Covered Services for which no benefits are paid. After a Covered Person has satisfied the Individual Calendar Year Deductible, the Plan will pay Benefits for Allowable Charges Incurred by that Covered Person during the rest of the Calendar Year. The deductible accumulation period is January 1 through December 31. NOTE: Copayments otherwise applied to Covered Services for which a benefit is paid prior to satisfying the Individual Calendar Year Deductible do not apply toward the deductible, except when the High Deductible Health Plan option is selected.

Family Calendar Year Deductible

If the dollar amount of the Family Calendar Year Deductible, shown in the Schedule of Benefits, is satisfied by the combined Allowable Charges for Covered Services applied to the Individual Calendar Year Deductibles of several Covered Persons in a family, the Individual Calendar Year Deductibles is deemed satisfied for all Covered Persons in that family with respect to Allowable Charges Incurred during the remainder of the Calendar Year. Once a Covered Person has satisfied the Individual Calendar Year deductible, no additional Allowable Charges for Covered Services Incurred by that Covered Person will be counted toward the Family Calendar Year Deductible.

Individual Out-of-Pocket Expense Maximum

Out-of-pocket Expenses are Allowable Charges that a Covered Person must Incur after the satisfaction of the applicable Calendar Year deductible before benefits are payable for that Covered Person at 100%. This is the Individual Out of Pocket Expense Maximum.

Benefits payable at 100% will continue for Allowable Charges Incurred during the remainder of that Calendar Year.

NOTE: See the Schedule of Benefits section for a list of charges that do not apply to the out-of-pocket expense amount.

Family Out-of-Pocket Expense Maximum

If the Family Out-of-pocket Expense Maximum, shown in the Schedule of Benefits, is satisfied by the combined out of pocket expenses for Allowable Charges of two or more Covered Persons in a family, all Covered Persons are deemed to have satisfied the Individual Out of Pocket Expense Maximum with respect to Allowable Charges incurred for the remainder of the Calendar Year.

MEDICAL BENEFITS

Covered Medical Expenses

The Plan pays Benefits only for Allowable Charges incurred for Covered Services. The following describes the services or treatments that constitute Covered Services, unless specifically stated otherwise. All expenses must be Medically Necessary, as determined by the Claims Administrator according to its current policies and procedures, unless specifically stated otherwise.

1. Transportation by a professional **ambulance** service or air to a local Hospital, convalescent facility or non-medical facility for Inpatient care or to the nearest Hospital for Emergency care.

2. Services and supplies used in the administration of **anesthesia**, when not duplicated in the Hospital charges.

3. Services and supplies for treatment of **attention deficit**/hyperactivity disorder.

4. **Augmentation communication devices** and related instruction or therapy.

5. **Autism services**. Treatment, consisting of:

    a. Therapy to develop interactive skills and skills necessary to perform the significant Activities of Daily Living (eating, dressing, walking, bathing, toileting and communicating). The therapy must be ordered by a licensed medical provider. This therapy is not intended for schooling of an individual, even if the schooling requires a special environment. The provider must submit a treatment plan including the type of therapy to be administered, the goals, periodic measures for the therapy, who will administer the therapy, and the patient's current ability to perform the desired results of the therapy. The treatment plan must be approved in advance by the Plan and updated annually with a report on the patient's condition, progress and future treatment plans. The provider must submit an evaluation every six months including objective evidence of progression towards goals.

    b. Care provided in accordance with the approved treatment plan by a non-licensed medical provider who is not a member of the patient's family, if the provider has been specifically trained to interact with the autistic patient and certified by a licensed medical provider as capable of working with the child.

    c. Training and educational services provided by licensed medical providers (or non-licensed providers as described above) under an approved treatment plan for the parents or legal guardian of an autistic individual to teach the principles and practical applications of behavior modification.

6. **Blood** and blood derivatives that are not donated or replaced.

7. **Cardiac rehabilitation**, Phase I and II only.

8. **Chiropractic treatment**.

9. **Colorectal cancer screening**.

10. **Diabetes** self-management training.

11. Rental **of durable medical equipment**, including, but not limited to, a wheelchair, hospital-type bed, respirator, and equipment for the administration of oxygen. Such equipment may be purchased if, in the judgment of the Claims Administrator, purchase of the equipment would be less expensive than rental or the equipment is not available for rental. If purchased, the Plan will cover replacement only after a five-year period.

12. Nutritional **supplements**, vitamins and electrolytes which are prescribed by a Physician and are administered through **enteral feedings**, provided they are the sole source of nutrition, including supplies related to the feedings.

13. **Room**, board and supplies (other than drugs and medicines) billed by an **Extended Care Facility** or Skilled Nursing Facility. Benefits are payable only if the confinement is required due to a need for extended medical care and not for Custodial Care. Confinement and discharge requirements, if any, listed in the Schedule of Benefits may be waived if prior authorization is obtained from the Plan.

14. **Genetic testing** or treatment.

15. **Growth hormones**.

16. **Home health** care, if prescribed by a Physician as a plan of treatment and begun within seven days after a Hospital confinement (the seven day requirement may be waived if prior authorization is obtained. The Physician must certify that the proper treatment of the Injury or Illness would require continued confinement as an Inpatient in a Hospital or Skilled Nursing Facility in the absence of the services and supplies provided as part of the home health care plan. Each visit by a member of a Home Health Care Agency shall be considered as one home health care visit and four hours of home health aide service shall be considered as one home health care visit.

17. **Hospice** care. Covered Services for Hospice Care include:

    a. Inpatient Hospice care;

    b. Services of a Physician;

    c. At-home care including part-time nursing care, use of medical equipment, rental of wheelchairs and hospital-type beds;

    d. Emotional support services and physical/chemical therapies; and

    e. Bereavement counseling sessions for Covered Persons following the death of a Terminally Ill Covered Person.

18. **Hospital** room and board, but only with respect to Allowable Charges for a semi-private Hospital room and board. If confinement is in a Hospital providing private rooms only, the covered expense shall be no greater than the rate listed in the Schedule of Benefits.

19. Other **Hospital** services and supplies furnished by the Hospital for medical care during confinement, exclusive of Physician's and other professional services.

20. **Infant formula** administered through a tube as the sole source of nutrition for the Covered Person.

21. Medical **laboratory** charges in connection with treatment of an Illness or Injury.

22. Treatment of **Mental/Emotional** Disorders.

23. Routine Hospital and Physician care for a **newborn child** prior to discharge from the Hospital.

24. **Occupational Therapy** performed by a licensed occupational therapist and ordered by a Physician. It must be considered progressive therapy, not maintenance therapy, and must not be performed for the purpose of vocational rehabilitation. Covered expenses do not include either recreational programs or supplies used in Occupational Therapy.

25. **Organ transplant** subject to the following:

    a. Covered organ transplants are limited to transplants of the kidney, cornea, bone marrow and/or stem cell, heart, heart/lung, liver, lung, and pancreas or other organ transplant approved by the FDA for a Covered Person. Bone marrow and/or stem cell transplants are considered organ transplants for the purposes of this Plan;

    b. Charges for obtaining donor organs are covered under the Plan when the recipient is a Covered Person. Donor charges include those for:

        i. evaluating the organ;

        ii. removing the organ from the donor; and

        iii. transportation of the organ to the place where the transplant is to be performed.

    c. Except as provided under (c) above, organ procurement does not include donor-related expenses while the Covered Person is awaiting the transplant, unless the donor is covered under this Plan.

    Prior to undergoing the procedures, the Covered Person who is the recipient of the transplant must receive two opinions with regard to the need for transplant surgery. Each opinion must be in writing by a board-certified specialist in the involved field of surgery. The specialist must certify that alternative procedures, services, or course of treatment would not be effective in the treatment of the Covered Person's condition.

26. The initial purchase, fitting and repair of an **orthotic appliance** (not including corrective or orthopedic shoes, arch supports or other similar, corrective foot devices or appliances) such as a brace, splint or other appliance required for support of a malfunctioning or deformed limb as a result of Injury, Illness or a disabling congenital condition. The Plan will cover subsequent repair, modification or replacement of the appliance only if the attending Physician certifies in writing that it is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing orthosis is unusable and cannot be repaired or modified to achieve proper fit and function.

27. **Outpatient Surgery** charges for necessary services and supplies for surgical procedures performed on an Outpatient basis at a Hospital, ambulatory surgical facility, or Physician's office, provided that benefits for such charges would be payable if the procedure were performed during a Hospital confinement.

28. **Physician's** fees for medical care and treatment of an Illness or Injury covered under the terms of this Plan.

29. **Physical therapy** by a licensed physical therapist.

30. **Preadmission testing** ordered by a Physician, done on an Outpatient basis and related to the condition for which the patient is to be hospitalized. These tests must be performed at a Hospital, ambulatory surgical facility, or Physician's office prior to confinement as an Inpatient. No benefits will be payable if the same tests are repeated after Hospital admission, unless Medically Necessary.

31. **Pregnancy** expenses. Under the Newborns' and Mothers' Health Protection Act of 1996, group health plans and health insurance issuers generally may not 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).

32. **Prescription drugs** necessary for the treatment of an Illness or Injury, if obtainable only on a Physician's written prescription and dispensed by a licensed pharmacist (see Prescription Drug Benefits section).

33. **Preventive** Care: The ACA requires group health plans to provide preventive care services in-network without cost sharing as follows: (i) evidence-based items or services that have in effect a rating of A or B in the current recommendations of the United States Preventive Services Task Force; (ii) immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention; (iii) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and (iv) with respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA. Reasonable medical management techniques may be imposed by the Claims Administrator where frequency and duration are not specifically addressed in the guidelines. For a general list of recommended preventive services required by the ACA, refer to the following website:

https://www.healthcare.gov/center/regulations/prevention/recommendations.htmlwhat-are-my-preventive-care-benefits

34. Replacement of a natural eye or limb with an artificial one (**prosthesis**), and subsequent repair, modification or replacement if it is Medically Necessary. Subsequent replacement is covered only if the attending Physician certifies in writing that such replacement is Medically Necessary due to:

    a. a physical change in the condition of the patient's site of attachment;

    b. the normal, physical growth of a dependent child; or

    c. the fact that the existing prosthesis is unusable and cannot be repaired or modified to achieve proper fit and function.

35. **Radiological** tests (X-rays), radium treatments, and treatments with other radioactive substances.

36. **Reconstructive surgery** of the breast on which a **mastectomy** was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from

all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person. Reimbursement will be made according to the "Schedule of Medical Benefits" section by type of service.

37. **Rehabilitation Hospital** charges, provided all the following conditions are met:

    a. The patient has a physical disability, and his medical condition and functional performance can realistically be improved through the intensive rehabilitation program offered by the Hospital;

    b. Other treatment programs offering less intensive care or Outpatient treatment would not achieve the realistic goals sought by the patient through the Hospital's rehabilitation program; and

    c. The patient requires close medical care by a Physician and 24-hour-a-day nursing supervision.

    The Utilization Management organization should be notified of the intended stay.

38. **Second Surgical Opinion** charges to confirm that recommended surgery is needed. The Physician who provides the second opinion must be board-certified for the medical condition for which surgery is advised. He must not be scheduled to perform the surgery or be in partnership with or have any financial affiliation with the first Physician in order for the surgical opinion benefit to be paid. If the second Physician disagrees with the first Physician, the Plan will cover a third surgical opinion.

39. **Speech therapy** by a qualified speech therapist. The therapy must be to restore or rehabilitate speech loss due to an Illness or Injury, or due to surgery for an Illness or Injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

40. Elective surgery for **sterilization**, including tubal ligation and vasectomy.

41. Treatment of **Substance Abuse**.

42. Medical **supplies** for treatment, including, but not limited to, an electronic heart pacemaker, surgical dressings, casts, splints, and crutches.

43. Surgeon's fees for the performance of surgical procedures, including necessary related postoperative care by a Physician, subject to the Reasonable and Customary fees in his area. Charges for **multiple surgical procedures** are subject to the following provisions:

    a. If bilateral or multiple surgical procedures are performed by one surgeon, benefits will be determined based on the Allowable Charge that is allowed for the primary procedures; 50% of the Allowable Charge will be allowed for each additional procedure performed through the same incision. Any procedure that would not be an integral part of the primary procedure or is unrelated to the diagnosis will be considered "incidental" and no benefits will be provided for such procedures;

    b. If multiple unrelated surgical procedures are performed by two or more surgeons on separate operative fields, benefits will be based on the Allowable Charge for each surgeon's primary procedure. If two or more surgeons perform a procedure that is normally performed by one surgeon, benefits for all surgeons will not exceed the Allowable Charge for that procedure; and

    c. If an assistant surgeon is required, the assistant surgeon's covered charge will not exceed 20% of the primary surgeon's allowance.

44. Treatment of **Temporomandibular Joint** syndrome, whether surgical or nonsurgical.

45. **Vision therapy** (nonsurgical treatment to the eye muscles).

46. **Wig after chemotherapy.**

DISEASE MANAGEMENT FOR CARDIOVASCULAR

Covered Persons in the Disease Management Program for Cardiovascular will have certain Allowable Charges paid at 80% for PPO Providers and 50% for Non-PPO providers. The Allowable Charges for which a Benefit is payable under this program are limited to office visits, including labwork and cardiovascular education (when billed with cardiovascular as the primary diagnosis). Allowable Charges for cardiovascular supplies will be paid at 100%, no deductible. This includes Covered Persons who have primary coverage with the Hamilton Health Care Plan with this diagnosis. Refer to the Plan Administrator for a list of approved drugs and supplies under this program.

DISEASE MANAGEMENT FOR OPTIFAST PROGRAM

The Optifast Program is a clinically proven, medically supervised 9- or 18-week weight loss program that includes a full meal replacement diet which restricts patients' food options for a limited time. Optifast products include formulas, soups and nutrition bars that provide complete, balanced nutrition. To be eligible, Covered Persons must be primary under the Plan and who meet the program requirements. The program cost is paid in full by the Covered Person up front. Hamilton Health Care System will reimburse 50% of the cost upon successful completion of the program. See the Plan Administrator for details.

DISEASE MANAGEMENT FOR DIABETES

Covered Persons in the Disease Management Program for Diabetes will have certain Allowable Charges paid at 80% for PPO Providers and 50% for Non-PPO providers. Allowable Charges for which a Benefit is paid are limited to office visits, including labwork and diabetic education (when billed with diabetes as the primary diagnosis). Allowable Charges for insulin pump and other covered diabetic supplies will be paid at 100%, no deductible. This includes both Eligible Associates and Eligible Dependents who have primary coverage with the Hamilton Health Care Plan with this diagnosis. Refer to the Plan Administrator for a list of approved drugs and supplies under this program.

UTILIZATION MANAGEMENT

A. Cost Management Services Phone Number

Please refer to the Associate ID card for the Cost Management Services phone number.

The patient or family member must call this number to receive certification of certain cost management services. This call must be made at least 24 hours in advance of services being rendered, or within 2 business days after an emergency.

Failure to precertify required medical services will result in an application of a Utilization Management Penalty, which is a $1,000 flat rate charge. The Utilization Management Penalty is not an Allowable Charge.

B. UTILIZATION MANAGEMENT

Utilization Management ("UM") is a program designed to help ensure that all Covered Persons receive necessary and appropriate health care while avoiding unnecessary expenses.

The program consists of:

a. Precertification of the Medical Necessity for the following non-emergency services before medical and/or surgical services are provided:

- Any Inpatient confinement (within 2 business days following an Emergency admission)
- Bariatric Surgery
- Hospice Care
- Home Health Care
- Durable Medical Equipment equal to or greater than $5000
- Outpatient surgeries (except those performed in the Physician's office)
- Dialysis

b. Concurrent review, based on the admitting diagnosis, of the listed services requested by the attending Physician;

c. Certification of services and planning for discharge from a medical care facility or cessation of medical treatment; and

d. Retrospective review of the Medical Necessity when precertification or concurrent review/discharge planning has not been secured.

This program is not designed to be the practice of medicine or to be a substitute for the medical judgment of the attending Physician or other health care provider.

If a particular course of treatment or medical service is not certified, it means that the Plan will not consider that course of treatment as appropriate for the maximum reimbursement under the Plan.

The UM organization's staff cannot and does not verify benefits or eligibility. The UM organization's staff cannot and does not ensure that all plan requirements are met or will be met on the date services are rendered. The UM program's purpose is strictly the verification of Medical Necessity and the appropriateness of care.

The attending Physician does not have to obtain precertification from the Plan for prescribing a maternity length of stay that is 48 hours or less for a vaginal delivery or 96 hours or less for a cesarean delivery.

In order to maximize Plan reimbursements, please read the following provisions carefully.

Here's how the program works.

Precertification. Before a Covered Person enters Hospital on a non-emergency basis, the Utilization Management administrator will, in conjunction with the attending Physician, certify the care as appropriate for Plan reimbursement. A non-emergency stay in a medical care facility is one that can be scheduled in advance.

The Utilization Management program is set in motion by a telephone call from the Covered Person. Contact the Utilization Management administrator at the telephone number on your ID card **at least 24 hours before** services are scheduled to be rendered with the following information:

- The name of the patient and relationship to the Covered Associate,

- The name, social security number and address of the Covered Associate,

- The name of the Employer,

- The name and telephone number of the attending Physician,

- The name of the medical care facility, proposed date of admission and proposed length of stay, and

- The diagnosis and/or type of surgery.

If there is an **emergency** admission to the medical care facility, the patient, patient's family member, medical care facility or attending Physician must contact the utilization management administrator **within 2 business days** after the admission.

It is important to remember that, if a claimant needs medical care for a condition which could seriously jeopardize his life or subject the Covered Person to severe pain, there is no need to contact the Plan for prior approval of the emergency care. The claimant should obtain such care without delay.

The Utilization Management administrator will determine the number of days of medical care facility confinement authorized for Medical Necessity.

Precertification is designed to determine if the services or treatment for which precertification is requested are "medically necessary" based on the facts and circumstances then presented. The fact that Plan has pre-certified the services or treatments as "medically necessary" does not necessarily mean that Benefits for such services or treatments will be provided. Benefits are determined in accordance with the terms of the plan as applied to all of the applicable facts and circumstances. If new information is received that is relevant to the certification that was not available at the time of the original certification, the Plan reserves the right to reverse its decision that the

service or treatment was Medically Necessary or make a determination that Benefits for the service or treatment are otherwise excluded from the Plan.

Under the Newborns' and Mothers' Health Protection Act of 1996, 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 following a vaginal delivery, or 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).Notification is still encouraged at the time of admission, and is **required** for any Hospital stay that is in excess of the minimum length of stay. Failure to notify the UM administrator of any stay that is in excess of the minimum length of stay will result in application of the penalty shown in the Schedule of Benefits to the Hospital expenses for the excess days not certified.

Concurrent review, discharge planning. Concurrent review of a course of treatment and discharge planning from a medical care facility are parts of the Utilization Management program. The Utilization Management administrator will monitor the Covered Person's medical care facility stay or use of other medical services and coordinate with the attending Physician, medical care facilities and Covered Person either the scheduled release or an extension of the medical care facility stay or extension, or cessation of the use of other medical services.

If the attending Physician feels that it is Medically Necessary for a Covered Person to receive additional services or to stay in the medical care facility for a greater length of time than has been pre-certified, the attending Physician must pre-certify the additional services or days.

C. CASE MANAGEMENT

Case Management is a program whereby a Case Manager monitors patients and explores, discusses and recommends coordinated and/or alternate types of appropriate Medically Necessary care. The Case Manager consults with the patient, the family and the attending Physician in order to develop a plan of care for approval by the patient's attending Physician and the patient. This plan of care may include some or all of the following:

- personal support to the patient,
- contacting the family to offer assistance and support,
- monitoring Hospital or Skilled Nursing Facility,
- determining alternative care options, or
- assisting in obtaining any necessary equipment and services.

Case Management occurs when this alternate benefit will be beneficial to both the patient and the Plan.

The Case Manager will coordinate and implement the Case Management program by providing guidance and information on available resources and suggesting the most appropriate treatment plan. The Plan will consider care outside its normal benefit limitations if the use of an alternative treatment plan results in savings for the Plan and is endorsed by the Covered Person. The objective of this service is to direct the patient toward the most appropriate care in a cost-effective environment. The Plan, attending Physician, patient and, in some circumstances, the patient's family must all agree to the alternate treatment plan.

Note: Case Management is a voluntary service. There are no reductions of benefits or penalties if the patient and family choose not to participate.

Each treatment plan is individually tailored to a specific patient and should not be seen as appropriate or recommended for any other patient, even one with the same diagnosis.

D. RETROSPECTIVE UTILIZATION MANAGEMENT

When Hospital precertification or continued stay review/discharge planning has not been secured, the UM organization may elect to use retrospective Utilization Management. Retrospective utilization management is the process in which the UM organization evaluates Inpatient, acute care hospitalizations which were not reviewed during the confinement. Using the established medical criteria for Hospital precertification and concurrent review/discharge planning, the UM organization will determine retrospectively the Medical Necessity and appropriateness of Inpatient hospitalization and treatment plan.

HEALTH REIMBURSEMENT ARRANGEMENT (HRA)

If you are a participant in the High Deductible Health Plan, then you are also eligible for the Health Reimbursement Arrangement, or "HRA."The HRA is an employer funded "account" from which you can be reimbursed for certain qualifying medical expenses, up to the annual maximum. Any amounts not used to reimburse expenses incurred during the Plan Year are forfeited—i.e. unused amounts are not carried forward each year.

Annual HRA Allocations

At the beginning of each Plan Year (or if later, the effective date of your coverage under the High Deductible Health Plan), the Employer will allocate an amount to the HRA on your behalf based on the level of coverage you elect. See the chart below regarding the annual allocation amounts.

Employer Contributions

Associate Only/$500 per year

Associate Plus 1/$750 per year

Associate Plus Family/$1,000

NOTE: The HRA annual allocation is reduced by 25% for each full quarter that you are not a participant during the Plan Year. For example, if you become a participant on July 5, your annual allocation is reduced by 50%. The HRA is a notional, bookkeeping account that tracks the amount of reimbursement you have available for the remainder of the Plan Year. If all of the amounts allocated to the HRA on your behalf are not used to reimburse qualifying medical expenses incurred during the Plan Year, the amounts allocated will be forfeited.

Qualifying Medical Expenses

You may use the amounts allocated to your HRA for any of the following expenses incurred by you and your Covered Dependents during the Plan Year (but not before the beginning of your or your Covered Dependent's coverage period for that Plan Year):

- Any expense that is applied to the deductible under the High Deductible Health Plan
- Your Coinsurance Amount or copayment for any expenses otherwise covered by the High Deductible Health Plan
- Any other expense that qualifies as "medical care" under Internal Revenue Code Section 213(d) (including but not limited to dental and vision expenses).

Special rule for Over the Counter Drugs or Medicines. Only over the counter drugs or medicines that are prescribed by a health care provider in accordance with applicable law qualify as "medical care" under Internal Revenue Code Section 213(d). You must submit a copy of the prescription with all other substantiation.

How to Seek Reimbursement

You will receive a debit card from the HRA Claims Administrator that will allow you to pay for certain medical expenses (e.g. the amount you are required to pay at the doctor's office) up to your HRA balance at the time the claim is processed. Although many of these debit card purchases are self-substantiating—meaning that you will

not have to provide any additional substantiation in order to receive reimbursement, you may be required to provide additional substantiation for some of these debit card purchases. In that case, you must provide the requested substantiation or you will be subject to certain correction procedures required by the IRS (e.g. you may be required to repay the unsubstantiated transaction).

In addition, you may request reimbursement by completing a reimbursement form, which you can obtain from the HRA Claims Administrator (identified in the Plan Information Section). You submit that form in accordance with the instructions on the form. You must also submit substantiation from the health care provider that identifies the following: (i) the date of the service or treatment (ii) the identity of the individuals for whom the service or treatment was provided (iii) a description of the service or treatment and (iv) the amount of the service or treatment.

Upon receipt of your claim, the HRA Claims Administrator, will review your request and determine whether it is payable or not. If your request for reimbursement is denied, then you will have the right to appeal in accordance with the internal appeals guidelines similar to those described in this Summary Plan Description (see Section XIV for more details).

All amounts allocated to your HRA that are not used to reimburse expenses incurred during the Plan Year are forfeited. You must seek reimbursement for all expenses incurred during the Plan Year by no later than 60 days following the end of the Plan Year.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

Note: See the Prescription Drug Benefit and Dental Benefit sections for additional exclusions and limitations specifically related to those expenses.

This section applies to all benefits provided under any section of this Summary Plan Description. In addition to those services or supplies not specifically identified as a Covered Service, this Plan excludes or limits coverage as described for the following:

Occupational Illness or Injury

Any Illness or Injury arising out of, or in the course of, employment with the Covered Person's employer or self-employment, or Illness or Injury covered under the Worker's Compensation Law or any similar legislation, are excluded.

Government Plan

Services or supplies furnished by or on behalf of the United States Government or any other government are excluded unless, as to such other government, payment of the charge is legally required.

Services or supplies are excluded to the extent benefits for them are provided by any law or governmental program under which the Covered Person is or could be covered, unless payment of the expense is legally required and the expense is otherwise a Covered Service.

See the "Coordination of Benefits" section below for more details on how the Plan coordinates with other plans or arrangements that pay for medical expenses, including but not limited to Medicare.

Unnecessary Services or Supplies

Any services or supplies not determined by the Claims Administrator to be Medically Necessary (where required by the Plan) for the care of the Covered Person's Illness or Injury are excluded.

Vocational, Scholastic, Educational

Charges made by a Hospital to the extent that they are allocated to scholastic education or vocational training of the patient are also excluded.

Weekend Admissions

If admitted to the Hospital on a Friday, Saturday or Sunday, charges for these days will be excluded unless admitted due to an Emergency or if surgery is performed within 24 hours of admission.

Excess of Allowable Charge

Any amounts the Claims Administrator determines to be in excess of the Allowable Charge.

Mouth and Teeth Conditions

Medical Benefits for mouth conditions due to periodontal or periapical disease, or involving any of the teeth, their surrounding tissue or structure or the alveolar process are excluded unless the charges are for the following:

1. Treatment or removal of malignant or benign tumors or surgical removal of impacted wisdom teeth;

2. Treatment of an accidental Injury to a Sound, Natural Tooth, or for the setting of a jaw fracture or dislocation if the treatment begins within three months of the Accident; or

3. Hospital services, supplies and anesthesia for oral surgical procedures for which a doctor (M.D., D.O. or D.D.S.) provides satisfactory certification to the Plan Administrator that hospitalization is Medically Necessary.

Foot Conditions

Physicians' services in connection with corns, calluses or toenails are excluded, unless the charges are for the partial or complete removal of the nail roots.

Charges for corrective or orthopedic shoes, arch supports or other corrective devices or appliances are excluded. Services for weak, strained or flat foot conditions are also excluded.

Vision Care

Medical Benefits for Physicians' services in connection with eye refractions or any other examinations to determine the need for, or the proper adjustment of, eyeglasses or contact lenses are excluded, unless for the initial examination following cataract surgery. The charges for eyeglasses or contact lenses are excluded, unless for the initial set following cataract surgery. Radial Keratotomy and any surgical procedures to improve refractive errors such as nearsightedness, etc., are also excluded. This exclusion does not apply to any services otherwise covered under vision benefits, if any.

Cosmetic or Cosmetic Surgery

Charges in connection with Cosmetic Surgery and other services and supplies that are for Cosmetic purposes are excluded unless they are:

1. Incurred as a result of accidental Injury;

2. For correction of a congenital anomaly; or

3. For reconstruction of the breast on which a mastectomy was performed, or for surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications from all stages of a mastectomy, including lymphedemas, in a manner determined in consultation with the attending Physician and the Covered Person.

Injury Due to Act of War

Any Illness or Injury due to war, declared or undeclared, or any act of war is excluded.

Hearing Aids

Examinations to determine the need for, or the proper adjustments of, hearing aids are excluded, unless Medically Necessary due to an Illness or Injury. Also, the purchase of hearing aids is excluded.

Other General Exclusions

Charges for services, surgery, supplies or treatment for the following are not covered:

1. **Abortion**: Elective abortions are excluded unless the life of the mother is endangered by the continued pregnancy or the pregnancy is the result of rape or incest. However, complications from abortions, whether elective or non-elective, are covered.

2. **Acupuncture**.

3. **Administrative fees**, interest or penalties.

4. **Aquatic therapy**.

5. **Blood** and blood derivatives that are donated or replaced, including fees for administration.

6. **Claim filed late**: Charges for which the claim is received by the Plan after the maximum period allowed under this Plan for filing claims has expired.

7. **Claim form**: Completion of a claim form.

8. **Complications from non-covered services**: Charges that result from complications arising from a non-covered Illness or Injury, or from a non-covered procedure. However, complications from abortions, whether elective or non-elective, are covered.

9. **Contraceptive** substances or devices that are not specifically covered under this Plan.

10. **Bariatric Surgery**: A charge for bariatric surgery (including, but not limited to, gastric bypass, intestinal bypass, adjustable gastric restrictive procedure, sleeve gastrectomy, stomach stapling, or similar surgeries, including the normal pre-surgery and post-surgery care related to those procedures) is excluded, unless the Claims Administrator itself, or through its delagee, such as a utilization review company, determines that the procedure is Medically Necessary to treat a medical condition in addition to obesity and gives documented confirmation of the determination to the provider

11. **Coverage not in force**: Charges for services or supplies incurred prior to becoming a Covered Person or after the date you cease to be a Covered Person.

12. **Custodial** care.

13. **Durable medical equipment**: Replacement of durable medical equipment within five years unless approved by the Claims Administrator.

14. **Education**, **training**, bed and board while confined to an institution that is primarily a school or other institution for training, or instruction in alternate life patterns, except for diabetes self-management training, listed in the Medical Benefits section.

15. **Electrical power**, water supply, sanitary waste disposal systems, saunas, hot tubs or swimming pools or their installation, or any similar expense associated with a residence.

16. **Equipment**: Air conditioners, dehumidifiers, air purifiers, heating pads, hot water bottles, home enema equipment, rubber gloves and any equipment or supplies not Medically Necessary.

17. **Experimental or Investigational**: Treatment, services, equipment, new technology, drugs, procedures or supplies determined by the Claims Administrator to be Experimental or Investigational at the time the

procedure is performed or service or supply is provided. However, the Plan will not deny Benefits solely because the otherwise Allowable Charges were incurred as part of an Approved Clinical Trial.

18. **Family member**: Services or supplies provided by a member of the Covered Person's immediate family or by an individual residing in the Covered Person's home.

19. **Fertilization**: Any means of artificial fertilization, including but not limited to artificialinsemination, in-vitro fertilization or gamete intra-fallopian transfer. Services of a surrogate mother are also excluded.

20. **Hair loss**: Care and treatment for hair loss including wigs, hair transplants or any drug that promises hair growth, whether or not prescribed by a Physician, except for wigs after chemotherapy.

21. **Hypnosis** (except where used in lieu of anesthesia), biofeedback, somnambular or environmental therapy.

22. **Impotence**: Diagnostic services, surgical/non-surgical procedures and injectable prescription drugs used to treat impotence.

23. **Infertility**: All specific treatments to correct infertility, including but not limited to diagnostic testing for and treatment of infertility and sterility (except elective surgery for sterilization).

24. **Marriage** or financial counseling.

25. **Newborn care**: Hospital care or Physician care of a newborn prior to discharge from Hospital, except in cases of Illness or as specifically listed for coverage under this Plan. Grandchildren of an Eligible Associate or Spouse are not covered.

26. **Not legally required to pay**: Any item for which the Covered Person is not legally required to pay, or for which a charge would not have been made if the Covered Person did not have this coverage.

27. **Not necessary**: Diagnostic services or treatments performed in connection with research studies, pre-marital examinations or any examination not necessary for the diagnosis of an Illness or Injury, unless specifically listed and included for coverage under this Plan.

28. **Oral statements**: Charges which are Incurred based upon oral statements made by anyone involved in the administration of the Plan that are in conflict with the benefits described in this Summary Plan Description.

29. **Organ transplants**: Donor-related health care services and supplies, except as otherwise specifically listed and included for coverage under the Plan.

30. **Personal** or convenience items.

31. **Physical Fitness**: Programs, services or equipment related to physical conditioning or weight loss (including but not limited to, weight control/loss programs, dietary regimens and supplements, appetite suppressants and other medications, food or food supplements, exercise programs, or exercise-related equipment, and other services or supplies that are primarily intended to control weight) are excluded excepted as otherwise specifically listed and included for coverage under the Plan.

32. **Physical or psychological therapy** where art, play, music, dance, drama, reading, nutrition, home economics, recreational activities, or other similar activity is the method of treatment.

33. **Prior to or after coverage**: Services or supplies that were rendered or received prior to or after any period of coverage under this Plan, except as specifically provided in this Summary Plan Description.

34. **Prison**: Charges for services received while confined in a prison, jail or other penal institution.

35. **Private Duty Nursing**.

36. **Radioactive contamination**: An Injury or Illness caused as a result of radioactive contamination.

37. **Room and board** for any other room at the same time the patient is being charged for use of a special care unit.

38. **Sales tax** on prescription drugs or on any other covered items.

39. **Scheduled visit**: Failure to keep a scheduled medical visit.

40. **Sexual dysfunctions**, penile implants, services or treatments related to sexual inadequacies, and sex therapy.

41. **Sleep disorders**: Care and treatment for sleep disorders, unless deemed Medically Necessary or specifically listed and included for coverage under the Plan.

42. **Sterilization reversal**: Reversal of previous sterilization treatments or surgeries.

43. **Telephone** conversations with a Physician.

44. **Travel expenses**, even if prescribed by a Physician.

45. **Utilization Management Penalty**.

46. **VAX-D** therapy.

47. **Violation of law**: The sale, use or administration of any supplies, services or treatment, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

48. **Vitamins** (except pre-natal vitamins prescribed by a Physician), minerals, nutritional food supplements, or any over-the-counter items, including, but not limited to nicotine gum or other smoking deterrents, whether or not prescribed by a Physician, unless specifically covered herein.

With respect to any Injury which is otherwise covered by the Plan, the Plan will not deny benefits provided for treatment of the Injury if the Injury results from an act of domestic violence or a medical condition (including both physical and mental health conditions).

PRESCRIPTION DRUG BENEFITS

Using Your Prescription Drug Card

As a Covered Person in the Plan, you will receive an ID card that allows you to purchase prescription drugs through the prescription drug card program. Participating pharmacies will display the prescription drug card company logo. If you present this card to a participating retail pharmacy when buying prescription drugs covered by the Plan or purchase eligible prescription drugs through the mail-order program, you will be charged as shown in the Schedule of Benefits; however, you must first satisfy the prescription drug deductible amount shown in the Schedule of Benefits. The per-Covered Person, per- Calendar Year deductible applicable to medical expenses does not apply to these prescription drug expenses.

A current list of participating pharmacies is available, without charge, from Express Scripts or through the website located at www.expressscripts.com. If you do not have access to a computer at your home, you may access this website at your place of employment. If you have any questions about how to do this, please contact your Employer. If you do not have your prescription drug card with you when buying eligible prescription drugs from a participating pharmacy or if you purchase prescription drugs from a non-participating pharmacy, you must pay the full price of the prescription drug and submit a claim form to the prescription drug card company for reimbursement. These expenses are reimbursable only by the prescription drug card company. These claim forms may be obtained from your Personnel or Human Resources Department. Any claim submitted to Gilsbar, Inc. for these expenses will be returned to you with the proper form for reimbursement by the prescription drug card company.

Covered Prescription Drug Card Expenses

The Plan pays Benefits for Covered Drugs relating to drugs purchased from a pharmacy participating in the prescription drug card system up to the Allowable Charge. Benefits are payable for Covered Drugs only if they are used to treat an Illness or Injury of a Covered Person in the Plan and can be obtained from a licensed pharmacist with a written prescription from a Physician. They are limited to the following:

1. Prescription drugs, including, but not limited to, pre-natal vitamins and vitamins with fluoride;

2. Injectable insulin, including insulin syringes and needles, and diabetic supplies furnished on written prescription of a Physician.

Covered expenses may not exceed a 30-day supply (90-day supply of insulin) when you purchase prescription drugs from a retail participating pharmacy, or a 90-day supply when you are purchasing a maintenance drug through the mail-order program or through Hamilton Health Care System facilities. The amount may not be more than the amount normally prescribed by your Physician.

An expense will be considered to be "incurred" for purposes of this benefit at the time the drug or medication is received from the pharmacist.

Exclusions and Limitations

In addition to any service or supply not specifically identified above, the following are also excluded from coverage under this Plan:

1. **Administration**: Any charge for the administration or injection of any drug or medication.

2. **Anorexiants** or any drug or medication used as an appetite suppressant.

3. **Blood** or blood plasma.

4. **Compounded medications**.

5. **Consumed on site**: Any drug or medication which is consumed or administered at the place where it is dispensed.

6. **Cosmetic purposes**: Drugs used for cosmetic purposes, such as hair growth stimulants and photo-aged skin products.

7. **Devices** of any type, even though they may require a prescription order (including but not limited to therapeutic devices, artificial appliances, support garments and other similar devices, regardless of their intended use).

8. **Diagnostic** agents.

9. **Experimental/investigational**: Drugs labeled: "Caution--limited by federal law to investigational use," or experimental drugs even though a charge is made to the Covered Person.

10. **FDA**: Any drug that is not approved by the Food and Drug Administration or that is prescribed for non-FDA-approved uses.

11. **Fluoride**.

12. **Immunization** agents or biological sera.

13. **Impotence**: Drugs for erectile dysfunction or organic impotence.

14. **Infertility**: Any drug or medication related to or used in the treatment of infertility.

15. **Injectables & supplies**: A charge for hypodermic syringes and/or needles, injectable medications or any prescription directing administration by injection for any medication or treatment other than insulin.

16. **Inpatient medication**: Any drug or medication which is to be taken by or administered to the Covered Person, in whole or in part, while he is a patient in a Hospital, rest home, sanitarium, Skilled Nursing or Extended Care Facility, convalescent Hospital, nursing home or similar institution which operates on its premises, a facility for dispensing pharmaceuticals.

17. **Medical exclusions**: Any drug or medication otherwise excluded by the medical plan.

18. **No charge**: Any drug or medication which may be properly received without charge under any local, state or federal program, including Worker's Compensation.

19. **No prescription**: Any drug or medication lawfully obtainable without a prescription order of a Physician, except insulin.

20. **Refills**: Filling or refilling of a prescription in excess of the number prescribed by the Physician, or the filling or refilling of a prescription after one year from the order of the Physician.

21. **Smoking** deterrents or smoking cessation medications or supplies. NOTE: Please see **Preventive Care** for a link to recommended services and supplies as recommended by the United States Preventive Services Task Force.

22. **Vitamins**, except pre-natal vitamins and vitamins with fluoride that require a prescription.

23. Any prescription drug issued or dispensed **prior to the individual becoming a Covered Person**.

DENTAL BENEFITS

If you incur Allowable Charges for the Covered Services listed in this Dental Benefits Section, no Benefits are payable with respect to such Covered Services Incurred by a Covered Person until that Covered Person has satisfied the Dental Deductible identified in the Schedule of Benefits. Benefits for Allowable Charges are payable during the Calendar Year are payable only up to the maximum benefit identified in the Schedule of Benefits.

Covered Services

The Plan pays benefits with respect to Allowable Charges Incurred for the Covered Services specifically identified below. In addition, drugs included as part of the recommended preventive services guidelines that are required to be covered by PPACA will be covered in accordance with the Plan's preventive care policy, as discussed on page 27.

An expense is incurred, for purposes of this section, on the date a service is performed or a supply is furnished, with the following exceptions, for which the expense will be deemed to be incurred as described:

1. For an appliance or modification of an appliance, on the date the master impression is made;

2. For a crown, a bridge, or an inlay or onlay restoration, on the date the tooth is prepared; and

3. For root canal therapy, on the date the pulp chamber of the tooth is opened.

If a particular Covered Service is listed under more than one type, the Allowable Charge for that service will be covered only under the listing for which you receive the greatest benefit.

Because many dental problems can be resolved in more than one way, the Plan Administrator reserves the right to determine the dental procedure codes as it deems appropriate that will represent the lowest-cost treatment which adequately restores the mouth to normal form and function. The codes used are based on nationally established standards of the dental profession.

Type I -- Preventive or Diagnostic Services The following are covered expenses:

Clinical Oral Evaluations

1. Periodic oral evaluation (limited to one every 6 months)

2. Limited oral evaluation - problem focused

3. Oral evaluation for a patient under three years of age and counseling with primary caregiver

4. Comprehensive oral evaluation - new or established patient (limited to one every 6 months)

5. Detailed and extensive oral evaluation - problem focused, by report

6. Reevaluation - limited, problem focused (Established patient; not post-operative visit) (limited to one every 6 months)

7. Comprehensive periodontal evaluation - new or established patient

X Rays

1. Intraoral - complete series (including bitewings) (limited to one series every 36 consecutive months, in combination with D0330) (a full mouth series includes 4 bitewings and 12 or more periapical x-rays)

2. Intraoral - periapical - first film

3. Intraoral - periapical - each additional film (up to 12) (benefits not to exceed a full mouth series)

4. Intraoral - occlusal film

5. Extraoral - first film

6. Extraoral - each additional film

7. Bitewing - single film (limited to one every 6 months with a maximum of 8 films per visit)

8. Bitewing - two films (limited to one every 6 months with a maximum of 8 films per visit)

9. Bitewing - three films (limited to one every 6 months with a maximum of 8 films per visit)

10. Bitewing - four films (limited to one every 6 months with a maximum of 8 films per visit)

11. Vertical bitewings - 7 to 8 films (limited to one every 6 months with a maximum of 8 films per visit)

12. Posterior - anterior or lateral skull and facial bone survey film

13. Sialography

14. Panoramic film, including bitewings and periapicals if necessary - (limited to one every 36 consecutive months, in combination with Intraoral – complete series)

15. Oral/facial photographic images (includes intraoral and extraoral images)

Tests and Laboratory Examinations

1. Collection of microorganisms for culture and sensitivity

2. Pulp vitality tests

3. Diagnostic casts

4. Accession of tissue, gross examination, preparation and transmission of written report

5. Accession of tissue, gross and microscopic examination, preparation and transmission of written report

6. Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report

7. Accession of exfoliative cytologic smears, microscopic examination, preparation and transmission of written report

8. Accession of brush biopsy sample, microscopic examination, preparation and transmission of written report

9. Other oral pathology procedures, by report

10. Biopsy of oral tissue - hard (bone, tooth)

11. Biopsy of oral tissue - soft (all others)

12. Exfoliative cytology sample collection

13. Brush biopsy - transepithelial sample collection

Other Diagnostic

1. Consultation - diagnostic services provided by Dentist or Physician other than requesting Dentist or Physician

2. Office visit for observation (during regularly scheduled hours - no other services performed)

3. Office visit - after regularly scheduled hours

4. Repair and/or reline or occlusal guard

Preventive Services:

Cleaning and Fluoride Treatments

1. Prophylaxis - adult (limited to one every 6 months)

2. Prophylaxis - child (limited to one every 6 months)

3. Topical application of fluoride (prophylaxis not included) - child - under age 19 (limited to one every 6 months)

4. Topical application of fluoride (prophylaxis not included) - Adult through 18 years of age (limited to one every 6 months)

5. Topical fluoride varnish; therapeutic application for moderate to high caries risk patients (limited to one every 6 months)

Other Preventive

1. Sealant - per tooth (child - under age 19)

2. Palliative (emergency) treatment of dental pain - minor procedures - no operative procedures performed

Space Maintenance - (passive appliances)

1. Space maintainer - fixed – unilateral
2. Space maintainer - fixed – bilateral
3. Space maintainer - removable – unilateral
4. Space maintainer - removable – bilateral
5. Recementation of space maintainer
6. Removal of fixed space maintainer

Minor Treatment To Control Harmful Habits

1. Removable appliance therapy
2. Fixed appliance therapy

Type II -- Basic Services

Restorations (including polishing) - multiple restorations on one surface will be considered as a single restoration

1. Amalgam - one surface, primary or permanent
2. Amalgam - two surfaces, primary or permanent
3. Amalgam - three surfaces, primary or permanent
4. Amalgam - four or more surfaces, primary or permanent
5. Resin-based composite - one surface, anterior (teeth 4-13 and 20-29)
6. Resin-based composite - two surfaces, anterior (teeth 4-13 and 20-29)
7. Resin-based composite - three surfaces, anterior (teeth 4-13 and 20-29)
8. Resin-based composite - four or more surfaces or involving incisal angle, anterior (teeth 4-13 and 20-29)
9. Resin-based composite crown, anterior
10. Resin-based composite - one surface, posterior
11. Resin-based composite - two surfaces, posterior
12. Resin-based composite - three surfaces, posterior
13. Resin-based composite - four or more surfaces, posterior
14. Gold foil - one surface

15. Gold foil - two surfaces

16. Gold foil - three surfaces

Crowns

1. Provisional crown (temporary crown expenses paid are subtracted from benefit for permanentplacement)

2. Prefabricated stainless steel crown - primary tooth

3. Prefabricated stainless steel crown - permanent tooth

4. Prefabricated resin crown

5. Prefabricated stainless steel crown with resin window

6. Prefabricated esthetic coated stainless steel crown - primary tooth

Other Basic Restorative Services

1. Recement inlay, onlay or partial coverage restoration

2. Recement cast or prefabricated post and core

3. Recement crown

4. Sedative filling

5. Core buildup, including any pins

6. Pin retention - per tooth, in addition to restoration

7. Core buildup for retainer, including any pins

Pulp Capping

1. Pulp cap - direct (excluding final restoration)

2. Pulp cap - indirect (excluding final restoration)

Pulpotomy

1. Therapeutic pulpotomy - (excluding final restoration) removal of pulp coronal to thedentinocemental junction and application of medicament

2. Pulpal debridement, primary and permanent teeth

Endodontic Therapy on Primary Teeth

1. Pulpal therapy (resorbable filling) anterior, primary tooth - excluding final restoration

2. Pulpal therapy (resorbable filling) posterior, primary tooth - excluding final restoration

Endodontic Therapy

(including Treatment Plan, clinical procedures and follow-up care)

Benefits for root canals in baby teeth are limited to a benefit for a pulpotomy.

1. Anterior (excluding final restoration)

2. Bicuspid (excluding final restoration)

3. Molar (excluding final restoration)

4. Treatment of root canal obstruction; non-surgical access

5. Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth

6. Internal root repair of perforation defects

7. Retreatment of previous root canal therapy - anterior

8. Retreatment of previous root canal therapy - bicuspid

9. Retreatment of previous root canal therapy - molar

10. Apexification/recalcification - initial visit (apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.

11. Apexification/recalcification - interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.

12. Apexification/recalcification - final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.). If over age 11 no benefit if performed within 12 months of root canal.

Apicoectomy/Periapical Services

1. Apicoectomy/periradicular surgery - anterior

2. Apicoectomy/periradicular surgery - bicuspid (first root)

3. Apicoectomy/periradicular surgery - molar (first root)

4. Apicoectomy/periradicular surgery (each additional root)

5. Retrograde filling - per root

6. Root amputation - per root

Other Endodontic Procedures

1. Surgical procedures for isolation of tooth with rubber dam

2. Hemisection (including any root removal) not including root canal therapy

3. Canal preparation and fitting of preformed dowel or post

Surgical Services (including the usual postoperative services)

1. Gingivectomy or gingivoplasty - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan

2. Gingivectomy or gingivoplasty one to three contiguous teeth or bounded teeth spaces per quadrant

3. Anatomicalcrown exposure - four or more contiguous teeth per quadrant

4. Anatomical crown exposure - one to three teeth per quadrant

5. Gingival flap procedure, including root planing - four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan

6. Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces per quadrant

7. Apically positioned flap

8. Clinical crown lengthening - hard tissue

9. Osseous surgery (including flap entry and closure)- four or more contiguous teeth or bounded teeth spaces per quadrant - limited to four quadrants per Treatment Plan

10. Osseous surgery (including flap entry and closure) - one to three contiguous teeth or bounded teeth spaces per quadrant

11. Bone replacement graft - first site in quadrant

12. Bone replacement graft - each additional site in quadrant

13. Biologic materials to aid in soft and osseous tissue regeneration

14. Guided tissue regeneration - resorbable barrier, per site

15. Guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)

16. Surgical revision procedure, per tooth

17. Pedicle soft tissue graft procedure

18. Free soft tissue graft procedure (including donor site surgery)

19. Subepithelial connective tissue graft procedures, per tooth

20. Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in same anatomical area)

21. Soft tissue allograft

22. Combined connective tissue and double pedicle graft, per tooth

Other Periodontal Services

1. Periodontal scaling and root planing - four or more teeth per quadrant - limited to four quadrants per Treatment Plan

2. Periodontal scaling and root planing - one to three teeth, per quadrant

3. Full mouth debridement to enable comprehensive periodontal evaluation and diagnosis (limited to six months from cleaning, or 12 months from any other periodontal services, whichever is later)

4. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report

5. Periodontal maintenance. No benefit if performed within three months of periodontal surgery

6. Unscheduled dressing change (by someone other than treating Dentist)

7. Occlusal guard, by report (only in conjunction with periodontal surgery or bruxism)

8. Repair and/or reline or occlusal guard (only in conjunction with periodontal surgery)

9. Occlusal adjustment - limited (only in conjunction with periodontal surgery or bruxism – limited to four quadrants per Treatment Plan)

10. Occlusal adjustments - complete (only in conjunction with periodontal surgery or bruxism - limited to four quadrants per Treatment Plan)

11. Odontoplasty 1-2 teeth; includes removal of enamel projections (only in conjunction with active peridontal treatment or bruxism)

Adjustment to Dentures - Separate benefits are allowed only after six months following installation of denture

1. Adjust complete denture - maxillary

2. Adjust complete denture - mandibular

3. Adjust partial denture - maxillary

4. Adjust partial denture - mandibular

Repairs to Complete Dentures - Separate benefits are allowed only after six months following installation of denture

1. Repair broken complete denture base

2. Replace missing or broken tooth - complete denture (each tooth)

Repairs to Partial Dentures

1. Repair resin denture base

2. Repair cast framework

3. Repair or replace broken clasp

4. Replace broken teeth - per tooth

Denture Rebase Procedures - Separate benefits for rebase are allowed only after six months following installation of dentures or partials

1. Rebase complete maxillary denture

2. Rebase complete mandibular denture

3. Rebase maxillary partial denture

4. Rebase mandibular partial denture

Denture Reline Procedures - Separate benefits for relines are allowed only after six months following installation of dentures and partials

1. Reline complete maxillary denture (chairside)

2. Reline complete mandibular denture (chairside)

3. Reline maxillary partial denture (chairside)

4. Reline mandibular partial denture (chairside)

5. Reline complete maxillary denture (laboratory)

6. Reline complete mandibular denture (laboratory)

7. Reline maxillary partial denture (laboratory)

8. Reline mandibular partial denture (laboratory)

Other Fixed Partial Denture Service

1. Recement fixed partial denture

Extractions

1. Extraction, coronal remnants - deciduous tooth
2. Extraction, erupted tooth or exposed root (elevation and/or forceps removal)

Surgical Extractions

1. Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth
2. Surgical removal of residual tooth roots (cutting procedure)

Other Surgical Procedures

1. Oroantral fistula closure
2. Primary closure of a sinus perforation
3. Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth
4. Surgical access of an unerupted tooth
5. Mobilization of erupted or malpositioned tooth to aid eruption
6. Placement of device to facilitate eruption of impacted tooth
7. Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
8. Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant
9. Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant
10. Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant

Vestibuloplasty

1. Vestibuloplasty - ridge extension (secondary epithelialization)
2. Vestibuloplasty - ridge extension (including soft tissue grafts, muscle reattachment, revision of soft tissue attachment and management of hypertrophied and hyperplastic tissue)

Surgical Excision of Reactive Inflammatory Lesions

1. Excision of benign lesion up to 1.25 cm

Removal of Tumors, Cysts, and Neoplasms

1. Excision of benign lesion up to 1.25 cm
2. Excision of benign lesion, complicated
3. Excision of malignant lesion up to 1.25 cm

4. Excision of malignant lesion greater than 1.25 cm

5. Excision of malignant lesion, complicated

6. Excision of malignant tumor - lesion diameter up to 1.25 cm

7. Excision of malignant tumor - lesion diameter greater than 1.25 cm

8. Removal of benign odontogenic cyst or tumor - lesion diameter up to 1.25 cm

9. Removal of benign odontogenic cyst or tumor - lesion diameter greater than 1.25 cm

10. Removal of benign nonodontogenic cyst or tumor - lesion diameter up to 1.25 cm

11. Removal of benign nonodontogenic cyst or tumor - lesion diameter greater than 1.25 cm

Excision of Bone Tissue

1. Removal of lateral exostosis (maxilla or mandible)

2. Removal of torus palatinus

3. Removal of torus mandibularis

4. Surgical reduction of osseous tuberosity

5. Radical resection of maxilla or mandible

6. Surgical reduction of fibrous tuberosity

Surgical Incision

1. Incision and drainage of abscess - intraoral soft tissue

2. Incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiplefascial spaces)

3. Incision and drainage of abscess - extraoral soft tissue

4. Incision and drainage of abscess - extraoral soft tissue - complicated (includes drainage or multiplefascial spaces)

5. Removal of foreign body from mucosa, skin, or subcutaneous alveolar tissue

6. Removal of reaction-producing foreign bodies - musculoskeletal system

7. Partial ostectomy/sequestrectomy for removal of non-vital bone

8. Maxillary sinusotomy for removal of tooth fragment or foreign body

Repair and Suturing

1. Suture of recent small wound up to 5 cm
2. Complicated suture - up to 5 cm
3. Complicated suture - greater than 5 cm

Other Repair Procedures

1. Sinus augmentation with bone or bone substitutes
2. Bone replacement graft for ridge preservation - per site
3. Frenulectomy (frenectomy or frenotomy) - separate procedure
4. Frenuloplasty
5. Excision of hyperplastic tissue - per arch
6. Excision of pericoronal gingiva
7. Sialolithotomy
8. Closure of salivary fistula

Anesthesia

1. Local anesthesia not in conjunction with restorative or surgical procedures
2. Regional block anesthesia (only with restorative or surgical procedures)
3. Local anesthesia (only with restorative or surgical procedures)
4. Deep sedation/general anesthesia - first 30 minutes when Medically Necessary
5. Deep sedation/general anesthesia - each additional 15 minutes when Medically Necessary
6. Intravenous sedation/analgesia - first 30 minutes when Medically Necessary
7. Intravenous sedation/analgesia - each additional 15 minutes when Medically Necessary
8. Non-intravenous conscious sedation when Medically Necessary

Drugs

1. Therapeutic parenteral drug, single administration

Miscellaneous Services

1. Treatment of complications (post-surgical) - unusual circumstances, by report

Type III -- Major Restorative Services

The following are covered expenses:

1. Inlay/onlay, crowns and other restorative services are covered only when necessitated by decay or traumatic injury.

Inlay/Onlay Restorations

1. Inlay - metallic - one surface
2. Inlay - metallic - two surfaces
3. Inlay - metallic - three or more surfaces
4. Onlay - metallic - two surfaces
5. Onlay - metallic - three surfaces
6. Onlay - metallic - four or more surfaces
7. Inlay - porcelain/ceramic - one surface
8. Inlay - porcelain/ceramic - two surfaces
9. Inlay - porcelain/ceramic - three or more surfaces
10. Onlay - porcelain/ceramic - two surfaces
11. Onlay - porcelain/ceramic - three surfaces
12. Onlay - porcelain/ceramic - four surfaces or more
13. Inlay - resin-based composite - one surface
14. Inlay - resin-based composite- two surfaces
15. Inlay - resin-based composite - three or more surfaces
16. Onlay - resin-based composite - two surfaces
17. Onlay - resin-based composite - three surfaces
18. Onlay - resin-based composite - four or more surfaces

Crowns

1. Crown - resin-based composite (indirect)
2. Crown 3/4 resin-based composite (indirect)

3. Crown - resin with high noble metal
4. Crown - resin with predominantly base metal
5. Crown - resin with noble metal
6. Crown - porcelain/ceramic substrate
7. Crown - porcelain fused to high noble metal
8. Crown - porcelain fused to predominantly base metal
9. Crown - porcelain fused to noble metal
10. Crown - 3/4 cast high noble metal
11. Crown - 3/4 cast predominantly base metal
12. Crown - 3/4 cast noble metal
13. Crown - 3/4 porcelain/ceramic
14. Crown - full cast high noble metal
15. Crown - full cast predominantly base metal
16. Crown - full cast noble metal
17. Crown - titanium

Other Restorative Services

1. Post and core in addition to crown, indirectly fabricated
2. Each additional cast post - same tooth
3. Prefabricated post and core in addition to crown
4. Each additional prefabricated post - same tooth
5. Labial veneer (laminate) - chairside
6. Labial veneer (resin laminate) - laboratory
7. Labial veneer (porcelain laminate) – laboratory
8. Temporary crown (fractured tooth)
9. Additional procedures to construct new crown under existing partial denture framework
10. Crown repair, by report

Dentures and Partials

Covered charges for dentures and partial dentures include temporary appliances within 12 months of installation, and adjustments and relines within six months after installation. Specialized techniques and characterizations are not covered. Benefit limited to space maintainers for all Covered Persons. Replacement of these services is limited to once every five years. Frequency not applicable if treatment is the result of Accidental Dental Injury.

Complete Dentures

1. Complete denture - maxillary

2. Complete denture - mandibular

3. Immediate denture - maxillary

4. Immediate denture - mandibular

Partial Dentures (including any conventional clasps, rests and teeth)

1. Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)

2. Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)

3. Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

4. Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

5. Maxillary partial denture - flexible base (including any clasps, rests and teeth)

6. Mandibular partial denture - flexible base (including any clasps, rests and teeth)

7. Removable unilateral partial denture - one piece cast metal (including clasps and teeth)

Repairs to Partial Dentures

1. Add tooth to existing partial denture

2. Add clasp to existing partial denture

Other Prosthodontic Services

1. Replace all teeth and acrylic on cast metal framework (maxillary)

2. Replace all teeth and acrylic on cast metal framework (mandibular)

3. Interim complete denture, maxillary (temporary denture expenses paid are subtracted from benefit for permanent placement)

4. Interim complete denture, mandibular (temporary denture expenses paid are subtracted from benefit for permanent placement)

5. Interim partial denture, maxillary (temporary denture expenses paid are subtracted from benefit for permanent placement)

6. Interim partial denture, mandibular (temporary denture expenses paid are subtracted from benefit for permanent placement)

7. Tissue conditioning, maxillary

8. Tissue conditioning, mandibular

9. Overdenture - complete, by report

10. Overdenture - partial, by report

11. Pediatric partial denture, fixed

Fixed Partial Denture Pontics

Replacement of fixed partial dentures is limited to once every five years. Frequency is not applicable if treatment is the result of Accidental Dental Injury.

1. Pontic - indirect resin based composite

2. Pontic - cast high noble metal

3. Pontic - cast predominantly base metal

4. Pontic - cast noble metal

5. Pontic - titanium

6. Pontic - porcelain fused to high noble metal

7. Pontic - porcelain fused to predominantly base metal

8. Pontic - porcelain fused to noble metal

9. Pontic - porcelain/ceramic

10. Pontic - resin with high noble metal

11. Pontic - resin with predominantly base metal

12. Pontic - resin with noble metal

13. Provisional pontic (temporary denture expenses paid are subtracted from benefit for permanentplacement)

Fixed Partial Denture Retainers

Replacement of fixed partial dentures is limited to once every five years. Frequency not applicable if treatment is the result of Accidental Dental Injury.

1. Retainer - cast metal for resin bonded fixed prosthesis
2. Retainer - porcelain/ceramic for resin bonded fixed prosthesis
3. Inlay - porcelain/ceramic, two surfaces
4. Inlay - porcelain/ceramic, three or more surfaces
5. Inlay - cast high noble metal, two surfaces
6. Inlay - cast high noble metal, three or more surfaces
7. Inlay - cast predominantly base metal, two surfaces
8. Inlay - cast predominantly base metal, three or more surfaces
9. Inlay - cast noble metal, two surfaces
10. Inlay - cast noble metal, three or more surfaces
11. Inlay - titanium
12. Onlay - porcelain/ceramic, two surfaces
13. Onlay - porcelain/ceramic, three or more surfaces
14. Onlay - cast high noble metal, two surfaces
15. Onlay - cast high noble metal, three or more surfaces
16. Onlay - cast predominantly base metal, two surfaces
17. Onlay - cast predominantly base metal, three or more surfaces
18. Onlay - cast noble metal, two surfaces
19. Onlay - cast noble metal, three or more surfaces
20. Onlay - titanium
21. Crown - indirect resin based composite
22. Crown - resin with high noble metal
23. Crown - resin with predominantly base metal

24. Crown - resin with noble metal

25. Crown - porcelain/ceramic

26. Crown - porcelain fused to high noble metal

27. Crown - porcelain fused to predominantly base metal

28. Crown - porcelain fused to noble metal

29. Crown - 3/4 cast high noble metal

30. Crown - 3/4 cast predominantly based metal

31. Crown - 3/4 cast noble metal

32. Crown - 3/4 porcelain/ceramic

33. Crown - full cast high noble metal

34. Crown - full cast predominantly base metal

35. Crown - full cast noble metal

36. Provisional retainer crown (temporary denture expenses paid are subtracted from benefit for permanent placement)

37. Crown - titanium

Other Fixed Partial Denture Services

Replacement of fixed partial dentures is limited to once every five years. Frequency not applicable if treatment is the result of Accidental Dental Injury.

1. Stress breaker (only with allowable appliance)

2. Cast post and core in addition to fixed partial denture retainer

3. Prefabricated post and core in addition to fixed partial denture retainer

4. Each additional cast post - same tooth

5. Each additional prefabricated post - same tooth

6. Fixed partial denture repair, by report

7. Fixed partial denture sectioning

Type IV -- Orthodontic Services

Clinical Oral Evaluations

1. Periodic oral evaluation (performed in conjunction with orthodontic treatment)

2. Comprehensive oral evaluation - new or established patient (performed in conjunction with orthodontic treatment)

3. Reevaluation - limited, problem focused (established patient; not post-operative visit) (performed in conjunction with orthodontic treatment)

4. Comprehensive periodontal evaluation - new or established patient (performed in conjunction with orthodontic treatment)

Radiographs/Diagnostic Imaging

1. Intraoral - complete series (including bitewings) (performed in conjunction with orthodontic treatment)

2. Panoramic film, including bitewings and periapicals if necessary (performed in conjunction with orthodontic treatment)

3. Cephalometric Film

4. Oral/facial images (includes intra and extraoral images) (performed in conjunction with orthodontic treatment)

Tests and Laboratory Examinations

1. Diagnostic casts (performed in conjunction with orthodontic treatment)

Other Surgical Procedures

1. Transseptal fiberotomy, supra crestal fiberotomy, by report

Limited Orthodontic Treatment

1. Limited orthodontic treatment of the primary dentition

2. Limited orthodontic treatment of the transitional dentition

3. Limited orthodontic treatment of the adolescent dentition

4. Limited orthodontic treatment of the adult dentition

Interceptive Orthodontic Treatment

1. Interceptive orthodontic treatment of the primary dentition

2. Interceptive orthodontic treatment of the transitional dentition

Comprehensive Orthodontic Treatment

1. Comprehensive orthodontic treatment of the transitional dentition

2. Comprehensive orthodontic treatment of the adolescent dentition

3. Comprehensive orthodontic treatment of the adult dentition

Minor Treatment To Control Harmful Habits

1. Removable appliance therapy (performed in conjunction with orthodontic treatment)

2. Fixed appliance therapy (performed in conjunction with orthodontic treatment)

Other Orthodontic Services

1. Pre-orthodontic treatment visit

2. Periodic orthodontic treatment visit (as part of contract)

3. Orthodontic retention (removal of appliances, construction and placement of retainer(s))

4. Orthodontic treatment (alternative billing to a contract fee)

5. Repair of orthodontic appliance

6. Replacement of lost or broken retainer (limited to replacement of broken retainer)

7. Rebonding or recementing; and/or repair, as required, of fixed retainers

Dental Exclusions and Limitations

In addition to those services or supplies not specifically identified as a Covered Service herein, the following are excluded from coverage under this Plan:

1. Charges excluded under the General Exclusions and Limitations section of the Plan, unless stated otherwise.

2. Any service or supply covered in whole or in part under the medical provisions of this Plan.

3. Any service or treatment for Cosmetic purposes. The following are always considered to be for Cosmetic purposes:

    a. facings on crowns or pontics posterior to the second bicuspid, and

    b. personalization of dentures.

    However, this exclusion does not apply to services required because of Injuries if:

    a. the services are rendered within six months after the Accident, and

b. the services are rendered while the person is covered for these dental benefits.

4. Replacement of a lost, missing or stolen prosthetic device or other device or appliance.

5. Appliances, restorations, or procedures for

   a. altering of vertical dimensions,*

   b. restoring or maintaining occlusion,*

   c. splinting,*

   d. correction of attrition or abrasion,

   e. bite registration,

   f. bite analysis, or

   g. treatment of Temporomandibular Joint Syndrome (TMJ).* By other than covered orthodontic treatment

6. Any service or supply not furnished by a dentist, except

   a. a service performed by a dental hygienist working under the supervision of a dentist, and

   b. X-ray order by a dentist.

7. Charges for plaque control programs or instruction in oral hygiene or diet.

8. Charges for dental implants.

9. Orthodontic services or dental care of a congenital or developmental malformation, unless included in the benefits for orthodontic services for Covered Dependent children.

FILING A CLAIM

Before submitting a claim, review this Summary Plan Description and the bills you have accumulated. Be sure you are submitting itemized bills for which benefits are payable.

If you participate in the PPO and receive care through network providers or you receive care at a Hamilton facility, you won't have to worry about filing medical claims. On your first visit to your network provider, you'll sign a form to assign benefits. For subsequent visits, your network provider will take care of claims for you.

You will be responsible for filing your own claims if you use providers not participating in the network, although some out-of-network providers will file claims on your behalf

You should file medical claims as soon as possible after the date you are billed. If your medical claim is not received within 12 months after the date the service or treatment was provided, no benefits will be paid. The Claims Administrator may periodically request a Medical/Dental Family Claim Form to verify continued eligibility for benefits. If you need a Medical/Dental Family Claim Form, you may download one from the Claims Administrator's (see the Plan Information section) web site at or you may notify your Personnel or Human Resources Department.

If you or a Covered Dependent receives care from an out of network provider, get duplicate Medical/Dental Family Claim Forms from your Personnel Department or the Claims Administrator's web site in advance. Sign the forms and send them to the Claims Administrator at the address listed on your ID card. Keep a separate running record of expenses for yourself and each Covered Dependent.

Save all bills, including those being accumulated to satisfy a deductible. In most instances, they will serve as evidence of your claim.

Submit the original bill, not a copy. Each bill must be complete and itemized and should show the patient's full name, date or dates the service was rendered or purchase was made, nature of the Illness or Injury, and type of service or supply furnished. Drug store cash register receipts or labels from containers are not sufficient proof of a claim.

Attach all itemized bills to the fully completed claim form and send all claims Incurred to the name and address shown on your ID card.

<u>Appointment of Authorized Representative</u>

A claimant is permitted to appoint an authorized representative to act on his behalf with respect to a benefit claim or appeal of a denial. An assignment of benefits by a claimant to a provider DOES NOT constitute appointment of that provider as an authorized representative for purposes of filing claims and appeals for Benefits under this Plan. This Plan does not recognize any assignments of benefits for that purpose. To appoint an authorized representative, the claimant must complete a form which can be obtained from the Claims Administrator. In the event a claimant designates an authorized representative, all future communications from the Plan will be with the authorized representative, rather than the claimant, unless the claimant directs the Plan, in writing, to the contrary.

CLAIMS PAYMENT AND APPEALS

Assignability

Benefits for Covered Services may be assigned by a Covered Person to the provider; however, if those benefits are paid directly to the Covered Person, the Plan shall be deemed to have fulfilled its obligations with respect to such benefits. The Plan will not be responsible for determining whether any such assignment is valid. Payment of benefits which have been assigned will be made directly to the assignee unless a written request not to honor the assignment, signed by the Covered Person and the assignee, has been received before the payment is made.

If you assign your right to receive Benefits to a Provider or other third party, you are merely assigning to the provider or third party your right to the payment of Benefits. You are not permitted to assign, and the plan does not recognize any assignment of your rights to file claims and appeals. .

Claims and Appeal Procedure

The following is a description of how the Plan processes claims and appeals for health benefits. The times listed are maximum times only. A period of time begins at the time the claim is filed in accordance with the Filing a Claim section above. "Days" means calendar days. The Plan Administrator has delegated to the Claims Administrator the discretionary authority necessary to determine if Benefits are payable in accordance with the terms of the Plan. The Claims Administrator will make such determinations in accordance with its usual and customary policies and procedures.

There are three types of health claims under this Plan and each has a specific timetable for approvals or denials. The definitions of the types of health claims are:

Pre-Service Claim. A claim for health care where prior approval for any part of the care is a condition to receiving the care. For example, the Plan requires that you precertify hospital admissions.

Concurrent Care Claim. A previously approved claim for an ongoing course of treatment to be provided for a period of time or for a number of treatments.

Post-Service Claim. A claim for care that has already been received.

In addition, a Pre-Service or Concurrent Care Claim becomes an Urgent Care Claim when the normal time frame for making a determination would:

- Seriously jeopardize the life of the claimant (in the view of a prudent layperson acting on behalf of the Plan who possesses an average knowledge of health and medicine or a physician with knowledge of the claimant's medical condition) or

- Subject the claimant to severe pain that cannot be adequately managed without treatment (in the view of a physician with knowledge of the claimant's condition).

Generally, the following steps describe your claim and appeal procedures (regardless of the type of claim — pre-service, concurrent care or other).

Step 1: Notice is received from Claims Administrator.

If your claim is denied in whole or part, you will receive written notice from the Claims Administrator that your claim is denied (in the case of urgent claims, notice may be oral). The period in which you will receive this notice is described in the Claims and Appeals Procedures Chart and will vary depending on the type of claim. In

addition, the Claims Administrator may take an extension of time in which to review your claim for reasons beyond the Claims Administrator's control. If the reason for the extension is that you need to provide additional information, you will be given a certain amount of time in which to obtain the requested information (it will vary depending on the type of claim). The period during which the Claims Administrator must make a decision will be suspended until the earlier of the date that you provide the information or the end of the applicable information-gathering period.

Step 2: Review your notice carefully.

Once you have received your notice from the Claims Administrator, review it carefully. The notice will contain:

a) The reason(s) for the denial and the Plan provisions on which the denial is based.

b) A description of any additional information necessary for you to perfect your claim, why the information is necessary, and your time limit for submitting the information.

c) A description of the Plan's appeal procedures and the time limits applicable to such procedures, including a statement of your right to bring a civil action following a final denial of your appeal.

d) A statement indicating whether an internal rule, guideline or protocol was relied upon in making the denial and a statement that a copy of that rule, guideline or protocol will be made available upon request free of charge

e) If the denial is based on a Medical Necessity, experimental treatment or a similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination or a statement that such explanation will be provided free of charge upon request, and

f) If the claim was an Urgent Care Claim, a description of the expedited appeals process. The notice may be provided to you orally; however, a written or electronic notification will be sent to you no later than three days after the oral notification.

g) Information sufficient to identify the claim (including the date of service, the health care provider, and the claim amount (if applicable).

h) An explanation of how to request diagnosis and treatment codes (and their corresponding meanings).

1) The contact information for the office of health insurance consumer assistance or ombudsman to assist you with your claims, appeals and external review.

Step 3: If you disagree with the decision, file an Appeal with the Claims Administrator.

If you do not agree with the decision of the Claims Administrator, and you wish to appeal, you must file a written appeal with the Claims Administrator within 180 days of receipt of the Claims Administrator's letter (or oral notice if an Urgent Care Claim) referenced in Step 1. If the claim involves urgent care, your appeal may be made orally.

You should submit all information referenced in Step 2 with your appeal. You should gather any additional information that is identified in the notice as necessary to perfect your claim and any other information that you believe will support your claim.

Step 4: Appeal Determination notice is received.

If the claim is again denied in whole or part, the Claims Administrator will notify you within the period described in the Claims and Appeals Procedures Chart, depending on the type of claim.

Step 5: Review your notice carefully.

You should take the same action as described above in Step 2. The notice will contain the same type of information that is provided in the first notice of denial provided by the Claims Administrator.

Step 6: If you still disagree with the decision, you may file a request for external review.

If your appeal is denied based on Medical Judgment and you wish to seek an external review from an independent review organization (IRO), you must file a written request for external review as described below.

You may also seek an external review by an Independent Review Organization for a denial of an Urgent Care Claim based on Medical Judgment provided that the time frames for completion of an urgent care appeal will seriously jeopardize your life or health or would seriously jeopardize Your ability to regain maximum function

You may also seek an external review for a Rescission of coverage. See "How to Request an External Review" below for more information.

Other important information regarding your appeals:

- Each level of appeal will be independent from the previous level (i.e., the same person(s) or subordinates of the same person(s) involved in a prior level of appeal will not be involved in the appeal).
- On each level of appeal, the claims reviewer will review relevant information that you submit even if it is new information. In addition, you have the right to request documents or other records relevant (as defined by ERISA) to your claim.
- If a claim involves medical judgment, then the claims reviewer will consult with an independent health care professional during the Appeal that has expertise in the specific area involving medical judgment.
- You may review the claim file and present evidence and testimony at each state of the appeals process.
- You may request, free of charge, any new or additional evidence considered, relied upon, or generated by the plan in connection with your claim.
- If at any level of appeal a decision is made based on a new or additional rationale, you will be provided with the rationale and be given a reasonable opportunity to respond before a final decision is made.
- If you wish to submit relevant documentation to be considered in reviewing your claim for appeal, it must be submitted with your claim and/or appeal.
- You cannot file suit in federal court until you have exhausted these appeals procedures. Except as otherwise required by applicable law you must exhaust the external review process before filing suit.
- Please note that you must raise all issues that you wish to appeal during the Plan's internal appeal process and during the external review. If you pursue legal action to appeal your claim, you are barred from raising any issue in your lawsuit that you did not raise during the administrative claims review process.

How to Request an External Review

You must file your written request for an external review with the Claims Administrator within 4 months of the date you received the applicable denial (see above for appeals that enable you to request an external review).

Within 5 business days of receiving your request for external review, the Claims Administrator will complete a preliminary review of the request to determine whether you were covered under the Plan at the time the expense was incurred and whether you have exhausted the internal appeal process where required. Within 1 business day of making the determination, you will be notified if the external review request is denied and you will be provided with (i) the reasons why the claim is initially ineligible for external review, or (ii) the information or materials needed for a complete request. In the event your request is denied due to lack of information or materials, you must perfect your claim by the later of the end of the 4-month period following the final internal Adverse Benefit Determination or 48 hours following notification that your request for external review was denied.

If initially eligible for an external review, the Claims Administrator will assign the request to an Independent Review Organization. The Independent Review Organization will make a determination and provide you and the Plan with notice of its determination within 45 days of receiving the review request.

If, due to your medical condition, the timeframe for completion of the standard external review process would seriously jeopardize your life or health or your ability to regain maximum function, you may request an expedited external review. Under an expedited external review, the preliminary review will be completed immediately. If determined to be initially eligible, the Claims Administrator will assign the request to an Independent Review Organization and the Independent Review Organization will complete the review as expeditiously as your medical condition requires, but in no event more than 72 hours after receiving the request.

Voluntary Appeal

If you disagree with the Claims Administrator's decision following the internal appeal, you may also file a voluntary appeal with the Plan Administrator. You must file this voluntary appeal in writing within sixty (60) days of receiving the appeal denial from the Claims Administrator.

You should include any additional information supporting your claim that you would like the Plan Administrator to consider when reviewing your appeal.

If you choose not to submit a voluntary appeal, the Plan will not assert that you failed to complete the administrative process with respect to any Adverse Benefit Determination made by the Claims Administrator. Also, the applicable statute of limitations or other timeliness requirements for filing suits against the Plan will be suspended during the voluntary appeal process. Your decision as to whether or not to submit a benefit dispute to this voluntary level of appeal will not affect your rights to any other benefits under the Plan.

Internal Claims and Appeals Chart

	Initial Claims			***Appeal***	
Type of Claim	***You'll be notified of determination as soon as possible but no later than…***	***Extension period* allowed for circumstances beyond Claims Administrator's control…***	***If additional information is needed, you must provide within…***	***You must file your appeal within…***	***You'll be notified of determination as soon as possible but no later than...***
Pre-Service	15 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	30 days from receipt of appeal
Pre-Service *involving Urgent Care*	72 hours (24 hours if additional information is needed from you)	None	48 hours (Claims Administrator must notify you of determination within 48 hours of receipt of your information)	180 days of claim denial	72 hours from receipt of appeal
Concurrent: To end or reduce treatment prematurely	Notification to end or reduce will allow time to finalize appeal before end of treatment	N/A	N/A	(Denial letter will specify filing limit)	15 days from receipt of appeal
Concurrent: To deny your request to extend treatment	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim	Treated as any other pre-service or post-service claim

	Initial Claims			*Appeal*	
Concurrent: Involving Urgent Care	24 hours, if claim submitted at least 24 hours before the scheduled end date of treatment. Otherwise, treated as Pre-Service Urgent Care: 30 days from receipt of appeal	None	N/A	(Denial letter will specify filing limit)	72 hours from receipt of appeal
Post-Service	30 days from receipt of claim	One extension of 15 days	45 days of date of extension notice	180 days of claim denial	60 days from receipt of appeal

No suit concerning the claim may be commenced until the appeal process set forth herein has been completed. The covered individual has one year from the date a final decision on appeal has been rendered or three years from the date the service or supply was rendered to file suit. Suit may not be brought after this period has passed.

Subrogation, Reimbursement, and Third Party Recovery Provision

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of benefits in those situations where an Injury, Sickness, Disease or disability is caused, in whole or in part, by or results from the acts or omissions of a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated Covered Person agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.

3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for any Injury, Sickness, Disease or disability caused in whole or in part by a third party. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.

2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Sickness or Injury to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of the initiation of any litigation and any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his or her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.

3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).

5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Sickness, Injury, Disease or disability.

Covered Person is a Trustee over Plan Assets

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any injury or accident. The Covered Person understands that he/she is required to:

    a. notify the Plan or its authorized representative of the initiation of any litigation within 30 days and also provide notice of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

    b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

    c. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

If at the time of Injury, Sickness, Disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

a. The responsible party, its insurer, or any other source on behalf of that party.

b. Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage.

c. Any policy of insurance from any insurance company or guarantor of a third party.

d. Workers' compensation or other liability insurance company.

e. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person(s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person(s).

Wrongful Death

In the event that the Covered Person(s) dies as a result of his or her Injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

Obligations

In addition to any other obligations specifically set forth herein**,** it is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:

a. To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights.

b. To provide the Plan with pertinent information regarding the Sickness, Disease, disability, or Injury, including accident reports, settlement information and any other requested additional information.

c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.

d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.

e. To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received.

f. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.

g. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Participant may have against any responsible party or Coverage.

h. To ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.

If timely repayment is not made, or the Covered Person and/or his or her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person's amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person to the Plan. This provision applies even if the Covered Person has disbursed settlement funds.

COORDINATION OF BENEFITS

The Plan contains a provision to prevent double payment for covered expenses. This provision works by coordinating the benefits under this Plan with any other arrangements under which a Covered Person may receive payments for medical expenses also covered under this Plan.

When a claim is made under this Plan, it may coordinates with any other arrangements you may have that pays or reimburses a Covered Person for medical services or treatments. If this plan is primary, it pays before any other arrangement pays. If this plan is secondary, the other arrangements pay before this Plan pays. If this Plan is secondary, amount you receive from the other arrangement and the amount you receive from this Plan will not exceed 100% of the Allowable Charge. If this Plan pays first but it should have been secondary, any excess amounts over 100% of the Allowable Charge, taking into account what the other arrangement paid, will be subject to the Plan's right of recovery provision.

The Plan coordinates with other arrangements in accordance with the following rules:

- The plan/arrangement covering the person as an active Associate rather than the plan/arrangement covering the person as a dependent (or a qualified beneficiary under COBRA) is primary.

- If a person is covered as an Associate by two plans/arrangements, the plan/arrangement covering the person the longest is the primary plan.

- If a child is covered by both parents' plans, the plan of the parent whose birthday falls first in the calendar year is considered the primary plan. If both parents' birthday falls on the same day, then the plan/arrangement covering the parent the longest is primary.

- In the case of divorce or separation:

    — First, the plan/arrangement covering the child as a dependent of the parent legally declared financially responsible by court decree is primary.

    — Second, the plan covering the parent who has custody of the child (if there is no court decree) is primary.

    — Third, in the event there is no court decree and the parent who has custody has remarried, the order of priority is:

        - The plan covering the parent who has custody is primary.

        - The plan covering the spouse of the parent who has custody is primary.

        - The plan covering the parent without custody is primary.

If the Plan is secondary in accordance with these provisions, but the primary plan attempts to reduce its responsibility under the primary plan solely because you or your family is covered under another plan, the Plan will only pay benefits under this Plan, in accordance with the maintenance provisions of this Plan, as though the primary plan paid benefits without regard to other coverage you may have.

Medicare benefits will be primary to the extent permitted under applicable law. Individuals who are covered under the Plan based on criteria other than current employment status — e.g. COBRA continuation coverage, certain disabled associates — will have Medicare as their primary coverage. Individuals with End Stage Renal

Disease (ESRD) may be subject to a coordination period during which the Plan is primary, after which Medicare will become primary. As a general rule, if you or your Covered Dependent becomes eligible for Medicare benefits, there are rules that determine whether the Plan pays benefits first, or whether Medicare is primary. If you are an active Associate covered by the Plan, the Plan would be primary for you and your Covered Dependent who is eligible for Medicare (for example, due to a disability or being age 65 or older). If you are disabled and not actively working, the Plan would be primary for you and any Covered Dependents who may be eligible for Medicare for the first six calendar months of your disability period. After the six-month period, if you are not actively working at the Company, Medicare pays benefits first for you and any Covered Dependents (if they are also eligible for Medicare).

In the event an individual is eligible for Medicare due to end stage renal disease (ESRD) and is covered by this Plan, the Plan will be primary during the coordination period (currently the first 30 months of ESRD). Thereafter, Medicare will be primary. Notwithstanding the foregoing, this Plan will coordinate against Medicare to the extent permitted under applicable law. During the time the Plan pays benefits first, you should submit a claim for any remaining expenses not covered by the Plan to Medicare. (Incidentally, you should apply for Social Security disability income benefits as soon as possible to make sure you have no gaps in income protection.) During the time Medicare pays benefits first, you should first submit claims to Medicare for payment. You should enroll in Medicare to the extent that the Medicare would be primary. If Medicare is or would be primary, and you do not enroll in Medicare Parts A and B, the Plan will pay Benefits as though you were enrolled in Medicare.

TERMINATION OF COVERAGE

Coverage will terminate for a Covered Associate on the earliest of the following:

1. The date the Plan terminates or is amended to exclude the Associate or the class of Associates to which the Associate belongs;

2. The date employment terminates except as otherwise specified herein;

3. The date the Associate ceases to be an Eligible Associate;

4. The effective date of your election to revoke coverage during the plan year (see the "Eligibility and Enrollment" section for more details;

5. The last day of the last coverage period for which the full, required contribution was timely received;

6. The date of the Associate's death;

7. The last day of the Plan Year to the extent that the Covered Associate elects (or is deemed to elect) no coverage during the annual enrollment period for the subsequent plan year; or

8. The date on which an Associate or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

Coverage for a Covered Dependent will cease on the earliest of the following:

1. The Date the Plan terminates or is amended to exclude the Dependent or the class of Eligible Dependents to which the individual belongs;

2. The date the Covered Associate's coverage terminates;

3. The date the Covered Dependent enters active service with armed forces of any country;

4. The date the Covered Dependent ceases to be an Eligible Dependent, except that coverage for an otherwise Covered Dependent child who turns age 26 will terminate at the end of the month in which the Dependent child turns age 26;

5. For a Covered Spouse, the date of the divorce or legal separation;

6. The last day of the last coverage period for which a required contribution was timely received;

7. The last day of the Plan Year to the extent that the Covered Associate elects no coverage (or is deemed to not have elected coverage) for the Covered Dependent during the annual enrollment period for the subsequent plan year

8. The date on which an Associate or his dependent submits, or has knowledge of the submission of, a fraudulent claim or any fraudulent information or intentional misrepresentation of a material fact to the Plan, including enrollment information.

An Associate or dependent whose coverage has terminated as described here may have rights to the continued coverage described in the next section, Continuation of Benefits.

CONTINUATION OF BENEFITS

If a Covered Associate ceases active employment due to a temporary layoff or an authorized leave of absence, participation may be continued on the same terms and conditions for a maximum of twelve months, pursuant to procedures adopted by the Plan Administrator and applied on a basis uniformly applicable to all Associates similarly situated.

Where coverage is continued under this provision, it shall run concurrently with any Family and Medical Leave required period.

Continuation During an FMLA Leave

The Family and Medical Leave Act of 1993 ("FMLA") requires employers to provide unpaid, job-protected leave during any 12-month period to Eligible Associates for certain family and medical reasons. This Plan will comply with the law at all times. Please see the Plan Administrator for details of the FMLA policy adopted by the Employer when you need to take FMLA leave.

COBRA Continuation of Coverage

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage.

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage by a Qualified Beneficiary when coverage would otherwise end because of a Qualifying Event. The specific Qualifying Events are listed below. Under the Plan, Qualified Beneficiaries who elect COBRA continuation coverage must pay the applicable premium otherwise required for COBRA continuation coverage.

If you are a Covered Associate, you will become a Qualified Beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced (including when you cease to be an Eligible Associate because you failed to have sufficient Hours of Service during one of the Plan's applicable Measurement Periods),

- Your employment ends for any reason other than your gross misconduct,

NOTE: if you take an FMLA qualifying leave of absence and you choose not to continue coverage, you have not experienced a qualifying event by virtue of the leave. However, if you fail to return from leave as required by FMLA, then your qualifying event date will be the date the FMLA period ends.

If you are the Covered Spouse of a Covered Associate, you will become a Qualified Beneficiary if you lose your coverage under the Plan because any of the following Qualifying Events occur:

- The Covered Associate dies;

- The Covered Associate's hours of employment are reduced;

- The Covered Associate's employment ends for any reason other than his or her gross misconduct; or

- You become divorced or legally separated from your Spouse.

If you are the Covered Dependent child of a Covered Associate you will become Qualified Beneficiary if you lose coverage under the Plan because any of the following Qualifying Events occur:

- The Covered Associate dies;
- The Covered Associate's hours of employment are reduced;
- The Covered Associate's employment ends for any reason other than his or her gross misconduct;
- The Covered Associate becomes entitled to Medicare benefits (Part A, Part B, or both);
- Your parents become divorced or legally separated; or
- You cease to be eligible for coverage under the Plan as a "Dependent child."

When is COBRA Coverage Available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator identified in the Plan Information section of this Booklet has been notified that a Qualifying Event has occurred. When the Qualifying Event is the end of employment or reduction of hours of employment, or death of the Associate, the Employer must notify the COBRA Administrator of the Qualifying Event.

You Must Give Notice of Some Qualifying Events

For the other Qualifying Events (divorce or legal separation of the Covered Associate and Covered Spouse or a Covered Dependent child's losing eligibility for coverage as a Dependent child), you must notify the COBRA Administrator within 60 days after the qualifying event occurs.

How is COBRA Coverage Provided?

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the Qualified Beneficiaries. Each Qualified Beneficiary will have an independent right to elect COBRA continuation coverage. Covered Associates may elect COBRA continuation coverage on behalf of their Covered Spouses, and parents may elect COBRA continuation coverage on behalf of the Covered Children who reside with them.

COBRA continuation coverage is a temporary continuation of coverage. When the Qualifying Event is the death of the Associate, your divorce or legal separation, or a Dependent child's losing eligibility as a Dependent child, COBRA continuation coverage lasts for up to a total of 36 months. When the Qualifying Event is the end of employment or reduction of the Associate's hours of employment, and the Associate became entitled to Medicare benefits less than 18 months before the Qualifying Event that is a termination of employment or reduction in hours of employment, COBRA continuation coverage for qualified beneficiaries other than the Covered Associate lasts until 36 months after the date of Medicare entitlement. For example, if a Covered Associate becomes entitled to Medicare 8 months before the date on which his employment terminates, COBRA continuation coverage for his Spouse and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months). Otherwise, when the Qualifying is the end of employment or reduction of the Associate's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months.

Disability extension of 18-month period of continuation coverage

If a Qualified Beneficiary is determined by the Social Security Administration to be disabled and you notify the COBRA Administrator in a timely fashion, each covered Qualified Beneficiary may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. You must notify the COBRA Administrator before the expiration of the 60-day notice period or the 18 month period, whichever ends first. The 60 day notice period begins on the latest of the following to occur: (i) the qualifying event (ii) the date coverage is lost as a result of the qualifying event and (iii) the date you receive notice from the Social Security Administration indicating that you are determined to be disabled.

Second qualifying event during 18 or 29-month period of continuation coverage

If a Qualified Beneficiary other than the Covered Associate experiences another qualifying event during the 18 (or, if applicable, the 29) month COBRA continuation coverage period, the qualified beneficiary (other than the Covered Associate) can get up to 36 months of COBRA continuation coverage measured from the date of the original Qualifying Event, if notice of the second Qualifying Event is properly given to the Plan. This extension may be available to a Qualified Beneficiary Spouse and/or any Qualified Beneficiary Dependent children receiving continuation coverage if the Associate or former Associate dies, or gets divorced or legally separated, or if the Dependent child stops being eligible under the Plan as a Dependent child, but only if the event would have caused the Spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

If You Have Questions

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) If you have other questions about your rights under COBRA, contact the COBRA administrator identified in the Plan Information section.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator and the COBRA administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send.

Failure to provide written documentation of any of the above events, within the required 60 days will result in loss of continuation rights.

If you do not choose continuation coverage, your group health insurance coverage will end.

If you choose continuation coverage, coverage will be provided which is identical to the coverage provided under the Plan to similarly situated Associates or family members.

The law also provides that your continuation coverage may be cut short for any of the following reasons:

1. The Group no longer provides group health coverage to any of its Associates;

2. The premium for your continuation coverage is not paid in a timely fashion;

3. You become covered by another employer's group health plan;

NOTE: If you become covered by another group health plan and that plan contains a Pre-Existing Condition limitation that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's Pre-Existing Condition rule does not apply to you by reason of credit for prior coverage, your group health coverage may be terminated.

1. You become entitled to Medicare;

2. You extended coverage due to your disability and there has been a final determination that you are no longer disabled.

A child that is born or placed for adoption with the Covered Associate during a period of COBRA coverage will be eligible to become a qualified beneficiary. In accordance with terms of the Plan and the requirements of Federal Law, these Qualified Beneficiaries can be added to COBRA coverage upon proper notification to the COBRA Administrator within 31 days of the birth or adoption.

You do not have to show that you are insurable to choose continuation coverage. However, under the law, you will have to pay all or a part of the premium for your continuation coverage. You will have a grace period of 45 days to pay any retroactive premium for the period from the date continuation coverage starts until the date you choose continuation coverage. You will have a grace period of 30 days to pay any subsequent premiums.

Additional Information

Additional information about the Plan and COBRA Continuation Coverage is available from the Plan Administrator. The Plan Administrator is identified in the Plan Information Section below.

USERRA Continuation of Coverage

If you take a leave of absence protected under the Uniformed Services Employment and Reemployment Rights Act (USERRA) that lasts 31 days or more, you will be entitled to both COBRA continuation coverage and COBRA-like continuation coverage required under USERRA—they run concurrently with one another. USERRA's COBRA like continuation is different from COBRA continuation coverage in the following ways:

1. Your USERRA COBRA-like coverage can extend up to 24 months or the date that you fail to return to work as required under USERRA, whichever is earlier.

2. All COBRA rights end at the end of the otherwise applicable COBRA period. Thus, neither you nor your qualified beneficiary family members may extend the continuation coverage for events occurring outside the 18 month COBRA period.

3. Your USERRA COBRA like continuation coverage may only be terminated during the maximum USERRA COBRA-like period for failure to pay premiums and/or fraud/intentional misrepresentation.

PLAN ADMINISTRATION

The Plan Administrator

The Plan Administrator has the exclusive right and discretion to interpret the terms and conditions of the Plan, and to decide all matters arising in its administration and operation, including questions of fact and issues pertaining to eligibility for, and the amount of, benefits to be paid by the Plan. Any such interpretation or decision shall, subject to the claims procedure described herein, be conclusive and binding on all interested persons, and shall, consistent with the Plan's terms and conditions, be applied in a uniform manner to all similarly situated participants and their covered dependents. The Plan Administrator may delegate certain discretionary authority to one or more persons, entities, and/or committees. For example, the Plan Administrator has delegated the discretion and authority necessary to determine whether Benefits are payable under the terms of the Plan to the Claims Administrator. The Plan Administrator retains all other discretionary authority necessary to administer the Plan, including but not limited to determinations of eligibility for the Plan.

Amendment and Termination

The Plan Sponsor expects to maintain this Plan indefinitely; however, the Plan Sponsor may, in its sole discretion, at any time, amend, suspend or terminate the Plan in whole or in part at any time. This includes amending the benefits under the Plan.

If the Plan is terminated, the rights of covered persons are limited to expenses Incurred before termination. All amendments to this Plan shall become effective as of a date established by the Plan Sponsor.

Expenses

All claims, expenses, or charges for the administration and operation of the Plan are payable by the Plan. The Plan may reimburse the Employer for any plan administration expenses paid by the Employer.

Notices

All payments or notices of any kind to an Associate, Covered Person, beneficiary or Plan official may be mailed to the address for that person last appearing on the records of the Plan Administrator. When such a notice is mailed by first class mail, it is deemed to have been (a) duly delivered on the date post-marked, and (b) duly received three calendar days after being deposited, postage prepaid, in the United States Mail. When such a notice is delivered in person, it is deemed to have been received the same day as delivery. Each Covered Person must keep the Plan Administrator notified of his current address. If there is doubt about the accuracy of an address, the Plan may give notice, by registered mail to any such person's last address, that payments and other mail are being withheld pending receipt of a proper mailing address from that person.

Other Statements

This written document and any later amendments to it constitute the complete and only statement of the Plan and cannot be changed by any oral or other written statement regarding the Plan.

ERISA Rights

As a Covered Person in the Plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all Covered Persons are entitled to:

Receive Information About Your Plan and Benefits
Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts (if any) and copies of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts (if any), and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan 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 Covered Person with a copy of this summary annual report.

Continue Group Health Plan Coverage
Continue health care coverage for yourself, 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.

Prudent Actions by Plan Fiduciaries
In addition to creating rights for Covered Persons, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Covered Persons and beneficiaries. No one, including your Employer 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.

Enforce Your Rights
If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 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 which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, a Medical Child Support Order or a National Medical Support Notice, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who would 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.

Assistance with Your Questions
If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest Office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

PLAN INFORMATION

Plan Name

The medical and dental benefits described herein are a component of the Hamilton Health Care System, Inc. Group Benefit Plan

Plan Number

501

SFP Number (for use by Claims Administrator)

S-2586

Plan Sponsor

Hamilton Health Care System, Inc.
1200 Memorial Drive
Dalton, Georgia 30722
706-272-6000

Tax Identification Number

58-1519913

Plan Administrator

Hamilton Health Care System, Inc.
1200 Memorial Drive
Dalton, Georgia 30722
706-272-6000

Employer Company

Hamilton Medical Center, Inc.
Hamilton Emergency Medical Service, Inc.
Royal Oak Community, LTD
Whitfield Place, Inc.
Hamilton Long Term Care, Inc.
Hamilton Physician's Group, Inc.

Benefit Services Manager/Claims Administrator

Medical/Dental
Gilsbar, Inc.
P.O. Box 998
Covington, Louisiana 70434
Telephone (985) 892-3520 or (800) 445-7227
Fax (985) 898-1500

www.myGilsbar.com

HRA Claims Administrator
Omni Group, LLC
9613 Brookline Ave.
Baton Rouge, LA 70809
Telephone (800) 375-6664
Fax (888) 926-6428

COBRA Administrator

Gilsbar, Inc.
P.O. Box 998
Covington, Louisiana 70434
Telephone (985) 892-3520 or (800) 445-7227
Fax (985) 898-1500

Type of Plan and Administration

This Plan is a self-funded group medical plan subject to ERISA.

Plan Year

January 1 through December 31

Plan Cost

All Benefits and expenses under the Plan are paid first with plan assets and then, to the extent necessary, with Employer Company contributions.

Agent for Service of Legal Process

Service of legal process may be made upon the Plan Administrator.

Plan is Not an Employment Contract

The Plan shall not be deemed to constitute a contract between the Employer and any Associate or to be a consideration for, or an inducement, or condition of, the employment of any Associate. Nothing in the Plan shall be deemed to give any Associate the right to be retained in the service of the Employer or to interfere with the right of the Employer to discharge any Associate at any time; provided, however, that the foregoing shall not be

deemed to modify the provisions of any collective bargaining agreement which may be made by the Employer with the bargaining representatives of any Associates.

ELIGIBLE RETIREE APPENDIX

The Plan provides the benefits for certain eligible retirees, as described in this Retiree Appendix. This Retiree Appendix is incorporated into and made a part of the Hamilton Health Care System, Inc. Group Benefit Plan Summary Plan Description. The terms and conditions set forth in this SPD apply to Eligible Retirees and their Eligible Dependents the same as they apply to Covered Associates and their Covered Dependents *except* as specifically described in this Appendix.

Eligibility and Enrollment for Eligible Retirees

A. Eligibility

Covered Associates who, at the time that they voluntarily terminate employment with the Employer Company, are at least 55 years old and less than 65 years old, and have completed 15 years of continuous service with the Employer are eligible to participate in the Plan provided they make a timely election. Length of service will be calculated based on the Associate's hire date, as determined by the Employer.

An Eligible Retiree who enrolls may also enroll individuals who satisfy the definition of Eligible Dependent as described in Section III of the SPD.

Associates involuntarily leaving employment with Hamilton for cause will be ineligible for Retiree designation and will not be entitled for Retiree medical, dental and vision coverage at the Hamilton retiree rate.

Retirees are also eligible for Bradley Wellness Center associate level memberships.

B. Enrollment

You will be provided an enrollment opportunity prior to last day of employment. You must enroll during the applicable enrollment period or you your right to enroll in retiree medical coverage.

Once enrolled, a Covered Retiree may add Eligible Dependents during the annual enrollment period or during a special enrollment period in the same manner as Covered Associates. See Section III of the SPD for more information on adding Eligible Dependents during the annual and special enrollment periods.

C. Interaction between Retiree Medical and COBRA

Upon retirement, Eligible Retirees will be given the right to elect COBRA continuation of active coverage if there is any difference in premiums or benefits between active and Retiree coverage. However, if you elect COBRA, you waive your right to elect to participate in Retiree medical coverage under the Plan.

Contributions

You will be required to a pay all or a portion of your and your Covered Dependent's retiree medical coverage. The Employer will provide you with information concerning the cost of coverage with your enrollment material.

Benefits

Except for contributions, Covered Retirees and their Covered Dependents are eligible for the same benefits as Covered Associates. NOTE: If you are eligible for but do not enroll in Medicare, the Plan may pay benefits as though you are enrolled in Medicare.

Termination of Coverage

Coverage for a Covered Retiree ends as of the date that the Covered Retiree becomes eligible for Medicare Part A for any reason unless and to the extent that Medicare is required by law to be secondary (e.g. during the ESRD coordination period). Coverage for that Covered Retiree's Spouse and other Covered Dependents will continue until such time as the Spouse becomes eligible for Medicare. Otherwise, coverage for a Covered Dependent ends for the same reasons any other Covered Dependent. See Section XIV for more information on when a Covered Dependent's coverage terminates.

Covered Dependents may be eligible for COBRA continuation of the retiree coverage if they experience one of the qualifying events applicable to Spouses and Dependent Children (e.g. divorce, dependent ceasing to be an Eligible Dependent), as described in Section XV of the SPD. Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to the Employer, and that bankruptcy results in the loss of coverage of any Covered Retiree covered under the Plan, a Covered Retiree will become a qualified beneficiary with respect to the bankruptcy. The Covered Retiree, covered Spouse, and Covered Dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan and COBRA will be provided in accordance with applicable COBRA law.